Housing an ageing population: lessons from North America

A report for the Winston Churchill Memorial Trust
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Firstly, thanks to the **Winston Churchill Memorial Trust** for funding my project and supporting me in such an incredible journey; it was the opportunity of a lifetime.

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I must also acknowledge the exceptional warmth and hospitality offered to me from the organisations I visited during my travels in America and Canada. All of the individuals I met demonstrated enthusiasm, passion and outstanding expertise. Some even entertained me socially, transported me and showed me the sites - this exceeded all expectations and was very much appreciated. Thank you.

Thanks also to my employer, the **Northern Ireland Housing Executive**, which has proven an exciting and inspiring organisation in which to work over the past 5 years. My experiences to date have given me the knowledge, interest and drive to complete this project.
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The background…

The population in the UK and Ireland is ageing. This is a positive demographic shift, reflecting the wonders of modern medicine and progress of humanity. Yet, somehow the challenges associated with an ageing population distract us from the progress it denotes and the opportunities it offers. It could be a catalyst for regeneration initiatives, innovation in housing design, better public transport and infrastructure, and safer, more accessible public spaces. Often the ‘elephant in the room’, though, people don’t generally want to talk about ageing. Nonetheless, it’s time to have the conversations, and to plan for success.

For the past five years I have been working for the Northern Ireland Housing Executive, the Regional Strategic Housing Authority for Northern Ireland and landlord of around 90,000 homes. In this time I have become aware that housing is one of the biggest concerns of people as they age. The Housing Executive has commissioned considerable research over the past few years on the issues surrounding this, including the role of sheltered housing, care and repair options, an analysis of the future needs of older people, equity release opportunities, electronic assistive technologies, the demand for retirement villages and a review of the housing related information needs of older people. This, along with research produced by government agencies, not-for-profits, charitable organisations and

- Population ageing refers both to the ageing of the population and the increasing number of people reaching older age
- Between 1985 and 2010 in the UK the number of people aged 65 and over increased by 20% to 10.3 million
- In 2010, 17% of the UK population were aged 65 and over
- Between 1985 and 2010 the number of people aged 85 and over in the UK more than doubled to 1.4 million
- Between 1985 and 2010 the percentage of the population aged 16 and under in the UK fell 2% to 19%
- Population ageing is projected to continue for the next few decades. By 2035 the number of people aged 85 and over in the UK is projected to reach 3.5 million which will be 5% of the total population
- By 2035 the UK population aged 65 and over is expected to account for 23% of the total population
- In contrast to these growing trends, the proportion of the UK population aged between 16 and 64 is expected to fall by 6% to 59% of the total population and 64 is expected to fall by 6% to 59% of the total population.
academics across the UK, and indeed globally, represents positive progress and a sound evidence base on which to build policies and strategies for the future.

My (not entirely unselfish) aspiration for Northern Ireland is that it will be the best place in the world to grow old. Having joined the housing world in 2008, I hope to contribute to improving housing options and opportunities for older people. This being the case, I applied to the Winston Churchill Memorial Trust in 2011 for funding to complete a project entitled ‘Housing an ageing population: lessons from North America’ and was delighted to be successful. I hoped that lessons could be learned from developments in the USA and Canada, where the baby boomers are now hitting retirement.

Research has shown that the preference for the vast majority of people is to remain living in their own homes as independently as possible as they age. I was keen to discover how ageing in place is facilitated in the USA and Canada as well as learn about the housing options for those who wish/need to move.

During my six week fellowship I visited Washington DC, New York, Boston, Vermont, Toronto, Montreal and Quebec where I met with housing professionals (from the private and public sectors), academics, charitable organisations and non-profits. It was fascinating, exciting, challenging and hugely rewarding; this report seeks to share my highlights and key points.

**The Village Model...**

Some of the most exciting projects I encountered during my travels were ‘Villages’. This model was something that appealed to my sense of community and seemed to me highly applicable within the UK, both in rural and urban settings. It has really taken off in America. The concept began in Beacon Hill in Boston in 1999 when a group of over 50s joined together to help each other to remain in their own homes as they age.
The idea was that members of the community would actively take care of themselves and each other rather than passively being ‘taken care of’. In 2002, a membership organization was formed wherein members pay an annual fee to gain access to a wide range of information and services through the Village office. Some activities are free of charge to members such as social events, walking groups and fitness programmes, others are pay as you go. Some services are delivered by volunteers, many of whom are also members, and others are delivered by Village partners who are vetted and often offer discounts to members. Volunteers can assist in providing members with transport to medical appointments, shopping, walking the dog, and ‘light’ gardening or household chores. In most Villages members range from age 50 all the way to centenarians. Some families buy membership as a gift for a relative and this can offer reassurance to both parties, especially where they do not live nearby.

There are now around 65 sister villages in operation and a further 200 in development across the country. Australia has developed two Villages also, as have Canada and the Netherlands. I visited Villages in Washington DC as well as Beacon Hill and discovered that, while all are largely organised around a basic model, each forges its own path in accordance with the particular needs and spirit of its community. Beacon Hill has created a Village to Village Network whereby villages can share ideas and best practice. I met with Judy Willetts, Executive Director of Beacon Hill Village who has travelled around the world promoting the concept. She believes that the key to the Village idea is demographics. It will work where there are likeminded people with a similar economic profile in reasonable density with places they can go in groups to socialise. It would not, in her view, work so easily in a sprawling
suburb, for example. She noted that the next generation of older people, whilst generally holding less savings than the current cohort, are more accustomed to using services; they don’t mind paying for something as long as they get value for money, and they generally accept the Village as an efficient model.

I visited two Villages in Washington DC; Capitol Hill Village and North West Neighbours Village. The Executive Director of Capitol Hill Village was Katie McDonagh, a social worker by profession and someone whose commitment to and enthusiasm for the project was remarkable. She gave me copies of their publications and literature – all completed in a little basement office in a leafy residential street within the Capitol Hill area of DC. A very professional and efficient operation, services are coordinated by Katie and delivered by a host of local volunteers. She explained there are many civic minded individuals of all ages living and working around Capitol Hill with a huge range of skills on offer. This is an area of Washington DC with a great history of voluntary work and so the Village concept has worked well here. Katie noted that around 50% of members are volunteers, which is really positive since there is a wide body of evidence which suggests voluntary work contributes to an improved sense of wellbeing and self-esteem. Many retirees find themselves at a loss, with a much reduced social circle. It is important for people to retain a sense of purpose and social life post retirement. The Village model facilitates all of these added benefits as well as meeting practical needs. Katie described it as the lynch pin of the community, connecting people and services. There are no other housing options within the community for older people in the Capitol Hill area – no assisted living schemes or nursing homes.

This Village has been operating since 2007 and at the time of my visit had 360 individual members and 255 households. The most popular service used by members here is transportation to medical and other appointments as well as help with shopping. They offer a medical advocacy service too where a
volunteer will accompany a member to a medical appointment and ensure that the client is clear about the information given. Often people attending medical appointments are stressed and do not ask questions or fully take in all of what is said so the advocate takes notes and asks relevant questions. As mentioned Katie is a qualified social worker and, as such, can help coordinate care services for members who may otherwise be battling alone in a system which can be cumbersome and disjointed. Also popular are the social events which are generally intergenerational. These range from dances, to coffee mornings, to parties at Christmas etc. Katie explained that they carefully vet any vendor services through the ‘Better Business Bureau’ before connecting clients with them and that they also carry out background checks on volunteers as standard. They hold orientation days four times a year for volunteers and members to make sure that everyone is clear on the system and the services available and to discuss new ideas for service improvement and development. In terms of financing 65% of Capitol Hill Village’s operating expenses are funded through membership fees and the remaining 35% is raised through a combination of fundraising and donations. The annual fee for an individual member is $530 or $800 for a household. They also offer a ‘membership plus’ option for low income households, the charge for a qualifying individual being $100 per year or $200 for a household. There is a separate fundraising stream to cover the costs of this.

Katie highlighted a number of challenges for the organisation, the main one being long term financial sustainability. They hope to be able to grow their
membership but note that many people don’t plan for old age and it is not until faced with a crisis that they reach out for help. She would like the Village to become an expert within the community on ageing in order to support their members to age in place and retain their independence for as long as possible.

Another village I visited in Washington DC was the North West Neighbours Village. The Executive Director there is Mariana Blagburn, an anthropologist by profession, and another hugely impressive and interesting character. She has concerns that in America, in general, people don’t talk about getting old and, therefore, don’t plan for it and are, thus, unprepared mentally, economically and in practical terms (I don’t think this is just the case in America). She believes we all tend to bury our head in the sand a bit when it comes to ageing because it makes us uncomfortable. But, unless we make plans we make it more difficult for ourselves and our families in the longer term.

This Village model is largely similar to that in Capitol Hill, albeit smaller (125 members and 90 volunteers). It is consumer driven, largely dependent on volunteers and a solid social network. It offers the same sorts of services as the others and connects members with vetted tradesmen/services as required. They have a ‘Buddy Alert’ programme which can be used in the event of an emergency such as the recent hurricane – basically this is a phone tree where I phone two people, who each phone two more, who each phone two more, and so it continues until it has been established that everyone is safe and well. Social activities organised by this Village have included picnics, soup salons, book
club, and an oral history project where the members relate stories from the past with younger generations. They also offer educational programmes where they share knowledge of scams, local services information and facilitate ‘difficult conversations’ about ageing which, Mariana believes, can reduce feelings of isolation, loneliness or despair. Volunteers at the North West Neighbours Village must take a mandatory three hour training course which covers, among other things, the psychosocial aspects of ageing.

It is Mariana’s view that scale is critical to the success of the model – if too small, it will not be financially viable and cannot offer rapid response services; if too large, it loses its person-centred ethos. She also emphasised the golden rule that Villages in DC do not compete with each other. Rather they work together, sharing best practice and ideas through the Washington Area Village Exchange (WAVE). Importantly, Mariana recognises that Villages cannot be all things to all people and must be clear in their messaging. This one offers non-medical support to older people who wish to remain living in their own home. It does not offer case management or any form of health assessment. Their current priority is to expand their membership by building their knowledge base and reputation. I’m sure they will succeed.

For me the beauty lies in the simplicity of Villages. They are grounded in a sense of community where people care for each other and strive to enhance each other’s lives. The model is very applicable, I believe, in Ireland, across the UK, and indeed Europe. It enables communities to help themselves. And, although those I visited were in urban settings, I see no reason why a tailored version with good coordination would not work in rural communities, where there are often no alternatives to ageing in place. In many communities, people already help and support each other; this model simply structures this. In the USA no government help was given to the concept yet it has managed, not only to work
but to grow. It is helping thousands of people remain in their own homes when they so wish.

**Housing and health...**

The links between housing and health are well established. It is in the mutual interests of housing and health departments to collaborate effectively. Falls among older people are all too common, often resulting in hospitalisation. It is estimated that falls affect one third of people over 65 in the UK and around 40% of those over 80, costing the NHS billions every year. Often they occur in the home and there are simple interventions which can help prevent them. These can include improved lighting, vigilance in terms of spotting and removing trip hazards, and even physical exercise to improve coordination and balance. There is a role for housing providers in the preventative agenda and in GB care and repair and home improvement services have grown in recent years. In Northern Ireland there is scope for the development of such services. Preventative measures of this kind will certainly help to reduce hospital admissions but realistically many older people will still require hospital care at some stage. Once hospitalised, the transition to another care setting or back home can be difficult on many levels.

I spent time with Leyla Sarigol, Project Director of the DC Money Follows the Person programme at the Department of Health Care Finance in Washington DC. She highlighted the difficulties around transitions from hospital to housing in the community and explained the programme’s mission is to obtain a "...system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual’s needs and preferences change”. Clearly, there is a very different health care system in the US and I confess I did not fully grasp the
complexities of Medicare. The Money Follows the Person Programme was a work in progress at the time of my visit. It has been fraught with difficulties, as yet unresolved. Leyla expressed frustration at how the housing and health worlds do not speak the same language, and often have different pressures and priorities. In DC they are looking at ways to share IT systems and set common targets for the various agencies to try to improve collaboration. Her department recognise that large scale social change comes from better cross-departmental coordination; it cannot be achieved through the isolated intervention of an individual organisation.

At this visit I heard about some best practice initiatives from across the country which sought to improve the transition of people from hospital to home or to improve the collaboration of housing and health care services to the ultimate benefit of customers. One which particularly impressed me was the ‘Community Connections’ project in North Carolina. It began in a development called ‘Carol Woods’ in Orange County. The community initiated collaboration between primary, acute and long-term care providers, community organisations to try to ensure older people could avail of the services they need in a timely and straightforward fashion. This is how they did it. In 2004 a Master Ageing Plan was developed for the County. It identified the services required to meet the needs of the current and future ageing population. One of the main issues it pointed to was the transitional difficulty older people face when moving from different care settings as their health requirements and support needs change.
In 2006 the Carol Woods development was awarded a grant of around $1 million to develop the community infrastructure to educate customers about local service options, improve communication and collaboration between social service and medical organisations, coordinate services to avoid fragmentation and duplication, and develop innovative transitional care supports. Interestingly, they found that it wasn’t really necessary to develop new services for the older community – most of what was required existed in some form or other – but it was piecemeal, lacking in overall direction, and many older people were unaware of what was available. Thus, the focus for Community Connections switched from service development to service integration and education. At an early stage in the process the team held a two day consultation event which drew in around 90 stakeholder groups from the public and private sectors. Together they mapped the current service provision, identified barriers to effective services, prioritised required actions and set up working groups to address the challenges. By way of example, a ‘Patient Advocacy at Transitions’ working group was set up which introduced some simple but effective procedures to improve transitions. One was that follow up phone calls are made to older adults post hospital discharge. Another is that those in the hospitals who are responsible for discharging patients are educated about services available within local communities which may be of help to them as they readjust to home life. There was also a working group set up to deal with outreach. They organise an annual ‘Resource Connections Fair’ to publicise information on
local services to residents. They also encourage agencies to cross-train staff so that they have a broader understanding and knowledge of services offered.

Community Connections has also helped to establish Community Resource Connections for Ageing and Disabilities involving around 20 local agencies. These aim to connect older people and/or people with disabilities to information on available support services. Unfortunately time did not allow me to visit this project in North Carolina but it is an example of what can be achieved through the appropriate investment of resources, listening to and understanding customer needs, and strategic planning and collaboration between agencies to meet these needs.

**Cathedral Square, Burlington, Vermont...**

I spent a week in beautiful Vermont. It is estimated that by 2017, one in every three Vermonters will be 55 and older and that there will be a 42% increase in the number of older people with a disability living in a community setting. Thus, there has been action to prepare and improve services for the older population across the state. In Burlington I visited the Cathedral Square Housing Corporation, about which I had read before travelling. I had corresponded with Jen Still (Manager of Compliance and Occupancy) before travelling; she was very helpful and enthusiastic about the scheme. I visited their assisted living residence in downtown Burlington where residents have their own private apartments whilst also having access to a range of support services 24/7. They have developed a ‘housing with services’ model by joining with other housing providers and LeadingAge to offer services to residents who wish to age in place. The model
has become known as SASH (Support and Services at Home). Housing providers not only manage the properties as landlords but help monitor the health and well-being of older residents and coordinate the services required to support independent living. In developing the model, Cathedral Square included the elderly residents in the design process (seen as key) from the very beginning and at all stages. They created a SASH site team comprising a number of individuals from a range of agencies. These included a coordinator, a nurse employed by the housing body, an acute care nurse (assigned by the Visiting Nurse Association), a case manager provided by the Area Agency on Aging (AAA), an ‘intake nurse’ from the Program of All-Inclusive Care for the Aging (PACE), a community mental health worker and representatives from other community organisations. The University of Vermont also placed students from health disciplines at the site.

Really the SASH coordinator has proven key to the success of the project, I’m told. It is they who keep things going, monitoring the needs of residents, including those in or discharged from hospital or nursing homes. Additionally, they are charged with training staff from the housing body, from managers to caretakers, to observe the resident behaviour and highlight to the SASH team changes in health which may warrant further investigation. The housing body’s nurse plays an important role too. She calls with residents checking vital signs and helping manage their medication.

A robust system is in place to facilitate the project aims. When a resident joins the SASH programme they are assessed by the team. Based on this assessment an ‘Individual Healthy Aging Plan’ is developed to identify goals for health improvement, e.g. more physical exercise, better diet, losing weight. The client is provided with information and support to help them realise their goals. Further to this a ‘Community Healthy Aging Plan’ is developed for the residents as a group. The SASH team programmes actions and interventions to meet the
needs of the community as a whole. I heard, for example, about the ‘Eat Less, Move More’ programme which formed part of the pilot because assessments showed many residents were not eating well and were not getting regular exercise. Whilst individuals may be reluctant to change eating habits or exercise alone, it seems when peer pressure is applied and they are part of a community action plan they make more of an effort and support each other. The team meets regularly to discuss progress and resolve any issues arising.

An important element has also been ‘buy in’ at a high level from each of the representative agencies. The SASH team is linked with an umbrella group known as the ‘Local Table’ comprising senior managers from the various participating organisations. This group meets bimonthly to update partners on relevant strategic developments in their respective organisations as well as monitor the progress of the project.

The SASH pilot ran for one year and achieved some considerable benefits:

- 19% reduction in hospital admissions among residents in the scheme
- 22% reduction in falls
- 19% reduction in the number of residents at moderate nutritional risk
- 10% reduction in physically inactive residents

SASH is generally considered to offer good value for money and deliver savings through the reduced hospital admissions etc. Additionally, the various partners involved recognise its value and find it helps them deliver their own objectives more effectively. The initiative is currently being rolled out across the state to other housing schemes and hopes eventually to be able to branch out into the wider community. The key to its success was the effective collaboration of housing and health professionals. This depended on commitment at the highest level in the agencies concerned and the development of common/joint targets.
Selfhelp Community Services, Inc...

In New York I was fortunate to spend time with Self Help Community Services, Inc, an award winning not-for-profit organisation which is leading the way in terms of seniors housing in the USA. When I arrived in their Flushing campus in Queens I was delighted to encounter their Virtual Senior Centre. Again the beauty of this project is its simplicity. I was taken into a small room with a group of older people sitting round a table having a music lesson. This in itself was great fun but what was special was that on the wall in front of the instructor was a computer with a split screen showing the happy faces of around 6 other housebound older people joining in via the internet. I was able to chat to those in the room as well as those in their homes and it was clear that this simple facility had provided a lifeline to many of them who had previously been very isolated.

Selfhelp have been running IT classes for older people for about ten years and these have helped people learn how to communicate online with relatives living far away as well as browse the internet and shop online. Following on from this, and in partnership with Microsoft and The City of New York’s Department for the Aging, they initiated the Virtual Senior Centre project. In the Senior Centre in Flushing, Queens, video cameras and monitors were installed so that the housebound seniors could watch and take part in the activities from home. The homes of the six individuals who piloted the project were fitted with
a computer, large touch screen monitor, video camera, microphone and connected to the internet. The staff at Selfhelp are clearly very proud of this project and have learned many lessons along the way. They are continually looking to expand into new areas and suggested if we set something like this in Northern Ireland they could link up clients for international friendships and discussions. What a great idea!

One very charming gentleman I talked to was Milton, aged 86, who has become the organisation’s poster boy for the Virtual Senior Centre. His life has been totally transformed by the project. Milton explained that before getting involved with this technology he was ‘alone with nothing to do’. Through the virtual centre he can get involved in discussions on current affairs as well as classes on a range of subjects. He told me he loves music and can now use the web to listen to Frank Sinatra and Dean Martin when he chooses. He is also a big fan of online shopping. His daughter who lives in a different state visits once a week. She used to spend most of her visiting time out at the supermarket collecting his groceries. Now he does his own shopping so she can spend time with him which he values more. Milton says he has more friends now than he had 20 years ago and that he loves to encourage others to get online and change their lives. The staff also told me about Adele, an inspirational character who, at 104 years of age, got involved in the project. Adele ‘skypes’ her daughter in California every morning and is completing a computer graphics techniques course through the centre which she hopes will enhance the fine arts degree she earned at age 83! I’m told Adele’s mantra is “if you learn something new every day, you will stay young”. Incredible.

Selfhelp’s Director of Technology Services, David Dring (who incidentally had worked for a number of years in Northern Ireland on the A2B project) was hugely passionate about his job. He explained that for them the important thing is to have client centred services. This way, he believes, you can’t go wrong as
you are catering for actual needs based on research and feedback rather than providing services that you guess people need or should have. In the seniors centres they have found that the WII has been a big hit and really improves the quality of life of the attendees. It helps them achieve healthier bodies and minds, improved hand-eye coordination, better reflexes and balance as well as increased social interaction. They hold centre-based as well as regional championships. It is likely that the next generation of older people who are generally more ‘digital’ will, not only enjoy but, expect this type of facility.

Selfhelp has also been piloting Remote Monitoring. This Quietcare technology is non-invasive – it monitors activities in a home in a passive way through motion detectors. It identifies patterns and can then pick out exceptions, raise an alarm where necessary so that checks can be carried out. So, for example, if there is unusual activity in the middle of the night, the red flag is raised and someone attends the property to investigate. This technology costs $80 per month and at the time of my visit around 100 individuals were using it. Clearly, not all households can afford this technology so it is David’s hope that the welfare system may subsidise the cost for low income households who require it in the future.
This company is into Telehealth in a big way and has recently introduced a congregate system. In the common rooms of their housing schemes they are installing pulse oxymeters, blood pressure cuffs, and scales to encourage residents to be more proactive about their health. It is perceived that the immediate feedback offered is an incentive for change. David explained it using ‘the Prius analogy’. Apparently, in Toyota’s Prius cars there is a monitor on the dashboard which tells you how much fuel you are using while driving, i.e. how efficiently you are driving. There is evidence that such immediate feedback actually changes how people drive – less unnecessary revving of the engine, smoother take off and braking etc. David believes that if people make lifestyle changes and see positive results they are more likely to sustain these. Equally, if they become aware that, for example, they have high blood pressure they can take steps to try to get this under control and can monitor it as frequently as they choose. There is evidence that re-hospitalisation rates are lower for their Telehealth users and that satisfaction levels with the technology is high.

They also offer health education programmes and have physical exercise classes in their senior centres. They run a Home Health Programme for private clients and provide services to four naturally occurring retirement communities (NORCs) too. In all they own and manage six large apartment blocks housing in excess of 1,000 elderly
residents. The seventh was under construction at the time of my visit and will be a ‘smart building’, i.e. entirely kitted out for all manner of digital technologies. At Selfhelp they believe that the baby boomers hitting retirement now are more at risk of social isolation that their parent’s generation. This is because nowadays many children move away from their home town or even country. It seems that more adults than ever are living alone and so they believe there is a huge future role for technology-based solutions and interventions to support ageing in place. They would like to collaborate with other organisations with similar goals and expertise to expand work in this area and share lessons learned. There is a lot of potential for growth in this area.

It is important to acknowledge the very interesting work going on in the UK and Ireland around assistive technology too. For example, Fold housing association in Northern Ireland is a leader in Telehealth services, constantly developing their services and enhancing their customers’ lives. Additionally, the CASALA living laboratory in County Louth offers early stage development and testing in a world-class virtual environment and a reconfigurable home-in-a-lab. It is unquestionable that technology will play an important role in supporting older people to retain independence and enjoy social interaction and a good quality of life in the future. Whilst costly, there are assistive technologies constantly developing to help those with dementia maintain a level of independence. The Dementia Services Development Centre based at the University of Stirling offers a first class information resource for those involved in designing and delivering services for those with dementia. Indeed the Iris Murdoch building (which can be viewed online) serves as an example of best practice and innovation in this field. With increasing numbers of dementia patients it is important to develop this work. We should maximise opportunities for the sharing best practice internationally.

Private sector opportunities…
In Boston I met with Dr. Eric Belsky, Managing Director of the Joint Center for Housing Studies at Harvard University. It was interesting to get an academic perspective on the housing landscape. He noted that people tend to be in their 70s typically when they make decisions about their housing (one quarter of this age group have moved house in the last 10 years). Often such moves are made out of necessity rather than choice and the choices are often limited; retirement villages tend to be expensive, as are assisted living schemes (Medicaid does not provide care for assisted living unless using a waiver), reverse mortgages as a means of releasing equity from the home are not popular, families are no longer inclined to take in elderly relatives, and public/affordable housing is limited - catering only for the poorest. He noted that there is a significant amount of capital deploying into the private seniors housing market across the USA. This is because it is seen as needs driven, and, therefore, a safe investment. Compared with other floundering areas in the real estate market, seniors housing continues to perform well. He also noted that whilst independent living units used to be the preference, increasingly assisted living schemes are viewed as a more secure option by investors. Again, this is because it is dependent on people’s needs, rather than their aspirations or choices.

So, what exactly is ‘assisted living’? In general assisted living communities comprise between 40 and 120 units, typically studios or one bed apartments. Residents can come and go as they please. Meals are served in a dining room with a restaurant style so that individuals can choose what they want. Within the facility there may also be a library, gym, games room, hairdressers, café and TV lounge. Care is provided as per the resident’s particular needs. This may include medication management, help with washing, dressing, grooming, and getting the person in and out of bed. Assisted living is not suitable for clients with a high level of care needs such as those with advanced dementia, or who require more than one person to assist them to move around. Basically, it caters for those who require a low level of support but who wish to retain a degree of
Residents do not sign a long term lease but rent the unit on a month to month basis. Medicare does not cover costs for assisted living schemes; normally it is those with long term care insurance, or a property to sell, who avail of this type of accommodation. Is there a market in the UK and Ireland for more of this type of housing? I believe there is; we should be seeking to attract more private sector investment into this market.

David Stenhouse, a previous Churchill Fellow, recently carried out research specifically looking at retirement villages in the USA and their applicability in the UK (his report ‘American Residential Retirement Communities: a model for the UK?’ can be found at www.wcmt.org.uk). He has written a very comprehensive report outlining his findings which I do not wish to duplicate. In Canada I visited private sector retirement communities and was surprised by what I found. I had expected vast communities with sprawling gardens, tennis courts, golf courses and bowling greens. Undoubtedly such places do exist across North America for the very well off, but those I visited were high rise apartment blocks clustered together in relatively small and low maintenance gated communities. The photo below shows the Faubourg Giffard residence in Quebec City, run by Allegro Residences, one of Canada’s largest providers of independent and semi-independent retirement residences. The apartments were finished to a high quality and there were good facilities on site. These included a swimming pool, spa, billiards room, library, dining room and a pharmacy. There was a nurse on site 24/7 and various care options.
including medication management were available. The main selling points were security and convenience. The Faubourg Giffard apartments were for rent but others offer accommodation in a range of tenures. Many retirement villages/communities now include ‘continuing care’ services which mean that on site there are also assistive living units and nursing homes to which one can move if and when that becomes necessary.

These types also exist in the UK, mainly in England, where there are some state-of-the-art examples. They have not been developed to date in Northern Ireland, although we do have naturally occurring retirement communities (NORCs) and a small number of private apartment complexes for the over 55s. Whilst housing complexes exclusively for the over 55s do not appeal to everyone, there is a market for them. In a good location, with a good balance of services developed on the basis of solid market research they have proven to be very successful.

**Cambridge Housing Authority…**

Dr. Belsky, at Harvard, put me in contact with Greg Russ, Executive Director of Cambridge Housing Authority, who I was advised knows everything there is to know about public housing in America. Clearly there are differences in the physical design of buildings there; many of those I saw were huge high rise blocks, not always aesthetically beautiful but practical and generally well maintained. It struck me that scale is one of the big differences in terms of social housing for seniors in the USA and here; the types of associated services
on offer are similar. Greg explained that the norm for public seniors housing is for the housing authority to construct it but to contract the management out to experts in seniors’ care, in this case Senior Living Residences Services. Public housing in North America is generally for low or moderate income households only. Cambridge Housing Authority has around 1,100 units of housing for the elderly in Boston. Healthcare, support services, education and social activities are offered in most of the developments and some include a couple of floors offering what they described as ‘assisted living lite,’ i.e. with meals and 24-hour care services for the frail elderly.

Greg’s perception is that many older people don’t know what types of housing and/or services are available or how to access them. This came up as a repeated theme in the various organisations I visited in both Canada and USA. It seems that housing and housing related information is not widely available in an accessible format to older people. I was initially surprised because, when researching organisations to visit during my trip, I was struck by the wealth of information available online compared to here. But many of today’s older people do not habitually use the internet. Of course, for future generations the internet will represent an invaluable resource. But at the moment there is, it seems, a communication breakdown. The response by housing authorities across the pond has been to employ service coordinators, sometimes social workers, to help connect individuals with the services they need. They believe the best way to ensure effective communication with older people is by face to face contact. Cambridge Housing Authority employs an Elder Services team which includes service coordinators who help link up their tenants with local services and programmes which may be of benefit to them. The approach works well for them and they see it as money well spent as the team helps sustain tenancies and sort out benefit entitlements, thereby ensuring rent arrears due not accrue unnecessarily.
Toronto Community Housing...

I found the same issues in Toronto where I visited blocks owned and managed by Toronto Community Housing, one of the largest social housing providers in North America. TCH accommodates in excess of 26,000 seniors (59 years or older). Many of them have aged in place in general needs units which are no longer adequate for their needs. 6,500 are 80 years or older. Staff at TCH highlighted the same communication difficulties as elsewhere and were excited that a seniors centre had recently opened to serve residents in two of their seniors’ apartment blocks in the Bloor Street area. This is run by a charity, Loyola Arrupe, which has a wealth of experience in this field. They offer social, educational and health improvement programmes to residents. They hope this centre will help breakdown the information barrier. Again, partnership working to provide required resources is proving it can bring solutions to the challenges faced.

Something different...

In Canada I came across a couple of housing types which I had not encountered in America. One was the ’mingle apartment’, and the other ’Life Lease’ housing. Mingle apartments are two independent suites with a shared entrance and shared kitchen and living areas. They are becoming increasingly available in Toronto and offer the best of both worlds to lone pensioners – independence but at the same time the security and social aspect offered by sharing. These appeal to some because they can be in a diverse community, not a large seniors-only complex.
Life Lease offers affordable housing for those over 65s who have capital to invest. In this option a resident neither rents nor owns the dwelling. They purchase an exclusive ‘Right to Occupy’ which includes occupation of their suite and use of common areas, parking etc. Life Lease schemes are developed and managed by non-profits, be it a housing association, church or faith group or other. Residents make an initial investment towards the construction of the project and then upon completion pay the balance. Then they pay a monthly fee to cover running costs. Ownership of the overall project rests with the non-profit who developed it and although the leasehold is available for the duration of the investor’s life, it can be sold at any point, even for a profit should the market swing in their favour. This is a relatively new model; it remains to be seen how successful or popular it will be.

The consensus among housing professionals in Canada was that the towns and cities there are not fit for an ageing population. Services generally revolve around the needs of the employed – public transport as one example. They recognise the need for changes and innovation. Much of the housing is unsuitable (see photos above) and they predict the need for more rental accommodation (particularly apartments or single storey dwellings) as older people are more likely to move from owner occupation to private rental than the reverse. They hope that flexibility within the planning system may result in innovative development. It was pointed out to me that modifying public facilities and housing to improve accessibility for older people –
improving safety, enhancing signage, more seating areas etc. – can only improve things for everyone.

An ‘intergenerational lens’…

I was delighted to meet with the Chief Executive and Communications Director of Generations United in Washington DC, Donna Butts and Colleen Appleby-Carrol. This is a national organisation that provides advocacy and training for intergenerational projects throughout the country. Their main message was that no matter what service you are seeking to provide, whatever the policy you are trying to formulate, you should bring an ‘intergenerational lens’ to it. It’s easy to think of services for older people in isolation from others, but society can be enriched through a thoughtful design of services which facilitates integration of the generations. For example, increasingly in America there are childcare facilities and centres for seniors located on the same site. Not only does this make financial sense, it enhances the life experiences of all concerned. Community strategies and plans should consider and seek to realise the benefits of intergenerational projects.

Donna highlighted that one of the problems with the traditional ‘retirement village’ in the USA is that it is generally ‘mono-generational’. She explained that whilst initially the idea of living in a community with likeminded people at a similar stage of life appealed to many, the reality for some has been a somewhat hollow existence in such villages. The best of them have introduced an intergenerational element by building a school or a leisure centre or something for the use of the wider public allowing for some degree of integration.

Another idea which has developed in America in recent times is the provision of seniors housing on university campuses. At the moment it is generally quite
expensive and availed of by former alumni but is seen as having considerable potential. Residents are allowed to attend lectures as they wish and use library and sports facilities, along with any other services available to students. It offers the opportunity for lifelong learning, a wide range of social activities and a sense of community for residents, and can be a lucrative business opportunity for the universities. Students benefit too from greater population diversity on campus. These are just some examples of how clever planning and design can provide the social and economic benefits of generational integration.

There is sometimes a misguided tendency to think of the older population as a drain on the economy. In the USA, however, states really compete to attract retirees, recognising their economic value (despite myths to the contrary, on average older people put more into the economy than they draw out). ‘Grey power’, in every sense, is growing and should not be underestimated. No doubt there are challenges to overcome if we are to effectively meet the needs of our ageing population. But as has been proven in the examples described in this report, these challenges represent opportunities - opportunities for community development and a chance to renew and improve infrastructure and services.

Summary of key lessons...
• It is imperative to monitor demographic changes and understand the aspirations and needs of those approaching older age.

• Northern Ireland requires a strategy for housing an ageing population; other UK jurisdictions have already produced and are implementing theirs.

• Older people should be fully engaged in communities and their skills and capabilities utilised to the maximum.

• We should map services available to older people at a local level and seek to improve accessibility and integration as well as to avoid duplication.

• Large scale social change comes from better cross-departmental coordination; it cannot be achieved through the isolated intervention of an individual organisation.

• There is no one size fits all approach to addressing the housing needs of the older population; a continuum of options across tenures should be available.

• We need to encourage more private sector investment in housing for older people.

• There are opportunities in the private and not-for-profit sector to deliver services to older households e.g. care and repair.

• We should ensure that housing related information is comprehensible, customer friendly and accessible through a range of media.

• The ‘Village’ model should be tested in the UK.

• We should continue to develop assistive technologies and maximise the potential of that which is already available.

• Planning departments should be cognisant of the ageing population when zoning land and producing area plans.

• Hearts and minds issues around ageing need to be addressed. Population ageing should be seen as positive.

• Community strategies and plans should seek to realise the benefits of intergenerational projects.
• We should continue to look at housing internationally to learn lessons as well as share our best practices.

A final thought...
There is undoubtedly a role for technology and design to play in enhancing the lives of older people in the future. But let’s not be mistaken, housing is really about people, and it will be people, individually and collectively, who will make the real difference on this issue.

Columbus Park, Chinatown, Manhattan
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