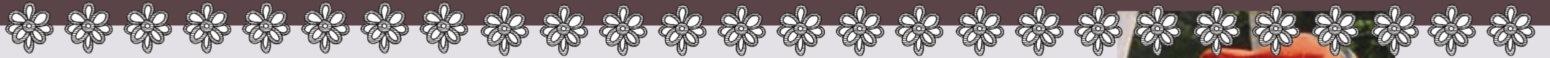
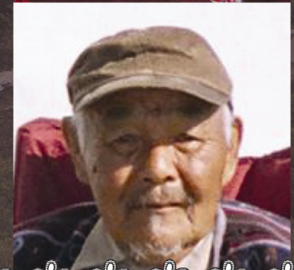
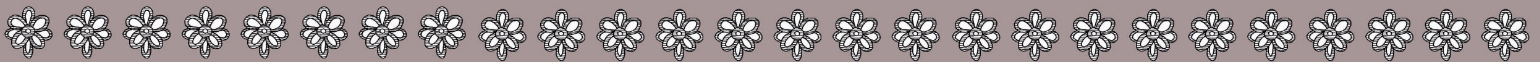


Living Conditions of the Elders of the First Nations of Quebec

Final Report



FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION



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The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) would like to thank the elders and representatives of the Quebec First Nations communities for their thoughtful and compelling contributions to the regional meetings, and in particular to the elders and organizers of the Elders' Gathering in Unamen Shipu for their collaboration during our visit. We remain always grateful to our elders for sharing their lives with us.

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Finally, the FNQLHSSC would like to express thanks to the ministère de la Famille et des Aînés du Québec for their diligence and support for this project.

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1. INTRODUCTION

1.1 Study

In 2007, the ministère de la Famille et des Aînés (MFA) held a public consultation on the living conditions of seniors in the province of Quebec. This consultation was intended to better understand the reality and the needs of its ageing population in order to respond more effectively to their needs. In this exercise, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHHSSC), in collaboration with the Assembly of First Nations of Quebec and Labrador (AFNQL), submitted a brief entitled "Our Elders, Our identity". This brief presented a portrait of the situation of the First Nations of Quebec Elders and an overview of the challenges faced by them in the different aspects of their lives.

During 2008, representatives of the Secretariat for Elders (MFA), the Secretariat for Aboriginal Affairs (SAA), and the FNQLHSSC met and the parties established an accord on the need for a further consultation on the living conditions of Quebec First Nations Elders. It was agreed that this project was necessary to provide a more in-depth and thorough understanding of the realities of First Nations Elders living in the First Nations communities of Quebec.

The FNQLHSSC organized, with the financial support of the MFA, a tour of regional consultations among the First Nations of Quebec to have all the information required to have a clear and realistic idea of the situation. In addition, the interveners working with First Nations Elders were asked to respond to questions in the form of a survey questionnaire. It was hoped that this information-gathering process would lead to a more informed determination of priorities to improve the living conditions of the Quebec First Nations Elders.

1.2 Authority

Created in 1985, the Assembly of First Nations of Quebec and Labrador serves as a periodic meeting place for the leaders of the 40 First Nations communities in Quebec and Labrador. The Chiefs in Assembly have mandated several commissions to provide assistance and information to the First Nations of Quebec. The FNQLHSSC provides technical support and advice to First Nations communities and to the AFNQL in the areas of health and social services.

The mission of the FNQLHSSC is to promote the physical, mental, emotional and spiritual well being of First Nation families and communities. The FNQLHSSC has several objectives, including providing technical support for research, developing and promoting community health and social services systems and models upon request of First Nations communities, ensuring that First Nations Government delivery systems meet the fundamental needs of Aboriginal citizens[1].

1.3 Overview

The following provides a brief overview of the literature on First Nations and in particular First Nations Elders.

1.3.1 Demographics

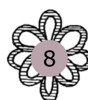
In December 2007, the First Nations population in Quebec numbered 72,090 people and accounted for approximately 1% of the total population of the province. Made up of 10 distinct First Nations, a majority (70.4%) of this population lives in some forty First Nations communities, with the rest living off-reserve.[2] Life expectancy at birth is estimated at 71.1 years for First Nations males and 76.7 years for First Nations females compared to 77 and 82.2 years respectively in the general Canadian population.[3]

The latest projections have indicated that the number of Aboriginal seniors is expected to grow more than two-fold by 2017 (Statistics Canada, 2005). In 2001, seniors represented 4% of the total Aboriginal population in Canada, and this is expected to increase to 6.5% of the total Aboriginal population by 2017. The percentage of Aboriginal seniors regionally in Quebec in 2001 was already 5.7%[4].

References in the literature as well as the Assembly of First Nations suggest that the age at which Aboriginal adults can be considered seniors be lowered from 65 to 55, due to lower life expectancy and rates of chronic disease within the population.

---

[1] FNQLHSSC, *Charter & General By-Laws*, June 1997, s. 3, 4 & 5.
[2] INAC (2009). *Indian and Inuit Populations in Quebec*. Source: INAC Indian Register as of December 31, 2007
[3] STATISTICS CANADA, *A Portrait of Seniors in Canada – 2006*, Minister of Industry, 2007, p. 223. Online: Statistics Canada: [http://www.statcan.ca/english/freepub/89-519-XIE/89-519-XIE2006001.pdf].
[4] Ibid, p. 258.



1.3.2 Health

First Nations cultures take a different holistic approach to health, well-being and disease. Good health emphasizes the whole person and the harmonious functioning of body, mind, emotions and spirit. A holistic approach which integrates the physical, emotional, mental and spiritual aspects of health is appropriate to understanding and addressing the multiple dimensions of wellness for elders from First Nations. This approach also views the individual in relation to the family, the family in relation to the community and the community in relation to the larger society.

The majority of First Nations elders have experienced unhealthy living conditions and poorer health than all other cultural groups in Canada for most of their lives - consequences of the "legacy of disadvantage" resulting from European colonization. Aboriginal elders have the lowest life expectancy of all groups in Canada, are more likely to suffer degenerative diseases normally associated with old age, as well as experience the social and psychological consequences of old age such as loss of friends, spouse or relatives earlier in their lives[5]. Aboriginal people are generally considered "seniors" at age 55 simply due to the chronic diseases and disability issues that affect them at a younger age.

The National Indian & Inuit Community Health Representatives Organization (NIICHRO) undertook a literature review and community consultation process to review the situation of First Nations Elders for its *Coming Full Circle* training project for Frail and Elderly. Some of the main issues seen in the literature affecting elders and in particular First Nations Elders:[6]

- Physical Inactivity
- Chronic Disease - Diabetes
- Isolation, Loneliness and Depression
- Lack of Motivation and Meaning
- Inadequate Transportation and Housing
- Availability of Home and Community Care
- Poverty
- Diet and Nutrition

[5] C. Armstrong-Esther (1994). "Health and Social Needs of Native Seniors." *Aboriginal Seniors' Issue: Writings in Gerontology*, Ottawa, National Advisory Council on Ageing: 43.
[6] NIICHRO (1997). *Coming Full Circle.* Literature Review and Community Consultation.

- Family Support and Caregiver Training
- The Effects of Residential Schools
- Literacy

Many elders have experienced a loss of self-esteem and independence resulting from the negative impact of residential schooling and the loss of traditional ways of life. One quarter of the Quebec First Nations Elder population responding to the 2002 Quebec Regional Health Longitudinal Survey attended a residential school. Of these, 42.8% believe their experience had a negative impact on their health. The main negative impacts cited by these people are physical and verbal abuse (68.1%), harsh discipline (66.3%) and being isolated from their families (61.5%)[7].

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors are often referred to as 'determinants of health' and they do not exist in isolation from each other. It is the combined influence of the determinants of health that helps determine overall health status.[8] Some of the health determinants for First Nations in Canada which impact on the situation of First Nations Elders are:[9]

- The proportion of Registered Indians on-reserve with less than a high school graduation certificate is twice as high as the equivalent Canadian proportion.
- The 2002 Quebec First Nations Regional Longitudinal Health Survey (RHS) reveals that this proportion with less than high school is 68.6% for First Nations Elders[10].
- The Registered Indian on-reserve unemployment rate is nearly four times that of the general Canadian rate.
- The median annual income for Registered Indians on-reserve is lower than that of the general Canadian population by almost fifty percent.
- The proportion of First Nations on-reserve households that are below the Canada Mortgage and Housing Corporation (CMHC) adequacy standard is over ten times that of households in the general off-reserve population.

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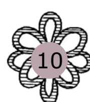
[7] FNQLHSSC (2006). *Quebec Region First Nations Regional Longitudinal Health Survey 2002*, page 188.
[8] PHAC (2005). *The Social Determinants of Health: An Overview of the Implications for Policy and the Role of the Health Sector.* Public Health Agency of Canada, November.
[9] Health Canada (2009). *A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003.* Publications.
[10] FNQLHSSC (2006). *Quebec Region First Nations Longitudinal Health Survey 2002 — Report on First Nations Living in Communities*, Wendake.



- The poor condition of dwellings is especially common on reserves, where about 44% of First Nations people live in a home requiring major repairs.
- In 2001, 9% of Aboriginal seniors were living in overcrowded homes, compared to 2% of non-Aboriginal seniors. On reserve, 15% of Aboriginal seniors were living in overcrowded homes[11].
- Nearly a quarter of First Nations housing units have a water supply that is inadequate in terms of volume and/or health requirements.

Comparison of chronic condition rates between the Canadian population and the First Nations and Labrador Inuit population (table below) clearly show that chronic conditions are present at profoundly higher rates for First Nations and Labrador Inuit.[12]

Chronic Conditions	Gender	Age Adjusted		45-53 Yrs		55-64 Yrs		65+ Yrs	
		FN/I	CDN	FN/I	CDN	FN/I	CDN	FN/I	CDN
Heart Problems	Male	13%	4%	14%	4%	24%	8%	44%	18%
	Female	10%	4%	10%	2%	24%	5%	30%	15%
Hypertension	Male	22%	8%	29%	9%	36%	5%	49%	23%
	Female	25%	10%	29%	10%	37%	22%	59%	32%
Diabetes	Male	11%	3%	18%	3%	34%	5%	32%	9%
	Female	16%	3%	22%	3%	34%	5%	32%	9%
Arthritis/ Rheumatism	Male	18%	10%	21%	10%	32%	21%	40%	33%
	Female	27%	18%	32%	18%	47%	33%	57%	47%

The findings from the First Nations and Labrador Inuit Regional Health Survey (Chapter 2, page 51) support the notion that elders are more functionally limited at a younger chronological age due to earlier onset of so called ‘old-age’ or chronic health problems. Functional limitations are manifest as profoundly higher rates for chronic medical conditions compared to age and gender matched Canadian citizens.

[11] STATISTICS CANADA, *A Portrait of Seniors in Canada – 2006*, Minister of Industry, 2007, p. 243. Online: Statistics Canada: [http://www.statcan.ca/english/freepub/89-519-XIE/89-519-XIE2006001.pdf]
[12] FNIRHS (2001). "An Examination of Residential Schools and Elder Health". *First Nations Regional Health Survey*, Chapter 2, page 43. FNIRHS National Steering Committee.

1.3.3 Social

Traditional cultural practices do not negatively affect the health and functioning of older individuals from First Nations communities. The social and political status of First Nations communities, poverty, cultural disruption, racism, sexism and ageism negatively affect elders' access to resources and to services which in turn affect their life chances, health, well-being, quality of life and aging itself. In this respect, First Nations elders are particularly at risk among other cultural groups in Canada[13].

Unwanted isolation appears to be a common problem for many elders, irrespective of cultural background. However, language barriers, cultural differences, minority status and limited access to services accentuate the problems of unwanted isolation for elders from First Nations communities.

Neglect and isolation are seen as forms of elder abuse. Studies to determine the types of abuse that most often affect First Nations elders are, to date, unavailable. First Nations elders are susceptible to being victimized for numerous reasons. In many instances, elders have lost their respectful standing in the family and community as a result of the colonization process and, most notably, the residential school system, which destroyed both the function of the Aboriginal family and the vital and respected roles elders played within it. As well, elders are at higher risk because of the current poor socio-economic conditions (i.e., lack of education, employment, housing, culturally-specific health and social services) that exist in remote, rural and urban settings, which could lead to increased family tension and result in violence.[14]

First Nations often turn to their Elders for traditional, historical and cultural knowledge. First Nations Elders have lived through many changes in their communities, and they are often considered an important link to the teachings of the past. For many First Nations, the transmission of culture from older generations to younger people has been disrupted by many factors. Prohibitions on cultural activities such as ceremonies and traditional gatherings, and the removal of children from First Nations communities through both adoption and federal residential schools, are just a few examples. The legacy of these schools is multi-generational, thought to be reflected in the unacceptably high rates of suicide

[13] Ship, Susan Judith & Tarbell, Reaghan (1997). Ageing and Cultural Diversity: A Cross-Cultural Approach, *In Touch*, Vol. 7, Number 4 Spring, NIICHRO.
[14] Dumont-Smith, C. (2002). *Aboriginal Elder Abuse in Canada*. Aboriginal Healing Foundation.

among First Nation and Inuit peoples, as well as high incidence of substance abuse, family violence and alcoholism[15].

Aboriginal languages, as minority languages, are also in constant danger of being "eclipsed" or overwhelmed by more dominant languages (Royal Commission on Aboriginal Peoples 1996a: 609). The loss of the intergenerational transmission of culture and language has had a deep impact on the traditional role of Elders in First Nations communities.

1.3.4 Services

The services that are funded through various federal government agencies for First Nations, and which can provide support to First Nations Elders include:

- First Nations and Inuit Home and Community Care Program (Health Canada)
- National Native Alcohol and Drug Abuse Program (Health Canada)
- Aboriginal Diabetes Initiative (Health Canada)
- Environmental Health Program (Health Canada)
- Non-Insured Health Benefits (Health Canada)
- Assisted Living (Indian and Northern Affairs Canada - INAC):
- Infrastructure and Housing (Indian and Northern Affairs Canada - INAC)
- Social Development (family violence, income assistance, etc) (Indian and Northern Affairs Canada- INAC)
- Food Mail Program (Indian and Northern Affairs Canada - INAC)
- Home Adaptations for Seniors Independence Program (Canada Housing and Mortgage Corporation - CHMC)
- Residential Rehabilitation Assistance Program (RRAP) On-Reserve (CHMC)
- Old Age Security pension and Guaranteed Income Supplement (Human Resources and Skills Development Canada - HRSDC)
- Income Security Program (INAC)(under the age of 65)

However, it must be noted that the character of services varies from community to community, and the level of resourcing and capacity of these services are greatly impacted or compromised by:

- The size and location of the community,
- The distance of the community from an urban center with the services of a physician,

[15] FNIRHS (2001). "An Examination of Residential Schools and Elder Health". *First Nations Regional Health Survey*, Chapter 2. FNIRHS National Steering Committee.

- The level of isolation of the community in regards to road access,
- The regularity of air and water transportation services for very isolated communities,
- The regional costs of purchasing due to isolation and/or road access,
- Information known about availability of services,
- Cultural profile of the community,
- The cultural and linguistic requirements for community services,
- The scope of social capital within the community,
- The level of training of program workers and continuous training,
- Existence and level of communication and information technology,
- Recruitment and retention of qualified health workers,
- Living and working conditions for outside health workers,
- Extent and condition of community infrastructure and housing,
- Existence of local organized transportation services,
- Existence and extent of financial deficit,
- Level of volunteerism in community,
- The social, economic and political development of the community.

Unlike other Canadian seniors, many First Nations elders have never had the opportunity to contribute to a pension plan, not even a federal or provincial plan. Moreover, according to the Quebec Public Consultation Report on the Living Conditions of Quebec Seniors, between 10% and 30% of aboriginal seniors do not receive the federal government Guaranteed Income Supplement to which they are entitled[16].

In addition, the grey area between federal and provincial/territorial control can affect a wide range of services for First Nations, including mental health programming, home-based palliative care and community long term care institutions (Lemchuk-Favel & Jock, 2004).

A research study of Continuing Care undertaken by the government of Canada in cooperation with First Nations and Inuit organizations in Quebec, Manitoba and Nunavik in 2004 established the following gaps in services: [17]

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[16] Quebec (2008). *Preparing the Future with our Seniors*. Public consultation report on the living conditions of Quebec Seniors. Ministère de la Famille et des Aînés.
[17] Health Canada (2007). *Continuing Care in First Nations and Inuit Communities: Evidence from the Research.* Minister of Health Canada.

- Families and caregivers require better access to home and community care during evenings and weekends and to respite care.
- The formal system should be structured to support families as much as possible when they can provide the care. This is critical for families to manage their heavy loads.
- Continuing care services need to be designed so that they also address the higher care needs including long-term and short-term facility based care.
- Supportive housing can also fill some of the gaps at lower levels of care.
- Various funding issues need to be addressed to meet the increased demand and higher level care needs and take into account case mix, community size and location and other factors such as culture and language requirements of the client, family and community.

Further investigation in the 2008 Health Canada Assessment of Continuing Care Requirements in First Nations and Inuit Communities (pages 89 & 90) lists several key points that need to be considered with respect to the future funding and provision of continuing care services in communities. These include the following[18]:

- The provision of continuing care services in First Nations and Inuit communities should focus on the needs of the individual and his/her family and the most appropriate responses to those needs.
- Professional health services need to be supplemented with various forms of supportive services that assist individuals to maintain their independence for as long as possible.
- The use of traditional healers, culturally relevant support services and culturally relevant community activities needs to be explicitly supported.
- Families and communities caring for individuals with continuing care needs should be supported.
- Although palliative care is not a focus of the Continuing Care Research and Costing Project, consideration needs to be given to the provision of care to individuals who are dying.
- Artificial stovepipes in the way health services are funded, structured and delivered should be eliminated.
- Jurisdictional issues among federal, provincial/territorial, and First Nations/Inuit governments need to be resolved. The identification of roles and responsibilities at each level may contribute to this process.

[18] Health Canada (2008). *An Assessment of Continuing Care Requirements in First Nations and Inuit Communities: Review of Literature and National Health Data Sources.* Health Canada, Ottawa, Ontario.

- Steps need to be taken to better integrate the programs and services offered by various governments.
- The active involvement of First Nations and Inuit in the development of programs and policies and the determination of realistic funding requirements with regard to the provision of continuing care services and related issues (such as the training of First Nations and Inuit health care providers) is critical.

Many First Nation communities, including those in Quebec, do not have long-term care facilities. Elders requiring institutional care are often placed in provincial facilities, some located a great distance away. The detrimental effects of being removed from their communities include[19]:

- culturally inappropriate care (including language barriers);
- isolation from family, friends and their community;
- the loss of their social role as an Elder;
- transportation issues for family members who want to visit them.

Following are the existing facilities for elders in First Nations communities:

Name of Center	Community
Tiosehrohon Tsiiontientahkwa	Kahnawake
Kaniatarakta iontorishentahkhwa	Kanesatake
Kiweda	Kitigan Zibi
Centre Tshishemishk	Mashteuiatsh
Anishnabe Long Term Care Centre	Timiskaming
Foyer Tshennuat	Uashat mak Mani-Utenam
Résidence Marcel-Sioui	Wendake

[19] NAHO (2007). *Aging.* Presentation to the Senate Standing Committee on Aging. Carole Lafontaine.

2. METHODOLOGY

2.1 Goal

The overriding goal of the regional meetings was to gather direct information from First Nations communities. This information-gathering was necessary to extend and complete the information documented by the FNQLHSSC, to obtain more specific knowledge of the reality of elders and to enable a determination of the priorities for actions to improve the living conditions of the elders of Quebec First Nations communities.

2.2 Objectives

The specific objectives of the regional study on the Living Conditions of Quebec First Nations Elders were as follows:

- To identify the unique characteristics of the communities and to discern more information about existing programs;
- To establish priorities for addressing elders' needs such as abuse and elder abuse, housing, knowledge of rights, health care priorities, etc. in relation to the different government levels;
- To become informed about the availability and access to on-reserve and off-reserve services in the communities;
- To emphasize some important factors related to the language and culture of First Nations;
- To highlight possibilities for the harmonization of certain services funded under the respective jurisdictions of the Federal and Quebec Governments;
- To exchange ideas and to determine priorities for capacity development and the continuity of services;
- To submit recommendations and plan a course of action for the improvement of living conditions of First Nations Elders.

2.3 Regional Meetings

Meetings with elders, and professionals or paraprofessionals working with elders, were held in Sept-Îles, Val-d'Or, Québec and Montréal. These meetings were facilitated by the FNQLHSSC. To assist with the participation, the travel expenses for one intervener and two elders from each community were defrayed.

A discussion guide was developed and followed as much as possible for each of the four (4) regional meetings. The attendance was as follows:

- **Val-d'Or**: 8 participants from the 3 French speaking Algonquin communities of Kitcisakik, Pikogan and Lac Simon
- **Montréal:** 17 participants of the English speaking communities of Kahnawake, Wolf Lake, Eagle Village Kipawa, Gesgapegiag, Barriere Lake, Listuguj and Kitigan Zibi
- **Wendake**: 26 participants of the French speaking communities of Wendake, Viger, Opitciwan, Mashteuiatsh, Manawan, Wemotaci, Essipit, as well as representatives from Kanesatake and Timiskaming.
- **Sept-Îles**: 17 participants of the Innu communities of Betsiamites, Unamen Shipu, Natashquan, Ekuanitshit, Uashat mak Mani-Utenam and Pakua Shipi

In addition to the four (4) planned regional meetings, there was an opportunity provided to attend the Innu Elders' Annual Gathering in Unamen Shipu. During the gathering, there was a workshop discussion held with between 15 and 20 Innu elders from the gathering. It also provided an opportunity to meet informally and observe the way of life of the Innu elders.

2.4 Community Questionnaires for Interveners

A questionnaire was developed and sent out with a letter of request to all of the First Nations communities in Quebec. The respondents were asked to complete the questionnaire and to fax or email it back to the consultant. A copy of the questionnaire is provided in appendix to this report.

There were 24 surveys returned. Some communities had more than one survey respondent, and some interveners worked together as a group to complete one survey. The respondents were:

Uashat mak Mani Utenam	Gesgapegiag	Winneway
Timiskaming	Wendake	Kitigan Zibi
Akwesasne	Kanesatake	Wemotaci
Natashquan	Mashteuiatsh	Matimekush-Lac John
Wôlinak	Eagle Village	Lac Simon
Kawawachikamach	Ekuanitshit	Kitcisakik
Listuguj		

3. RESULTS OF REGIONAL MEETINGS

The following section provides a summary of the discussions held with the Elders and interveners in the regional meetings. The responses were varied as there are many differences between communities, and among the situations of the Elders themselves.

3.1 Living Conditions/Needs for Health and Social Services

3.1.1 General Conditions

One Innu elder explained that "When I got married I didn't have a house. We lived in a tent in the woods and ate traditional foods. There is a lot of change now in the way we live. We have 6 kids. I go into the woods very often and teach my children how to live in the bush. In the woods - I hunt and trap. I hunt caribou, porcupine and beaver. I worked so I also collect an old age pension. My wife cannot go in the woods anymore as she has trouble moving. Life has changed a lot. Now there are men who stay at the house with the women."

The living conditions vary from Elder to Elder, from community to community, and from region to region within Quebec. Most elders have stated emphatically that they want to stay in their homes. Many Elders reported living alone, and many of these elders felt lonely. Some are house bound and cannot go out. A lot of elders are not used to technology which contributes to their isolation. Some Elders do try to keep themselves busy by volunteering.

Those who are housebound would like to have someone visit them. Some elders only have a visit from the nurse's aide; this is the only visit they have. A few said that very often the only time they see their families is when their check comes in. Grandchildren are sometimes dropped off for them to take care of, but this becomes abusive when the needs of the elders are not considered.

Those that live with their families often feel isolation too. A lot of elders live with their children. There is a lot going on in the homes and they are either forgotten, or left to take care of their grandchildren. The homes are noisy, and the elders feel there is no place to be quiet. They miss having someone their own age to talk with. Sometimes, if they have family living with them, they are not eligible for services such as in-home support.

There are those elders that said they would like to live as much as possible on the land, they want to eat the meat of the bush. The problems they face in the communities are not there on the land. But for many it would be hard to live the whole year in the bush like before.

Very often, the inadequacy of the elders' homes was mentioned, and the lack of adaptation of these homes to suit the needs of the elders. "I have an inadequate house - it is rotting and I asked for help from the band council. It seems as though they want to wait until it completely falls apart before they will help me. There is an auxiliary who comes to help me."

For many, their home becomes a liability due to the need for repairs. The Residential Rehabilitation Assistance Program (RRAP) funds are not always applied by the Band Council to elders' homes; or, the RRAP doesn't apply to the elder's house; or, if they have accessed it, it can't be applied again for 10 years. The installation of grab bars and other safety measures requires a letter from an occupational therapist. This makes it extremely difficult for isolated or semi-isolated communities to meet these requirements.

Many of the elder's homes are not suitable to their needs. "Since I was married I only have had one house. I didn't get much service. We always had to pay for them even though we were on social assistance. We asked for a new house but were always refused. Request after request - 19 years later and still no house. My current house is not adequately constructed. In some of the house there are insect infestations/holes in the structures/flooding etc. After one flooding we asked the nurse and inspector to come and document the conditions. I have heart problems and I am sure it is because of the house conditions".

The winters are seen to be extremely difficult as the isolation increases, and the elders need help during the winter. A lot of elders don't have enough money to buy oil. Some use their ovens to heat their homes. A lot of them won't ask but they need help to shovel the snow. Some communities mentioned that they provide a delivery of wood for elders with a wood stove, but the elders still need help to cut the wood, carry in the wood, or even to keep the wood stove going if it is in the basement.

In one community, there is no electricity or running water. The Elders who live alone are totally dependent on someone bringing them water, and also wood for the stove in the winter. Some have to give up living in their homes during the winter months because they are alone, and it is too difficult to bring in the wood and to keep the stove going for heat. They stay with family or with another elder in another reserve. Since their community is isolated, and is without services, they must pay someone to go and get groceries. Some individuals charge as much as $150 - $200 for this taxi service. The groceries are necessary to subsidize their food supply since wild food is becoming very limited.

In other communities, the general environmental conditions such as blowing sand, littering, and poor road conditions coupled with the unsafe use of all-terrain vehicles by the youth causes health and security issues for the elders. All-terrain vehicles are not regulated, and are often driven recklessly at great speed.

Some of the interveners mentioned that today, the traditional roles of the families have changed. Families are not the same as they were even 20 years ago. There are no more traditional caregivers. The interveners are working to get the extended families and the community more involved in the care of the elders. Some mentioned that they do have volunteers to help out, but funding is not there to support the programs that the elders need. Many communities try to provide some form of activities program for the elders at least one day a week or a trip once in awhile, but in most communities it is limited by a lack of local space, and by funding.

In the communities with no land base, many of the elders have to live off-reserve and pensions are very small. They do not have services. Most of them do not know what services they are eligible for because they do not receive any information. They would like to have more support and information provided to them. They would like to have the chiefs take up their issues.

Even though the elders stay in their homes or enter a residence as autonomous or semi-autonomous, over time their health gradually diminishes and they can no longer meet the criteria for even Type ll care. For some there is no choice but to go to a long-term care facility outside of the community, sometimes quite far away. The Elders are not familiar with the outside, the culture is different, the food is not

traditional and they are not able to speak the same language. They do not see family or friends very often, and they become very lonely and depressed.

Because of the language barrier and changes in their society, in many communities the Elders do not transmit the culture to the young and there is much sorrow about the lack of culture. A void exists between the youth who have lost their culture and the elders who can no longer transmit culture and language to the young.

3.1.2 Personal Needs

In the regional meetings, one elder said: "When we were younger we took care and gave baths to our elders, or to the sick, but now, when we will need it who will bathe us and care for us?"

Elders who live alone often need help. They need help just in understanding the instructions for their medications. They need to have the information translated into their language. In some cases, elders have prescriptions that may not be covered by the Non Insured Health Benefits (NIHB) with Health Canada, or for which they must pay partially. It is very important that the population be informed of what is covered under the NIHB program.

A few elders reported that the Nurse is always so busy so that no one wants to say they don't feel well because they don't want to stress her out. Some interveners mentioned that there is a need to adjust the Health Canada regulations so that more nursing can be done in the homes at night and on weekends, instead of at the day clinic, especially in isolated communities.

There are a lot of needs for foot care services, but the funding is not there to support these needs. In some communities, the health center provides a nurse for foot care who passes once a month, but some elders require more frequent services. Often, elders must pay for these services. As for prescriptions for special shoes it may be covered under non-insured health benefits. However, the procedures would require that the patient contact their Health Center who must work with the client and the supplier to prove that:

1. The client is a candidate for prescription shoes and that existing orthopedic brands of shoes are not adequate enough to meet the client's needs;
2. The shoes will not exceed $1200 on average;

3. The measurements (prescription) has been done by a qualified individual;
4. The client's prescription meets all of the eligibility requirements of Non-Insured Services.

It was reported by some of the interveners that some elders have addiction problems and gambling issues. Some are able to handle 6-8 beers a day until they have health problems, then they experience conflict with the medications. All their money goes to their addiction, no money left for food. Some will try to save money for gambling so they don't buy food - reuse tea bags etc. In one meeting, it was stated that some elders buy drugs, and share with youth just to have the youth visit them in their house.

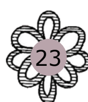
Elders complained that they are not involved in situations that involve Youth Protection. Social Services usually deal with parents but often though, it is the elders who have raised the children, and they are not consulted. They do not understand why Social Services have taken the children away.

Some interveners mentioned that there are elders who do not want any services even if they need them. Sometimes it becomes a curator issue. Then, there are others who are demanding and want even more than what is being provided.

3.1.3 Home and other Support Services

One of the larger communities commented that with the funding for First Nations and Inuit Home and Community Care (FNIHCC), there are physical constraints to providing home care services. With a large population, or higher incidences of morbidity, this limits the level of services available, especially since not all of the FNIHCC clientele are 65 and over, some are convalescent/handicapped or mentally disabled.

The Health Center tries to fill in the gaps in services as best they can. In one community, the CLSC does the baths for the clients because they do not have trained personal workers. In another more isolated community, there has been no doctor for 3 years, so they have gone back to using traditional medicines. They prepared an 8 hour video in their language on the medicines and traditional healing so the young people would know what to do. In some, they offer respite care, "within home care we sit with the patient for a while so family members can take a break and do chores or run errands…"



One elder said that she has some health problems with her heart. When she is sick she is afraid to disturb others, not wishing to call someone. Once she called at the health center and the nurse said for her to go there but she would have had to walk because she doesn't have a car – she would have to ask someone. So she didn't go. The communities said that they need a service with a nurse who speaks their language and goes to elders to see if they are alright. Also there should be some sort of transport service for elders to go to the health center.

When elders or children live with someone who has Alzheimer, the care is needed 24/7. There is a lot of insecurity and guilt attached to taking care of someone like this on the part of the spouse or child who is taking care of them. It is difficult to come to the point where you have to decide if it's too much of a burden and you have to send the elder away. There are new medications for Alzheimer and related mental health diseases that are more effective and they're available in the province. The NIHB only pay for "old" medicines that are not as effective.[20]

One intervener stated that there is a lot of administrative work involved with bandages and dressings for Homecare. "Get approval for one kind and doctor changes prescriptions for newer kind that is a standard for this situation. So we have to reorder requisitions again and get approval or wait for approval again. Then redo it when standards change".

Many of the respondents spoke about the inadequacy of the INAC Assisted Living In-home support program to assist them:

- The program in many communities does not provide for heavy cleaning tasks such as windows, but the elders cannot do this work, nor do they have the money to pay for it;
- If they own their home but have a family member living with them, they are not eligible for any assistance at all, even if there is no help from the family member[21];
- They cannot get help to stack wood for the stove, or to bring wood in to keep the stove going;
- The elders would prefer to have family members look after them;

[20] Since winter 2008-2009, some medication for treating Alzheimer have been added and are now covered by Non Insured Health Benefits – Health Canada.
[21] Regulations may vary from one community to the other.

- There is a large turnover of workers, and this creates instability for the elders as they need consistency and don't like changes in staff;
- Sometimes the elders do not get along with the workers who are sent to them, there may be a history from the past, a choice of workers is not always possible;
- In some cases, it's hard to recruit workers because the wages are so low, they are paid less than provincial workers doing the same work;
- In one situation, home support was working to its full extent but the service had to ask the family to help with the personal care of the male clients, because they do not have male workers.

There was a general feeling that the government pushed Homecare and In Home Support for so long; people won't do anything for free anymore. Natural care givers disappeared with the advent of these programs, money has changed attitudes. Nevertheless, there were still some communities who said they do have volunteers to support recreational and social activities for elders.

The interveners reported that elders are being challenged by having to pay for non-insured services such as special shoes and insoles for diabetics, when Health Canada pre-established criteria are not met. Reimbursements for foot care were cancelled by Health Canada. Nevertheless, foot care is very costly to those on a limited income, and important to those who have diabetes because this is not a choice, it's a necessity.

It was also stated that there are no geriatric assessments being done. The psychiatric problems in First Nations communities are very different. But there is always language problems associated in accessing these services and the assessment tools are not adapted to First Nations languages.

Those who are more traditional, closer to nature, do not have the same needs. Usually ask for very little, and these elders often fall between the cracks and then when the community has to intervene to place them in a center, or to get them services, it is very difficult to do the legalities.

Some communities referred to a lack of emergency services, which results in elders not knowing who to call. There is often hostility with outside police services. Many communities do have medical transportation which is available for elders. A few communities mentioned that they do have the support of a night nurse at the local

hospital for medical problems. Access in emergencies is especially difficult in isolated communities, but it can also be problematic in rural communities due to 'situations' within the community or the alienation of the police services.

3.1.4 Income/Finances

"When we talk about old age security pension, it is not enough to pay all we have to pay; hydro, telephone, TV, etc. I know some elders live in unacceptable conditions."

Everyone lives on a fixed income. In most First Nations communities, the salaries earned are not on the same level as the province, and many do not have the same benefits as outside employees. Most First Nations communities did not provide pension plans when these elders were working. Some only have enough money to cover the bills and minor living expenses, not much left after that. Some have family who help with finances.

The income of most elders is very limited:

- "The cost of living has increased today. If something breaks in the house, there is not enough to cover the cost of repairs. Having a hard time to make ends meet - not enough to cover any other cost. Have to be careful with budget".
- "Do sewing to make extra money but I am not able to do as much before. Sewing is down…"
- "Manage okay with budget though have problems with children taking money. Can't buy food or clothing, spend money on wild meat – I arrive 'just' with my pension".
- "Some of my money was stolen by the children from the bank, I had trouble to pay my hydro, and it got cut".

Accessing provincial or federal programs to provide additional financial support is difficult to do. Some interveners said that some limited things can be done internally – "we do provide assistance if health conditions are a factor".

Some of the interveners from the border communities stated that a lot of elders are entitled to U.S. pensions but the services have to assist them so that they don't get penalized by unknowingly "double dipping". Some elders do come back to the reserve and are well to do because they have sold their home, but those on reserve

are penalized because they can't do the same. Only 5% of elders actually sell their homes as income, most pass their home onto their family.

Many elders have difficulty in filling up the forms for accessing pensions and other services. There is a need for services to help the elders complete their applications for guaranteed income supplement, and to provide them with assistance and advocacy. The elders need to complete tax forms each year to receive a pension. They need to have information on how to do this, First Nations don't pay income tax if they work on reserve and so they sometimes don't fill out a tax form. They also don't know that they need to make a request for their pension or they won't receive it.

3.1.5 Food/Nutrition

"We need to teach our children how to prepare traditional foods in the bush, but the animals are disappearing and what do we do? With all the pollution we have today, I don't know if I can trust the traditional medicines anymore. They are affected by the pollution in the environment". (Elder)

The elders said they eat other foods in addition to wild meat but they find that food is much more expensive now. "It costs a lot to live in the territory compared to other centers. Here (on the reserve) it costs you two times for bread and milk". The cost of transportation to go and get food is very expensive for those that live away from urban centers. Some people charge $60-80, and some charge $150-200 per trip. A regular taxi, when it is available, is only $45 to go and come back to buy food.

Elders prefer to eat wild meat and fish; compared to store bought food. Sometimes they miss out on traditional foods. When there is traditional food, it is good - wild game, fish. Today however it is more limited. A lot of families do sugar bush and share with the elders. Families share wild meat. Wild food consists of - depends on the season - fish and moose meat, trout/wild foods, smoked meat and dry meat. One intervener said the elders are missing traditional foods and being on the land. They ask: "why you don't pay someone to go hunt for us, we don't like store food?"

"I find my food in the territory. When I went hunting, there was no one. Now we have rules about where we go to hunt the caribou. I feel good when I am in the

territory. I stay only a month at the house, and then I go back on the land." (Innu elder)

Not many communities have a "Community Hunt". Very often it is up to the individual to decide if they will share their hunt. When/if there is a community hunt, during festivals there is usually a community dinner. When the community has too much meat (in freezer), they distribute it to the elders in the community. Elders often ask the workers to have camping trips as they get much stronger when they are in the bush; they do carving, tan hides, prepare birch bark and collect medicines.

"I place a lot of importance on the traditional medicines - never go to a clinic. Up to when I got married I lived on the land only. Today the government has broken our territories. The food from the woods has changes in its taste. The government raises our children. I healed my son using traditional medicines. We live so good and we rest well when we are on the land. My great niece is there; we took her on the land. We took our food and our education on the land".

Some communities have meals on wheels services. One community stated that their meals on wheels program stopped because they didn't have enough money to continue. Another was not able to find drivers for the meals on wheels programs. One community reported doing "Meals on Foot" where they walked to the elders homes with a hot meal. Some provide "community kitchen services" at least once a week where the elders can bring home prepared meals, or they serve a hot meal as a social event.

3.1.6 Prescriptions/Medications

Not all of the prescriptions are paid for by Health Canada, and sometimes elders will do without their prescriptions because they do not have the money to pay for it. Elders often require support with the management of medications. Many do not understand the instructions provided, and need a translation, and some need to have assistance with taking the required dosages. Most elders need to have their prescriptions picked up for them.

Natural caregivers still use medicinal plants. The homecare workers prepare traditional medicines for the elders. There is a large demand for that as it helps with diabetes.

One elder said: "I am taking a lot of pills - a lot of elders are taking a lot too. At the hospital they asked me what pills I take and I had to phone the pharmacy to have a list made. I speak French and I still don't know why I am taking them but can you imagine an elder who doesn't speak French and who has to take pills 3 times a day! Someone should go in the houses and explain the medication. See if they are being taken. Some elders are exchanging pills, 'oh try this one it worked good for me.' Can you imagine how dangerous this could be?!"

Some interveners also stated that some elders do abuse their prescription drugs such as oxycontin, or they sell their prescription drugs for money, or they are forced to share their prescription drugs with youth. Some elders go as far as contemplating suicide because of prescription drug abuse or end up in psychiatric wards. Addictions cause depression and not feeling valued plays a big part. Many do not realize that they have become addicts.

3.1.7 Abuse

There was agreement in the meetings that there is elder abuse, but most often it is with money. "Give me money and I will take care of you". When the old age security pension checks come in, then there is verbal abuse, violence. "In my time I helped the elders with their homes - doors, windows, proper heating. Now the youth is just occupied with the drugs, sometimes I am afraid in my house that I will be killed for money to fix their habit".

Young women exploit elders a lot, as the elders will send them to the store with money and they won't come back. Sometimes the children threaten suicide if the grandparents or parents don't give them money. Certain elders said they have children that have drug and alcohol problems. Sometimes these elders live in the garden shed for 2 or 3 days at a time because of the drug and alcohol problems of their children.

Even when the interveners suspect there is abuse, it is difficult to point out. There is a lot of fear from elders regarding what the abuser will do to them next. Abuse by families occurs quite often, but the elders prefer to protect their families and will not press charges. Unlike Youth Protection, unless the elder comes forward to press charges, the police will not intervene. There is often no security of life for elders.

Abandonment or neglect such as family not visiting or not providing assistance is a form of abuse that is also witnessed by the interveners. In many cases, the elders have great difficulty living alone but the families do not provide any help to them. Some elders get passed around from one child to the next. Others are treated like children and are not consulted on decisions taken about them.

Some interveners said that the elders were not aware that their grandchildren were using their names, making them sign something. There is a lot of financial abuse such as bringing elders to the bank to sign loans, etc. (now Social Services contact the bank).

One intervener is an elder who is working with Social Services. She described the situation of elders she is working with: "One is living with her daughter who is 36, and the elder is living in the living room of the house. It is going okay, but it is difficult. Right now I am working with elders for Social Services. They are alone, we live alone. Sometimes we cry, a lot of them don't live well. Their mattresses are on the floor. Some of them have fractured hips. Most of the time in our community, when they break their hips, they die within a year".

To counteract some situations, the elders are encouraged by the workers to be in charge of their own home and to administer it. The workers state that this works out better for them instead of being in a family where they get passed around from one child to the next.

Some services said they ask the elder if they wish to stay in their home, and if they do, they call in the family and ask what each can do to maintain the elder at home. This helps to counteract any situations of abuse or neglect. It is rare that the family is not implicated in the tasks needed to maintain them. The elders have large families that are capable of sharing the responsibilities. The services organize the family. Some of the provincial seniors' residences do provide respite care for families who travel.

3.1.8 Legal Rights

One elder summed up the concerns of many when he said, "At the moment I am still strong enough to tell my children what to do, but what about later when I am not strong anymore. What will happen to me?"

Information on legal rights is not there, and there are very few people in the communities who know, and it is not clear what the rights of the elders are. A service to protect the elders doesn't exist. Elders aren't always aware of their rights. There is a need for more information on legal issues, wills, succession issues, and matrimonial real property issues.

"Estate" (on reserve) comes with INAC; every registered member may be entitled to 2 500 $ per person for funeral services.[22] But there is more than this about estate that should be known. It is hard even for the community workers to understand all the legal terms and legalities involved with having a procurator, power of attorney etc.

If someone who is First Nation gives a mandate in case of incapacity, then his "person" is not always considered the same in the eye of the law, federal and provincial. INAC has responsibilities for the individuals who live on reserve. This leads to uncertainty among elders, not knowing if the government will change what they have written or mandated.

To put someone under care (mandatory) may be a legal nightmare for some First Nations people. One community has worked for five (5) years on this subject to try to unlock this situation of 'power of attorney by two different jurisdictions'. Ottawa has to get involved and clarify the situation. There is a need to have a consensus of Band Councils to clarify the legal rights of First Nations elders; the code has to be the same everywhere. First Nations should be able to handle their own affairs without the federal government.

Similarly for those in residence, interveners cannot force the elders to do things or refuse to let them go for "a walk in the woods" unless they have a mandate signed. They cannot force services on those who do not want them. It has to be a really bad situation before they can use "exceptional service" interventions under the law.

[22] "A special allocation can be provided through the Income Security program towards the cost of a funeral up to a maximum of $2,500 for each deceased person. Requests for funeral allocations for those who are not welfare recipients will be studied individually according to the regulations in place at the time of the application. For all questions, individuals should refer to the Welfare officer in their own community."

"La succession" is not in the native culture. Younger generations see the importance of planning for succession. It is a file that needs to be addressed in all the communities; it needs to be talked about.

Succession is different under the Indian Act, and the interveners said that individuals have to be very careful if they have been nominated as 'executor' of a will. If they have, they should get INAC to determine that the estate has been 'settled' in writing. An individual can be held responsible for any debts that are left. One worker mentioned that after her father died, she had to pay all of his debts as well as his funeral costs. Workers must be sure to insist with elders and explain to them the importance of having a will. There is a lot of bureaucracy involved but there is a strong need to provide elders with the information.

3.1.9 Stereotyping

Some of the elders' experiences that were shared included:

- "We didn't go to school, we can't read, so our opinion is no good…"
- "They treat us like children. They say since we don't know how to count money it doesn't matter if they give us less because we won't know…"
- "We are not consulted about issues, especially those concerning us".
- "Utility of elders can be compared to dead wood".
- "They don't know or even try to listen to us (politicians)".
- "…consider us mentally and physically slow - so we aren't important".
- "Get frustrated and mad at us too quickly- don't give us a chance".
- "They don't know what they want…"
- "We always told the children to respect the experience and wisdom of the elders - we will lose it if we don't".
- "My father doesn't hear well - but I have to tell my brothers and sisters that he is just deaf and that he is not a child, and to let him do what he wants in his house".

3.1.10 Communication

"I don't see many services for elders. When we speak of pension there is no one in the community to help us. We have to go out of town. We need to have this type of service offered within the community. We forget to do our tax returns - the non-natives know all about this service - we don't. They threaten to cut these services

but we don't have the information that will help us get it done. Elders need this service - information and help".

Face to face communication is the best way to inform the elders about things, or to seek their opinion on matters. They often only speak their own language, and are able to read written material with limited facility.

The elders remarked that they liked this type of meeting in which all the elders shared together in person. The elders present in all of the regional meetings said they wished to have more consultations such as this in a face-to-face format with the persons responsible for services and with each other. Being able to share what they (the elders) have understood and what they think about is good. "It helps me when I see the other elders, hear other communication. It is better for the sharing and maintaining of knowledge".

They saw this type of forum also as a means to sensitize others about the needs of elders. One intervener said: "This meeting should have been done in the community so more people can hear what they have to say". The communities should organize contacts between 'others' in the communities and the elders. They saw it as a possibility for intergenerational awareness and transmission, a possible mobilization of the community, using the tools available.

3.1.11 Traditional Role of Elders

One of the elders said "We are slowly losing our old ways - it is important to teach the ways to our younger generations to slow down the losses we are experiencing".

Many of those present in the regional meetings felt that the traditional role for the elders doesn't exist anymore in First Nations communities. There is not a lot of planning that involves the elders. Many don't want to listen to the elders. The younger generations don't want to make the connection between histories. The extended families as they knew them traditionally are not there anymore. "The relationship gap between youth and elders is sensitive in some communities - because of different religious affiliations. Hard to discuss passing on values because of this" (intervener).

But the elders insist that they need to relearn and know their ceremonies and their culture and the roles as mothers and fathers. They say that they need to bring traditional ways back so that they can pass it on.

Young people don't know who the elders are; they need to be more involved with them. There are not many interactions in the activities organized around each group – elders and youth – they are not often together. The school has taken on the role of the Elder to pass on language. But they do still have elders in the schools. They tell stories to the children in their language. Some elders volunteer in school for culture days. Some are asked to show the children about the medicines.

The elders are involved in the school during festivals in the community. There are cultural days for everyone in which the elders participate; but not like before. There is elder participation with Aboriginal Head Start in some communities. Many don't feel that the elders are being used properly; their stories and their experiences are really valuable in growing up.

Knowledge of mapping was asked of one elder in one community but he did not want to share the knowledge with non-natives because he felt they're going to make money from it. Elders are very protective of the knowledge. In the woods and on the land, that is where they are open to tell stories. Some language from the bush, from canoeing, from water is only used on the land because they don't use it so much (it is part of the old language). That is why it is important to go on the land with the elders.

A lot of youth don't have a connection with the elders and the elders do not feel valued. The rites of passage are not used or valued anymore. There is a break in the relationship that came with the loss of language following residential schools. Many feel that they were robbed of their elders, and the elders feel it too. One community has applied for a grant to work with youth to have elders teach traditional skills.

Some said that they lost their language even though their elders tried to teach them. People should respect them more than they do. Some said that they only realized this now that they are adults. Some of the participants felt that there should be elders involved in band council meetings.

3.1.12 Social Needs

"Gatherings (social) are so important and are also "good medicine". We laugh and exchange stories…" (Elder)

Lots of elders are living alone and experience loneliness. Before, there was not so much to do, or going on, and people had the time to visit each other. Not today, so elders are often forgotten and left alone. "People don't visit much anymore. Sometimes I walk in my community and go to youths that I know and I am beside them planning to talk to them and they just look at me and walk away." (Elder)

In one community, the elders have set up a tent where they can meet, tell stories and play cards. Sometimes they miss firewood, and they ask to have some brought. It was suggested that a Day center is needed to gather the elders together. There is less time needed to do activities together in a center than to visit them in their homes. Going from one home to another takes a lot of time and doesn't have the same effect as bringing elders together to share stories and a meal. There is a need for adapted transport for those in wheel chairs; they cannot participate right now in the activities, as there is no transportation for them.

It was agreed that there should be funding to support an Elders' Committee in each community. The committee would work on behalf of the elders. They felt that it is important not to put the elders aside but to have them involved in everything in the community, and in planning for their own needs.

3.1.13 Expressed Needs

In addition to the needs mentioned in the previous sections, other expressed needs included regarding living conditions were:

A. Most of the respondents cited the need for an Elders' Residence in the communities that would be able to respond to the requirements of a continuum of care that goes as far as type 4 and 5 care (care given in hospitals and CHSLD);
B. Many of the respondents mentioned the need for an Elders' Day Center to bring the elders together, to share stories over a traditional meal, to provide information and physical activities.

C. Although some communities have Elders' Committees, other communities expressed a need for one.
D. Some of the interveners referred to the need to provide support and respite care to "sandwiched families" – those 'children' caring for parents and their own children at the same time.
E. It was suggested that rental and hydro rates be adjusted or subsidized for elders.
F. Funding for an elders' program is needed.
G. There should be some form of transportation services for those who live in the woods, and do not have a permanent address.
H. Workers specialized in geriatrics, psychiatrics and social services would be so beneficial. Need that specialty help - need some psychiatric follow-ups. There is a language problem in accessing services.
I. There should be more support services for elders who have been in residential schools.
J. There is a need for palliative care services, most elders want to come home (out of the hospital) to die.
K. There should be information provided on programs and services "specially" for the Elders (a catalogue of services).
L. Transportation should be provided to the elders for these services and activities available to them. Some cannot attend due to a lack of transportation. In addition, there should be subsidized "community transportation" to go to stores, bank, services etc. This helps them to keep their autonomy and able to take care of themselves with these types of support.
M. Create a position in the communities for an "Intervener for the elders".
N. There is a lack of information on Alzheimer and Dementia in First Nations communities. There is a need for a support group for family members.
O. Offer respite services for families looking after elders through in-home support and/or home and community care.
P. Need to provide awareness to the children/family on the needs of ageing parents.
Q. It was suggested that having dialysis services in the community or closer to the community would be beneficial, and could be paid for in the reduction of the cost of the taxi, or the cost of lodging for those that have to relocate for these services.

R. There is a need to have someone designated to help them fill out tax forms and applications for old age security pension and the guaranteed income supplement.
S. There should be a coupon program to help with the cost of transportation to go to get food. Elders should have vouchers for certain foods that are more expensive such as meat.
T. Interesting to have partnerships with notaries to hold information sessions on succession with elders so that they understand.
U. There should be a designated local in each community for elder activities.
V. Need to do some prevention with the Elders concerning their pension (how to) and that they do not have to give their entire pension to their children. They need to be told that they can get services from the Health Center. They also need to be told the effects of Drugs and Alcohol on their grandchildren who are with them - so they know what to expect, what behaviors they can have.

3.2 Existing Programs for Elders

3.2.1 Community Services

There is a continuum of health care services provided in the communities to elders whose needs depend on their level of autonomy range from independent to chronically ill. Many communities offer palliative care but there is no funding for it. Most of the Health Centers have programs for diabetes - weigh in and walk and share special meals.

Some communities have a wood cutting/delivery program for elders, and some provide an allocation for elders to purchase wood. There is some service for snow removal for stairs and front door - but not for driveways. In some communities, the pharmacy or the health center will deliver medication prescribed to elders.

3.2.2 Social Activities

Most communities try to provide some form of social activity around a shared meal; while some manage to organize outings, projects or trips to the woods:

- Meetings around lunch/ or a meal.
- Shopping trips
- Go blueberry picking every year
- Fishing

- Brunch every week
- Exchanging of gifts at Christmas, special activities for holiday
- Walks in the woods, and traditional meals together
- Sometimes with the school; take kids in the woods. Teach them cultural competencies such as for jobs in forest, etc.
- Card playing tournament between elders and youth
- Make booties/covers/bonnets for newborns to create contact between the elder and the baby
- Visit to Ste-Anne de Beaupré
- Try to get some computers to have the youth teach the elders how to use it (creates contact with the youth)
- We try to celebrate all the holidays with our elders so they are not alone.
- We try to visit those who are more isolated
- Community dinners for festivals that include the elders
- Once a month elders' lunch organized by Health Center with traditional food. We do gatherings with youth and younger children to teach them some traditional skills near river or in the woods.
- We are making a DVD filming the elders doing plays to teach the children stories.

A few communities have an Elders Committee that organizes programs for the elders, trips to visit other communities, as well as visits for those elders who are in residences outside the community.

3.2.3 Prioritization for Elders

The majority present at the regional meetings agreed that First Nations communities have to change the politics and make elders a priority. There is a need to develop consensus on a policy for elders. There should be a willingness of the community workers and the Band Council to see and acknowledge the needs of the elders. Elders don't participate very often in community meetings as no one goes to get them, and their needs are not always considered.

3.3 Elder Access to Public Services

The following sections deal with the challenges and barriers for elders in accessing public services inside and outside the community as stated by the participants at the regional meetings:

3.3.1 Language Barriers

As much as possible, some communities try to get a family member to go with the elder, even with medical transportation, as they need an escort to show the way and to translate. Some of the elders are deaf, and absolutely need an escort with them to assist them. In some communities, the Elders do not always want the services of a translator when they go to clinics because they do not believe they translate properly. The level of medical language can be problematic. Information is difficult to understand. It is essential that the translation is accurate for prescriptions or to explain treatment procedures.

For the Anglophone First Nations communities there are barriers in general around language, in addition to being speakers of their own language, many elders are very limited with French. Language is a difficult problem for the elders who are hospitalized. One community is fortunate to have an interpreter at the hospital which receives their community members.

3.3.2 Cultural Barriers

Some interveners explained the difficulties they encountered with the lack of cultural awareness at hospitals and provincial long-term care facilities. Many are not culturally respectful for customary beliefs concerning dying and giving birth. Some examples included only allowing 2 visitors in at a time which is difficult when it is customary to have the extended family visiting, not allowing the use of sweet grass which is an important traditional cleansing ritual. One person mentioned that they spent a month in a hospital and made a video of how they were treated.

3.3.3 Accessibility to Medical Services

There are a lot of problems in finding and hiring medical doctors for the Health clinics. Even when there are doctors, getting an appointment is often a problem. The doctor shortage is a big problem and creates mix-ups for prescriptions, or difficulties in getting prescriptions renewed. Some stated that specialists come once

every 3 months but there is no follow-up and no link with the hospital. Another community stated that they were fortunate to have two doctors coming for clinics on the reserve.

3.3.4 Inter-jurisdictional Issues

There are inter-jurisdictional issues for border communities who seek English language services in another province. Services provided in New Brunswick are being changed for border communities, and Quebec residents cannot access English online versions of services or applications, and there are also Quebec residency issues to access services available in Campbellton, New Brunswick.

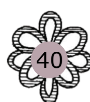
The border communities try to contact community services if elders have a lot of problems. A lot of elders see doctors in Ontario from the Algonquin communities, but if they need specialists, they have to wait a long time because the doctors are not paid right away. Inter-jurisdictional issues are a big problem.

Many interveners and elders said that the policy and procedures of INAC and HC need to be looked at with the on-reserve/off-reserve situation; it becomes a conflict and a mess. Those who live next to the community (off-reserve) because of housing shortages, and have family on the reserve cannot receive services provided by the community health centre i.e. homecare.

3.3.5 Coordination with Community Services

In most cases, there are no liaison officers at the local hospitals who are aware of community services in the First Nations communities, so there are not any referrals being made or notifications if an elder is released and requires services. Many stated that they really need a liaison nurse at the hospital who can let the services know the needs of the patient being released. One community said that they had developed a direct liaison between the hospital and the Home and Community Care program.

Many communities have very few contacts with the CLSC, and some said the CLSC staff does not come on-reserve. Others work with the local CLSC to fill in the gaps to ensure 24 hours, 7 days a week nursing services where needed. Another community said that a follow-up plan for ‘after hospital’ is established with CLSC. They develop an “agreement” about who does what.



When people are in hospital, there is a need to have a worker to go and visit to help them out with understanding what is going on. The person, who is accompanying an elder to the hospital, and the community worker doing visits, must receive training.

One community explained that they have an agreement with the hospital to have Atikamekw services, but elders who live off reserve (because of housing/medical needs), with their addresses (postal codes), they don't get the same services that are written in the agreement.

3.3.6 Transportation and Lodging

Many have to travel long distance for dialysis treatments. Others have to be transported to Montreal to a specialty hospital, a great distance away. It is a challenge for some communities to deal with the organization that runs the transportation and lodging services in urban center (there was a long discussion on the abuses of clients by this organization contracted service). The place they have to stay in is really not suitable - beds in a hallway with no separation, no curtain between – dirty, no doors - charging health Canada for a full meal - no privacy/dirty. Patients are taken to the hospital and left there on the door step without any escort.

A Health Director from one First Nations community went undercover to investigate the services and the lodging from this organization. A report was made. The conditions in the report were documented with Health Canada, so now patients from this community can stay at a Travel Lodge instead. But Health Canada continues to contract this service for the patients in other communities.

One community provided an example of the difficulties policies can create. Due to INAC policies for institutional care, the community has 2 elders (a couple) residing in two different institutions; one on reserve, one off reserve. With the lack of adapted transportation or public transportation, it is very hard to provide visits for the couple to see each other.

Dialysis is a new problem and often the elders must move out of the community for dialysis services. Some remarked on the difficulties of the medical transportation policy which stipulates that if an elder has to leave for medical services; Health Canada can only pay for one person to go. After 3 months, however, the Health

Center cannot provide lodging and the elder must find an apartment in the city and live there. The workers try to provide services but they are limited by regulations.

Other communities do not have any problems with transportation. But some remarked that there was a lack of escort services of people who can translate medical issues.

3.3.7 Other Services Available

Many said that for the most part, particularly in small or isolated communities, services are not available in the community, and elders must go outside the community. One intervener said that there is a center for Abuse to the Elderly in an urban center open to elders from the community. They also have to go outside the community for medical services, specialists, psychological services, massage therapy, reflexology, etc.

Some interveners remarked that there are cultural and linguistic barriers when they go outside. Sometimes with urban centers close to the reserves, there are long-standing prejudices, and the elders are not always well treated.

3.3.8 Information on Services

Some interveners said that they use a case management approach that creates an understanding of the process, and the client is made aware of the services available. Others said that they empower the family to take care of appointments but the team helps. This leads to informed decisions because as service providers they give them all of the information they need to follow through, and it is up to Elders to make decisions, but it must be an informed decision.

The members are told to always come to the Health Center if they have problems. The Health Center explains and gives information. In many cases, workers also send out bulletins, letters, and flyers. Many use the community radio station, where available, to give out information. Many elders listen to the community radio station and this is very effective.

Sometimes, Health Canada and the Quebec Health care system ask a lot for approvals of services, and the community health workers have difficulties with them. Very often in many communities Elders' medical cards are not updated which adds another difficulty in getting services for them.

4. SURVEY RESULTS

The following are the results of the survey sent in the communities. There were 24 questionnaires returned from 19 different communities, from a total of 31 First Nations communities in Quebec. They were completed by various health care workers, administrators, social services interveners and program staff working with elders.

4.1 Living Conditions

4.1.1 General Living Conditions of the Elders

Some elders live in acceptable conditions, while others live in abject poverty. Most live in isolation. They can receive home and community care or homemaker support if they are eligible, but sometimes when they live with their children they are not considered eligible for homemaker services (under Assisted Living Program). It is often their children and grandchildren who make their lives difficult. In many communities they are left alone, there are no activities organized for them. Sometimes this is due to their precarious health situations. Safety and security are major issues. Most Elders are poor in comparison to other members in their communities.

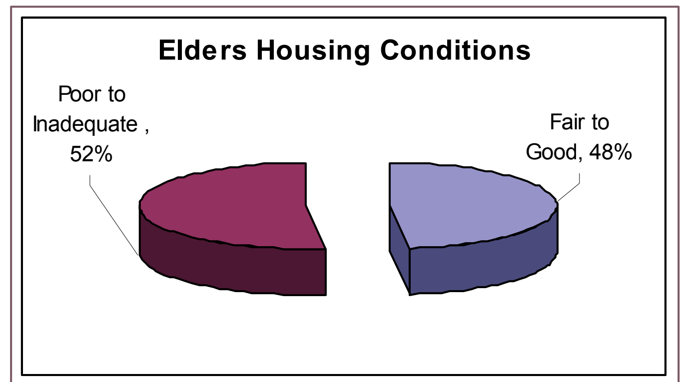
Some have support from their extended family as long as they are paid to take care of them, but this has to be monitored for abuse. Many Elders suffer financial abuse by their children and grandchildren. They face a loss of their autonomy and are often passed around in the family.

In the ideal situation, the elders have the choice of living at home, receive home and community care with regular nurse visits, and receive heavy duty cleaning once a year. They have a weekly get together (meal and bingo); have access to medical transportation and do receive some home repairs. In winter time, they receive help in snow removal, yard, and stove wood. In summer, where applicable, their grass is cut. In other cases, the Elders will be asked to share these costs.

In one community all of the homes are heated with wood stoves, which make the gathering of wood and the supply of wood for the stove difficult for the elders. In this community, ramps are non-existent or badly constructed and dangerous. In many, there is a need just for basic housing. An Elders' residence is badly needed in many communities so the elders can live more comfortably.

4.1.2 Housing Conditions of the Elders

In some communities, the elders live in acceptable housing but that is often coupled with an urgent need for repairs and or the adaptation of the houses to suit the physical needs of the elders. In other communities there are extremes with some elders living in acceptable housing, and others living in extremely poor housing conditions.



Many reported that the elders' housing is often very basic with no comforts or security. Many live in substandard housing or in crowded homes with their extended families. Very often in First Nations communities there has been no budget for housing repairs for the last 10 or more years. There is a limited number of housing program subventions to help the elders and sometimes they can be difficult to access.

In a few communities, all the basic needs, water and sewer, and ramps if needed, are there. Some health centers spend a lot of dollars in modifying living areas. Ramps are a huge cost to the health center. In only one or two communities, most of the elders live in newly renovated or new housing. The home and community care program keeps check on their needs for adapted living so most homes in these few communities are adapted to their needs. (With ramps, rail, bath handles, chairs etc.)

In many others, there are houses that still need repairs, mostly because of the age of the house. The housing needs often drop to the bottom of the "to do" list. There is a need for more renovation and/or additions for elders with disabilities or mobility concerns. Many times there is need for wheelchair ramps to access homes, which comes at the client's expense, not all are capable financially. There is a waiting list for occupational therapist assessments. The area that is lacking for the elderly is housing for disabled (physically) and those with special needs (e.g. Psychiatric, Alzheimer).

No homes are designed specifically for disabled seniors. There is a need for bath bars, telephone showers, adaptations of the toilet. Services are very slow in coming

because of the bureaucratic requirements for approval, and the budgets. Sometimes when it comes, it comes too late for the elder.

One community reports that there is overcrowding and poor housing conditions as they cannot afford renovations due to their precarious economic situation. The elders have great difficulty in finding just lodging, and then in finding affordable lodging.

Others report that the conditions in the homes varies with some having handicap apparatus and ramps. Many need repairs to homes from mold due to sewage backups, roof leakages; asbestos; lack of handicap adaptation to maintain their independence. The elders struggle with this due to fixed incomes and not being able to afford repairs. Having proper adaptations such as ramps, bars, etc., is a concern for most of the communities responding to the surveys.

There is always a long list for housing needs in the communities that includes single parent families, low income, those with medical conditions, those with special needs or chronic illness and the elders must compete on the list with all of these. There are no special subventions for housing for the elderly, or for disabled elderly.

4.1.3 Nutritional Needs of the Elders

The cost of food is too high especially in isolated regions. The elders are eating what they can afford, which is not necessarily what they should be eating. Nutritional needs are not always met due to the high cost for food. If the Elder is a diabetic, they cannot always afford to buy the type of foods they should be eating.

In some cases, the grocery stores are 10 km or more away, and the Elder must pay someone to go to the store or to take them. This is an additional cost to an already small food budget. They are sometimes charged too much for this service.

In more isolated communities elders eat mostly traditional foods. There are community activities such as hunting and fishing for the elders. The availability of traditional foods is not always sufficient or shared among the families. In a few communities, traditional food is not eatable. Fish is full of mercury. Vegetable gardens are meager related to environmental pollution from manufacturing plants.

These elders depend on local grocers for their nutritional needs and costs are rising. The elder who lives alone is often the one that lacks proper nutrition.

Some communities have a community freezer on hand if anyone wishes any traditional food. The hunters provide wild meat, and fish which is shared but it is dependent on availability. Some health centers have support staff for nutritional food when needed. This is because with deteriorating health conditions, some elders cannot go out on the land for traditional hunting and fishing.

The traditional food of the elders is much better than what is actually offered to them now. The appreciable advantages related to eating game are recognized (higher in protein and reduced in fat). The replacement of wild meat can have harmful effects on their health. What the elders generally buy is the cheapest food, it energizes, but it is not very nourishing. They eat whatever they have in their kitchens. The fresh fruits and vegetables they need are expensive, and many of the elders are unaware of the ways of preparing not-traditional food.

Communities that are next to larger rural communities or close to urban centers have food stores or grocery chains in close proximity and do not have the same difficulties of transportation or inflated pricing. In more isolated areas, grocery stores have a monopoly and they are more expensive.

The elders in most of the urban, and in many of the rural communities, follow the North American diet which is not very good for the elders. Most First Nations are very susceptible to diabetes. Thirty-three percent (33%) of the Elders who responded to the 2002 Quebec Region First Nations Regional Longitudinal Health Survey reported having diabetes[23].

4.1.4 Specific Situations that Negatively Affect the Elders

A. Physically

Most of the elders lead a more sedentary life; they are no longer out in the bush where they were more active. There is a lack of recreational outlets for the elders. Their physical needs are aggravated by the isolation, safety concerns, minimal outings, lack of services, lack of community events, lack of transportation for

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[23] FNQLHSSC (2006). *Quebec Region First Nations Regional Longitudinal Health Survey 2002*, page 187.

recreational activities, lack of exercise programs for the elderly, lack of doctors, and a lack of services to monitor medication intake.

Those living in families are most often in overcrowded homes and are responsible for looking after the children and grandchildren. Sometimes the home life is further aggravated because of the presence of drugs and alcohol. They are always in danger of falling because of toys and other things scattered everywhere. In fact, there is always a risk of a fall as most of the homes are not adapted. Many of the elders who have lost their autonomy refuse to leave their homes even if they can no longer cope at home. They do not want to go to a residence.

For one community that straddles many borders, one of which is to the United States, there are a lot of delays and difficulties for elders traveling from one side of the reserve to another just to go for groceries or for a medical appointment.

B. Mentally

Studies have shown the serious health conditions of First Nations elders, the percentages of chronic disease are much higher. The differences between their health status and that of the elderly Canadian population are also seen in their general emotional, mental and social wellbeing.

The elders do not socialize together as much as they should. Some have conflicts with their families which can cause family breakdown and loneliness. Others are ignored and neglected which causes depression. Sometimes the Elders are moved from house to house depending on who will take care of them. They become mentally stressed because they don't know where and when they are going next, and how to address the situation.

A lack of assessments, lack of family support, isolation, undiagnosed cases, the stigma of mental health, lack of services in their language of choice, all contribute to a lack of wellbeing among the elders. Some live with psychological violence and abuse. But nearly all live with isolation and solitude.

C. Emotionally

In some communities, a lack of community growth (future) impacts elders physically, politically, socially, and emotionally. A low sense of security leaves them feeling frightened, as there is a mistrust of the Sûreté du Québec. They feel lonely

because of a lack of family support, and isolated from each other. They feel sadness because they no longer have a place with the youth.

Sadly grief is always present for them with the loss of a close loved one - spouse, child, friend, family member etc. There is often verbal abuse, extended family demands, and financial abuse by family members. There is also a loss of autonomy.

D. Spiritually

Some reported that the elders are often sad that the young people are not more understanding of their culture and open to spirituality. The teachings which the elders learned from their parents have now become a subject in school textbooks.

Some said that overall the elders' spirituality is shattered. The destruction of their way of life, including the rupture of the spiritual bonds which they maintained with mother earth, and the destruction of the land and its inhabitants is reflected in the social disorganization within the community, and in the spiritual vacuum which the elders feel inside.

Some of the respondents indicated that many elders follow the Catholic religion, but they can't go to church because they don't have transportation or someone to accompany them. They often listen to the Mass on the radio.

4.1.5 Changes/Developments to Improve Situation

The following were suggested by the respondents to improve the situations cited above:

A. Physically

The community should organize more cultural activities each year, and arrange to have community celebrations so that the elders can participate. This will bring them out of their solitude and break the isolation.

The recreation departments in the communities should develop more activities for elders, possibly hiring a recreational technician. Presently a lot of recreation is centered on children and youth. There should be a day center where the elders can get together for these activities, possibly one with exercise equipment.

Each community should possibly conduct an evaluation of physical needs of each elder, and plan for them. There should be an elder's residence in each community as an alternative for those who do not wish to stay in their homes, but who want to stay in the community.

Housing for the elders should be properly regulated. They should automatically receive the needed adjustments and adaptations as a policy. For new elder housing or apartments, the adaptations should be done before they move in or as the needs arises.

B. Mentally

It was suggested to develop intervention strategies for elders which are culturally appropriate to them, and which are based on First Nations health experience. There should be exchange and discussion with elders on topics so they can share their knowledge, and become implicated in future directions.

There should be an elders' advocate to present the elders' issues to Council. This would lead to the development of programs specific to these issues, such as an increase in social gatherings for elders, help in dealing with abusive situations, sensitizing the youth. Some also suggested more funding, more activities made just for the elders that would allow for self expression of thought through plays, crafts, travel, etc.

The mental health worker should be more visible with the elders, and they should make occasional home visits. The health center should have elders assessed for their mental health status, encourage more family involvement, there should be more home visits by elder community worker and mental health, so elders start to have a sense of security and safety.

Finally it was suggested to have an elders' residence where they could all go and receive the proper services, and not worry and wonder where they would be placed next.

C. Emotionally

It was suggested to try to find ways to involve the elders more often with the youth, help them become more "positive with their lives". There should be more volunteers doing home visits. Communities should actively encourage families to

interact with the elders and participate in activities with them. An elders' advocate would assist with this.

Improving the elders' living conditions will allow them to better manage their own lives. This would improve their health and would strengthen the whole community.

D. Spiritually

First Nations often fulfill their spiritual needs by going back to their traditional ceremonies. Therefore we should put in place programs that touch on culture, draw ideas from old practices and traditional cultural ways to reorganize health care and special services intended for the elders. For others that prefer to follow other beliefs, there should be common approaches to well-being that still respect basic traditional beliefs.

Community services should get the Elders to help the younger population know who they are and their history. Today's generation of kids are too involved with technology and forget their roots. Have activities that center around both traditional and non-traditional teachings. Reinforce culture and allow all generations to be included.

For elders that follow Catholic or other religions, it would be important to encourage the priest or pastor to visit the elders more often, and to get the community services to organize transportation for the elders to mass or other services.

4.1.6 Role of the Extended Family

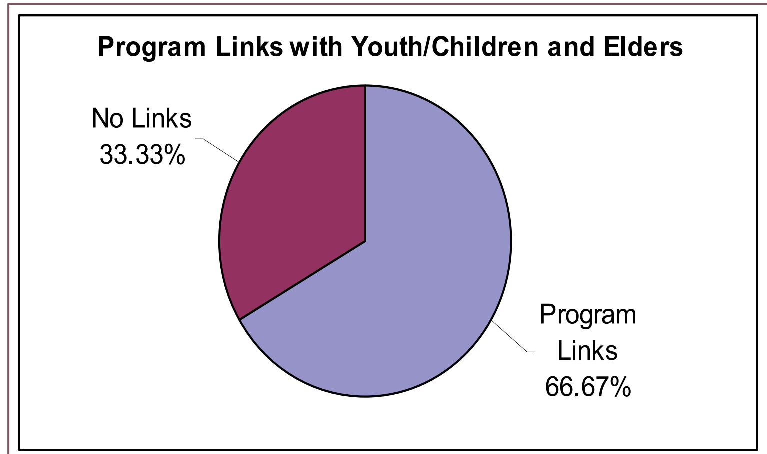
Most people still respect their Elders. However in many cases the family seems to be busy with their own lives and pay little attention to their parents. A small number of elders continue to advise and direct children's upbringing like traditional diets, beliefs and language.

Some extended family members are active in supporting elders. Some expect to be paid. Other families do not help out due to work/their own families. Some elders are fortunate to have family support. They provide help to them through meal preparation, doing errands, shopping etc. Some families have a strong sense of family values such as having regular weekly meals together. Some elders live with their adult children.

4.1.7 Links between the Elders/Adults/Youth and Children

Majority of the respondents (66.67%) indicated that there were links between the elders and children/youth within the community. Some of the links mentioned were through different types of programs offered in the community, culture week, school visits, early childhood programs, etc. The other 33.37% of the respondents indicated that there were little to no links among the youth and elders. Some of the reasons were due to language barriers, no access, lack of programming offered.

Some mentioned that the links are strongest in the family, especially between grandparents and grandchildren. Some examples of shared activities included: fishing, cooking, skinning animals, butchering of moose, deer, partridge etc., walking in the woods, canoeing, boating etc.



In some of the communities, the schools have culture week where the elders are involved in taking the children/youth to their camps in the bush, teaching them cultural values and getting them to practice survival skills. They also teach them how to hunt fish and prepare traditional food.

Some respondents suggested that the formation of an Elders' Council in each community would provide the elders with a decisional role that could reaffirm their traditional role. It could provide an opportunity for the elders to work with the youth on various projects. One example that was given was to work together on a civil code for the community.

4.1.8 Financial Situation of the Elders

Most of the elders are on a fixed income. They receive an old age security pension, and some receive a guaranteed income supplement. Some worked in the states and have a pension from there, so their pension is adjusted. Many of the responding communities said that there is someone (such as the CHR) to help the elders with the forms and applications, but sometimes this doesn't happen.

Many elders find it difficult to meet their financial obligations. Added to this is the fact that certain medications that they need are not always covered through Non Insured Health Benefits. It is also important to mention that, only until recently, First Nations were not allowed to contribute to the Régime des rentes du Québec (RRQ) unless they worked off reserve. Some don't know how to budget their money, and give it away to their children, others suffer from financial abuse by their children or grandchildren. Most find that the cost of living is very high, and they can just manage to live by the month.

4.2 Community Services

4.2.1 Services for In-Home Support

The In-Home Support services are provided when a request has been made and an evaluation is completed. The types of services listed in the surveys included maid services, meal preparation, help with bathing, accompaniment for medical appointments, errands/shopping, banking, medication assistance, budgeting, counseling services and respite care. One community said that through their Home Support Program they have a case manager who coordinates any additional support the elders may need (ex: pension application, dealing with certain affairs, housing needs). Not every community was able to provide the full list.

Other surveys reported various in-home services that also included some Home and Community Care (HCC) services. The services that were mentioned were nursing, personnel support workers, family support workers, medical, social workers, welfare, foot care, home maintenance (limited), massage therapy, ambulance, lifeline, occupational therapist assistance and case management and home makers.

In one community, a cooperative for services is in place to provide assistance and home support to elders on request. Home maintenance and meal preparation are the types of services offered based on an average of 2 visits per week. These services are not free of charge; the elders must pay for them.

4.2.2 Issues, Changes or Adjustments

There is a need for more trained home care workers and personal support workers. There should be more appropriate funding for home care workers and personal

support workers based on needs and not a formula. But there is also a need to avoid duplication of work between the two services.

There is often a lot of staff turnover, and there is a need for training for the workers. It was suggested that maid services should not be done by family members. The working conditions of homecare workers should be improved. Palliative services need to be funded, and natural caregivers should receive respite care. In some cases the workload needs to be increased to expand home visits to other elderly clients in the community. Elders, who do not have a pension from working, do not have enough money to pay for services such as maid services or meal preparation and delivery.

4.2.3 Home and Community Care (HCC) Services

The elders who are referred by the Health Center for specific care treatments can benefit from the services of home care workers for a limited duration. The elders must meet specific eligibility criteria, or they may also be referred by a hospital. Some of the services that they may receive include: hospital visits, telephone calls from nurse, bandage changes, injections, medication checks, medical supplies, follow-ups, foot care services, respite care, case management, home visits (in-home nursing), personal care services, bathing, in-home equipment.

Some communities have combined Home and Community Care program and the In-Home Support component of the Assisted Living program and, consequently, they included homemaker services as well in their responses to this question. Also included were such services as community kitchens and hot meals, assistance in daily living, escort/translation services, third party administration for financial issues/management, counseling, preparation of a will, and pension applications.

4.2.4 Issues, Changes or Adjustments

There is a need for occupational therapists to assess elders. The program should be “needs-based” to better service our clients, and not the limited hours that INAC restricts us to. There is a need for uniformity in access, with better collaboration between HCC and In-Home support. There should be more linkage with the CLSC for different services and priorities.

There is a need for more access to transportation. The HCC program should spread the care and prevention to all elderly members, and also to other individuals who are unable to care for themselves. All elders should be assessed periodically as prevention. Palliative care is not financed but is provided anyway in the communities very often.

There is a need for support services to be available for overnights evenings and weekends on a case by case basis, while at the same time, there is a need to expand the residential setting as many people are requiring this form of housing to meet their individual needs.

There is a suggestion to provide more nurses or nurses' aides to assist the nurses. There is not always enough staffing for everyone and maybe some home care workers could actually take courses as part of their job. Homemakers should be considered as permanent employees to provide more stability to the program.

4.2.5 Issues on Access

One respondent stated that the difficulty is what the funding agency (Health Canada) views as "access", in many cases the criteria are too strict. Another said that the access is not difficult but when needed care is required it is hard to find the right qualified resources. There is difficulty of access when the elder in need has to have a referral from a doctor to have Home and Community Care (HCC) services, not easy to see or obtain a doctor just to get a referral slip for HCC.

For some there is no difficulty for access at the moment, but in the future with increasing numbers of clients and decreases in staff, it will become a problem. For others, the difficulty in accessing services is that there is not enough staff due to the working conditions that social services provide (agreements with INAC); workers are underpaid and there is no security if they get hurt performing their duties. For others, there is no training for staff, and it is difficult to find resources. Some mentioned that the Band Council may provide services to some and not others which creates an inequality of access.

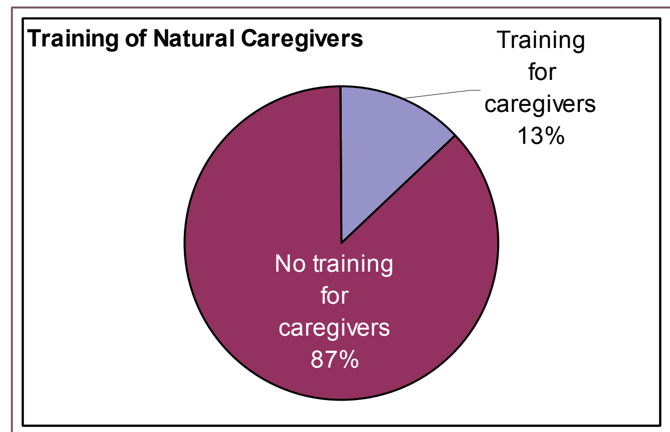
Some elders are isolated and do not come to the health center, others prefer to have one of the members of their families care for them. Some natural caregivers have the necessary skills to support the elders, while others find themselves with

this responsibility but not having the skills necessary. As a result, many elders do receive the services according to their needs.

Some of the surveys mentioned transportation as an issue that prevents access to services, particularly medical services, for the elders. Some mentioned that the elders needed to have information on the services that could be available to them, and the lack of information was a barrier.

4.2.6 Natural Caregivers

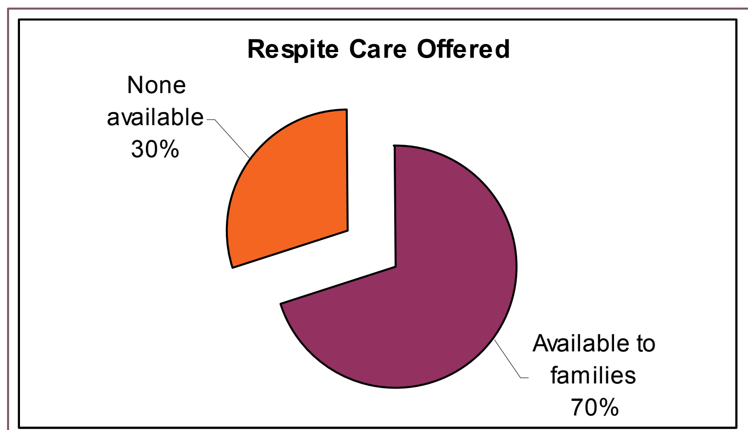
Immediate family members give services when caregivers cannot provide them. Most family members take part in this on the weekends. Most of the respondents (87%) stated that natural caregivers are not trained. But a few (13%) said that the nurse provided some training to family members on how to care for the elder they are looking after.



4.2.7 Program of Respite Care

There is a rotation of family members in some cases to allow the elders to stay inside their homes. In most of the others, it is the families of Home and Community Care (HCC) clients that receive respite care services based on the weekend/ evening and sometimes daily care of an elder. Respite care is also provided in cases of palliative care.

Some respondents said that while this service exists, respite care is not well known. Another respondent mentioned having an agreement with a CSSS and a provincial program to provide respite care.

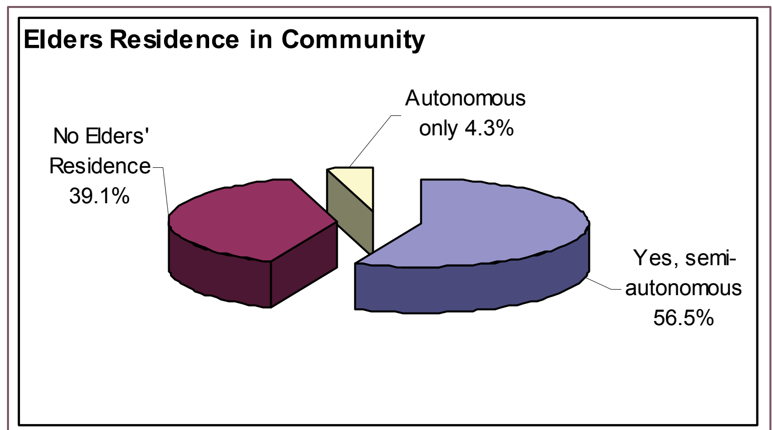


Social services also provide respite care by sending the elder to a long-

term care facility for a period of time. Other respondents provided examples of the local nursing home/elders residence being used for respite care. One stated that they offer respite care to families looking after elders, but since they are paid to do this, they do not want to take time off.

4.2.8 Elder's Residence

A total of 60.7% of the respondents stated that they had an elders' residence in their community. Some are full and have a waiting list. In 4.3% of the cases, the residence was only for autonomous clients, and 56.5% was for semi-autonomous.

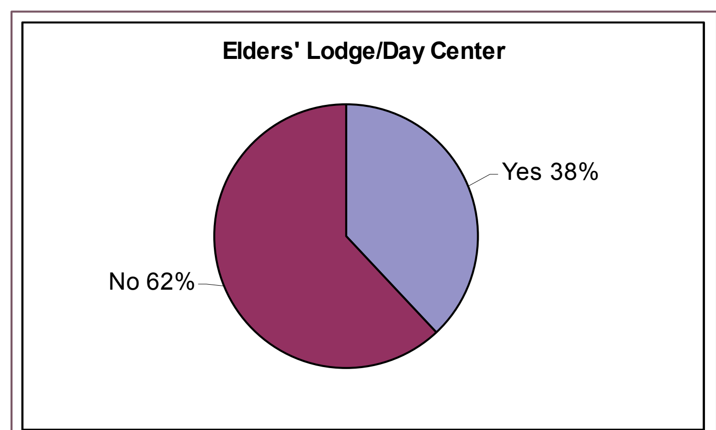


Many of the other respondents (39.1%) are trying to work on projects to get an elders' residence built in their communities. A few communities have elders' apartments but these apartment buildings require security adaptations, and one requires an elevator.

A few reported that their residences provided respite and long-term care with nursing services and a doctor on call. Others remarked that the training of the workers at their facilities was minimal, and there were no recreational programs for the residents. Some respondents mentioned the need for training the workers in dealing with mental health issues such as Dementia and Alzheimer's.

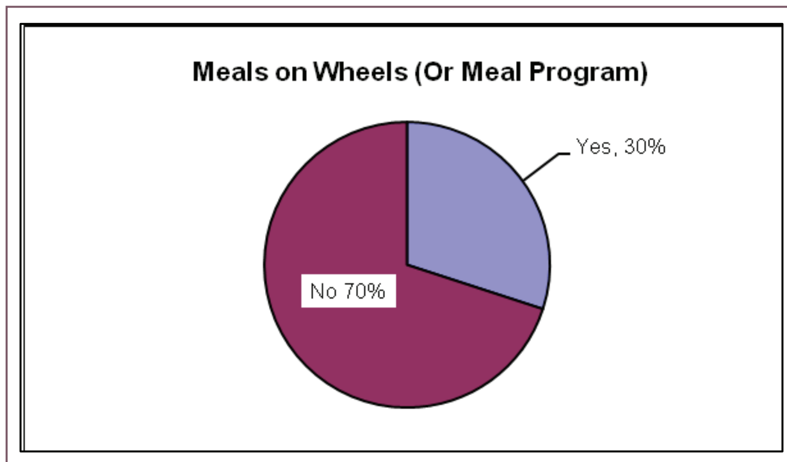
4.2.9 Day Center or Elder's Lodge

Those 38% that have an Elders' Lodge or Day Center offer social activities such as bingo, cards, arts and crafts and a shared meal. In one case, the Day Center is attached to the Elders' Residence. In another, it is the Elders' Committee that organizes the activities at the center.



4.2.10 'Meals on Wheels' (MOW) Program

Most MOW programs provide lunch 5 days a week. Sometimes weekend meals but funding would have to be increased in order to fully service elders in the community with meals 7 days a week. In one case, the meals on wheels is prepared at the elders' nursing home and then distributed to the elders. In another, they were able to provide meal service but there was no transportation so the service was not utilized.

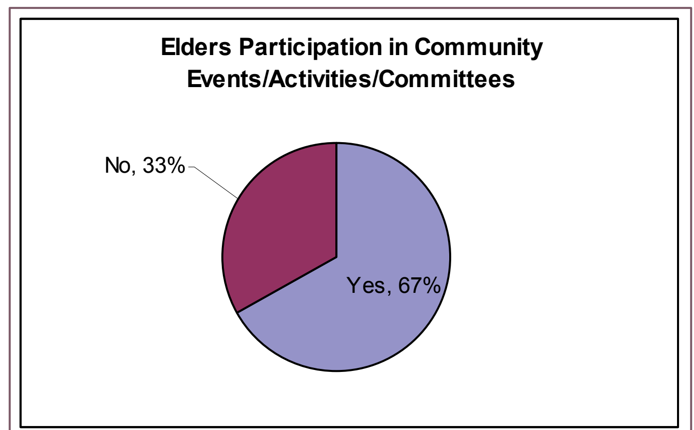


In one community there is a cooperative that can offer this service including housekeeping services up to a maximum of 15 hours per week, with an average cost of $580/month. The workers find that this is too expensive for the majority of elders who have needs and few resources, and for the most part the elders do not meet the eligibility criteria (established considering the co-op's financial means and human resources). Elders (who are referred clients) who have specific dietary needs could benefit from a meals' preparation service.

One community stated that they provide the services of a collective community kitchen once a week.

4.2.11 Elder Participation on Committees

67% of the respondents indicated that the elders do participate within the community through various events, activities and or elders' committees. Those who disagreed (33%) indicated that it was not possible due to lack of transportation, isolation of the elders etc.

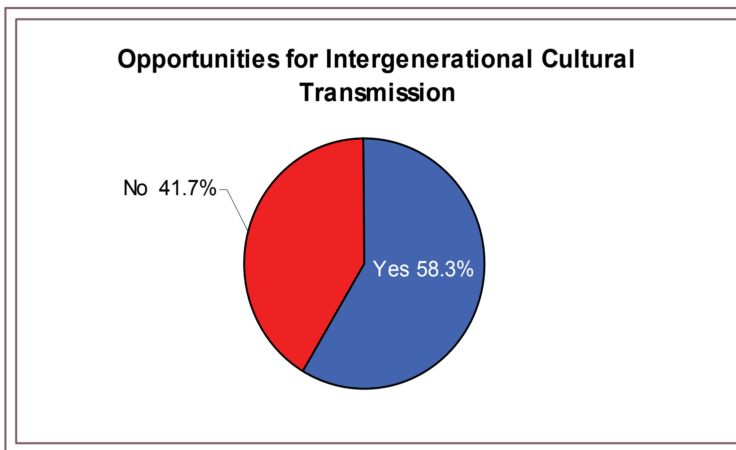


A few communities said that they have places on their committees for elders who

provide guidance, cultural and emotional support. Some are asked only to do the opening and closing prayers. Others said that the elders find it too hard to be on committees, but they participate in community activities.

4.2.12 Opportunities for Cultural Transmission

58.3% of the respondents claimed that there are opportunities for the intergenerational transmission of culture, language and traditional skills through various community-based projects/events, holidays, cultural day (week) etc.



Some said it was being done through talking circles, language retention programming, and using the Elders Lodge in the community to host cultural awareness. Other opportunities where culture, language and skills are transmitted include outings in the woods for the school children, summer camp, science camps, organized outings, canoe trips etc.

Those who disagreed (41.7%) stated that it is only possible through family, or that there were no programs within the community that allowed for this (did not exist). Where the opportunities for cultural transmission are not happening, it was stated that it is still needed. The language is becoming extinct. Traditional medicines are becoming non-existent, and there are very little cultural activities, drumming and singing is done very little, and only to certain groups. There are no legends or storytelling. There is a real need to have elders and others willing to volunteer, to offer their knowledge.

4.3 Health and Social Services

4.3.1 Health Issues

Diabetes is the most frequently cited disease for the elders. The elders have the hardest time in getting proper care which leads to other complications such as sores and hypertension. For the men, in particular, chronic lung disease touches them. Poverty often leads to malnutrition, as many of the elders do not have the

financial resources to purchase the types of foods that their health requires (dietary needs), and many of them do not have the financial resources and the needed information to obtain or renew their dental prostheses, which limits the foods they can eat.

Some of the other main health issues mentioned in the surveys were: hypertension, arthritis, cancer, asthma, chronic pain and illness, kidney disease, Alzheimer's Parkinson's, Huntingdon's, and thyroid disease (hyper/hypo).

Other health related issues mentioned in the surveys: Need for specific programs developed based on prevention and intervention, the need for medical transportation, need for closer monitoring of their medication, and the lack of physical activities for elders.

4.3.2 Other Health Services for Elderly

Other health and social services available in the community included:

- Pharmacy, dental, wellness, welfare, non-insured health benefits, community health, ambulance, Meals On Wheels, elders' centers, nursing homes, etc.
- Elders Lodge/Golden Age Club that provides Bingo which is very important for their social life, 4-5 gatherings per year for them to see each other.
- Psychological services are available as well as Addictions Counseling.
- Community health nursing clinics, a doctor's visit (limited) and access to telehealth.
- Foot care nurse twice a month, medical transportation services, environmental worker, and social workers for elders.

There were a few respondents who indicated that there were no other services for elders available in their community.

4.3.3 Gaps in Services

Some services are there, but they do not fully meet all the community needs. An example provided: an Elder that needs a health service that is available but still needs someone to interpret and speak with the RN on duty, which is not available.

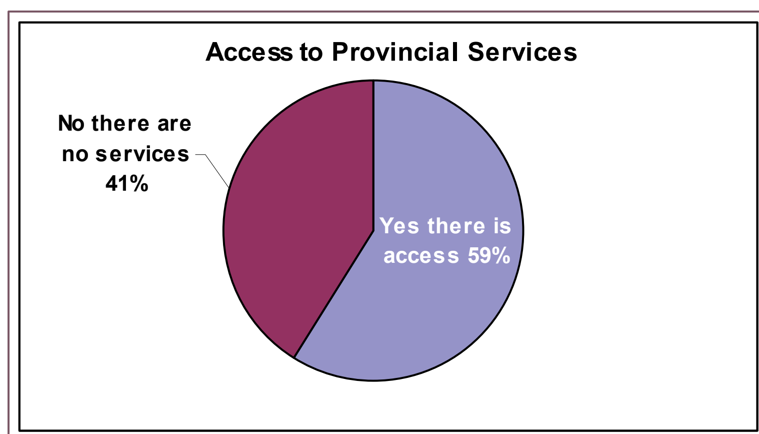
Other gaps in services that were listed in the surveys included:

- Lack of first line workers and trained professional workers (specialists and the proper equipment needed in related services)
- Social workers not properly addressing the needs of the elders
- Lack of prevention and intervention (information gaps)
- Gaps in non-insured health benefits
- Gaps in funding
- Interpreters who can accurately describe what the doctor is saying and who can relate the information back at a level that the elders can understand.
- Difficulties with handicap access to some buildings and to homes
- Transportation services and translation services
- Only CLSC services on the weekends, no HCC or home support available.

Another survey said that there is no foster-level care for elders i.e. Alzheimer's. There are no adult protective services. There is no back up for any forms of elder abuse. As previously stated, in the near future we will require specific types of residential setting in addition to more regular residential units. As well, it would be beneficial to implement a more independent setting for elders e.g. apartment style units.

One community mentioned that some elders are isolated and do not receive suitable care services because there are not any systematic visits to elders organized by professionals working in health. There is no day center or meeting place for elders to associate together and to break the isolation and solitude suffered by many elders. There are no plans to provide respite care to the many families who are looking after an elder.

4.3.4 Elders Access to Provincial Services

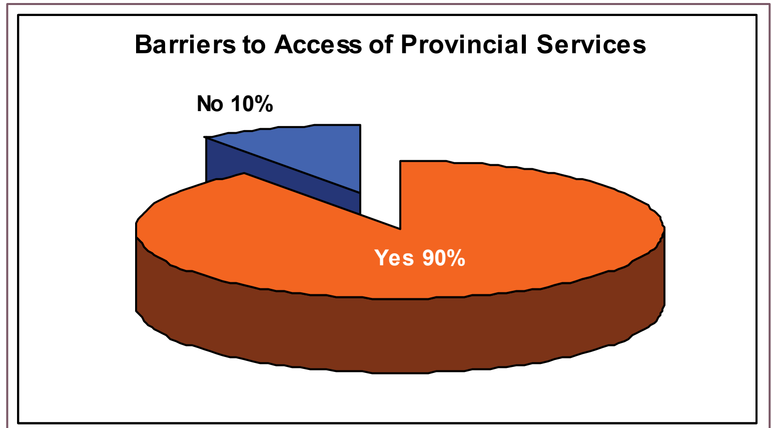


59% of the respondents said that the elders in their communities did have some access to provincial services inside and outside of their community. The outside services included the CLSC on the weekends and holidays, hospitals and clinics.

41% of the respondents disagreed that there was access for elders to provincial services. Some of the reasons included language barriers, fear of abandonment while outside the community, lack of transportation, fear of being put in a long-term care facility outside, etc.

4.3.5 Gaps or Barriers in Access to Provincial Services

90% of the respondents indicated having barriers to accessing provincial services; language was indicated as being the biggest barrier. Only 10% stated that there were no barriers to access provincial services.



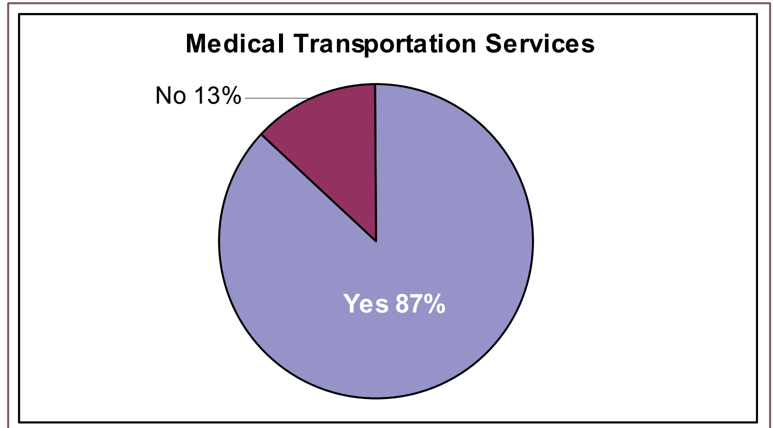
The barriers included:

- Difficulties in the language of communication; cannot understand written documentation. Medical terms are hard to understand. Even spoken language can be hard to understand at times.
- Lack of understanding of what services are provided, and where to access/knowledge of those services;
- Being told repeatedly that they are a federal responsibility;
- Transportation (especially on weekends or at night);
- Waits of up to a year and a half for specialists such as audiologist or ophthalmologist, occupational therapist, and physiotherapist;
- Limited finances to pay costs for additional equipment to bring in certified professionals;
- Wait of up to 2 years for a bed in long-term care facility;
- When clients are transferred, we cannot presume a continuity of care with the same services;
- Health Canada is covering less and less services to the elderly, particularly the medications for the elders, they are being cut off from what they had, and they are caught between systems.

4.3.6 Transportation Services

87% of the respondents indicated having some sort of medical transportation and 13% said they did not. Usually the medical transportation included some adapted transportation.

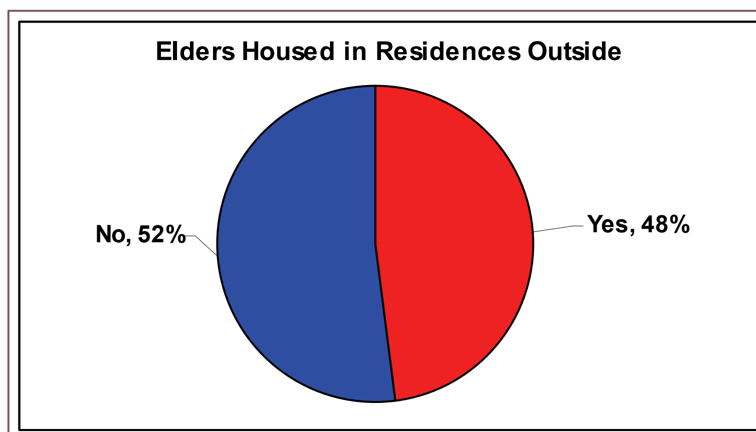
In most cases, the transportation is limited to working hours only, none on weekends or at night. Many communities do not include internal transportation to attend clinics at the health center; the transportation is strictly for outside appointments.



Some stated that the rules concerning transportation outside by train or air are the same for elders as they are for other community members. In a few cases, the transportation is limited to internal appointments only, and it is very costly for the elders to go outside.

What is often stated as not being available is the transportation to visit a spouse or an elder who is hospitalized or in a residence outside the community. In addition, there is no community transport for social needs. This is an issue that should be further explored as elders are often isolated from community events or social activities as they have no means of transportation.

4.3.7 Elders Institutionalized Outside



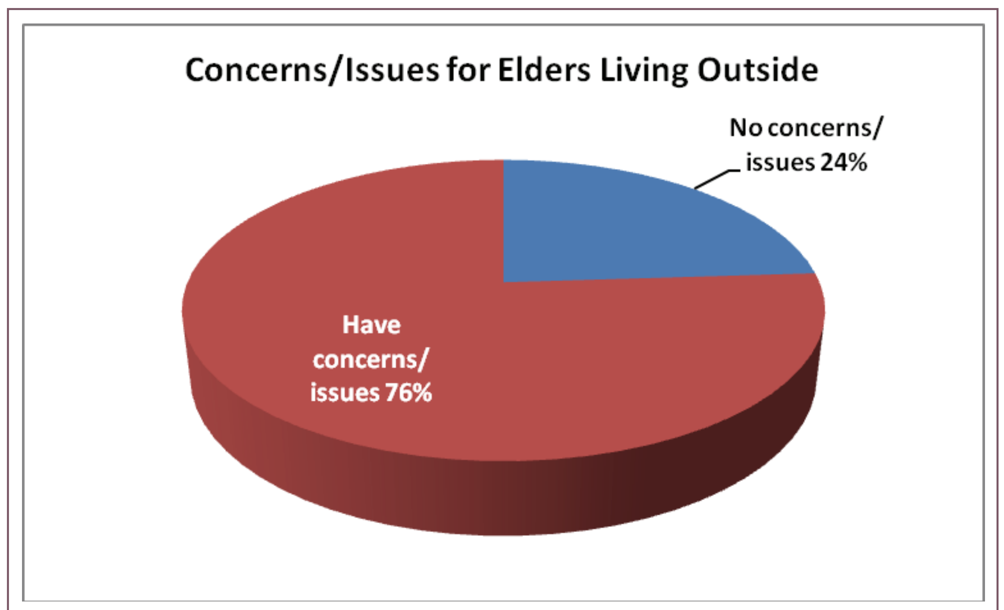
52% of the respondents stated that they do not have elders in residence outside the community. One respondent stated that community does not believe it is appropriate to place elders in an outside home or residence. It is too much of a language and cultural shock.

Another 48% said that they do have to place the elders in residences outside the community. In many cases, it was because they do not have a long-term care facility or residence in the community. There really is no choice in the case of dialysis but to go outside if the services are far away.

One community said that they convinced some elders with a lot of needs to accept to go into a long-term care facility outside, but now the families are pushing the services to have their elders back in the community.

4.3.8 Issues or Concerns

76% of the respondents indicated that there were issues and concerns about the elders living in institutions outside the community.



Loneliness, isolation and language barriers were among the most frequently mentioned concerns. Others included: type of food (not being able to eat traditional foods they were use to), money, loss of culture and traditions, distance from family members and community, depression and loneliness, and losing the continuum of care from the community.

There is also the issue of those who are on welfare (not yet receiving their pension) and who must pay a daily fee to live in these institutions. They cannot afford to pay these fees. They should be paid by INAC, but they are not.

4.3.9 Services Not Available

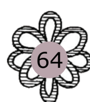
- The need for personnel to help the elderly properly. An Elder Facility on reserve that can house and meet the needs that the elders are facing.

- No local medical transportation provided to and from the Health Center for medical needs. Translation and simplicity of information given to elders.
- Foster level or supervised residence for elders. Particular services relating to addictions for the elderly population.
- Having the nurses salary covered for after-hour care would be very beneficial for those elders at the Nursing Home.
- Need more funding for in-home support for workers to check on elders in the evenings and weekends or for overnight stays. Elders are afraid when there is drinking in the home or in the community, they do not feel safe.
- For some it is not a question of 'not being available', but more a question of payment lacking or refused because the service is often sought in another province, and the professionals want to be paid immediately. Many elders don't have the cash, and therefore don't go, and it is affecting their health.
- The elders need to have a residence available to them, the only possibility that they have at the moment is a long-term care facility for those who have lost their autonomy. But for many their needs are just having social interaction which will improve their health and wellbeing in the long term.
- An Elders' Day Center is an important need in each community to bring the elders together for activities and socialization.

4.4 Prioritization of Needs

The following is a list of the issues that the respondents agreed that need to be addressed in order of their priority:

1. Elder abuse (particularly monetary)
2. Adaptation of homes to suit elderly needs
3. Lack of family support
4. Isolation and loneliness
5. Language barriers
6. Emotional distress
7. Loss of traditional role of elders
8. Poverty
9. Training for caregivers
10. Housing Conditions
11. Transportation
12. Access to information regarding services
13. Legal issues such as power of attorney, wills



14. Family violence
15. Turnover of staff
16. Visits from family members
17. Prescription medications
18. No of places in elders' residence
19. Elder Suicide
20. Stereotyping and prejudice
21. Ageism
22. Access to specialized medical services
23. Quality of life
24. Level of services in Elders' Residence.

4.5 Additional Comments Added

The following are additional comments that were added at the end by the survey respondents:

- "We need a full time community nurse to work with the Elderly. This would be better and would focus on prevention and wellness activities".
- "I believe that it is imperative that the Elders have a voice in the community. Someone who can speak on all their behalf and not for a few. We have a lot of elders who stay home, quiet and do not participate in all the activities, meetings that happen in the community. We have elders who stay home and are mindful of their business. These are the elders we find that no one sees – therefore when they need repairs to their homes (a very real concern for them) nothing happens until it's time for election. They are promised many items and all not followed through causing frustration and an over-whelming sense of despair".
- "A person who just advocates for the elders (speaks for them, works with them and provides them with the needed support). This would in-still pride and self-worth, feel they are contributors to our community".
- It has already been a year that I have been trying to have a center for the elders. The Band Council has given me a place to modify but I am missing the money and the resources to do this. The elders need a place, and they have asked me not to abandon them! Where do we find the money for their center?

- "One of the main issues is the cross border services (professional). Because of language we must cross the border for services. An elder does not want to go to Montreal when North Bay or Sudbury provides the same services and you can be there the same day. The Quebec government does not pay the same rate and the payment is delayed or in some cases doctors rather not take patient. Elders rather not go".
- "Discrimination is #1 priority. Because some services offered from the community funding is not at the same level of out-residents who go to the non-native society, where the government would pay the full rate without questioning. Budget is not sufficient to meet the demands".
- "A total of 567 elders, aged 65 and more, live out of the community (233 men and 334 women). Several of them have never lived in the community, on the other hand, not being able to correct the housing problems will ensure that even more have to live outside because they have no other choice".
- "The elders need an advocate to help them when their own children or families steal food or money from them. There should be laws that protect the elders when they don't want to call the police on their own children. Would like to see council get more involved in assisting our elders, more supportive housing projects that would assist the elders to live on their own (elders apartment with 24hr services) they would have their own living area with bedroom and sitting area within their apartment. Meals to be served in room or dining room for all the elders. Gives them a chance to remain independent and also monitored and provided with care. Elderly couples could live at ease without the stress of paying for heating, maintenance interior/exterior, or stairs or non accessible areas in their homes. Restructuring of social and health services and programs would be beneficial for the elders and community members and service providers".
- "I believe that it is imperative to look at the impact of the residential school experience and how this trauma began the splitting of families, loss of culture, language. We should also consider how this experience further led communities to abuse alcohol and drugs to attempt to dull the loss, pain, and grief. Subsequently, we must look at how these problems further impacted upon the next generation and so on".
- "Elders do not use personal support workers; they would rather use family members to help for their personal care. Elders choose their own home maintenance workers and they are not trained. There is an issue of not having a family doctor but they do not have access to doctors. Through

emergency, telehealth, doctors visit the community but the concern is lack of follow-up by same doctor, it is a different doctor each time. Emergency doctors only cover their present situation and don't have the time to analyze their medical history".

- "Training is needed for employees of SAD. There is a need for an elders' residence. We need the services of an occupational therapist. Social evenings for the elders".
- "Is it possible to know the results of these surveys?"

5. SUMMARY AND RECOMMENDATIONS

This last section looks at the overall needs and priorities of First Nations Elders, and makes recommendations based on the results of the surveys and the regional meetings, and where appropriate, provides a comparison with the MFA Strategic Action Plan for 2008-2012 which followed the public consultations by the MFA in 2007.

5.1 General Living Conditions

The living conditions of First Nations Elders vary from elder to elder, from community to community, and from region to region within Quebec. Some elders live in acceptable conditions, while others live in abject poverty. Most live in isolation. Almost 52% of elders, as reported by the surveys, live in substandard housing. Those who live in acceptable housing still do not have the needed adaptations to their homes. However, most elders want to stay in their homes.

It is often their children and grandchildren who make their lives difficult. In many communities they are left alone, there are no activities organized for them. Sometimes this is due to their precarious health situations. Safety and security are major issues. Most Elders are poor in comparison to other members in their communities. Many traditional elders still live on the land and eat traditional food. They state that they feel better when they eat traditional food and stay on the land.

The winters are seen to be extremely difficult for many elders as the isolation increases, and most elders need help during the winter, some not being able to afford the increased costs of wood and heating. Some elders in more isolated communities live in extreme conditions, some without even electricity and running water, many live with financial abuse when their cheque comes in.

Those living in families are most often in overcrowded homes and are responsible for looking after the children. Sometimes the home life is further aggravated because of the presence of drugs and alcohol. They are always in danger of falling because of toys and other things scattered everywhere. In fact, there is always a risk of a fall as most of the homes are not adapted. Many of the elders who have lost their autonomy refuse to leave their homes even if they can no longer cope at home. They do not want to go to a residence, because in many cases, this means going outside the community to an urban center.

Recommendation 1

Factors that determine and improve the health and well-being of elders need urgent investigation and a detailed strategic plan with the aim to develop, plan and implement integrated community based interventions. A Strategic Plan should be developed by the FNQLHSSC, in concert with the First Nations communities of Quebec, and with funding support in the same manner as provided to the MFA by the provincial government of Quebec.

Further it should be stated that failure to address the legitimate health concerns of elders by tolerating inadequate social and economic circumstances (determinants of health) will likely be reflected in higher costs for medical interventions.

5.2 Elder Abuse

This is considered to be a top priority by the interveners working with elders. Elder abuse in First Nations communities most often takes the form of neglect and isolation or financial "taxing" through threat, coercion or deceit. Negligence is easier to address at a community level through community services. The second is more difficult because the elders either do not want to get their family members in trouble, or are afraid of retribution.

It has been suggested to address this in a similar way to Youth Protection, but this will require working at a higher level with the province to bring about relevant changes in provincial legislation for Quebec. It will also imply that community Chief and Council take a stand on elder neglect and abuse. They can also implement community by-laws to address this issue as well.

In the meantime, working with elders on their rights, building up their self-esteem, teaching them what to expect in behaviors and providing explicit training to police officers, health workers and social interveners may assist in reducing the situations of abuse.

Some of the recommendations in further sections such as putting in place an Elders Advocacy program, and re-instilling the traditional role and respect for elders will also help to mitigate the instances of abuse.

The Quebec Government Action Plan to Combat Elder Abuse will inspire us so that similar actions are taken based on the three principles of prevention, evaluation and intervention.

Recommendation 2

The FNQLHSSC and the AFNQL should develop a strategy using different tools to create an awareness of the situation of First Nations elders and the importance to adopt appropriate behaviors with elders. This should parallel the Quebec strategy by making visible, using various media, the signs and symptoms of elder abuse.

In addition to this, there should be a campaign in each community to inform elders of their rights, and provide them with information on the services available, and the choices open to them.

Community police officers, as well as community interveners who work with elders and their families, should be better trained to prevent, evaluate and intervene for elder abuse. This type of training should be included in relevant postsecondary programs such as for police officers, social workers, community health workers.

5.3 Housing and Adaptations for Elders

Most elders want to stay in their homes, however many are caught between the shortcomings of the physical structure of their homes and the limitations of federal support programs. The inclusions of certain criteria, such as the need for an approval by an occupational therapist, make housing adaptation unrealistic especially for remote communities.

Almost 52% of elders, as reported by the surveys, live in substandard housing. Many have difficulty in finding affordable housing. Those who live in acceptable housing still do not have the needed adaptations to their homes. However, most elders want to stay in their homes. Further, if housing is to contribute to well-being of communities, it must be sustainable.

The MFA Quebec Strategic Plan calls for $12.5M dollars to be spent over the next 5 years to adapt services and infrastructure for elders based on regional planning.

The strategic orientations also call for elders to stay in their homes as long as possible supported by a safe and secure environment.

Recommendation 3

There should be a review of existing programs such as the "Residential Rehabilitation Assistance Program (RRAP)" or the "Home Adaptations for Seniors Independence Program" to develop more suitable eligibility criteria for elders. Other special incentives should be developed between INAC and CHMC to create an overall "Housing Initiative Fund for Elders" that would provide more options and support to First Nations communities to deliver:

1. *Newly revised incentives for Minor Adaptations to Elders Homes*
2. *Housing Subventions for Elder Repairs and Major Adaptations*
3. *Mortgage/Grant Incentives to Communities for Construction of Elders' Low Income Apartments (with specific adaptations for elders)*
4. *Program for Construction and Maintenance of Elders' Residences (that will include autonomous, semi-autonomous and long-term care clients).*

5.4 Lack of family support

Many elders live without family support as stated in the regional meetings and the surveys. There are natural caregivers that do provide care but without support or training. Where feasible, families must be implicated in the services that are provided and not left to feel that it is being taken care of for them. This requires a community strategy but also the ability to provide training and respite care. If families are to be asked to provide care and support to their elders, they should have access to appropriate training and respite care services.

On his part, the provincial government will provide funding for projects that will provide respite and natural caregiver services for families that look after elders through the Strategic Action Plan of the MFA (2008-2012).

Recommendation 4

Community service workers and social interveners should strategize to work with the families of elders to ensure that they provide support as family members. Policies and funding from agencies such as Health Canada and INAC (Social

Development) should address the need for respite care and the training of natural caregivers.

5.5 Elder Advocacy

The surveys have suggested that the elders require an advocate who can provide information and assistance to them, seek out services on their behalf, and assist them to speak out. This person must have a certain level of training to work in this capacity. The advocate would work with or establish an Elders' Committee to seek services to influence policy changes and to improve the quality of life for community elders.

Some of the needs that the advocate would work to address would be: lack of family support, isolation and loneliness, language barriers, emotional distress, access to information regarding services, information on legal rights of elders, preparing wills, ageism, stereotyping and prejudice and elder suicide prevention.

Therefore, it would be important to have an Elder Advocacy Program in each community funded by the government. Some of the needs that the advocate would work to address would be: lack of family support, isolation and loneliness, language barriers, emotional distress, access to information regarding services, information on legal rights of elders, working to increase the participation of elders in community activities and programs, preparing wills, ageism, stereotyping and prejudice and elder suicide prevention.

Recommendation 5

It is recommended to have an Elder Advocacy Program implemented in each First Nations community. This could be jointly funded by Health Canada and INAC Social Development programs. This program would provide the resources for an Elder Advocate, and funding for an Elders' Committee.

5.6 Legal issues

Many of the respondents have suggested that the question regarding Elders' legal rights be clarified and to ask for the Chiefs' support so that their rights are

respected in the communities. The issues surrounding will and legal succession should also be addressed.

Recommendation 6

As stated in Recommendation 2, it is necessary that elders be informed of their rights. It is also recommended that the Chiefs of Quebec support Elders' rights, as well as with the administration of the followings: power of attorney, wills and legal succession in First Nations communities. This should lead to the development of measures to clarify these issues.

5.7 Loss of traditional role of elders

First Nations often fulfill their spiritual needs by going back to their traditional ceremonies. Therefore communities should put in place programs that touch on culture, draw ideas from old practices and traditional cultural ways to reorganize health care and special services intended for the elders. For those who have other beliefs, there should be common approaches to well-being that still respect basic traditional beliefs, and the role of elders.

Community services should develop more opportunities for the elders to help the younger population know who they are and their history. Today's generation are too involved with technology and forget their roots. Communities should have activities that center around both tradition and non-traditional teachings, reinforce culture and allow all generations to be included.
Some respondents suggested that the formation of an Elders' Council in each community would provide the elders with a decisional role that could reaffirm their traditional role. It could provide an opportunity for the elders to work with the youth on various projects. One example that was given was to work together on a civil code for the community.

The strategic orientations of the MFA (2008-2012) call for a more active participation of elders both in the workplace, and as citizens, as community volunteers.

Recommendation 7

It is recommended that each community be encouraged to form, if it wishes to do so, an Elders' Council that would have an advisory role and would also oversee the affairs of elders in their community and the transmission of culture and traditions.

It is also suggested that community services could develop more opportunities for the elders to help the younger population learn about their identity and their history. Communities should reorganize health care and special services intended for the elders based on common approaches to well-being that still respect basic traditional beliefs, and the role of elders.

5.8 Poverty

Many elders find it difficult to meet their financial obligations. Added to this is the fact that certain medications that they need are not always covered through Non Insured Health Benefits (NIHB). Some don't know how to budget their money and give it away to their children and others suffer from financial abuse by their children or grandchildren. Most find that the cost of living is very high, and they can just manage to live by the month.

It is important to ensure that all elders are provided with full information and assistance to access the pensions and subsidies to which they are entitled. This should be monitored by community services. In addition, the federal government (INAC) should extend its Food Mail Program to ensure that more isolated communities, such as some Innu communities, can receive subsidies for food purchases. It was suggested in the consultations that rental and hydro rates be adjusted or subsidized for elders just as they do other "seniors" benefits as advertised outside for example in banking services, restaurants, movie theaters, etc.

The strategic orientations (2008-2012) of the MFA also call for actions against poverty and the social exclusion lived by many elders.

Recommendation 8

To mitigate many of the underlying causes of poverty, the following issues should be addressed:

1. *FNIB must ensure that all necessary measures are put in place in order to eliminate additional costs of prescription medication.*
2. *Elders (Possibly through the Elder Advocacy Program as recommended above) should be provided with full information and assistance with forms to access and maintain pensions and other subsidies.*
3. *Communities should work towards subsidized rental and hydro rates for elders.*
4. *Community services should ensure that elders do not have to pay exorbitant costs for transportation to purchase food.*
5. *Some traditional elders are dependent on a supply of traditional foods which either they hunt or receive through community hunts. To assist with this nutritional need, the government should provide funding to communities for the development of measures aimed at encouraging hunters living in more remote communities much as it does for farmers.*

5.9 Health and Community Services

Cultural care practices are required in all aspects of the care process given to First Nations elders in Quebec: assessment and intervention, staff selection and training, policy and procedure implementation, and facility location and design. Culturally sensitive care requires accommodation and negotiation with clients as partners in the process.

All communities offer Home and Community Care (HCC) and Assisted Living homemaker and residential care services, health clinics and many provide additional services such as medical transportation, escort and information services, elders' activities and meal services.

Community level care management, prevention, rehabilitation services and specialized services specifically targeted to the special needs of elders is an urgent need that will only become more pressing in the future.

Adequate and appropriate medical transportation and access to medical escort and language services are an important and critical health service for elders. These services should be reviewed at the community level, and then regionally with the funding agencies.

Recommendation 9

Community planning is required to address many of the needs outlined in this report, including the surveillance of prescription medications, the use of prevention workers to address the abuse of medications and other substances, appropriate medical transportation and escort services, training programs for caregivers, reduction of staff turnover, and staff training.

Each community should receive a non-recurrent allocation to conduct an Assessment of Capacity for Elders Services that would include an Implementation Plan. The results of the assessments would be discussed regionally with the funding agencies to see what support can be provided, as needed.

5.10 Elders Residence

Just over 48% of the survey respondents stated that there are elders from their communities that are housed in residences outside. There are many difficulties which this brings to the elders: loneliness, isolation and language barriers, type of food (not being able to eat traditional foods they were use to), lack of funds, loss of culture and traditions, distance from family members and community, depression and loneliness, and losing the continuum of care from the community.

An Elders' Day Center is an important need in each community to bring the elders together for activities and socialization. Sending Elders away to urban centers for care and housing takes an enormous toll on cultural strength, and may damage links between youth and Elders. Housing for Elders, including residences within remote communities, and Elders' Day Centers is definitely needed in order to sustain community and individual well-being.

Recommendation 10

Each elder is entitled to receive the same level of services and quality of life no matter where they live. On that basis, each community should receive funding for the construction or enlargement of an Elders Residence that would include a facility for an Elders Day Program.

5.11 Harmonization with Provincial Services

While there are gaps in services between the two jurisdictions, almost 90% of the communities reported that there are barriers for the elders to access provincial services. The most frequently cited barrier was language. Others involved policy implications, the ability to travel there, and some were related to their reluctance to leave the community for fear of being institutionalized outside.

There are disparities in services between what the federal system provides and what provincial norms are. As well, there are differences in the services provided in First Nations communities and in the province. Some examples include:

Type of Program	First Nations	Province
Home and Community Care (HCC)	• HCC Week days only	• CLSC has services 24 hours a day, 7 days a week as needed for eligible clients
Institutional Care	• Only support up to 2.5 hours of nursing • Many workers do not receive any training.	• Long-term full care • All workers receive training and must be certified.
In-Home Support (Homemaker services)	• Workers are paid $9.00 per hours with no benefits.	• Provincial workers receive higher salaries with benefits.
Palliative Care	• Not funded at all but provided by communities through existing resources and family support.	• Available
Prescription Medications	• Health Canada, through NIHB is covering less and less services, particularly with the NIHB; they are being cut off from what the elders had, and they are caught between systems.	• Insurance Plan for medications
Cultural Care	• Continuum of culturally appropriate care.	Many times culturally inappropriate care is provided.

Discussions that could lead to the harmonization of services though tripartite agreements could alleviate many of these gaps or deficiencies that are indicated in the table above. One example could be for long-term care. If an elder is sent to a residence outside, the province must cover all of the costs with the exception of the user's (elder) financial contribution. If the elder were to stay in the community residence and receive funding for the additional nursing care above the 2.5 hours paid by INAC from the province, it would be less costly for the province and 100% more beneficial for the elder.

Further, at the First Nations Socioeconomic Forum held in October 2006, the MSSS committed to systematize the referral function to make it easier to ensure continuity of care for individuals who have received treatment outside the community and then return to continue treatment within their own community. This would allow for faster and better convalescence.

Nevertheless, it should be highlighted that the suggestion for the harmonization of services in no way reduces the fiduciary responsibilities of the federal government and its funding agencies.

Recommendation 11

It is suggested that the FNQLHSSC, in collaboration with the First Nations communities of Quebec, work at improving a complete continuum of care for First Nations elders, taking into account both federal and provincial jurisdictions and responsibilities. This could be achieved through the harmonization of services using tripartite agreements could alleviate many of these gaps or deficiencies that are indicated throughout this report.

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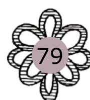

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