Integrated Housing Models for Older Adults Experiencing Mistreatment

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Introduction

Canada's population is aging rapidly, bringing increased attention to the housing needs of older adults and the systems required to support them. Older Canadians represent a diverse population with varying needs shaped by income, health status, mobility, and social circumstances. As of 2022, 93% of older adults express a strong preference to age in place, remaining in their homes and communities as they grow older rather than move into continuing care settings [1]. Consistent with this preference, many older adults live in private dwellings within the community, with approximately 92.1% residing outside of traditional care settings in 2018 [2]. Most also live in population centres (79.5%), highlighting the importance of urban housing systems in shaping older adults' experiences.

As needs evolve, older adults encounter challenges in accessing housing that is affordable, accessible, and connected to appropriate supports [4]. According to the 2016 Canadian census, 24.9% of older adults live below housing standards based on affordability, adequacy, and suitability, and approximately 14% of older adult households are in a core housing need, primarily driven by affordability (85%) [1, 2]. Housing need is more pronounced in census metropolitan areas compared to smaller towns and rural communities, further emphasizing the pressures within urban housing markets [3].

Patterns of housing need among older adults also reflect underlying social and economic inequalities, especially for older women. Housing need is most pronounced among older women, the oldest-old (85+), those who are visible minorities and/or immigrants, individuals with low-to moderate incomes, LGBTQ2S+ older adults, and those living with disabilities [3, 4, 6]. These challenges are further influenced by factors such as geographic location, Indigeneity, education level, cognitive impairment, and an increased likelihood of living alone, all which can compound vulnerability and limit access to appropriate housing options [1, 4, 5].

Within this broader context, older women experience particularly elevated levels of housing insecurity. In 2018, a higher proportion of older adult

women (4.7%) lived below the low-income cut-off compared to older men (3.3%) [2]. Older women are also more likely to live alone, to be retired or not engaged in full-time employment, and less likely to be married or in common-law partnerships [2]. As a result, they are more likely to rely on fixed or limited incomes, increasing their exposure to housing insecurity. They are also more likely to be renters and to live in apartment housing, further shaping the types of housing options available to them [3].

Housing challenges for older adults extend beyond affordability alone. Canadian policy research increasingly points to the importance of integrated housing needs, which include not only adequacy, suitability, and affordability, but also access to services, safety, accessibility, and community supports [1]. Gaps across these areas can limit the ability of older adults to live safely and independently in the community. Limited availability of supportive services, barriers to home modifications, and difficulties navigating fragmented systems further contribute to vulnerability among aging populations [7].

Within broader context, there is a growing recognition that older adults experience domestic violence (DV), intimate partner violence (IPV), and other forms of elder mistreatment (EM), often within private homes and caregiving relationships [8]. These experiences are frequently shaped by financial dependence, social isolation, and changing health needs [9]. Despite this, housing and violence-response systems have developed separately, and existing housing options are not designed to respond to the complex realities of older adults experiencing mistreatment [10].

Service integrated housing has emerged as a promising approach to addressing these intersecting challenges. Identified in Canadian research as a key innovative housing model, service-integrated housing combines residential environments with coordinated health, social, financial, environmental, and community-based supports to improve well-being, enhance safety, and enable aging in place [5, 11]. While these models are expanding across Canada, critical gaps remain. Challenges persist in ensuring that housing options are inclusive, accessible, and responsive to the growing diversity of older adult populations, as well as in improving the availability and coordination of supportive services [12]. Limited evidence exists on how current housing models address the needs of older

adults experiencing mistreatment, highlighting a critical area for further research and policy development.

This report examines service-integrated housing models with a particular focus on their relevance for older adults experiencing DV, IPV, and EM. It explores existing models, identifies key gaps in housing and service integration, and outlines design principles to support the development of more responsive, equitable, and integrated housing solutions. By positioning housing as a central platform for coordinated supports, this report aims to contribute to efforts to ensure that older adults can age in place safely, with dignity, and with access to the services they need.

Aging in Place

Aging in place has become a central principle in Canadian housing and aging policy, reflecting the strong preference among older adults to remain in their homes and communities as they age [6]. This approach supports continued connection to community, access to familiar services, and the ability to avoid or delay relocation to traditional care settings. Beyond personal preference, aging in place is associated with maintaining independence, preserving social connections, and supporting overall well-being [5, 6]. Social support, participation, and inclusion are also critical, contributing to a sense of belonging, acceptance, and connection within the community [12]. Opportunities for meaningful engagement, such as participating in tenant advisory boards or other forms of community involvement, can further strengthen these connections and support overall quality of life [12].

Further, aging in place is shaped by the relationship between individuals and their environments. Emotional attachment to one's home and neighbourhood plays a significant role, influencing both well-being and a sense of stability over time. This concept of person-environment fit highlights to importance of ensuring that housing and community contexts continue to align with evolving needs [12]. At the same time, autonomy and control over living arrangements are central to aging in place, particularly for older adults with lived experiences of trauma [12]. Together, these factors emphasize that aging in place is not simply

about remaining in the same location, but about maintaining choice, connection, and a supportive environment that enables individuals to live safely and with dignity [12].

Challenges to aging in place can be understood across three interconnected areas: individual factors (such as health, mobility, and social isolation), the availability and suitability of housing (including affordability, accessibility), and the strength of community supports that enable participation and connection [6]. Framing aging in place in this way provides a foundation for understanding why some older adults may need to move, the importance of aligning housing to individual needs, and the role of community in supporting overall well-being [12, 13].

Reasons for Moving

Although most older adults prefer to age in place, relocation may be necessary when their current housing or community no longer meets their needs. Housing moves among older adults are typically categorized as lifestyle, planned, or crisis moves [3]. Lifestyle moves are often choice-driven and may reflect a desire to downsize, increase convenience, or pursue leisure opportunities [3]. Planned moves are proactive, based on anticipated changes in health, mobility, or household composition, while crisis moves are reactive and often triggered by events such as the death of a spouse, sudden illness, or unsafe living conditions [3]. These decisions are often shaped by a combination of push factors (i.e. loss of a caregiver, unsuitable housing conditions) and pull factors (i.e. proximity to family or community supports) [3].

Despite these drivers, older adults are less likely to move than the general population, reflecting strong preferences for remaining in familiar environments and maintain social and community connections [3]. Housing decisions are determined by a combination of personal choice, necessity, and the capacity of the surrounding environment to support independence [14]. As noted by the World Health Organization, physical and social environments are key determinants of whether individuals can remain healthy, independent, and autonomous as they age [3]. Access to supportive services, safe and accessible housing, and

opportunities for social participation all influence whether aging in place remains viable or whether relocation becomes necessary.

Housing characteristics and community context also play a direct role in prompting relocation. Older adults may leave homes that physically unsuitable (i.e. due to stairs or poor accessibility), financially burdensome, or lacking essential supports, and instead seek environments that better accommodate mobility, independence, and safety. Similarly, broader community factors, such as access to transit, healthcare, social programs, and opportunities for engagement, can determine whether aging in place can be sustained [12]. Understanding these intersecting factors provides a foundation for reframing aging in place as aging in the right place, where housing decisions are guided by choice, safety, and connection rather than constraint or crisis.

Aging in the "Right" Place

The concept of aging in the right place (AIRP) has emerged as an important reframing of traditional aging in place. Rather than emphasizing remaining in a single location, AIRP focuses on ensuring that housing and community environments align with an individual's evolving needs, preferences, and circumstances [12]. In this context, secure and appropriate housing is not defined by location alone, but by the extent to which it supports an individual's abilities, lifestyle, and well-being over time. As such, the 'right place' varies across individuals and is shaped by a range of personal, social, and structural factors.

Access to AIRP, however, is not evenly distributed. AIRP is often more attainable for older adults with greater financial resources, strong social networks, and access to health and support services [12]. For those with fewer resources, including individuals experiencing housing insecurity or homelessness, the ability to secure housing that meets their needs is significantly more constrained [12]. This highlights the importance of an equity-focused approach to AIRP, as well as the need for housing and service models that support a broader range of older adults.

The built and natural environment plays a critical role in shaping both the desire and ability to AIRP [12]. Housing design, accessibility, and proximity to essential services influence where individuals can maintain

independence and quality of life [12]. At the same time, the broader community context, including access to transportation, healthcare, social and recreational activities, and green space, can either enable or limit meaningful participation in daily life [12]. In this way, AIRP extends beyond the housing unit itself to encompass the broader neighbourhood and community context.

Aging in Community

AIRP is connected to the concept of aging in community, which emphasizes the role of supportive, inclusive, and well-connected environments in enabling older adults to live safely and independently. In contrast to aging in place and AIRP, aging in community shifts the focus to how communities themselves are structured and responsive to changing needs over time [3]. In this way, aging in community moves beyond housing decisions to consider the broader systems, services, relationships, and conditions that shape quality of life.

This perspective reflects a broader reframing of aging. Aging in place has often been associated with avoiding relocation to continuing care, placing responsibility on individuals to remain independent for as long as possible [11]. In contrast, aging in community emphasizes fostering independence through shared responsibility, where communities, systems, and service providers play an active role in supporting well-being [11]. This includes a shift from reactive to proactive approaches, from viewing older adults as care recipients to recognizing them as active participants, and from unidirectional service delivery to more reciprocal and engaged systems of support [11].

At a systems level, aging in community depends on the availability, coordination, and adaptability of community-based programs and services. These systems must continually evolve to meet the needs of diverse and aging populations, including those in rural, remote, and underserved communities [15]. Key considerations include accessibility, service coordination, and the ability to navigate available supports, as gaps in these areas can limit the effectiveness of otherwise well-designed programs [12]. Knowledge of available resources is also essential, as access alone does not ensure uptake [5, 12].

Conceptualizing aging in community in practice aligns closely with the development of age-friendly communities, which focus on creating environments that support participation, inclusion, and well-being across the life course [6]. The AFC framework identifies key domains such as transportation, housing, social participation, respect and social inclusion, civic participation and employment, community and health services, and communication, emphasizing the need for coordinated policies and infrastructure that respond to diverse needs [6]. Within this approach, housing is understood as part of a broader ecosystem that includes access to services, opportunities for social participation and engagement, and supportive community design [6].

Aging in community can also be supported through a community development approach, in which communities work collaboratively to identify priorities and generate solutions using existing human and material resources [15]. This approach encourages flexibility, collective action, and local responsiveness, enabling communities to strengthen supports, address gaps, and improve quality of life [15]. For populations experiencing greater vulnerability, including older adults experiencing homelessness, this may involve integrated models that combine housing with wraparound supports, such as healthcare, mental health and spiritual services, food security (i.e. community gardens, communal meals, and access to grocery stores), financial assistance, and access to communication technologies, internet, and transportation [12].

At a broader level, global initiatives, such as the United Nations Decade of Healthy Ageing (2021-2030), reinforce the importance of creating supportive and inclusive environments, combating ageism, and ensuring access to integrated care systems [13]. The efforts recognize that aging populations are both growing and changing. Future cohorts of older adults are more likely to be educated, engaged in managing their health, and adopt technologies that support independence and well-being [13]. In this context, older adults also represent an important social and economic asset, contributing to communities through participation, volunteerism, and engagement in leisure and wellness activities [11].

Together, these perspectives position aging in community as a systems-level approach that extends beyond housing to encompass the broader

environments, services, and relationships that support well-being. This provides a foundation for more integrated and responsive approaches to housing and care, where the focus is not only on where adults live, but to enable older adults to live well within their communities.

Elder Mistreatment

Older adults' ability to live safely and well in their homes and communities can be undermined by mistreatment, neglect, or exploitation. EM is internationally recognized as a widespread, complex, and growth public health and human rights issue, with profound consequences for both individuals and communities [16]. The World Health Organization estimates that approximately one in six older adults experience some form of mistreatment in home settings annually, including physical, emotional, sexual, and financial abuse, as well as neglect [16]. Beyond individual harm, DV and EM disrupt social ties, diminish community safety, and negatively affect the atmosphere and overall quality of life in neighbourhoods [16].

Scope and Impact

IPV and DV remain significant drivers of EM. IPV alone accounts for nearly 30% of all police-reported crime in Cada, with women representing 79% of victims [17]. For women, IPV is also a leading cause of homelessness in Canada and the United States, and older women are the fastest-growing segment of homeless and at-risk populations [17]. Even when housing is available, maintaining residence can be challenging due to financial constraints, mental health concerns, or ongoing safety issues [17]. Some older adults cannot leave abusive situations due to a lack of housing options, while others live in precarious conditions and sacrifice necessities such as food, clothing, and medical care [18]. Homelessness among older adults, particularly older women, often arises through crisis-driven pathways, but structural factors, including housing scarcity, insufficient policy protections, and social inequities, play a key role [18]. As such, homelessness should therefore be understood as a societal and governmental issue, rather than an individual failing [18].

Older adults face unique risk factors that increase vulnerability to mistreatment. Dependence on caregivers, social isolation, cognitive or physical impairments, housing insecurity, and financial dependence all contribute to heightened risk [13]. For example, immigrant older adults, particularly those concentrated in large urban centres, may experience additional barriers including communication challenges, prejudice, and changing family models that increase isolation and vulnerability [13]. Histories of mistreatment early in life can also lead to experiences of homelessness or continued exposure to unsafe environments in later years [18]. Housing is both a site of risk and a key point of intervention: unsafe, inaccessible, or poorly supported living arrangements increase vulnerability, while integrated housing and community supports can reduce risk and facilitate detection of mistreatment.

Housing and Service-Based Interventions

Specialized shelters and emergency housing are critical components of addressing EM [15]. Yet, existing shelters often focus on women and children, lack the resources needed to support older adults' medical, cognitive, legal, and social service needs, and rarely accommodate older men experiencing mistreatment [15, 16]. Shelters also face chronic systemic barriers, including insufficient legislative protections, inadequate funding, limited social and housing supports, overlapping information systems, and poor data collection [21]. For example, research from the United States demonstrates that the state-funded programming for low-income older adults often poorly serves the homeless and does not meet the specific needs of older adults experiencing housing insecurity [18]. The COVID-19 pandemic has further intensified these pressures, producing a "shadow pandemic" with significant increases in calls for help and strain on shelters and crisis lines [21].

Researchers identify two complementary perspectives regarding shelter provision for older adults: one emphasizes the need for emergency shelters to keep older women safe from immediate violence, while the other highlights the importance of designing shelters that focus on the elderly rather than solely on homelessness, bridging sheltering to long-term care solutions [18]. Programs that are tailored to older adults, such as the Unison Elder Abuse Shelter (serving individuals 55+ of any gender) or Calgary's Elder Abuse Response Team (EART), provide temporary refuge and multidisciplinary support while

emphasizing privacy, security, and comfort [19]. Housing design that feels homelike, allows companions animals, and is in urban settings with access to services has been found to enhance both safety and emotional well-being [18].

Wraparound services offered in housing environments are also essential [15]. Integrated models that incorporating family violence services, victims' services, social and health services, law enforcement, legal and financial support, and faith-based programs help ensure comprehensive care planning and coordinated responses [15, 20].

Prevention and Empowerment

Preventative strategies aim to empower older adults, increase awareness, and reduce social isolation. This can include home-based supports (i.e. friendly visitor programs, Meals on Wheels, home support), adult day programs, and opportunities for social participation outside of the home [15]. Rather than only focusing on how help is offered, empowering older adults focuses on educating them on mistreatment and the actions to take if it occurs [15]. Fostering empowerment can look like providing support and information respectfully, encouraging self-efficacy, teaching skills for self-protection and assertiveness, and sharing knowledge about rights and problem-solving strategies [15]. Furthermore, access to transportation, safe communication channels, and age-appropriate crisis lines further support timely intervention and prevention [15].

Coordinated Community Responses

Coordinated community responses (CCR) have emerged as an effective framework to prevent, identify, and address EM by undertaking education, advocacy, and other strategies to reduce EM and enhance community safety for older adults [20]. CCR initiatives provide a common philosophical framework, standardized policies and protocols, coordinated communication among service providers, prevention activities, and access to integrated resources [20]. Community-based EM intervention and consultation teams, such as EART, exemplify CCR in practice by combining professionals from government, law enforcement, and social

services to consult on complex cases, identify solutions, and develop care plans [15, 20].

Systemic and Policy Context

Globally, adult protective services remain limited, available in only one-third of world regions, making them the least implemented victim support service worldwide [16]. Domestic Violence Death Review Committees (DVDRCs) are multi-disciplinary advisory bodies that review DV-related deaths and provide non-binding recommendations to governments, non-profits, and professional organizations [21]. DVDRCs exist in Canada, Australia, New Zealand, the United Kingdom, and the United States [21].

In Canada, the first DVDRC was established in Ontario in 2002, and most provinces maintain some form of review mechanism [21]. Alberta dissolved its Family Violence Death Review Committee in late 2025 [22]. Established in 2013 under the Protection Against Family Violence Act, the committee reviewed cases to identify trends and inform prevention strategies [23]. Its final report (2024-2025) indicated that victims ranged in age from 0 to 79 years and older, with two victims 70 and older, while two perpetrators were between the ages of 60 and 69 [23].

The decision to dissolve the committee was based on the assessment that its operation was not an efficient use of resources. The provincial government indicated that other review mechanisms and priorities may better produce actionable strategies or policy direction [22]. These include investigations conducted by the Office of the Child and Youth Advocate and fatality review boards [22]. No dedicated mechanism has been introduced to replace the committee specifically for domestic and family violence, highlighting an ongoing gap in coordinated, violence-specific review processes in Alberta [22].

Co-Caring

Experiences of aging, housing, and well-being are often shaped not only by formal systems of care, but also by the informal relationships and supports that exist within communities. The concept of co-caring reflects a model of

neighbourly, mutual support that extends the forms of care traditionally provided within families and communities [11]. Rooted in long-standing practices of shared responsibility, co-caring emphasizes a vision of aging that is socially connected, engaged, and grounded in reciprocity [11].

At its core, co-caring supports independence through an understanding of interdependence [11]. Rather than positioning older adults solely as care recipients, this approach recognizes that individuals both give and receive support over time. In this way, interdependence is not defined by the absence of need, but by the ability to remain connected, contribute meaningfully, and access support when required. Co-caring can therefore play a critical role in enabling older adults to maintain autonomy while reducing isolation and vulnerability [11].

Co-caring is closely aligned with models such as cohousing where shared living environments are intentionally designed to foster connection, collaboration, and mutual support among residents. In these settings, individuals develop the ability to articulate their needs, offer support to others, and receive assistance with dignity [24]. This includes cultivating practices of asking for what is needed, giving what one is able, and accepting help with respect and without stigma [24].

Within the context of EM, co-caring offers both opportunities and considerations. Strong social networks and regular interaction can support earlier identification of risk, reduce isolation, and create informal safety nets for older adults experiencing or at risk of mistreatment. At the same time, co-caring models rely on trust, communication, and shared norms, and may require clear boundaries and supports to ensure that responsibilities are balanced and that individuals are not placed at risk within informal caregiving relationships.

As part of broader service-integrated and community-based approaches, co-caring highlights the importance of designing housing and community environments that enable connection, participation, and mutual support. When combined with formal services and coordinated systems of care, co-caring can contribute to more resilient, responsive, and inclusive models of aging that support older adults to live safely, with dignity, and as active participants in their communities.

Service Integrated Housing

Service Integrated Housing (SIH) is an innovative approach that combines residential environments with coordinated supports to meet the complex needs of older adults. These interventions integrate physical, social, and technological dimensions alongside services and supports, providing a more holistic response than traditional housing models [6]. SIH typically includes access to health, social, and where possible, legal supports, enabling older adults to live safely, independently, and with dignity while remaining connected to their communities [25].

SIH exists along a continuum, ranging from independent housing with optimal supports, to fully supportive housing, and to campuses of care that offer higher levels of integrated services. This continuum distinguishes SIH from traditional seniors housing or emergency shelters, which often focus narrowly on accommodation or crisis response rather than holistic, coordinated care. Across the continuum, the goals to provide housing not just as a physical space, but as a platform for delivering services that support aging in place, well-being, and autonomy,

Many SIH initiatives historically focus on program and service delivery. Age-friendly efforts represent a shift towards supporting older adults not only individually but by shaping the environments of the communities where they live [25]. Examples included enhancing the physical environment (i.e. accessible housing, transportation), advocating for legislation and regulation (i.e. zoning to support older adults needs), improving dissemination of information, increasing access to venues associated with positive health behaviours (i.e. fresh food markets), encouraging the development of social capital, and promoting volunteerism [25]. These approaches highlight the broader potential of SIH to support health, participation, and inclusions within age-friendly communities.

Design Principles

At its core, housing is conceptualized as a service platform, integrating residential space with health, social, and ideally legal services. This

approach emphasizes aging in place and person-centred design, ensuring that both the physical environment and the services offered respond to individual abilities, preferences, and life circumstances. Supportive housing interventions should integrate physical, social and technological dimensions, recognizing that independence and well-being are influenced by not only the home itself, but also by the surround environment and the accessibility of services and supports.

In addition to core principles, housing that is response to IPV and EM incorporates trauma-informed design, with attention to privacy, safety planning, and staff training in abuse detection. Access to legal and financial supports is essential, along with flexible models that can respond to the complex needs of individuals who have experienced mistreatment. Housing environments should feel homelike, safe, and supportive, acknowledging that older adults may be vulnerable due to social isolation, dependency on caregivers, or past histories of mistreatment [15]. These considerations recognize that most initiatives geared towards improving older adult lives have traditionally focused on program and service delivery, but effective SIH also attends to the environment in which these systems operate [25].

Housing Models & Examples

Housing models for older vary in structure, service integration, and responsiveness to risks such as EM and IPV. Overall, leading types of new housing models include co-living, cohousing, home sharing, cooperative housing, affinity communities, service-integrated housing, life lease housing, and community hubs [1]. These models aim to provide housing that is more affordable and supportive while promoting independence, social connection, and well-being. Potential benefits include lower rates of depression, decreased need for formal care, encouragement of healthy behaviours, increased social activity, reduced loneliness and isolation, and intergenerational environments that foster mutual support [1]. Nonetheless, these models face challenges such as difficulty sustaining and expanding programs, limited external funding and support, and gaps in inclusion [1]. Access to core community supports often varies depending on location, including non-medical services such as landscaping [13]. Older adults consistently express a preference to live near essential services such as grocery

stores, health clinics, pharmacies, bus stops, and malls, while avoiding locations near commercial or industrial zones or bars, highlighting the importance of both physical and social neighbourhood environments [13].

Table 1: Housing Models for Older Adults [6, 11, 14, 24, 26, 27, 28, 29, 30, 31]

Model	Description	Canadian Examples	Strengths & Limitations for EM Response
Building-Based Models Supportive Housing & Integrated Service Models (ISM)	Self-contained apartments or units for older adults who are functionally independent; may include integrated health, social, and wellness services. ISM integrates physical, social, and technological supports into housing. Emphasizes aging in place, person-centred design, and tenant participation.	**Horizon Housing Society – Pineridge Project, Calgary, AB** 65 units for low-to-medium income residents, accessible design, common spaces, secure parking, walking distance to schools, grocery, transit, green spaces. **Tenants First ISM Project, Toronto, ON** Tenant-focused care coordinators, wellness hubs, staff training, policies/procedures for older adults,	**Strengths** Provides holistic support, centralizes access to services, fosters dignity and autonomy, reduces social isolation, encourages tenant engagement. **Limitations** May not fully address IPV/EM abuse without trauma-informed staff and legal/financial support integration; relies on sufficient funding and trained personnel.

		tenant input prioritized.	
Community-Based Models Naturally Occurring Retirement Community Supportive Services Program (NORC-SSP), Hub & Spoke	Older adults remain in their own homes or apartments within existing communities; services delivered in place through partnerships between government, health authorities, and third sector organizations. Emphasizes social support and prevention.	**OASIS Seniors Supportive Living, Kingston, ON** Partnership between residents of Bowling Green Apartment Complex, the property owner (Homestead Landholdings, and the Home and Community Care Support Services.	**Strengths** Maintains independence, encourages neighbourly support and co-caring, reduces reliance on government services, promotes early detection of mistreatment through social engagement. **Limitations** Limited inclusivity for diverse populations, requires strong coordination, smaller scale may struggle to respond to complex EM cases or IPV.
Campus/Co-Located Models	Centralized location offering a range of	**Trent University, Peterborough, ON**	**Strengths** Strong social integration;

Campus of Care, Seniors Villages, Intergenerational Campuses	housing types (independent, supportive, life lease) and on-site or co-located health, social, and wellness services. Flexible to evolving needs. Emphasizes operational efficiencies, economies of scale, and intergenerational integration.	Integrates seniors housing within a university campus, promoting social connection, lifelong learning, and intergenerational engagement.	reduces isolation though intergenerational engagement; access to shared services and infrastructure; supports mental well-being and community participation. **Limitations** May lack formal health/service integration unless paired with supportive services; not inherently designed for IPV/EM response, requires additional coordination for safety planning and specialized supports.
Cohousing/Co-living/Home sharing/Affinity Communities	Intentional communities combining private dwellings	**Wolf Willow Cohousing, Saskatoon, SK**	**Strengths** Builds strong social capital and informal

	with shared amenities and participatory social support; promotes co-caring and independence. Older adult-focused cohousing emphasizes neighbourly mutual support, universal design, and social engagement. Home sharing provides intergenerational support and housing security.	21-unit condo-style development with shared kitchen/dining lounge, music and craft rooms, guest suites, workshop and gardens, and wellness spaces. **Harbourside Cohousing, Sooke, BC** 31-unit resident-developed community with a dedicated care suite, strong emphasis on mutual support, and required education on aging in community. Fully sold prior to construction with waitlist.	monitoring networks; reduces loneliness and isolation; promotes health behaviours and independence; co-caring environments may support earlier identification of risk or abuse. **Limitations** Often lacks formal service integration, difficult to scale and sustain, limited external funding, not consistently inclusive of diverse populations; may not adequately support individuals with complex needs or those actively fleeing abuse

			without additional supports.
DV-Specific Housing Seniors Shelters, Transitional Housing, Safe Space	Temporary or transitional housing designed for older adults experiencing DV or EM. Trauma-informed, secure, and accessible; integrates social, medical, legal, and financial supports.	**Unison Elder Abuse Shelter, Calgary, AB**	**Strengths** Provides safety, specialized support, and temporary refuge; multidisciplinary approach addresses complex needs; privacy, comfort, and homelike environments improve accessibility. **Limitations** Limited availability, programs largely concentrated in US/Canada; shelters often urban-centered; ongoing funding and systemic support needed.

Implications

The range of housing models outlined highlights that no single approach fully addresses the diverse and evolving needs of older adults. Instead, these models operate along a continuum of service integration, from informal, community-based supports to highly coordinated, building-based and

campus environments. This variation has important implications for how effectively housing can respond to risks such as social isolation, housing insecurity, and EM.

Models with higher levels of integration, such as supportive housing and campuses of care, offer greater opportunities for coordinated service delivery, earlier identification risk, and more structured responses to mistreatment. The co-location of health, social, and potentially legal supports can enable multidisciplinary approaches and more comprehensive care planning. At the same time, these models require significant resources, cross-sector collaboration, and sustained funding to operate effectively.

In contrast, community-based models and cohousing approaches encourage independence, social participation, and mutual support. These models can play a critical role in prevention by reducing isolation, strengthening social networks, and fostering environments where changes in well-being may be noticed earlier. Still, reliance on informal supports and limited integration of formal services may constrain responsiveness to complex or high-risk situations, particularly those involving IPV or ongoing mistreatment.

The limited availability of housing models specifically designed for older adults experiencing DV or EM further highlights a critical gap. While specialized shelters and transitional housing provide essential short-term safety, they are often geographically limited, under-resourced, and not well integrated into broader housing and service systems. This underscores the need to embed mistreatment-responsive design and supports across all housing models, rather than relying solely on crisis-oriented interventions.

Taken together, these findings reinforce the importance of service-integrated housing approaches that combine the strengths of different models. This includes designing housing as a platform for coordinated services, strengthening connections between formal and informal supports, and ensuring that environments are responsive to the needs of diverse populations of older adults. Greater attention to scalability, inclusivity, and system-level coordination will be essential to advancing housing solutions that support aging in place while also addressing the risks of isolation, instability, and mistreatment.

Recommendations for BSF

The Brenda Strafford Foundation is well-positioned to take incremental, high-impact steps that build on existing strengths while advancing more integrated and responsive approaches to housing and services for older adults experiencing mistreatment, vulnerability, and isolation.

Strengthen Service Integration Within Existing Sites

Rather than developing entirely new models, a practical first step is to enhance service integration within existing housing sites. This can include formalizing partnerships with community organizations to provide on-site or regularly scheduled services (i.e. health navigation, social work support, financial counselling). Small scale additions, such as designated service days or visiting providers, can improve access without requiring major structural changes.

Build Staff Capacity to Identify and Respond to Mistreatment

Frontline staff are often best positioned to notice changes in resident well-being. Providing targeted training on EM, IPV, and trauma-informed approaches can strengthen early identification and response. This does not require creating new programs, but rather integrating clear protocols, referral pathways, and basic training into existing operations.

Improve Navigation and Awareness of Existing Supports

A consistent gap is not just access to services, but awareness of them. The Foundation could implement simple navigation supports, such as resource guides, service directories, or periodic information sessions for residents. Partnering with local organizations to deliver these supports can help reduce isolation and improve uptake of available services.

Pilot Small-Scale Integrated Supports

The Foundation could trial targeted pilots within sites, including a weekly wellness or service hub and partnerships with existing community response teams.

Piloting allows for learning and adjustment before expanding, while also generating internal evidence to support future funding.

Incorporate Safety and Privacy Considerations

Large redevelopment to sites may not be feasible, and smaller design readjustments can improve safety for residents experiencing vulnerability. This can include reviewing lighting, visibility, private meeting spaces, and staff access points, as well as ensuring residents have safe ways to seek help. These changes can often be integrated into ongoing maintenance or upgrades.

Strengthen Community Connections

Social isolation is a key risk factor for both declining health and mistreatment. Supporting low-cost, resident-led or partner-led programming (i.e. peer groups, communal meals, volunteer programs) can strengthen social networks within housing sites. Exploring opportunities for intergenerational or community partnerships can further enhance connection without significant new investment.

Additionally, the Foundation can align more closely with existing local initiatives (i.e. community hubs, outreach teams, or age-friendly efforts). This may help leverage existing infrastructure and avoids duplication, while strengthening coordinated responses across sectors.

Conclusion

Canada's aging population is reshaping the way housing and care must be understood and delivered. While most older adults express a strong desire to age in place, this report highlights that the ability to do so safely and with dignity depends on more than remaining in a single location. It requires housing environments that are affordable, accessible, and meaningfully connected to services, supports, and community.

Across Alberta and internationally, a range of housing models are emerging to respond to these needs. SIH, community-based approaches, campus models, and alternative arrangements such as cohousing each offer

distinct strengths. At the same time, no single model fully addresses the complexity of older adults' experiences, particularly for those facing social isolation, housing insecurity, or EM. Gaps remain in service coordination, accessibility, and that availability of housing options that responsive to diverse needs.

This report also underscores that housing plays a critical role not only as a place to live, but as a site of both risk and intervention. Experiences of DV, IPV, and EM often occur within private homes and are also shaped by factors such as dependence, isolation, and limited access to supports. Despite this, housing and violence-response systems continue to operate largely in parallel. Addressing these challenges requires more integrated approaches that bring together housing, health, social, and community service in ways that support safety, autonomy, and well-being.

SIH offers a practical and promising pathway forward. By strengthening connections between housing and services, supporting early identification of risk, and fostering environments that promote social connection and inclusion, these models can help address both immediate and long-term needs. At the same time, advancing this approach does not require large-scale system redesign. Incremental changes, such as enhancing partnerships, improving service navigation, building staff capacity, and piloting targeted supports, can have meaningful impact.

For organizations such as the Brenda Strafford Foundation, this presents an opportunity to build on existing strengths and continue evolving housing models in ways that are responsive, integrated, and grounded in the realities of older adults' lives. By focusing on practical, scalable improvements and contributing to applied research and innovation, there is potential to strengthen both local practice and broader system learning.

Ultimately, supporting older adults to age well requires a shift from viewing housing as a standalone asset to understanding it as part of a broader system of care and community. Creating environments that enable safety, connection, and choice will be essential to ensuring that older adults can not only remain in their homes and communities but thrive within them.

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