euPrevent | SFC
senior friendly communities

euPrevent Senior Friendly Communities Project

Assessment report

Euregion Meuse-Rhine (EMR)

Crossing borders in health

Live safely, Enjoy life, Stay involved.

CONTENT

Introduction 5

- The 'Senior Friendly Communities' project (SFC)
- The ageing challenge
- Reader's guide
- Contact

Chapter 1 WHO: Active Ageing 6

- The Active Ageing framework
- The three pillars of Active Ageing
- Health
- Participation
- Security

Chapter 2 Demographic data 7

- Dementia
- Depression
- Care

Chapter 3 Results 8

- Introduction
- Method
- Results Belgium 9
- Results Germany 11
- Results the Netherlands 13

Chapter 4 Remarkable observations and conclusions 16

Chapter 5 Partners 17

- Project partners
- Participating Communities

Sources 18

The Senior Friendly Communities project is carried out within the framework of Interreg V-A Euregion Meuse-Rhine and is supported by the European Union and the European Regional Governance Authority Interreg V-A Euregion Meuse-Rhine Development (allocation: EUR 983,167.50). The project also receives co-financing and the project partners pay their own contribution.

© The euPrevent | EMR Foundation and the SFC project team, November 2017

INTRODUCTION

The 'Senior Friendly Communities' project (SFC)

'Together we are creating Senior Friendly Communities in a cross-border setting to ensure that all senior citizens in the Euregion Meuse-Rhine can continue to enjoy participating in daily life.'

The three-year euPrevent project 'Senior Friendly Communities' (SFC) began in the autumn of 2016. The project aims to establish senior friendly communities. Communities that are care-friendly, carer-friendly and inclusion-friendly. The project focuses on mental health, with special attention to dementia and age-related depression.

Nine euregional partners are working on this project together with 32 participating municipalities from the Euregion Meuse-Rhine (Aachen, Dutch Limburg, Belgian Limburg, province of Liège and and the German-speaking community of Belgium). Project staff have conducted an assessment to test senior friendliness in the participating communities. The results of all of the assessments are described in this report.

The ageing challenge

With the rise in the number of seniors in the total population, the demand for care, facilities and understanding for the needs of the elderly is also increasing. By making societies senior friendly, people can grow old in health and security and continue to take part in society.

The municipalities in the Euregion have a comparable demographic composition and therefore face the same challenge: ageing. The differences in approach and in the legislation and regulations bring benefits through cross-border exchanges of experiences. The nine partners in the euPrevent 'Senior Friendly Communities' project, together with the 32 participating municipalities, are taking up this challenge. At the start of the project, the way in which the euregional municipalities support their senior citizens in the first stages of dementia or late-life depression and their informal caregivers was recorded. This involved looking at policy and the range of facilities and activities on offer. The next steps in the project are as follows:

1. Linking existing activities (the activity buffet) in the Euregion to the municipalities.
2. Linking the municipalities to one another.
3. Assisting the municipalities with the selection and implementation of the activities.

Reader's guide

This report is structured as follows. Chapter 1 gives a brief overview of the 'Active Ageing' framework of the World Health Organisation (WHO), the three pillars of which, 'health', 'security' and 'participation', form the basis of this project. Chapter 2 provides an overview with demographic data for the three countries and the estimates of the number of people with dementia and (late-life) depression. In Chapter 3, the results of the assessment are presented, divided by country. This assessment consisted of a questionnaire and the results observed by mystery guests. The mystery guests looked at the accessibility of the municipalities for people in need of help on the basis of two cases from the perspective of the citizen. Finally, Chapter 4 sums up the results and remarkable observations.

Contact

This report was drawn up by the project coordinators of the project, Dr. Marja Veenstra (coordinator Dutch communities), Mr. Karl-Heinz Grimm (coordinator German communities), Ms. Isabelle Lazarus (coordinator German-speaking Belgian communities), Ms. Caroline Glaude and Ms. Marie Geurten (coordinators Walloon Belgian communities), Mr. Frank Willems (coordinator Flemish Belgian communities), and the project staff member, Ms. Mignon Schichel, under the responsibility of the Management Board of euPrevent 'Senior Friendly Communities'.

If you have any questions, please get in contact via e-mail: info@euprevent.eu.

CHAPTER 1 WHO: ACTIVE AGEING

Within the 'Senior Friendly Communities' project, the emphasis is on the mental health of the elderly. The project focuses on policies and activities for older people with dementia or late-life depression and on informal caregivers. The 'senior-friendly' topic is based on the broader concept of 'Active Ageing', as defined by the World Health Organisation (WHO) (WHO, 2002). The WHO is a United Nations organisation that focuses specifically on health. The WHO understands older citizens to be people aged 60 years and over (WHO, 2002, p. 4). This project adopts a guideline of 65+ years, but municipalities are free to interpret this guideline as they please.

The Active Ageing framework

The WHO sees the ageing population as a challenge. According to this organisation, actions in the 'Active Ageing' framework can offer an answer here. The WHO has defined the 'Active Ageing' framework on the basis of three pillars, the aim being to promote health, participation and security among older citizens in order to improve their quality of life.

According to the WHO, 'Active Ageing' policies and programmes for older people should be based on the rights, needs, preferences and capacities of the elderly. The various ways in which people age must be taken into account. Remaining active does not only relate to physical activity but also to continuing to take part in society. Older people must be able to continue to participate under the best possible conditions of physical, mental and social health. This project looks at the various ways in which municipalities promote health, participation and security for older people. The three pillars of Active Ageing are explained below, paraphrased from the document (WHO, 2002, p. 45-46).

The three pillars of Active Ageing

Health: There is a need to ensure a higher quality of life for older people, maintaining their health and the ability to manage their own lives, so that there is less need for medical treatment and care services. The focus here is on limiting the risk factors for chronic diseases and functional decline. Those who do need care should have access to a wide range of health care and social services.

Participation: The aim is for people to continue to make a productive contribution to society in both paid and unpaid activities. The labour market, education, health and social policies should support people in this participation. Attention must be paid here to the specific capacities, preferences, needs and rights of older people.

Security: The social, financial and physical security needs and rights of people must be guaranteed, including as they age. They must continue to feel secure, dignified and well-cared-for, even if they can no longer ensure their own security. The (local) network around these older people must be supported in these efforts to ensure security.

CHAPTER 2 DEMOGRAPHIC DATA

Dementia

In 2013, it is estimated that 1.77% of the population in Belgium has dementia. The prevalence of people with dementia in Belgium is estimated at 191,281 persons (62,972 men and 120,309 women). In the Netherlands, the estimation is that 1.47% of the population has Dementia, that means 245,561 persons (83,247 men and 162,314 women) 83,247 persons. In Germany, the estimation is that 1.92% of the population has Dementia, that means 1,572,104 persons (517,136 men and 1,054,968 women) (Alzheimer Europe, 2013).

Depression

The Social Cultural Plan Bureau (SCP, of the Netherlands) made a comparison of care and support for persons who are 50 years or older in fourteen European countries. For depressive complaints they found that in Belgium the percentage of the population who lives at home and is 50 years or older is for mild depression about 12%, for moderate depression 9% and for severe depression about 6%. In the Netherlands the percentage with mild depression is about 10%, for moderate depression 6% and for severe depression about 3%. In Germany the percentage with mild depression is about 13%, for moderate depression 7% and for severe depression about 3% (Verbeek-Oudijk, 2016).

Care

In the same report of SCP, they also compared the percentage of care a person aged 50 years and older still living on their own receives. In Belgium around 27% receives care, of which 11% receives unpaid care, 7% receives a combination of paid and unpaid care, and 9% receives only paid care. In the Netherlands around 21% receives care, of which 9% receives unpaid care, 5% receives a combination of paid and unpaid care, and 7% receives only paid care. In Germany around 23% receives care, of which 13% receives unpaid care, 5% receives a combination of paid and unpaid care, and 5% receives only paid care (Verbeek-Oudijk, 2016).

CHAPTER 3 RESULTS

Introduction

This chapter provides an insight into the results of the assessments in all of the participating communities' regions. The assessment consisted of a questionnaire and the experiences of the mystery guest. The answers to the questions given by the participants in the assessment discussion formed a sort of self-assessment, supplemented by information from and the experiences of the mystery guest, who looked at whether and how a citizen in need of help can be assisted by the municipality. It was not aimed to make comparisons between municipalities (benchmarking), nor did we want to award a distinction as regards to the senior-friendliness of the municipality. We examined the status quo in the municipalities and offered the municipalities levers to improve their senior-friendliness so that they are able to better form policy on the basis of the three WHO pillars. This chapter describes the most important results, providing a summary of what policies and activities related to the prevention of dementia and/or depression, and/or the support of people with dementia, depression or informal caregivers were already in place in the communities altogether, and drawing comparisons between the countries.

Method

The assessment questions were sent to the contact person of the municipality in the Senior Friendly Communities project beforehand. On the basis of these questions, the municipality invited people who can best judge the current range and state of affairs regarding the policy. In the municipality, representatives of the municipality as well as other care- or senior-organisations that were deemed experts on the topics or considered of added value, were present at the assessment. In addition to the verdict of the municipality, the accessibility and helpfulness of the municipality were also charted by a mystery guest. The mystery guest took a case with related questions as a basis to look at what help and support individuals can receive from the municipality and how this process works from the perspective of the citizen. The assignment was mainly to focus on the possibilities and to be persistent in order to obtain a clear picture by asking and searching. In each municipality, one mystery guest worked on the basis of a case involving a person with suspected dementia and one mystery guest on the basis of a case focusing on a person with late-life depression. After summarising the main findings and providing advice as to what elements could be improved to each individual community, this report, summarising the findings in the whole of the Euregion Meuse-Rhine, was written.

Results Belgium

Political system and care

In Belgium, the municipalities stated that they are not necessarily responsible for providing care and information about care, but they do this in close cooperation with other organisations and healthcare providers. The communal competences are very broad, covering all that belongs to the "communal interest", that is to say the collective needs of the inhabitants. Theoretically, a municipality can do anything that is not forbidden to it, for example, to build a sports hall as well as to build a road or to build a rest home. It is controlled by the supervisory authorities, that is, the federal state, the communities, the regions and the provinces. Municipalities must also carry out the tasks imposed on them by the higher authorities (Belgium.be, 2017). Each community has its own organisation/centre for the wellbeing of the public and organizes its services. The OCMW (Openbaar Centrum voor Maatschappelijk Welzijn, in Flemish-speaking parts)/CPAS (Centre Public d'Action Sociale, in French-speaking parts)/ÖSHZ (Öffentliches Sozialhilfezentrum, in German-speaking parts), is responsible for social services and the well-being of all citizens of the community, particularly the fragile inhabitants, which might include the care of the elderly and mental health care.

The Belgian federal state is responsible for organising and providing health care, whereas the communities can organise health prevention (with other governance levels in Belgium). Within the policies of the municipality, there are generally no specific target groups, as they are rather broadly formulated to include all people in the community. When it comes to health care, the municipalities generally are not responsible for care tasks. Instead, they refer people to the General Practitioner and/or the abovementioned centre for the wellbeing of the public. The municipality is not necessarily responsible for providing the public with information about mental health problems, as this is done by the aforementioned actors or an overarching network of several communities, such as at the German-Speaking community (DG) level network. Such a network also formulates policy and finances the activities, which are provided in several and not just one community. Within small communities, the social network is often strong and people look out for each other. The municipality can provide subsidies to volunteers and volunteer organisations who organise activities to prevent dementia/depression and/or support people with dementia/depression and/or informal caregivers. Activities often span several target groups instead of one and are not necessarily focused on prevention but rather on support after diagnosis.

Dementia

The municipalities are more familiar with the topic of dementia than with depression. Instead of focusing on dementia as such, there is often a focus on topics like self-reliance and living at home for as long as possible, and municipalities often stated this should be the case for all elderly, not just the target group of people with dementia. For information and education about dementia, there are service centres who tackle this topic or memory clinics, walk-in activities of mental health service centres or Alzheimer Café's. The diagnosis of dementia can be done by General Practitioners or specialists, but is not done by (employees of) the municipality itself. Some municipalities have projects together with the police to signal and help lost people to come home safely and not cause unsafe situations. People with dementia

can receive support at the aforementioned organisations, and people with early-stage dementia can also receive support in associations (hobby and sports clubs, for example). Furthermore, support can be provided by volunteers, enabling the informal caregivers to leave their relative for a short period and to have some rest. There are several activities possible to support the self-reliance of the people with dementia. At the overarching policy level, such as at the DG-level, there can be dementia-consultants. The Belgian Alzheimer League also proposes yearly a training to municipality employees and also a concept of "Dementia Friendly Community".

Depression

Depression is a less well-known topic than dementia in the municipalities. Many municipalities state that they are not very informed yet about this topic, and it is a taboo topic, making it difficult to identify the persons affected by depression. Instead of depression as a whole, the (prevention of) social isolation and loneliness, as well as the creation of strong social networks in general, are more familiar topics for the municipalities and are tackled with activities. Providing information about depression and signalling persons with symptoms of depression are not seen as a task of the community, but done by neighbourhood-care organisations. Loneliness is tackled by means of several activities where people can meet each other, also by other organisations than the municipality, such as associations, and in some cases widows are taken into account as a specific target group whereas often they are included in the general offer for tackling loneliness or depressive symptoms. Municipalities often seem to overlook the fact that many activities aim to prevent loneliness or social isolation also fight against depression, and therefore overlook what offer they have that is also suited for the prevention of depression. The municipalities think that depression has a more negative/taboo image than dementia.

Informal Care

The communities recognise the importance of informal care and generally provide support to both informal caregivers (family or friends of the person with mental health problems) and volunteers in care. For example, there is financial support for the informal caregivers and for associations of volunteers, the provision of day care and cooked meals to offer respite care (although this is not provided in all communities yet) to the informal caregiver, some municipalities have a Day of the informal Caregiver to show appreciation, and cafés or other activities for mental support. Furthermore, informal caregivers can receive education in how to communicate with people with mental health problems or deal with their role of informal caregivers, although these trainings are often not for caregivers in general but tailored to the topic of dementia. Volunteers in care are also supported. Identifying the informal caregivers remains difficult. Municipalities believe they are unable to reach all informal caregivers, and are not sure if the informal caregivers make use of the existing offers/activities.

WHO Pillar Health

The municipalities cooperate with or refer people to healthcare offers from other organisations, as healthcare provision is not the responsibility of the municipalities, but rather that of doctors. Health policy of the municipality focuses on the general public, without specific target groups. Social security, insurances or financial help are not within the influence of municipalities, and neither is controlling the quality of care provided. In general, health care is accessible financially as there is support for persons with low income, but there may be problems in individual cases when the person is for example insured in Germany or the Netherlands and prefers to make use of care in

a Belgian community, as insurances do not always account for that. The municipalities have contacts with General Practitioners, memory clinics, centres where there are free walk-in activities, etc. In general, waiting times are low, but it varies greatly according to what kind of care is needed.

WHO Pillar Participation

Participation is widely recognised as important for the whole of the community and without specific target groups, although special attention is devoted to creating a private as well as public space that encourages participation. Municipalities greatly adhere to the principle that people should be able to live at their own homes as long as possible. To facilitate this, the municipalities cooperate with organisations in this field, such as occupational therapists and residential construction organisations, to adapt housing. Furthermore, the municipalities aim to lower physical as well as mental barriers to access care and lower physical barriers in existing as well as new buildings. In addition, by creating strong social networks, they aim to prevent social isolation. In some communities, there are supporting services that guide people in returning home after a hospitalisation. In some cases, the activities centred around participation focus on the work of Alzheimer groups specifically.

WHO Pillar Security

The security of all people is a priority; again, there are no specific target groups for this pillar in the municipalities. The community cooperates with other organisations in this field, such as the police to retrieve people with dementia who are lost, to establish projects for people with dementia to have contact data with them, or to carry emergency-call-devices or to have self-defence courses, as well as with residential construction organisations to adapt houses to make them more secure. Municipalities are responsible for maintaining public order on their territory but do not specifically focus on the security on those target groups. Regarding the social security, the municipalities thought that the topics of dementia and depression remain taboo-topics in their communities and there is still a big need to lower the threshold for people to talk about these mental health problems, although the taboo is estimated to be slightly less among the general public who are not directly affected.

Results Germany

Political system and care

Similar to the Belgian system, municipalities in the German area of the Euregion Meuse-Rhine do not have an own responsibility to provide care in the field of seniors and mental health, as policies and care or other activities are instead provided by an overarching network of several municipalities together, called a “Kreis”. Within the communities, the activities that are offered are generally not offered by the municipality but by other organisations of welfare care (such as the Arbeiterwohlfahrt, Deutsches Caritasverband, Diakonie Deutschland or private initiatives), and have a broad outreach instead of specific target groups. Health, Participation and Security are not considered the responsibility of the municipality, but that of the Kreis, and if the municipality would want to offer other activities than those already in place it would be considered a voluntary task, outside of the responsibilities and therefore also outside of the regular budget of the municipality, therefore limiting the extent to which municipalities have an influence on these offers. To some extent, they do have an influence in what subsidies to give to organisations.

Dementia

Providing offers for (the prevention of) dementia is not the responsibility of the municipality, but that of the Kreis. As a result, although most municipalities recognise the need to act on this topic, they do not have the personnel or financial capacities to do so. At the level of the Kreis, there are information conferences on ageing and care and several activities for support, such as information and education about dementia, dementia-counselling for patients and informal caregivers and day care, or support in housekeeping. The municipalities stress the importance of the social network in communities, and the support for the self-reliance of people with (early-stage) dementia can receive from associations (such as choirs or hobby- and sports clubs). In very few cases, shop owners in the communities are also trained in communicating with people with dementia. Advice and signalling of dementia is done by the General Practitioners, pharmacies, gerontologists, neurologists, memory clinics or care services, for example. Very rarely, there are employees of the municipality that offer consulting on the topic of dementia, although this does not include the signalling of symptoms of dementia.

Depression

The responsibility regarding depression and social isolation, as well as the prevention and signalling thereof, does not lie with the municipalities but rather with the Kreis. Furthermore, the problem of geriatric depression is not (yet) recognised as such and therefore rather low on the political agenda. Instead of specifically focusing on depression, many offers target social isolation instead, which can affect depression. The recognition and treatment of depression should be done by the General Practitioner or psychotherapists. Information about dealing with a depression is available from several organisations, including the social services department of some of the municipalities. In addition to that, there is day care, advice and support for informal caregivers or support in housekeeping to support patients and caregivers. For the municipalities, it is difficult to identify signs of depression and people with depression, and thus to reach this target group.

Informal Care

To take some of the burden off of informal caregivers' shoulders, most communities have respite care, day care, visitation offers, short term stay possibilities as well as training and self-help groups for informal caregivers. These are not provided by the municipalities but by the abovementioned organisations of welfare care. Such activities are not fully used by the informal caregivers and it is difficult to reach informal caregivers. There is also a high importance attributed to care volunteers ("Ehrenamtlich Tätige" in German), who in some communities receive support or discounts as a thank you and recognition of the work they have done.

WHO Pillar Health

The pillar Health is not a responsibility of the municipalities, and therefore to some extent not regarded as a relevant topic in local politics. The Kreis is responsible for health services, amongst other things. Similar to the state health conference, there are also municipal health conferences (kommunale Gesundheitskonferenzen, KGK), which advise questions of heath care at the local level. The conferences include representatives of all institutions involved in health care on-site. Subjects treated on-site include addictions, drugs, addictions, child and adolescent health, old age health, health promotion, mental health care or patient transfer. The KGK make recommendations, agree on solutions and implement them. With comments and recommendations, the municipal health conferences also participate in health reporting. Preventing health problems is mainly done by offering information about (mental) health problems. Waiting

times for receiving care vary greatly, from within 24 hours for acute needs up to six months for some measures. The quality of the provided care is checked by the medical services of the insurances (called Medizinischer Dienst der Krankenkassen, MDK, for public insurances and MEDICPROOF for private insurances), not by the municipality.

WHO Pillar Participation

Although the community supports the principle that people should be able to live at home for as long as possible, this topic and the pillar of participation are not the responsibility of the municipality. There are no concrete measures to foster participation in the community yet. As mentioned, associations support people with (early-stage) dementia to continue participating in the association. In terms of the physical accessibility for all, the public buildings and activities are not yet all barrier-free, in several communities the physical accessibility remains to be improved.

WHO Pillar Security

The communities are unsure whether or to what extent they have a role to play regarding security. In the public sphere, more precisely in traffic, elderly (in general) are taken into account by the committee on traffic, and there are also transport measures for elderly. Regarding the social security of being able to speak about mental health problems, in general, the municipalities think that there is a higher taboo on depression in their communities than on dementia.

Results the Netherlands

Political system and care

Since 2015, the Wet maatschappelijke ondersteuning (Wmo – law on societal support) has shifted some of the responsibility for creating an inclusive society from the Dutch state to the municipalities. According to some municipalities in the project, the municipalities are especially responsible to support people in order to make it possible for them to participate in the society, therefore the focus is more on wellbeing and less on care. They work together with several other organisations, such as the GGD, the communal health service, and many others on specific topics. The municipalities have a task regarding participation and security of people in the community, but policies are framed in an inclusive way meaning that there are no specific target groups described, but rather broad policies. The municipalities have the task to arrange certain care offers from different organisations, and by doing so, have an influence on what offers to buy for the community or not. Municipalities can also offer subsidies to local initiatives or organisations who provide care or other forms of support. Within the Wmo, there are set rules set and checks for the quality of the care that is offered, as well as standard waiting times in which care or support should be offered.

Dementia

Some of the Dutch municipalities in the Euregion Meuse-Rhine have set a goal for their communities to become "dementia friendly", and often have a counselling committee focusing on this goal. In other words, the topic of dementia is in many cases already embedded in the policies and activities offered in the communities. Municipalities cooperate with Alzheimer Nederland, Hulp bij Dementie, psychologists at the General Practitioner's, neighbourhood support teams or counsellors, for example. Hulp bij Dementie offers casemanagers who act as kinds of consultants for people with dementia and their network. In many communities, there are trainings for informal caregivers in

dealing with dementia, as well as social activities, and there are case managers by Hulp bij Dementie. In general, except for the education and training, there seems to be room for improvement in the prevention of the diseases, but the topic dementia as such is already well-known in the communities.

Depression

Rather than depression overall, the theme of supporting self-reliance and the prevention of loneliness is important in most participating municipalities. There are no specific target groups defined among the people with depression. Municipalities generally think that they cannot play or do not need to play a role regarding depression, as this role lies with the General Practitioner instead, who is also responsible for signalling and recognising the symptoms of depression among people. There is often a lack of awareness of what depression entails among the municipalities and what role they could play, and about the link of activities preventing loneliness and preventing depression. In some cases, indirectly the preventive activities offered also assist in preventing depression, but the communities are not always aware that this offer can target depression as well. Rarely, the communities that focus on information about dementia mention the difference with depression as well (which is not necessarily clear-cut in the early stages of the diseases). For the prevention of social isolation/loneliness, there are for example meeting places such as "living rooms" where people can freely and low-key walk in and meet other people without any obligations. The municipality has a close cooperation with several organisations like the elderly associations, consultants for caregivers, district nurses, home care, psychologists at the General Practitioners', psychologists etc.

Informal Care

The target group of informal caregivers are mostly well-represented in the policies and activities of the Dutch participating communities. There is often a large array of support activities, such as training and education of caregivers (also aimed specifically at the theme dementia), support by volunteers, housekeeping offered by the municipality, information/education from senior's associations, specific events for informal caregivers to get together, the "Day of the informal Caregiver" (on the 10th of November) as an appreciation of their work, respite care and tailor-made care. Furthermore, the communities cooperate with other organisations who offer such activities as mentioned here, for example the Steunpunt Mantelzorg, an organisation that specifically supports informal caregivers. However, the municipalities state that it is difficult to recognise (all) who are informal caregivers, and that the exact numbers and names are not known to the municipalities. As a result, it is also not known if the offered activities fully fit the needs of the caregivers. In some cases, the offers are not fully utilised. In addition to informal caregivers, volunteers are also supported by the municipality, with finances, facilities and training.

WHO Pillar Health

Health is a topic that municipalities consider in a broad, integral manner, as social policy is broad and health should be important for all, not only for certain target groups specifically. Signalling and prevention of health problems is considered important, although some communities wonder if this pillar is part of their responsibility. Instead, they think the responsibility lies with the General Practitioner, psychologist or dementia consultants. Some of the municipalities are unfamiliar with how long the waiting time is for certain care and support offers, unless the offers are from the municipalities themselves. The Wmo sets standard waiting times as a framework for how long a person needs to wait before care or support will be provided, and in most communities, these are upheld. The waiting

times for receiving support from a volunteer are often very long. The diversity of the care offer is important to the municipalities, and offering a diverse pallet of activities is occasionally mentioned as a criterion for organisations to receive subsidies/ be bought from the municipality. Checking the quality of care is also embedded within the law of Wmo, and several of the municipalities carry out 'customer satisfaction' checks regularly to test if the offer suits the needs of citizens. The financial accessibility of care is to a large extent possible due to the availability of how much money citizens need to contribute that is based on their income, and the insurance offered by the municipalities for people who cannot afford an insurance.

WHO Pillar Participation

Tackling loneliness and involving all people to participate in society are important themes to the communities. Within small communities, there is often a strong social network, in which all people know each other and look after each other, which means that there is an informal manner of early signalling in case people stop participating in community life. The communities greatly support the principle that people should live at home as long as possible, and therefore, (social) structures in the neighbourhoods should be strengthened. Many communities have plans for adapting and building age-friendly buildings/housing. Also, the physical accessibility of buildings is very important in the communities and virtually guaranteed in all public buildings. Future buildings are subject to checks of physical, barrier-free, accessibility.

WHO Pillar Security

The municipalities think physical security is important, and therefore many have an activity that offers the prevention of stumbling/falling down for the elderly, to keep them feeling secure and stay mobile, again fostering participation. In addition to that, several communities have projects regarding tackling the problem of lost persons, usually in cooperation with the police. There are also Safe Neighbourhood- and Safe Home-teams, amongst others to prevent abuse. In terms of the social security to address certain topics, the municipalities generally seem to agree that there is still a taboo on both topics, but that talking about dementia has become easier than about the depression, whereas some remarked that there are also less informal caregivers of people with depression visible than of people with dementia, or perhaps that there is an information gap in this regard.

CHAPTER 4 REMARKABLE OBSERVATIONS AND CONCLUSIONS

In addition to the information about the target groups and pillars of the Senior Friendly Communities project, the assessments also yielded other remarkable insights, which can be summed up as follows:

- Municipalities in all five regions aim at the rather broad target group for their policy, and not on specific subgroups.
- Several communities, in all three countries, refer to many different organisations for more detailed information on the project's topics, and do not have this information in-house.
- Some communities overestimate how many offers and activities they have in place, whereas many are of a rather general topic or focus on support after diagnosis instead of prevention.
- Some communities underestimate how many offers and activities they have in place, and especially regarding the topic of depression seem to forget that the prevention of isolation can have a positive effect on the prevention of depression.
- All of the communities seemed to be more familiar with the topic of dementia and how to tackle this as a municipality, than with the topic of depression.
- Signalling of depression is in most cases considered a task of the general practitioner or dementia consultants, not a task of the municipality.
- Almost all of the communities showed some interest in cooperation within the Euregion Meuse-Rhine, across borders, in order to exchange best practices.
- The most commonly mentioned obstacles to Euregional exchange were (in random order): unfamiliarity with the employees in another community, unfamiliarity with the work of another community across the border, different rules and laws making it difficult to judge whether an activity can be implemented in a similar fashion, the lack of an overview of the former three, a language barrier, time constraints, not prioritizing it as a topic, and budgetary constraints.
- In all five regions, it was mentioned that it is difficult to find and reach the informal caregivers, and for that reason there are doubts if the activities offered in a community really fit the needs of the target groups.
- All participating communities stress the importance of a (strong) social network.
- The mystery guests found that in many communities, regardless of which country, it was rather difficult to ask a question for information without specifying more personal details about the person that is the patient, or without providing personal data of themselves, by staying anonymous, for example.
- Municipalities and communities in general can not only offer support in terms of care and support but can also play a role in giving attention and emotional support to both the person in need of care and the informal caregiver.

CHAPTER 5 PARTNERS

Project partners

- Universiteit Maastricht, NL (Lead Partner)
- Huis voor de Zorg, NL
- Mutualité chrétienne Verviers-Eupen, BE
- Centre Hospitalier Universitaire (CHU) de Liège, BE
- Kreis Heinsberg -Gesundheitsamt/Stabsstelle für demografischen Wandel und Sozialplanung, DE
- Limburgs Gezondheidsoverleg (LOGO), BE
- Dienststelle für Selbstbestimmtes Leben, BE
- GGD Zuid Limburg, NL
- Stichting euPrevent | EMR, NL

Participating Communities

Belgium	Germany	The Netherlands
Amel	Aldenhoven	Beek
As	Dahlem	Beesel
Hamont-Achel	Erkelenz	Eijsden-Margraten
Hasselt	Euskirchen	Kerkrade
Kelmis	Herzogenrath	Maastricht
Liège	Hückelhoven	Mook
Plombières	Jülich	Onderbanken-Nuth-Schinnen (Beekdaelen)
Tessenderlo	Stolberg	Roermond
Thimister-Clermont	Wassenberg	Valkenburg aan de Geul
Verviers	Wegberg	Venlo
		Venray
		Weert

Participating in the assessment but not in the entire project

- Sittard-Geleen (Netherlands)

SOURCES

Alzheimer Europe. (2013). The prevalence of dementia in Europe. Retrieved 31-10-2017 from http://www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/2013-The-prevalence-of-dementia-in-Europe

Belgium.be (2017). The powers of communes. Retrieved 10-11-2017 from https://www.belgium.be/en/about_belgium/government/Communes/competence

Verbeek-Oudijk, D. Putman, L. (2016). Verzorgd in Europa: kerncijfers 2013 Een vergelijking van de zorg en ondersteuning voor 50-plussers in veertien Europese landen. Sociaal Cultureel Planbureau. Retrieved 31-10-2017 from http://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2016/Verzorgd_in_Europa_kerncijfers_2013

World Health Organization. (2002). Active Ageing-A Policy Framework. A contribution of the World Health Organization to the Second United Nations World Assembly on Ageing. *Madrid (ES): WHO.*

“Together we are creating Senior Friendly Communities in a cross-border setting to ensure that all senior citizens in the Euregion Meuse-Rhine can continue to enjoy participating in daily life.”

WWW.EUPREVENT.EU/SFC/