GUIDELINES FOR ELDERLY MENTAL HEALTH CARE PLANNING FOR BEST PRACTICES FOR HEALTH AUTHORITIES

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Executive Summary

The purpose of this document is to serve as a guide for health authorities in designing, developing, implementing and evaluating services that maximize quality of life for elderly people who have complex and challenging mental health problems. It is anticipated these activities will be reflected in the health authorities' planning.

The demographic profile of British Columbia's population will change significantly over the next three decades. During that time it is estimated the elderly population will increase by 121 per cent, compared to an increase in the under 19 population of 11 per cent. If efficient, effective and innovative approaches to providing care are not developed, the resulting service pressure will reach crisis proportions for the baby boom generation of about 1,186,000 seniors in 2026. Studies show the prevalence of mental health problems affecting elderly people is between 17 and 30 per cent: McEwan, et al (1991),[1] suggested 25 per cent as a reasonable figure.

The *Principles of Elderly Mental Health Care*[2] and nine key elements, considered vital to the provision of mental health care for the elderly, provided the core principles and assumptions upon which the recommendations made in this document were founded.

The *Principles of Elderly Mental Health Care* were developed to guide the design of the service system and the delivery of care. They are:

- client and family centred;
- goal oriented;
- accessible and flexible;
- comprehensive;
- specific services; and
- accountable.

Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities was developed to guide the design of the service system and the delivery of care

Primary care services and programs are the backbone of elderly mental health care

The key elements considered vital to the provision of mental health care are:

- health promotion and early intervention;
- education;
- family support and involvement;
- psychosocial rehabilitation and recovery;
- environmental milieu (i.e. housing);
- integrated and continuous services;
- quality improvement and evaluation processes;
- volunteers, mentors and peer counselors; and
- advocacy and protection.

Primary care services and programs are the backbone of the elderly mental health care system. Professionals with specialized knowledge and skills in geriatric care who work in the secondary and tertiary care sectors only provide care to those elderly people whose problems are more complex or challenging than can be accommodated in the primary care system. They also provide consultation to many primary care providers to divert referrals from the secondary or tertiary system.

The formal service system for elderly mental health care consists of:

Primary

Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care providers, such as home nursing, home support or, upon direct request by patients/clients, placement in a facility.

Secondary

Specialized preventive, diagnostic and therapeutic care — usually requiring referral from a primary source. Includes outreach community-based teams, inpatient elderly mental health care, day hospital services and outpatient clinics.

Tertiary

Highly specialized services including professional/technical skills, equipment or facilities — usually requiring referral from a secondary source. Includes inpatient services, university research clinics and rural and remote community outreach.

Community outreach mental health teams constitute the foundation of mental health care services at the secondary care level

Community outpatient/outreach mental health teams, whether hospital or community-based, and inpatient elderly mental health care constitute the foundation of the elderly mental health care system at the secondary care level.

To be effective, an elderly mental health care service should remain closely connected to psychiatric expertise. This expertise is traditionally found in the mental health service structure. Effective elderly mental health care also requires the development of a formalized collaborative relationship with home and community care.[3] Home and community care provides and/or coordinates many direct, in-home and residential services for elderly people, many of whom have complex mental health or behavioural issues. Elderly mental health care services provide specialized expertise in support of clients with more complex mental health or behavioural issues and their caregivers in a variety of care settings. Defining the organizational relationship should be done locally, taking into account the needs of the population, existing resources and the size and location of the community. The need for a formalized collaborative relationship is also required with adult mental health and inpatient services.

Footnotes

1 Kimberley L. McEwan, PhD, Martha Donnelly, MD, CCFP, FRCP, Duncan Robertson, MBBS, FRCP, and Clyde Hertzman, MD, M.Sc, FRCP(1991): *Mental Health Problems Among Canada's Seniors: Demographic and Epidemiologic Considerations*, Ottawa, Health and Welfare Canada.

2 Taken from the British Columbia Psychogeriatric Association's *Principles of Psychogeriatric Care* (available at http://www.bcpga.bc.ca/).

3 Home and community care. Formerly referred to as continuing care or long term care.

Introduction

The number of elderly people is increasing more rapidly than other age groups in British Columbia

Purpose

This document was developed to serve as a guide for health authorities in designing, developing, implementing and evaluating services that maximize quality of life for elderly people who have complex and challenging mental health problems. It is anticipated these activities will be reflected in health authorities' planning.

Over the next few years, the Ministry of Health Services, in partnership with health authorities, will be monitoring changes in the availability and delivery of services for the elderly with mental health problems using these guidelines as a reference point.

Reasons for the Development of the Guidelines Document

- Need for quality mental health care services for the elderly to be available across the province.
- The target population is increasing more rapidly than other populations in British Columbia.
- A review of the seven Best Practices Reports[4] revealed that while some of the best practices identified for the adult population are appropriate for the elderly population, consideration of the service needs of the elderly were not specifically addressed by the reports. Brief reviews of each of the Best Practice documents from the perspective of appropriateness to elderly people appear in Appendix 1.1.

For the elderly, normal aging processes often complicate the presentation and treatment of mental health conditions

- The impact of normal aging often complicates the presentation and treatment of mental health conditions.
- Elderly people, many with disturbances of cognition or behaviour, remain in hospital beds longer than required. This delay ultimately puts pressure on inpatient beds and emergency rooms.
- The limited number of long term care beds requires systems that allow elderly people with mental health problems to remain at home as long as possible.

Process Used to Develop the Guidelines Document

This document was developed by Mental Health and Addictions, Ministry of Health Services, British Columbia, with the support of a working group of individuals who have extensive expertise and experience providing care for elderly people with mental health disorders.

The document was developed from reviews of the literature and expert opinion. A vast body of literature exists on aging and the care of elderly people with various medical, psychiatric, social, economic and other problems. Some of this literature is written for professional care providers and crosses many disciplines, but there is much published for the public as well. Appendix 2.0 provides selective literature reviews. These reviews provide useful information for the development of services for elderly people with mental health problems and were incorporated into the recommendations contained in this document. The focused areas of the literature reviews are:

- inpatient psychogeriatric care;
- educational issues;
- family support and involvement;

- rehabilitation and recovery for older people with mental illness;
- environmental milieu (housing);
- quality improvement;
- service and program evaluation; and
- health promotion.

In order to ensure the information and advice provided are realistic and valid, a consultation process was completed with groups and individuals who possess knowledge and/or experience in this area. Early drafts were sent out for review to clinicians in the field, program managers, the Mental Health Advocate, BC Mental Health Monitoring Coalition, Continuing Care Renewal Implementation Committee and the Ministers' Advisory Committee on Mental Health. Focus groups with family members and others were also held in some communities. The feedback received from all these sources has been considered and used in the preparation of this final document.

Consultations were undertaken with groups and individuals involved in mental health issues

The document includes: a discussion of the target population, prevalence rates and best practices, a description of the array of required services, principles of care and recommendations, service components needed and nine care elements and approaches to care. The information in the care elements section provides background and support for the recommendations.

This document also draws upon the rich experiential resources of practitioners, as well as upon published research and evidence-based material. One model will not fit all situations: better practices develop when client needs are the focus and innovative, sometimes unique, approaches are developed to meet those needs. Some of the approaches developed in communities and submitted to the steering committee as examples of "best practices" in their areas are included in Appendix 3.

The elderly population is expected to increase by 121 per cent over the next 25 years

Target Population

The demographic profile of British Columbia's population is entering a stage in which tremendous increases and changes will be forthcoming over the next three decades. The current population of elderly people constitutes a low birth rate cohort: those born before or during the Great Depression. The high birth rate baby boom generation, born between 1945 and 1960, are now middle-aged and will be seniors over the next 10 to 25 years. Over the next 25 years, it is estimated the elderly population will increase by 121 per cent, compared to an increase in the under 19 population of 11 per cent. Mental health services as they are currently organized and delivered for elderly people are not meeting the needs of the population of approximately 540,000 seniors living in British Columbia. If efficient, effective and innovative approaches to providing care are not developed, the resulting service pressure will reach crisis proportions for the baby boom generation of about 1,186,000 seniors in 2026.

The population targeted by this report is elderly people with mental health problems. The definition of the population is as follows:

> *"Elderly people with mental health problems is a general term used to describe people over the age of 65 years who have emotional, behavioural or cognitive problems which interfere with their ability to function independently, which seriously affect their feelings of well-being, or which adversely affect their relationships with others. These problems have a variety of biopsychosocial determinants and methods of treatment and care. People under the age of 65 who have conditions more commonly seen in elderly people, such as early dementia, are included in this group."* [5]

Included in the target population are:

1. People who develop mental health problems in their older years or who have recurrent conditions, such as anxiety or depression.
2. People with long-standing, chronic, serious psychiatric disorders who grow old.

The goal of elderly mental health (psychogeriatric) care in British Columbia is:

> *"… the reduction of distress to the client and family, the improvement and maintenance of function, and the mobilization of the individual's capacity for autonomous living. These should be the goals for all clients, whether living at home or in institutions: a degree of autonomy should be possible in all settings. Independence should be maximized and maintained at the highest level that can be reached."* [6]

The term "psychogeriatric" is frequently used, in relation to the target group, to indicate disturbances of cognition or behaviour or conditions that occur in later life. "Elderly" is usually inclusive of the population 65 years and above. It should be noted conditions or disorders experienced primarily by people over the age of 65 can also affect younger populations, specifically individuals in their 40s or 50s.

The phrase "mental health", as conceptualized by consumers, families and mental health professionals, is defined in *Mental Health: Striking a Balance* [7] as:

> *"The capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality."*

The goal of psychogeriatric care is to reduce distress, improve and maintain functioning and allow the individual to be as independent as possible

About 25 per cent of British Columbia seniors have mental disorders or conditions

Prevalence Rates for Mental Disorders/Conditions Among Elderly People[8]

Table 1.1: Prevalence Rates

Age Group	Dementia	Depression	Substance Abuse	Anxiety	Schizophrenia and Bipolar
65-74	2.1%	8.8%			
75-84	7.5%	10.5%			
85+	26.2%	12.6%			
Average	6.7%	9.8%	5.7-11%	3.5%	2%
Expected # of >65 population of 537,679[9]	37,100	52,700	30,180 - 58,241	18,531	10,589

Source: Health and Welfare Canada (1991): *Mental Health Problems Among Canada's Seniors: Demographic and Epidemiologic Considerations.*

The determination of prevalence rates is affected by a number of factors and different studies provide data that vary considerably from one study to another.

The above table provides a conservative estimate of the prevalence rates of mental health problems that are most commonly experienced by elderly people.

Prevalence rates for mental disorders or conditions among elderly people are presented in detail in Appendix 1.2. Overall, the prevalence of mental health problems affecting the elderly has been cited as between 17 and 30 per cent; McEwan, et al (1991), suggest a middle figure of 25 per cent. In British Columbia, this translates to approximately 178,000 individuals over the age of 65.

The impact on individual health regions varies according to the demographic specifics of each health region and the number of available services.

Delirium

Reliable statistics on delirium are difficult to establish and most estimates are based on studies of patients admitted to hospital. Unquestionably, the actual prevalence of delirium is much higher but is less easy to count when ill elderly who become delirious are treated out of hospital. Further, delirium is often missed because behavioural changes resulting from delirium are too often assumed to be part of a dementia syndrome and are not given suitable attention. Delirium, a reversible condition, is potentially very serious and can result in death. It should, therefore, be promptly recognized and treated.

McEwan, et al (1991), report that 13 per cent of all hospitalized elderly develop delirium. Recognizing the potential for delirium is of vital importance and the application of focused delirium intervention protocols with older hospitalized patients can significantly reduce the number and duration of delirium episodes.

Thirteen per cent of hospitalized elderly patients develop delirium, a very serious and potentially deadly condition

Elder Abuse

Elder abuse is an issue that frequently confronts those who provide services to the elderly. The 1992 publication *Principles, Procedures and Protocols for Elder Abuse*[10] reports a prevalence rate of 54 persons per 1,000 elderly persons living in private dwellings. Abuse can be physical, psychological, financial or sexual, involve alcohol or medications, be a violation of civil or human rights or simply occur as a result of neglect. In British Columbia, legislation has been in place for some years to protect seniors living in licensed care facilities and, since February 28, 2000, new adult guardianship legislation provides similar protection for elderly people living in the community.

What is "best" in one community may not be "best" for another community with different demographics, resources or other factors

Best Practices

This report acknowledges the limited amount of published research specifically addressing best practices in mental health for elderly people. It also recognizes and values the practice wisdom of those providing services to this population. This report articulates best practices developed and reported by service providers, as well as from literature. For best practices, see http://www.cebmh.com/.

While a service or program must ultimately reflect demonstrable evidence of quality, it must also be recognized there is no one best service system that is appropriate in all situations, for what is "best" in one community may not be "best" for another community with different demographics, resources or other factors. Services and programs must, therefore, reflect local variations in need and the potential for innovative responses to needs, as well as more general standards for efficacy, efficiency and quality. All programs, old as well as new, should have goals and objectives that are stated, achievable and measurable. Appropriate evaluations should be done regularly to ensure that each program continues to meet the local needs, as well as the stated goals and objectives. Once standard evaluations for needs, processes and outcomes are established, it will be possible to compare British Columbia practices to Canadian and world standards. The information will also improve local programs and practices.

Footnotes

[4] BC Ministry of Health and Ministry Responsible for Seniors (2000): *B.C.s Mental Health Reform -- Best Practices*, Victoria, Province of British Columbia. Best practices are available on: housing, assertive community treatment; inpatient/outpatient services; consumer involvement and initiatives; family support and involvement; and psychosocial rehabilitation and recovery. The best practices reports will be available online at http://www.hlth.gov.bc.ca/mhd/.

[5] BC Ministry of Health Services and Ministry Responsible for Seniors (1992): *Services for Elderly British Columbians with Mental Health Problems (A Planning Framework),* Victoria, Province of British Columbia, 5.

[6] National Department of Health and Welfare (1988): *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders,* Ottawa, Ministry of Supply and Services, 14.

[7] National Department of Health and Welfare (1988): *Mental Health: Striking a Balance*, Ottawa, Ministry of Supply and Services, 4.

[8] For a description of the disorders and prevalence, please see Appendix 1.2.

[9] Estimated population in 2000 (P.E.O.P.L.E. 25 data): Population estimates and projections were submitted by BC STATS, BC Ministry of Management Services, and provided by the Health Data Warehouse, BC Ministry of Health Planning and BC Ministry of Health Services.

[10] BC Ministry of Health and Ministry Responsible for Seniors, Continuing Care Division and Interministry Committee on Elder Abuse (1992): *Principles, Procedures and Protocols: For Elder Abuse*, Victoria, Province of British Columbia.

Mental Health Care Services for Elderly People: Description, Principles and Recommendations

The guidelines address elderly people with existing chronic mental illness and people who develop psychiatric disorders or conditions in later years

Introduction

This section begins with a diagram designed to show the array of services required by elderly people experiencing mental health problems. This is a complex task from an organizational perspective because of the number of components involved and the key role each one plays. The challenge is to have discreet components organized in a comprehensive, coordinated fashion to meet the diverse and often multiple needs of elderly people. Following the diagram are the principles upon which the recommendations, found in this section, are built.

Mental Health Care Service System Diagram

Diagram 1.2 of the mental health care service system (see page 10) for the elderly depicts the major components that make or support a comprehensive service system.

The majority of elderly people experiencing mental health challenges, primarily dementia and depression, are cared for by family, home support, home nursing, residential care and family physicians. Of those people, a smaller number may require the services of a specialized mental health service. Clients may require a progression from general to specialized services, based on their individual needs.

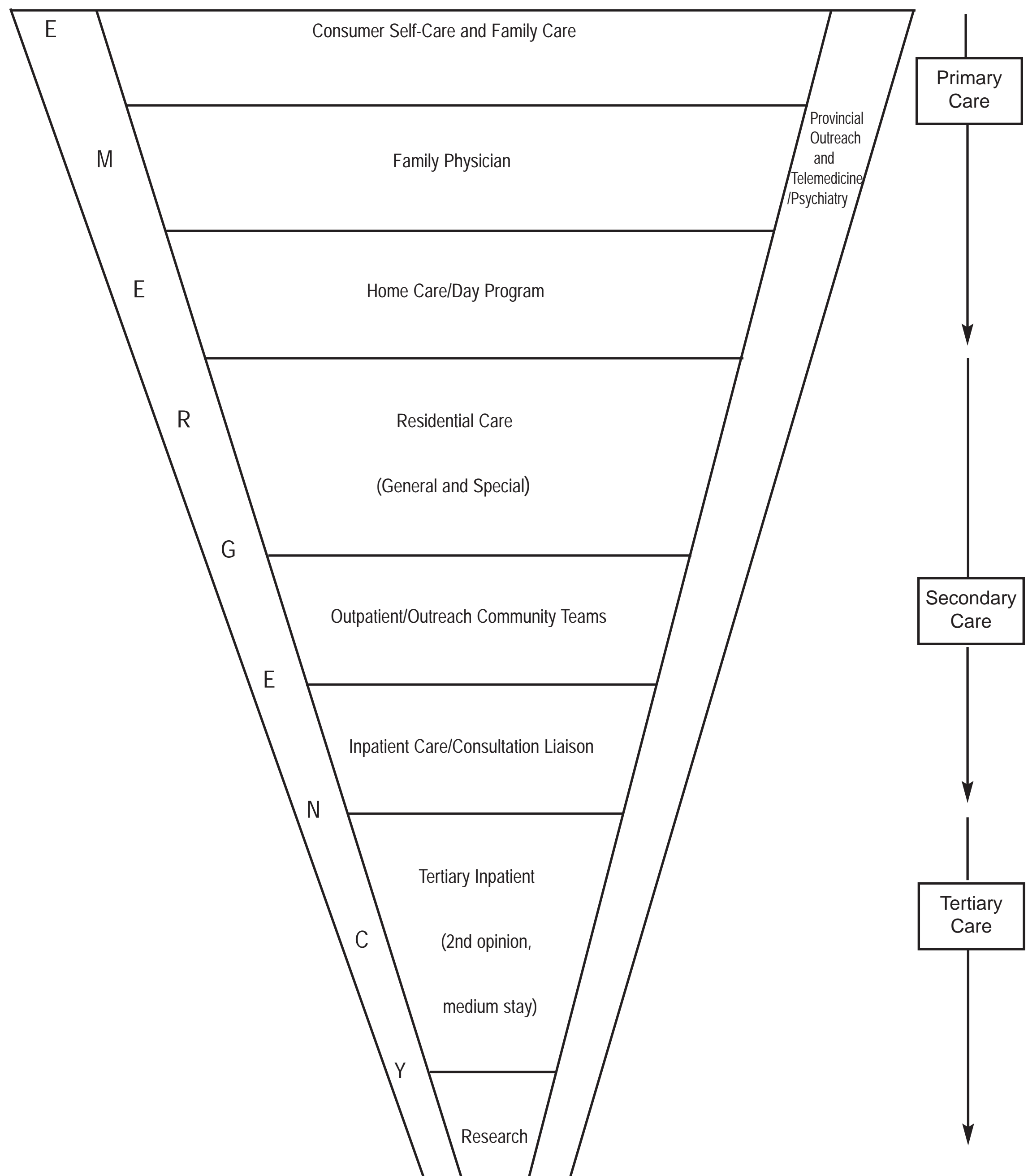
Research and evidence-based practice forms the foundation for developing services.

Emergency response capacity is vital

The section marked "emergency" illustrates that emergency response capacity at all stages is a vital component of the system.

Provincial outreach and telehealth support communities to improve their capacity to provide primary and secondary care.

1.2 Diagram: Mental Health Care Service System for the Elderly



I. Principles of Elderly Mental Health Care and Recommendations for Health Authorities[11]

PRINCIPLES

Better practices develop when client needs are the focus

Principle 1: Client and Family Centred (client and family directed where possible but always client centred):

- Maintains the dignity of older adults and treats them with respect.
- Involves the person and the family in care planning and management.
- Is culturally sensitive.
- Is sensitive to the complex and unique ethical issues that arise in the context of decision making about care for older persons, especially those with significant mental health concerns and end of life decisions.

RECOMMENDATIONS

1.1 Ensure the physical and social environment in which care is provided is developed as a therapeutic tool, including a shift in focus from tasks to relationships.

1.2 Develop and foster a culture of caring across the spectrum of care that acknowledges the need for a meaningful life (rather than just living) and recognizes people's relational needs. A culture of caring would prevent alienation, anomie and despair that many elderly persons feel and would promote optimal mental health.

Principle 2: Goal Oriented:

Goals of psychogeriatric management and treatment are:

- Reduction of distress to the person and the family.
- Improvement and/or maintenance of function.
- Mobilization of the individual's capacity for autonomous living.

PRINCIPLES

A goal of psychogeriatric management and treatment is the reduction of distress to the person and family

- Maximization and maintenance of independence at the highest level possible.

RECOMMENDATIONS

2.1 Establish a culture of caring, that includes principles of psychosocial rehabilitation, to maximize quality of life for this population. These principles emphasize the importance of consumer involvement in developing and realizing their own personal care and life goals. The need for treatment and supports that help consumers manage their symptoms and build on their strengths is also recognized.

2.2 Provide increasingly supportive or assistive environments, driven by clients' changing needs, when maintenance of function is not possible (e.g. in deteriorating cases of dementia).

Principle 3: Accessible and Flexible:

- User-friendly.
- Readily available.
- Responsible service that listens to and understands the problems and acts promptly and appropriately.
- Takes into account geographical, cultural, financial, political and linguistic obstacles to obtaining care.
- Integrates services to ensure continuity of care and coordinates all levels of service providers including local, provincial and national governments with community organizations.
- Individualized to provide service to each person wherever most appropriate (e.g. residence, hospital).

PRINCIPLES

Accessible and flexible mental health services are user friendly and readily available

RECOMMENDATIONS

3.1 Formalize defined links for transitions between acute care, facility care and community-based services. These relationships should be defined locally according to the needs of the population, existing resources, the size and location of the community and the local environment. The need for a formalized collaborative relationship is also required with adult mental health.

3.2 Ensure all staff caring for this population has appropriate skills. This includes acute care and crisis response/emergency services staff.

3.3 Develop and adopt, in partnership with the Ministry of Health Services, competencies expected of professionals working with this population.

3.4 Provide access for clients, families and other informal caregivers to education, emotional support and support services, including crisis services.

Principle 4: Comprehensive:

- Takes into account all aspects of the person's physical, psychological, social, financial and spiritual needs.
- Makes use of a variety of professionals, resources and support personnel to provide a comprehensive range of services in all settings, including the community, facilities and acute care.

RECOMMENDATIONS

4.1 Implement a biopsychosocial model of care that addresses the biological, psychological, social and environmental needs of the population being served. A biopsychosocial model moves the focus from individual pathology alone to a consideration of the whole person within the context of their social environment.

PRINCIPLES

Family members need to be part of the care team

RECOMMENDATIONS

4.2 Ensure all teams, regardless of size, include service delivery (direct and indirect), education and quality improvement as part of their mandate. In order to perform these roles, team members require access to ongoing education and consultations with other professionals in the field.

4.3 Develop a team approach, regardless of the size of the community, that utilizes a variety of skills in a collaborative manner ensuring attention to team dynamics and functioning. (See Appendix 1.16: Interdisciplinary Teamwork in Psychogeriatrics.)

4.4 Ensure family members are included as part of the care team.

4.5 Ensure nonmedical community service providers, such as police, service clubs and volunteers, who assist seniors in various ways are also part of the larger care team.

4.6 Develop and establish clear lines of authority to handle crisis response/emergency services. It is appropriate for all clients in crisis to remain connected with their family physician. The family physician can liaise with the secondary or tertiary services as required to handle the emergency. Excellent communication between the client's family physician and secondary and tertiary referral personnel is a must in all circumstances.

4.7 Develop the ability to provide intensive at-home care as needed in crisis and urgent, time-limited situations. This could include respite, home support and added care.

4.8 Develop preventive interventions, including strategies for maintaining wellness, and early interventions for mental health disorders. Incorporate this information into specific training programs for both informal and formal caregivers.

4.9 Expand, in partnership with the Ministry of Health Services and the Mental Health Evaluation and Community Consultation Unit (Mheccu), psychogeriatric outreach to rural and remote communities. This expansion should include more consultations by a broad range of disciplines using modern technology as appropriate (e.g. telehealth).

Principle 5: Specific Services:

- Recognizes the needs of older adults with mental health problems are qualitatively different from mentally well older adults.
- Recognizes the needs of older adults with a mental health problem are qualitatively different from the younger population with a mental health problem.
- Designs appropriate and relevant services specifically for this population.

PRINCIPLES

Service planning begins with the recognition that the needs of older adults with mental health problems differ from younger people with similar conditions

RECOMMENDATIONS

5.1 Ensure access to secondary[12] and tertiary services[13].

5.2 Provide support to the primary and secondary service system through increased, ongoing education.

5.3 Maintain and continue to develop the specialized body of knowledge and expertise within geriatric mental health.

5.4 Identify the unique service needs of elderly people with mental health problems (outpatient and inpatient) and develop plans for meeting those needs with adequate and appropriate resources.

5.5 Ensure staff that work with elderly people, regardless of their discipline or job, are supported to maintain knowledge and skills needed to provide informed and competent services.

Principle 6: Accountable Programs and Services:

- Accepts responsibility for assuring the quality of the service delivered and monitors this in partnership with the client and family.

PRINCIPLES

The clinical effectiveness of medium and long stay tertiary psychiatry beds needs to be evaluated to help in resource planning

- Responds to reasonable expectations from clients, families and those providing service.
- Anticipates and responds to changing demographics.
- Incorporates relevant evaluation strategies and research findings to determine optimal methods of service delivery.

RECOMMENDATIONS

6.1 Health authorities, in partnership with the Ministry of Health Services, complete a formal evaluation of medium and long stay tertiary psychiatry beds for the elderly to assist in further planning and/or development of these resources.

6.2 Develop and adopt, in partnership with the Ministry of Health Services, a standard framework for describing services to help compare types and amounts of services across the province. This would include:

- standardized elements that constitute "a case";
- ways to track indirect work, including telephone consults, discussions about cases with other professionals and educational sessions; and
- the development of standardized quality improvement criteria, including access criteria, discharge criteria, case loads, staffing benchmarks (see Appendix 1.8) and outcomes.

6.3 Employ a variety of methodologies and approaches to monitor and evaluate the clinical effectiveness of all programs and innovations in the provision of care.

6.4 Once every two years, compile a report of services for elderly people with mental health problems in the health authority and submit it to the Ministry of Health Services for the development of a provincial report.

6.5 Support local accreditation and program evaluation of elderly mental health care services.

6.6 Encourage and support research on mental health and aging, service delivery models and programs.

Footnotes

[11] *Principles of Elderly Mental Health Care* is based on the British Columbia Psychogeriatric Association's *Principles of Psychogeriatric Care* and was modified by the working group.

[12] See page 18 for a description of the secondary service system.

[13] See page 25 for a description of the tertiary service system.

II. Components Needed in the Formal Service System for Elderly Mental Health Care

Introduction

Traditionally, the major components of the health care system have been defined as primary, secondary and tertiary.[14] Included in this discussion are crisis response/emergency services for the elderly.

A. The Primary Service System

- Family physicians and other primary care service providers can manage many problems without direct consultation from specialists. Family physicians and community health workers (nurses, rehabilitation therapists, social workers, psychologists, homemakers) are the basic infrastructure of the mental health care system for seniors. In order to enable providers in the primary care system to care for an increasing

Family physicians and community health workers are the basic infrastructure of the mental health care system for seniors

Shared care is usually the most effective way of delivering health care to elderly patients

number of elderly people with complex high level needs, specialized training and supports are needed.

- The primary service system is commonly the point of entry to all subsequent services that may be provided through the secondary and tertiary systems. Often, it is the family physician who first sees the individual experiencing problems. In certain circumstances, the family physician may want to try sequential or stepped care management strategies[15] prior to involving other resources that may be needed to provide care or support for the person or family caregivers.
- Shared care[16], also known as interdisciplinary, community-based primary care, remains the most cost effective and efficacious means of delivering health care services[17].
- The primary service system includes family physicians, seniors' day care and nonspecialized beds in long term care facilities. In addition to these services, family physicians may admit to acute care hospitals (without psychiatric consultation).
- Best practices in the primary care system depend on knowledgeable clinicians, co-ordination and collaboration among caregivers and service providers with as much integration and continuity of service flow as possible. Some examples of best practice models of primary care are provided in Appendix 1.13: Descriptions of On-Lok, CHOICE and SIPA.

B. The Secondary Service System

- The secondary service system delivering mental health care for the elderly provides specialist care by professionals who have specific training in geriatric mental health, psychiatry or geriatric psychiatry. Secondary services are provided in a variety of settings (e.g. outreach teams, inpatient services). They provide indirect services, such as

consultation to professionals, and education to care providers. Direct services, such as assessing the client and/or assisting with ongoing care, are also provided. It is essential that the primary system continues to provide ongoing overall medical and supportive care and that consultation and liaison are maintained between the primary and secondary service system providers.

- The secondary system delivers care for (and only needs to care for) a small percentage of older clients with mental health problems (perhaps 10 to 15 per cent of those who are ill or about three per cent of the population as a whole). It is believed that the secondary system is presently not seeing a high percentage of those who genuinely need their services because resources are limited. Secondary resources may need to be assessed, especially in rural areas.

Community outreach teams constitute the foundation of the secondary service system

Components of the Secondary System

i. Outpatient/Outreach Community-based Mental Health Teams

Making house calls and providing services outside formal offices or clinics is the essence of outpatient/outreach community-based services. Community outpatient/outreach mental health teams, whether hospital or community-based, constitute the foundation of the secondary system. Individual clinicians in very small towns or remote areas can be successful if they work as a team even though they may not be organizationally connected. For instance, a family physician consulting with a community nurse around care for a senior with mental health problems may well be the foundation of a psychogeriatric support system in an area that is too small to have a specific psychogeriatric mental health team. In this case, a defined linkage to regional secondary services needs to be developed. Teams can, therefore, vary from this basic two-person liaison to sophisticated teams with four or five disciplines working in an ideal interdisciplinary format. (See Appendix 1.16.)

The client's family physician and community health professionals are part of the care team and need to be involved in decisions about clients

Outpatient/outreach teams require access to:

- physicians (family physicians, geriatricians, psychiatrists, geriatric psychiatrists);
- nurses and psychiatric nurses;
- social workers;
- rehabilitation therapists (occupational therapists, physical therapists);
- psychologists; and
- administrative support (secretaries, receptionists).

These individuals would constitute the core team members. In addition, it is important to note that the client's family physician and other community health service professionals must always be involved. Case management issues (i.e. accountability and responsibility) should be defined among the collaborating professionals.

Other team members needed for occasional consultation may include pharmacists, neurologists, Licensed Practical Nurses, health care aides and life skills and home support workers trained for psychogeriatric care. Access to lawyers, ethics consultants, nutritionists and staff from the Office of the Guardian and Public Trustee should be available as needed. In keeping with general community mental health principles, clients should be seen wherever it is appropriate to see them — within their own home, within an outpatient team environment, in a long term care facility, at a day program or in hospitals.

The role of the community mental health outreach team includes:

- assessment (including collection of collateral information);
- recommendations for care;

- direct care[18] (treatment, case management, followup);
- indirect care[19] (consultation to other care providers, e.g. shared care);
- competency assessments or at-risk assessments as required;
- consultation regarding program development or environmental approaches to care;
- education and training for formal and informal caregivers; and
- research and evaluation.

Models of service delivery can be developed with more direct or more indirect care as is appropriate for an individual community and local community capacity should determine the most appropriate model.

Local community capacity can determine the balance between direct and indirect care for elderly people with mental health problems

ii. Inpatient Elderly Mental Health Care Services

Health authorities should consider the following points concerning the provision of inpatient secondary elderly mental health care services.

1. The service design should take into consideration the size of the community and the professionals in that community (local capacity).
2. The recommended range of services includes:
   - family practice services;
   - psychiatry services;
   - geriatric psychiatry services (see Appendix 1.9 for a description of the St. Vincent's model of inpatient care);
   - geriatric medicine services; and

Inpatient elderly mental health care services need clear, measurable admission criteria and protocols

- inpatient medical and psychiatric geriatric assessment and treatment services (e.g. short-stay assessment and treatment units).

3. The development of clear, measurable admission criteria and protocols for access is needed.

4. Program development should ensure that psychosocial rehabilitation needs are met, along with biological assessment and treatment, whether elderly people with mental health needs are located in general medicine or psychiatry beds.

5. Medical consultants, as needed, should be accessible for specific case problems. For example, geriatricians, specialists in internal medicine, neurology and cardiology, etc.

6. Care protocols, clinical path models and/or practice guidelines should be defined for assessment and treatment.

7. Discharge criteria and planning, with connections back to the community and appropriate involvement of family/caregivers, are essential.

8. Quality improvement activities, including utilization processes, should be in place.

9. Integration between outpatient/outreach and inpatient care is essential. This could occur in several ways, including having the outpatient/outreach and inpatient care connected by being at the same site or by having protocols for access to individual services. Another model could have the case manager of the outpatient outreach team act as

the continuous case manager through inpatient admissions and back to the community.

10. Liaison with home and community care services and the family physician for discharge planning and arranging of supports is essential and should be considered as part of the continuum of integrated care across several different spectrums, such as outpatient/inpatient, acute care/home and community care and specialist/family physician care.

See Appendix 2.1 for an Inpatient Services Literature Review.

Appendices 2.1 to 2.8 provide selective literature reviews on aging and the care of elderly people with mental illness

iii. Day Hospital Services

A day hospital provides an alternative to inpatient hospitalization by providing rehabilitation for those whose care requirements are greater than can be provided through outpatient services. Further, day hospitals allow for early discharge of inpatients, the prevention of unnecessary inpatient admissions and the provision of a longer period of observation than is available in other community settings. Geriatric day hospital services may provide both psychiatric and physical care needs (e.g. Vancouver Hospital).

In smaller communities, where it is not possible to justify a day hospital, it may be possible to provide a similar function in a day care facility or in a general hospital setting.

iv. Outpatient Clinics

An outpatient clinic is very similar in form and function to an outpatient/ outreach team, the only difference being that clients come to the clinic rather than being served in their residence. Generally, outpatient clinics, located in hospitals, have a major role in followup of discharged inpatients (e.g. Geriatric

Electroconvulsive therapy is successful for patients with severe depression or who are suicidal

Psychiatry Outpatient Clinic at Vancouver Hospital). The Alzheimer Clinic at UBC (University of British Columbia) is an example of a specialized clinic for diagnosis, assessment and consultation on dementia.

v. Outpatient Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) may be offered by hospitals on an outpatient basis for both acute or maintenance ECT treatment. The scientific evidence regarding the efficacy of the treatment has been firmly established in the professional literature. ECT has a higher success rate for severe depression than any other form of treatment. It can be life saving and produce dramatic results and is particularly useful for people who cannot take antidepressants due to problems of health or lack of response. A patient who is very intent on suicide, and who would not wait three weeks for an antidepressant to work, would be a good candidate for ECT.

vi. Private Psychiatrists

Private psychiatrists, although not remunerated by the health authority, can be an important service provider. They see older clients in their offices. For more complicated cases, requiring visits to the client's home and intensive support, they generally refer the client to multidisciplinary teams.

vii. Inpatient Geriatric Psychiatry Consult Liaison Services

Formally constituted consult/liaison services are generally available in large acute care settings. These services consist of consultation to acute care hospital inpatient programs or liaison with them around psychiatric or geriatric psychiatric problems. Typically, a psychiatrist sees the client and gives an opinion. Most often the client's psychiatric needs are treated where they are receiving care. Occasionally, the psychiatrist may facilitate the transfer

of the client to a psychiatric unit. Teams may be created to perform the consult/liaison service. Teams may include nurses, social workers or rehabilitation therapists along with physicians.

Consult/liaison services may include indirect consultation — discussing cases without seeing clients — or education for staff about how to identify psychiatric illness or how to manage challenging behaviours. In smaller hospitals, the outpatient/outreach team may undertake the role of the geriatric psychiatry consult liaison service.

COMPONENTS

Geriatric psychiatry consult/ liaison services give care providers access to expert advice and second opinions

C. Tertiary Service System

- The tertiary service system delivers care for individuals needing more than secondary care can offer. These most complicated of cases amount to about one per cent of the elderly population as a whole or about 10 per cent of those receiving secondary services. Ideally, referrals to tertiary care should always be made by a secondary resource.

Components of the Tertiary Care System

i. Inpatient Tertiary Elderly Mental Health Care Services

Although only a small number of tertiary medium stay inpatient service beds are needed, these beds are vital to the overall functioning of the system. Without them, incredible pressure on the secondary and primary systems develops. As mentioned in recommendation 6.1 (page 16), this is clearly an area where health authorities, in partnership with the Ministry of Health Services, should complete a formal evaluation of medium and long stay tertiary beds. This review would assist in further planning and/or development of these resources.

Outreach services for elderly people in rural and remote communities could benefit from partnering with health authorities

Tertiary inpatient services require highly specialized, trained staff and programs to provide care for people whose behaviours or complicated disorders are beyond the capacity of secondary staff and resources. Inpatient services at the tertiary level consist of either medium or long stay beds. Medium stay is considered to be 60 to 180 days and long stay is greater than 180 days. A question arises as to whether or not some of the tertiary long stay clients could be managed in other facilities, such as long term care facilities with special care environments. If this is found to be an option, it should be noted that appropriate care would require additional staffing with specialized training. There is some regional capacity for tertiary medium stay beds, but this capacity depends on resources, particularly staff, being locally available.

ii. Rural and Remote Community Outreach

With funding provided by the Ministry of Health Services, the University of British Columbia (UBC) Department of Psychiatry (through the Geriatric Psychiatry Outreach Program) has been providing support for geriatric psychiatrists, geriatricians and nurses to travel to distant communities for consultation, education and direct service. This outreach program, now the responsibility of the Mental Health Evaluation and Community Consultation Unit (Mheccu), Department of Psychiatry, UBC, could benefit from improving partnerships with health authorities. Future planning needs to consider:

- expanding the program to include, as needed, other experts, such as specialist nurses, rehabilitation therapists, psychologists and/or social workers;
- expanding regionally-based support systems, rather than focusing on specialists based in Vancouver or Victoria;
- continuing to include community or program development, as well as educational and direct client services; and

- exploring new technologies, such as teleconferencing and telepsychiatry, that could be increasingly used in order to serve rural communities that currently have difficulty accessing specialized geriatric services.

iii. University Research/Teaching Clinics

University teaching clinics, such as the UBC Alzheimer's Clinic and Movement Disorders Clinic, are primarily research focused. In the future, technologies such as telehealth may support access to these services by remote communities. These research/teaching clinics, as well as other university programs, not only offer opportunities for research, but also provide education for many of the professional care providers.

D. Crisis Response/Emergency Services

Crisis response/emergency services need to be available for the elderly

Crises or emergencies can occur with clients being treated in any part of the service system — primary, secondary or tertiary care. In fact, it would be expected that the majority of crises would occur where the majority of clients are treated within the primary system and that most would be minor and could be handled within the primary system of care. If the crisis is more serious, this may be the point at which a client is introduced to the secondary system for the first time.

As with the mental health system as a whole, the structures, which are appropriate for treatment of mental health emergencies in the elderly, depend on the size of the community and availability of trained personnel. The crisis response/emergency services described in the young adult best practices document are equally appropriate for seniors. The executive summary of that report is appended as a suggested model (see Appendix 1.5).

The very high prevalence of medical and psychiatric symptoms in elderly people requires that crisis services include a medical assessment

It is important to note that elderly people need medical assessment in crises because of the very high prevalence of medical/psychiatric co-morbidities presenting as emergencies. Ideally, the family physician should be involved in all assessments. However, crisis staff personnel must be trained to identify medical problems in psychiatric emergencies in elderly people or know how to quickly obtain a medical assessment quickly. It is equally important that community and hospital staff work together to ensure a continuum of community services are available for elderly people who present in emergency departments.

Footnotes

[14] After reviewing various definitions of primary, secondary and tertiary care, the Elderly Mental Health Care Working Group found the definitions developed by the Lower Mainland Project Steering Committee for Riverview Hospital Replacement Project were the most appropriate. See Appendix 1.3 for a complete copy of the definitions.

[15] Von Korff, M., Katon, Wayne, MD, Unutzer, Jurgen, MD, MPH, Wells, Kenneth, MD, Wagner, Edward H., MD: Improving Depression Care Barriers, Solutions, and Research Needs, *The Journal of Family Practice*, 50:6 (2001).

[16] The *Shared Care Initiative in British Columbia* defines shared care as a cooperative effort between psychiatrists, psychologists, family physicians, nurses, social workers and other mental health professionals to collaboratively enhance the quality of care provided to people suffering from mental illness. Nick Kates, FRCPC, Marilyn Craven, CCFP, Joan Bishop, FRCPC, Theresa Clinton, CCFP, Danny Kraftcheck, CCFP, Ken LeClair, FRCPC, John Leverette, FRCPC, Lynn Nash, CCFP, Ty Turner, FRCPC: “Shared Mental Health Care in Canada”, *The Canadian Journal of Psychiatry* 42(8):809-810, 1997, and *The Canadian Family Physician* 43 (1997): 1785-86.

[17] Canadian Psychological Association (2000): *Strengthening Primary Care —The Contribution of the Science and Practice of Psychology*, Ottawa, Canadian Psychological Association.

[18] Direct care/consultation — Consultation in which one professional, or team of professionals, upon referral, sees an individual and makes recommendations to the consulter.

[19] Indirect care/consultation — Consultation in which one professional service provider discusses a case with another professional without the second professional seeing the individual.

III. Key Elements and Approaches to Care

A number of care elements and approaches to care for the elderly are required in the mental health care system, regardless of the community size or location, service sector or the type of care provider.

Brief summaries of these care elements and approaches are as follows:

1. Education for Clients, Family, Informal and Formal Caregivers

Knowledge is the cornerstone of elderly mental health care. It is essential everyone involved, from the client/families to the specialized professional, have knowledge appropriate to the kind and level of involvement. Education must, therefore, be available and be geared to the specific needs of the particular individual.

Education for clients, family and informal caregivers should provide a basic understanding of what is happening with the elderly person experiencing mental health problems. Education for service providers requires a more specialized and detailed focus. The planning, development and implementation of strategies, policies and programs for education and training of service providers should follow a logic that is based on identifying the knowledge and skill sets that are needed by each type of service provider, establishing competency standards and ensuring that appropriate education and training are available.

Two diverging trends have profound implications for the system of services for elderly people:

- increasing numbers of clients with more intensive and complicated care and service needs means service providers need increasingly specialized knowledge and skills in order to meet the care needs of these clients; and
- while the care needs of clients are shifting upward towards requiring more intensive and complicated care, a downward shift is occurring in the workforce towards greater numbers of workers with lower levels of training and education. As shortages of professionals and costs in the health care system escalate, hiring workers with lower levels of training and skills is increasingly attractive to employers because of their availability and the typically lower rates of pay for these employees.

KEY ELEMENTS

Two trends have profound implications: the need for skilled and knowledgeable staff to work with more complex patients and the need to control costs

Psychosocial rehabilitation services help clients to be in control of and enjoy their lives

It is important to ensure that health care aides and other nonprofessional[20] workers receive adequate education and training.

See Appendix 2.2 for the Education Literature Review.

2. Family Support and Involvement

At present, the majority of elderly people with dementia, depression or some type of mental health problem are cared for at home with the support of family physicians and a variety of home support services. The needs of the majority of these informal caregivers, and the people they are caring for, have been well reviewed and documented in the 1999 review of home and community care services in British Columbia[21] and the 1995 report on respite care services.[22] The populations addressed in this document, *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities*, are those individuals whose behaviour makes it difficult for both formal and informal caregivers[23] to provide care. These behaviours can be long standing, periodic or episodic. The needs of informal caregivers in the home environment are central and there is an overlap with the needs of the formal caregiving system.

See Appendix 2.3 for the Family Support and Involvement Literature Review.

3. Psychosocial Rehabilitation and Recovery

Psychosocial rehabilitation promotes optimal performance in areas of cognition, interpersonal skills, self-care, leisure and utilization of community resources. Success in these areas is crucial to mental well-being. The goals of mental health services relevant to psychosocial rehabilitation are helping older adults find pleasure and meaning in their lives, appropriate supports and retain as much control over their lives as possible.

Central to the rehabilitation process are:

(a) the identification of common problems and needs;

(b) the co-ordination and collaboration between available services/ programs; and

(c) the articulation of ways to help clients identify their own needs.

Whenever possible, to foster independence, maximize choices and assure the opportunity to make decisions consistent with the individual's own values, autonomy should be supported through minimum interventions.

Various approaches, including behavioral approaches, cognitive-behavioral approaches, family systems perspectives, psychotherapy (family, individual and group), biofeedback and psychosocial educational skill building, can lead to positive outcomes with respect to well-being. Peer counselling is another resource that has been beneficial.

Ensuring appropriate access to programs is very important. Ways to improve access could include outreach programs, adapting programs to meet the needs of the client, flexible time scheduling for programs and collaboration between agencies (e.g. community support programs, life skills programs) and in a variety of settings (e.g. clients' homes, doctors' offices, seniors' centres, community centres, religious organizations, educational institutions).

The Integrated Group Therapy Program in Kelowna is an example of a psychosocial rehabilitation program. The integrated group approach they use is designed to assist clients through a continuum of treatment of illness, prevention, recovery and sustaining wellness. The health promotion focus of addressing the underlying conditions that lead to illness is an integral part of the program's philosophy. For details,

KEY ELEMENTS

A variety of approaches can help elderly clients to be as independent as possible and be involved in decisions

KEY ELEMENTS

Access by elderly people with mental health problems to residential housing is an important management issue

see Appendix 3.16 — Integrated Group Therapy Program, Kelowna Mental Health Centre. See Appendix 2.4 for the Rehabilitation Activities — Psychosocial and Functional Literature Review.

4. Environmental Milieu (Housing)

Housing is recognized as a critical determinant of health. The concept of environmental milieu goes beyond the physical environment in which a person lives to also consider the psychosocial milieu. The following comment received in feedback from an earlier draft seems particularly relevant:

> *A healing and therapeutic person-centred approach and milieu is important. This is the context for the delivery of individual care. It is a matter of the physical and the social aspects of care. In the physical, there are many aspects -- architecture, interior design (i.e. color, pictures, furnishings, etc.), but also access to a garden, to pets and to people. The social side is founded on the relationships among staff, visitors and volunteers. Creating and maintaining an environment with a positive outlook, mutual respect and communications is demanding work. Like a parent's work, it is ongoing, always changing and often unrecognized. But it is evident.*[24]

The majority of elderly persons with mental health problems live in their own homes or in long term care facilities. Practical supports for individuals living in their own homes are generally provided by family, friends and/or home and community care (e.g. home support services). Home and community care also provides long term care (facility) housing.

Home and community care services (in-home and facility) have evolved from the acute care model. This model did not lend itself to the promotion of optimal mental health. It was not person-centred because the focus was on physical care structures and the daily routines of staff with respect to clients/residents. The client's person-hood was often underemphasized

and strengths and abilities were missed. (See Appendices 1.10 Communication from Margaret Neylan; 1.11 Working Toward Quality of Life in Nursing Home Culture; and 1.12 The Eden Alternative.)

While adult mental health programs have historically included housing for the younger population in their mandate, housing for the elderly is primarily the responsibility of home and community care services. Access by elderly people with mental health problems to residential housing is an important management issue. Mental health is available to provide home and community care services, with consultation regarding mental health aspects of both program development and individual care.

Those who have grown old with a mental illness that first developed in younger age may continue staying in mental health residential facilities with specialized elderly mental health care (psychogeriatric) services brought in to help maintain them there. Integrating elderly chronically mentally ill individuals into home and community care residential facilities raises issues of stigma and lack of knowledge and skills.

Staff in community care facilities may need training and education to assist them to provide care for elderly individuals with long-standing mental illnesses.

- Adequate levels of home support and respite care should be available in order to facilitate older people remaining at home as long as possible. An expansion of the range of services provided to clients in their homes and in facilities is thus required so that psychological, spiritual and social needs are identified and addressed. This will necessitate the inclusion of a wide variety of disciplines to provide care, train staff and develop programs.

- Mental health consultation should be provided to agencies and facilities to help them develop the appropriate environment

KEY ELEMENTS

Staff in community care facilities may need training and education to assist them to provide care for elderly individuals with long-standing mental illness

KEY ELEMENTS

The key is working together to solve client/family problems and improve access to care

and culture to meet the needs of psychogeriatric clients. This consultation could relate to facility design, program design, etc.

5. Integration and Continuity of Services

Without case management and integration of information systems, clients and families have to repeat basic information or may be subjected to duplication of services.

This is most likely to occur when in transition between service systems such as:

- outpatient/inpatient treatment teams;
- home and community care/mental health/drug and alcohol staff;
- acute care/home care/residential care staff; and
- family physicians/medical specialists.

Service personnel from all systems should be brought together to provide client-centred care for an individual case. This may range from client conferences all the way to integrated teams.

Some regions may choose to have shared staffing between various health sectors. For example, physicians may work with mental health teams and with other programs or facilities in a community. Other regions may choose to establish effective communication links between separate staff. No matter what system is adopted, the key is working together to solve client/family problems, improve access to care and allow for creativity as a means of directing client care operations.

New systems of care, using integration of care as a central tenet, have been

developed to care for "frail" seniors in North America. Examples include On-Lok, Choice and SIPA (see Appendix 1.13).

The Canadian College of Family Practice and the Canadian Psychiatric Association have jointly developed a model of shared care between family physicians and psychiatrists to improve continuity of client care, stretch scarce psychiatric resources and to improve family physicians' skills in assessment and treatment of clients with psychiatric problems.[25]

The concept of "shared care" across disciplines and between formal care providers and families is being pursued in communities and regions across the country.

6. Quality Improvement and Evaluation

All services for mental health care for the elderly should have defined quality improvement (QI) processes to improve their performance on an ongoing basis. A standard framework for describing services should be adopted to help compare types and amounts of services across the province. See Appendix 1.4 for examples of a template for describing mental health services for the elderly and a standard problem list on referral. Further, it is recommended that once every two years a report is compiled of services available for elderly people with mental health problems using a defined template, such as the one offered in Appendix 1.4.

The standard problem list on referral form is also useful in the planning, monitoring and evaluation of services. Consistent use of the form helps to identify the kind and frequency of problems that the service or program encounters. Changing trends or patterns in referral can then be accommodated with service or program changes, thus ensuring that services are effectively organized and deployed.

KEY ELEMENTS

A Quality Improvement/ evaluation framework should be adopted throughout the province

KEY ELEMENTS

Volunteers, mentors and peer counsellors increase the range of services mental health agencies can provide

A quality improvement/evaluation framework should be adopted throughout the province so that province-wide comparisons of systems can be made (see Appendix 1.14 on performance evaluation created by the Vancouver/ Richmond Evaluation Working Group). There should be communication between health regions about quality improvement/evaluation so that rural and remote areas can be evaluated in comparison to urban centres.

The attainment of personal goals as an outcome measure (for clients and families) should also be encouraged. These goals will vary and be unique from one person to another, but they will help provide both subjective and objective measures of service quality. A tool that can be used to provide insight and information about personal goals and the degree to which services help in their achievement is the Goal Attainment Scale (GAS). See Appendix 1.19 for a research report by David J. Evans on the use of goal attainment scaling at the Elderly Outreach Service in Victoria.

All services for mental health care for elderly people should work towards being accredited. The use of standardized accreditation models and processes allows comparisons across regions, provinces or countries.

See Appendix 2.6 for the Quality Improvement Literature Review and Appendix 2.7 for the Service and Program Evaluation Literature Review.

7. Volunteers, Mentors and Peer Counsellors

Volunteers, mentors and peer counsellors provide helpful services that are often unrecognized and, therefore, undervalued, perhaps because this work is by definition "work without remuneration".[26] Candy stripers and hospital auxiliary volunteers are familiar figures in the acute care setting. Many communities also have a number of volunteer services available for seniors, such as transportation services, delivery of Meals on Wheels

and companionship through friendly visiting. Not only is volunteer work beneficial to the recipients, but the volunteers themselves usually benefit in various psychological or personal ways from the experience.

Mentoring and self-help are often provided through groups that meet for the purpose of mutual aid, support and personal growth. A mentor acts as a role model to provide help or give advice to a person with a mental illness or other life management problem. Self-help or mutual aid groups are available in most communities, often organized for individuals with a similar problem, such as a mood disorder. The aim of mentoring and self-help is to provide help in coping or managing through mutual efforts, rather than professional interventions.

Peer counselling, in which experiences are shared as peers help peers, is a variation on the volunteer/mutual aid theme. Senior Peer Counselling of British Columbia is an incorporated nonprofit society that provides training for seniors to help other seniors by providing emotional support, guidance and empathy to at-risk seniors troubled by loneliness, depression, isolation or grief.

Volunteers, mentors and peer counsellors who work with people with mental health problems should have training that will enable them to better understand the problems and needs of the people they are helping. They also require support in their work from other service providers.

8. Advocacy and Protection

Advocacy is defined as action taken on behalf of an individual (including one's self) or a group of individuals to promote and defend needs, rights and interests. Advocacy seeks to ensure vulnerable individuals have access to the services and benefits to which they are entitled and a voice

KEY ELEMENTS

Advocacy helps vulnerable people obtain services and benefits and to have a voice in their treatment

KEY ELEMENTS

Protection from financial, physical and psychological abuse is vital for frail elderly people

in the treatment decisions that affect them. Vulnerable individuals include those who have been socially marginalized and those with moderate or severe mental or physical disabilities who face structural and attitudinal barriers to service and participation.

The spectrum of advocacy ranges from individual advocacy to systemic advocacy. Individual advocacy helps people speak out, exercise their rights and obtain access to the health services they or their relatives need. Here, advocacy attempts to redress a power imbalance and/or to respond to abuse, neglect, isolation and discrimination. At the other end of the spectrum, systemic advocacy promotes the needs of an identifiable population by influencing law, regulation, policy, practice, guidelines and/or service delivery.

In funding and/or providing health care services, the Ministry of Health Services and health authorities have an obligation to monitor and evaluate the delivery of those services and to provide constructive solutions to problems of service delivery. This obligation is particularly important in relation to those services used by people who face structural and attitudinal barriers to participation.

Protection from financial, physical or psychological abuse is absolutely necessary for elderly people who are potentially vulnerable because of physical or mental frailty. New legislation intended to provide protection from harm is contained in the *Adult Guardianship Act* and the *Representation Agreement Act*, parts of which came into effect in February 2000. The *Adult Guardianship Act* provides a legislative foundation for providing protection from situations of abuse, neglect and self-neglect to vulnerable people, including those who are elderly. Within this legislative package, the *Representation Agreement Act* enables adults to plan ahead for a time when they may become incapable of making their own decisions; Part 3 of the Act — Support and Assistance

for Abused and Neglected Adults — promotes a coordinated community response (e.g. Community Response Networks) when abuse, neglect or self-neglect are identified; the *Health Care (Consent) and Care Facility (Admission) Act* establishes procedures for providing health care when an adult is incapable of making their own decisions; and the *Public Guardian and Trustee Act* provides the Public Guardian and Trustee with powers in the investigation of financial abuse.

KEY ELEMENTS

Client-centred services value and respect people by encouraging and enabling participation in care decisions

9. Health Promotion and Prevention

In this document, distinctions between primary, secondary and tertiary intervention for mental health problems and illnesses have been outlined. However, equally important are the issues of prevention and early intervention. This is an area often neglected in the elderly mental health field.

One reason why health promotion efforts are lacking may be the pervasive belief that little can be done to prevent dementia — and Alzheimer disease in particular. Since dementia often dominates in terms of population prevalence and pervasiveness of impact, this attitude may well be extended to all psychogeriatric disorders. Promotion of wellness and prevention of illness or injury must be given higher priority if needless suffering and incapacitation is to be prevented. See Appendix 2.8 for the Health Promotion Literature Review.

Footnotes

[20] The distinction between nonprofessional and professional used here refers to whether or not the individual is licensed or accredited by a professional body. nonprofessional workers may have completed course work that leads to a diploma, but they are not licensed or accredited in the same way as a registered nurse, social worker, physician, psychologist, etc.

[21] BC Ministry of Health Services and Ministry Responsible for Seniors (1999): *Community for Life: Review of Continuing Care Services in British Columbia*, Victoria, Province of British Columbia.

[22] BC Ministry of Health Services and Ministry Responsible for Seniors (1995): *"For I and mine…" — Respite Services in British Columbia (1995): Report of the Respite Advisory Committee*, Victoria, Province of British Columbia.

Efficacy, efficiency, quality, innovation and local responses are key to mental health care

[23] Formal -- paid staff. Informal -- usually family members, but can also include friends, volunteers and others who provide care or support without remuneration.

[24] Margaret Neylan. 6 April 2000. Letter. See Appendix 1.10 for a longer excerpt.

[25] Nick Kates, FRCPC, Marilyn Craven, CCFP, Joan Bishop, FRCPC, Theresa Clinton, CCFP, Danny Kraftcheck, CCFP, Ken LeClair, FRCPC, John Leverette, FRCPC, Lynn Nash, CCFP, Ty Turner, FRCPC, "Shared Mental Health Care in Canada", *The Canadian Journal of Psychiatry,* 42:8 (1997), and *The Canadian Family Physician,* 43 (1997).

[26] Harriet P. Lefley (1997): "Advocacy, Self-help, and Consumer-Operated Services in Tasman", *Psychiatry*, 1st ed., W. B. Saunders Company.

III. Conclusion

High quality care of elderly people with mental health problems begins wherever the individuals are — in their own homes, hospital or residential facilities. The formal system of elderly mental health care has been outlined earlier in this document, but the importance of family, friends, volunteers and others in the informal context of peoples' lives is also recognized as playing a necessary role. Above all, it is vital to remember that if services are to be truly client-centred, the individual must be valued and respected by encouraging and enabling participation in decision making at the highest level of their ability.

This report acknowledges the limited amount of published research specifically addressing best practices in mental health for elderly people. It also recognizes and values the practical wisdom of those providing services to this population. This report articulates best practices developed and reported by service providers, as well as from literature.

While a service or program must ultimately reflect demonstrable evidence of quality, it must also be recognized that there is no one best service system that is appropriate in all situations, for what is "best" in one community may not be "best" for another community with different demographics, resources

or other factors. Services and programs must, therefore, reflect local variations in need and the potential for innovative responses to needs, as well as more general standards for efficacy, efficiency and quality.

All programs should have goals and objectives that are stated, achievable and measurable. Appropriate evaluations should be done regularly to ensure that each program continues to meet the local needs, as well as the stated goals and objectives. Once standard evaluations for needs, processes and outcomes are established, British Columbia will be better able to understand its own practices in relation to Canadian and world standards.

Appendix 1.0

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Appendix 1: General Documents

Appendix 1.1: Background and Review of Adult Best Practices Reports[1]

A review of the seven best practices reports revealed that while some of the best practices identified for the adult population are appropriate for the elderly population, specific consideration of the service needs of the elderly is generally absent. Brief reviews of each of the best practices documents from the perspective of appropriateness to elderly people appear below.

A. Housing

The Housing report is a comprehensive document that addresses the needs of the adult mental health population very well. It also has applicability to elderly people who have had mental illnesses throughout their lives and have previously received mental health services.

The principles of providing a range of housing alternatives that maximize personal values generally apply to the elderly. Consideration for specialized aspects of the aging process, such as mobility issues, also need to guide the planning and provision of housing for elderly people.

B. Assertive Community Treatment

The Assertive Community Treatment report is directed primarily to younger adults with psychosis or personality disorders and recommends highly intensive involvement over an extended period of time. By contrast, psychogeriatric outreach teams now focus on at-home visits, with intense support only as needed. This intense involvement with older adults is most likely to arise in

the context of a life-threatening situation and to be time limited. The difference in focus and duration of intense involvement common to working with elderly people limited the usefulness of the Assertive Community Treatment report in a psychogeriatric context. However, it is important to acknowledge that a need for intense involvement does sometimes arise in the process of providing mental health services to older adults and should, therefore, be addressed by psychogeriatric outreach teams, as needed.

C. Crisis Response / Emergency Services

The Crisis Response/Emergency Services report is very relevant to the elderly population. Appendix 1.1 provides the executive summary of this report.

The procedures and organizational arrangements for responding to crises may work differently in communities of different size and/or composition. A crisis line, for example, may work well in some communities and not in others or may be more useful to elderly individuals and their caregivers if it functions as a help/support resource, rather than as part of a crisis response system. Wherever a crisis line is used, the service should be monitored to see how many elderly people or their caregivers use it and for what reasons.

The use of psychogeriatric outreach can provide some emergency capacity to prevent walk-in presentation in hospital emergency departments.

Emergency response teams, as well as generalists, should have training in geriatrics. It is essential for them to understand that presentations that first appear to be psychiatric may, in fact, be medical problems and that access to medical treatment is crucial in many emergency situations.

Overall, except for its lack of recognition of the needs of medical personnel for knowledge and skills to assess and treat medical problems in elderly people who present with psychiatric illness, this document is very helpful for an older population.

D. Consumer Involvement and Initiatives

The Consumer Involvement and Initiatives report is not relevant to the psychogeriatric population. Many elderly consumers suffer from cognitive impairment, chronic illnesses and frailty and may also have physical and practical barriers (e.g. transportation) that make their involvement in consumer initiatives problematic.

It is important, however, that client and family involvement in an advisory capacity be included for elder care. This would ensure that the perspectives and values of clients and/or their families are taken into account in planning and delivering services for elderly people with mental health problems.

The 1999 review of home and community care services[2] emphasizes the increasing expectations for consultative decision making by clients, caregivers, advocates and taxpayers. If it is to be effective and meaningful, education and support for this consultative process is essential. In planning to meet the needs of older people with mental health problems, it is important that all stakeholders (e.g. clients, family, service providers) work together collaboratively to promote quality of life for elderly people with mental health problems, individually and collectively.

E. Psychosocial Rehabilitation and Recovery

The Psychosocial Rehabilitation and Recovery report is not relevant to an elderly population because of the exclusive focus on employment and education.

Psychosocial rehabilitation and recovery for elderly persons requires an acceptance of the view that the quality of life for the elderly is more than basic health and custodial care. Linkages to community resources are, therefore, encouraged (e.g. liaison with existing programs in the community). Mental health may provide psychosocial rehabilitation programming around specific issues when appropriate programs do not exist.

Although the report identifies leisure as one of four life-related domains (along with personal life, education and work), no further mention is made of how the principles of psychosocial rehabilitation and recovery should be implemented. With respect to the elderly population, leisure may be very different for those who are physically ill, as well as having mental health problems. Physical illness, then, must be considered in terms of program development for the elderly with mental health problems.

F. Family Support and Involvement

The Family Support and Involvement report has a great deal of relevance, especially with respect to providing counselling for family members, including families in planning and evaluating services, developing respite options, offering public education and providing training for professionals to help them understand the needs of families. We do not believe, however, that a provincial approach for holding meetings is inappropriate — rather, we see a regional process as more relevant.

Psychogeriatric care needs also should be linked to specific organizations, such as the Alzheimer Society, Parkinson Group and Advocates for Care Reform, all of whom are major support organizations for elder care. Better regional support systems for elderly caregivers are needed which include training for family members. For example, a caregiver training program

in Australia[3] has demonstrated delay of institutionalization and longer life for people with dementia when their caregivers received training. (See also Appendix 1.2: Caring and Learning Together.) We suggest that support for family members needs to occur within facilities, as well as throughout the community.

G. Inpatient / Outpatient Services

This report is geared primarily towards the young mentally ill. As a model of inpatient care, the report's description of geriatric psychiatry services at St. Vincent's Hospital is reproduced in Appendix 1.9.

Footnotes

1 Ministry of Health and Ministry Responsible for Seniors (2000): *B.C.s Mental Health Reform -- Best Practices*, Ministry of Health and Ministry Responsible for Seniors, Province of British Columbia. The reports on best practices are: housing; assertive community treatment; inpatient/outpatient services; consumer involvement and initiatives; family support and involvement; and psychosocial rehabilitation and recovery.

2 Continuing Care Review Steering Committee, Ministry of Health Services and Ministry Responsible for Seniors (1999): *Community for Life: Review of Continuing Care Services in British Columbia*, Victoria: Province of British Columbia.

3 H. Brodaty., M. Gresham and G. Luscombe (1997): "The Prince Henry Hospital Dementia Caregivers' Training Programme", *International Journal of Geriatric Psychiatry*, 12: 183-192.

Appendix 1.2: Principal Psychogeriatric Disorders and Prevalence

Prevalence rates for aging people with mental illness are not readily available and are estimates at best. If approximately two per cent of the adult population is identified as suffering from a serious and persistent mental illness, it can be expected that a significant number of these individuals will eventually grow old and require many of the same services as those with age-related disorders. As a rough indicator of the number of adult mentally ill who grow old in British Columbia and continue to receive services from the adult mental health system, approximately 22 per cent of the community mental

health residential beds are occupied by individuals 65 years and over.

Epidemiological studies of mental disorders in long term care facilities indicate occurrences of all psychiatric disorders to be between 52 and 94 per cent, with the nonorganic mental disorders accounting for 10 to 39 per cent (*Services to Elderly Residents with Mental Health Problems in Long-Term Care Facilities: 1990*).[1] The four studies used in this comparative analysis identified the psychiatric disorders most frequently seen, the behaviours that cause problems and the underlying causes of these problems. The article notes, however, that the identification of a “problem behaviour” is subjective and may say as much or more about the facility or service provision than about the behaviour. For example, in one of the studies cited, five behaviours were identified by staff as “disruptive”, but residents identified a different behavior — “someone entering the wrong room” — as most disruptive.

Dementia

Prevalence rates for the age-related psychiatric disorders also vary considerably from study to study. The most frequent psychogeriatric disorder is dementia; the rates established in the 1991 Canadian Study of Health and Aging for dementia show that of the two major dementia forms, the Alzheimer's form is over three times more prevalent than the vascular form and occurrence of both rises dramatically with age. Further, females outnumber males in all cases except for vascular dementia in the 65 to 85 age range. This discrepancy increases with age and probably reflects, at least to some degree, the higher morbidity rate of aging men. McEwan, et al (1991), estimate prevalence rates by age group and project these rates over time; dementia in the 65 to 69 age group, thus, is estimated at 1.4 per cent, but climbs exponentially to 38.6 per cent for the 90+ age group. Anticipating

the trend for more people to live longer, McEwan, et al (1991), predict that the average prevalence rate will increase from 5.6 to 7.4 per cent between 1986 and 2006. In British Columbia, these rates indicate that almost 60 of every 1,000 people 65 years and over have dementia.

Countering this projection is the suggestion of Patterson, et al (1999), that, as more information is gained about the etiologic factors for dementing disorders, prevention and/or delay of dementia may become a reality. The impact on service provision and utilization would be dramatic if, as they suggest, it may be possible that the onset of dementia could be delayed. They estimate that the prevalence could be reduced by 50 per cent if onset were delayed by five years and by 75 per cent if delayed by 10 years. Effective clinical and laboratory assessment and treatment are, therefore, recommended by Patterson, et al (1999).

Depression

Depression is the next most frequent psychogeriatric disorder, often coexisting with dementia. Again, prevalence rates vary from one study to another. McEwan, et al (1991), predict that, with an increasing number of elderly in total and, particularly, increasing numbers of individuals over 85 years, the prevalence of depression will increase from 9.6 per cent in 1986 to 9.9 per cent in 2006. As health care providers become increasingly educated about the existence and treatability of depression in the elderly and as the numbers of elderly increase, the prevalence rates are expected to be adjusted upward to reflect both increasing numbers and better identification and treatment. In British Columbia, if an average of 9.8 per cent of the elderly are diagnosed with depression, approximately 100 of every 1,000 individuals 65+ years will be affected.

Suicide is often considered one extreme indicator of depression. The 1996 Statistics Canada Census Data rank suicide as 10th in the list of causes of death.

McEwan, et al (1991), found that, in the 1986 census data, suicide among people over 65 accounted for 13 per cent of all suicides. As with all age groups, suicide is more frequent among older men than women. With increasing age, the disparity increases dramatically such that men 65 to 69 are twice as likely as women in the same age group to commit suicide and men 85+ are 22 times more likely to end their own lives. According to the National Institute of Mental Health in the United States, white men over the age of 85 years have the highest suicide rate for all ages (at a rate of 65.3 per 100,000 population). These rates do not translate to impressive absolute numbers, especially in rural and remote regions with small elderly populations, but the significance of the risk should not be overlooked in the provision of elderly mental health services.

Delirium

Reliable prevalence rates for delirium are difficult to establish and most estimates are based on studies of patients admitted to hospital. Unquestionably, the actual prevalence of delirium is much higher, but is less easy to count when ill elderly who become delirious are treated and recover out of hospital. Further, delirium is often missed because behavioural changes resulting from delirium are assumed to be part of a dementia syndrome and are not given suitable attention. Although prevalence rates are difficult to establish, delirium is potentially very serious and can result in death. McEwan, et al (1991), estimate that 13 per cent of all hospitalized elderly develop delirium. Recognizing the potential for delirium and demonstrating the effectiveness of intervention is the focus of a recent study reported in the *New England Journal of Medicine* (Inouye, et al, 1999). This study found that directing focused delirium intervention protocols to hospitalized older patients significantly reduced the number and duration of delirium episodes.

Other Problems

Alcohol abuse, anxiety and paraphrenia are disorders that occur less frequently than dementia, depression and delirium. The *Report on Older Adults with Alcohol Misuse* (1994) points out that alcohol misuse among older adults is "often hidden, denied and unrecognized" and that "one third of problem drinking older adults begin misusing alcohol after they reach old age" (p. 13).

McEwan, et al (1991), provide the following statistics in their review of the literature on alcohol abuse, anxiety and paraphrenia:

- alcohol abuse is estimated to affect between five and 11 per cent of seniors and is more common among males than females;
- anxiety and somatoform disorders (3.5 per cent prevalence) are particularly common among people with chronic medical conditions; and
- paraphrenia (paranoid psychosis that develops in later life) is poorly captured within the DSM-IV as late onset schizophrenia. The prevalence is considered to be quite low, with four per cent of community dwelling elderly exhibiting this condition in one study. However, it has been reported that approximately 15 per cent of all cases seen by a geriatric mental health outreach team in Victoria over a six-month interval involved clients with delusional beliefs. In two-thirds of these cases, dementia was presented. The remaining one-third of cases evidenced no dementia and were found to be quite resistant to intervention.

A number of barriers to intervention were identified for people with delusions, including their lack of awareness of the problem and suspiciousness of intervention. Although the prevalence of these disorders may be low

in the general population, they are highly represented on the caseloads of those working in the field of mental health.

Elder Abuse and Neglect

Elder abuse is not a mental disorder, but is an issue that frequently confronts those who provide services to the elderly. The 1992 publication *Principles, Procedures and Protocols for Elder Abuse*[2] identifies a prevalence rate of 54 persons per 1,000 elderly people living in private dwellings.

Abuse can be physical, psychological, financial or sexual, involve alcohol or medications, be a violation of civil or human rights or simply occur as a result of neglect.

The Implications of Prevalence Figures

Overall, the prevalence of mental health problems affecting the elderly has been cited as between 17 and 30 per cent; McEwan, et al (1991), suggest a middle figure of 25 per cent.

In British Columbia, this translates into approximately 130,000 individuals over the age of 65.

The impact on individual regions varies according to the demographic specifics of each region and the number of available services. A region with a small absolute number of elderly individuals with psychogeriatric disorders will be as equally challenged (or more so) in providing appropriate services as larger regions with larger populations but with a greater number and range of services.

Footnotes

[1] Subcommittee on Institutional Program Guidelines (1990): *Services to Elderly Residents with Mental Health Problems in Long-Term Care Facilities: Guidelines for Establishing Standards*. Ottawa: Health and Welfare Canada.

[2] Ministry of Health and Ministry Responsible for Seniors (1992): *Principles, Procedures and Protocols: For Elderly Abuse*. Victoria, Continuing Care Division, Province of British Columbia, and British Columbia Interministry Committee on Elder Abuse.

Appendix 1.3: Definitions of Primary, Secondary and Tertiary Care

The following definitions were developed by the Lower Mainland Project Steering Committee, British Columbia Mental Health Society, Riverview Hospital Replacement Project.

1. Primary Care

General Definition

Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care providers. This care can be sought directly by the patient, without referral, and is usually initiated through visits to private offices or clinics in the community outside a hospital (except in the case of visits to hospital emergency services or primary care clinics).

Mental Health Care Context

Includes use of general practitioner private practices, mental health clinics, social services, hospital emergency services, hospital primary care clinics, support groups and counselling services.

2. Secondary Care

General Definition

Preventive, diagnostic and therapeutic health care provided by physicians and other health care providers involved in the medical, surgical, obstetrical,

mental health and rehabilitative disciplines. This care is usually provided after referral from a primary care source. The patient need not be ill (e.g. eye examination) nor need they be a hospital patient, however, most services provided in acute care hospitals are at the secondary care level.

Secondary care also includes the ongoing care of people with physical or mental disabilities.

Secondary care does not include the provision of primary care to compensate for regional service deficiencies.

Mental Health Care Context

Includes use, after referral, of psychiatrists, psychologists and other mental health care providers in the community and most of the mental health care services provided in acute care hospitals on an inpatient or outpatient basis (short-term assessment and active treatment). Acute hospital inpatient care services may include short-term assessment and treatment of patients who have been committed under the *Mental Health Act*.

Secondary level care also includes patient rehabilitation and community reintegration services by a variety of community-based providers.

3. Tertiary Care

General Definition

Diagnostic and therapeutic health care provided through highly specialized programs incorporating sophisticated and/or unique professional or technical skills, equipment or facilities.

This level of care is usually associated with techniques or procedures which need to be centralized within a regional area by reason of limited

volume, limited skills or extraordinary cost of services. This care always requires a referral from a source of secondary care.

Tertiary care does not include the provision of secondary care to compensate for regional service deficiencies.

Mental Health Care Context

The care of persons with serious, complex and/or rare mental disorders who cannot be managed by the resources available at the primary and secondary levels of care in the province.

Footnotes

1 Lower Mainland Project Steering Committee, British Columbia Mental Health Society, Riverview Replacement Project.

Appendix 1.4: Template and Standard Problem List

The following are examples of a template and standard problem list that could be used to help compare types and amounts of services across the province.

A standard framework for describing services should be adopted (See Appendix 1.3 for a list of definitions of primary, secondary and tertiary services.) Further, it is recommended that once every two years a report be compiled of available services for elderly people with mental health problems using a defined template, such as the one offered in this appendix (see Diagram A).

Another approach to planning, monitoring and evaluating services is to use a tool, such as the Problem List on Referral (Diagram B). Consistent use of a tool such as this helps to identify the kind and frequency of problems that the service or program encounters. Changing trends or patterns in referral can

Template for Describing Mental Health Services for the Elderly

- Program title
- Context of care
  - Geographical area
  - Type of area, rural, semi-rural, urban
  - Percentage of seniors
  - Number of seniors in the population served
- Type of service
  - outpatient/outreach
  - day hospital
  - inpatient
  - emergency
  - combined program
  - other

Staff/FTEs numbers:

- Doctors ______
- Nurses ______
- Social workers ______
- Psychologists ______
- OT's ______
- Secretaries ______
- Other ______

- Average time on wait list
- Average time admitted to the service (discharge date minus admission date)
- Defined services linkages
- Average age of client
- Sex of client
- Problems on admission (according to a common problem list - see following problem list)
- DSM-IV diagnosis on admission (Axis I and II)
- DSM-IV diagnosis on discharge (Axis I and II)
- Average caseload per FTE
- Number of new admissions per year
- Outcomes measures used
- QI initiatives in the past year
- Educational activities offered by staff
- Future program initiatives planned
- per cent of time (of average FTE) on indirect consultations
- per cent of time on community development and advocacy
- Range of caregiver services offered
- Use of volunteer services

APPENDIX 1.4

Template and Standard Problem List

Problem List on Referral	1 - Primary (primarily one only)	2 - Secondary (check up to 4)
1. Assessment and treatment of depression		
2. Assessment and treatment of cognitive impairment.		
3. Differentiating depression from dementia		
4. Anxiety		
5. Adjustment to physical illness		
6. Substance abuse		
7. Caregiver stress		
8. Aggression		
9. Noisiness		
10. Agitation		
11. Wandering		
12. Resistance to care		
13. Inability to care for self		
14. Other behavioural problems		
15. Paranoia/psychotic symptoms		
16. Schizophrenia		
17. Followup from hospitalization		
18. Family or marital discord		
19. Placement		
20. Consultation only		
21. Physical abuse		
22. Financial abuse		
23. Competency assessment		
24. Need for committal under *Mental Health Act*		
25. Speech, hearing and/or sight impairment		
26. Other		

then be accommodated with service or program changes, thus ensuring that services are organized and deployed effectively.

Appendix 1.5: Executive Summary — Adult Best Practices: Crisis Response/Emergency Services[1]

This document represents a component of a comprehensive program of mental health system reform in British Columbia. The program, which is outlined in *Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan*, provides continued strong support for community-based care for people with serious and persistent mental illness. One of the direct consequences of this emphasis on community care is a shift in the locus of mental health crisis response/emergency service (CR/ES) from mental hospitals to a large number of different community settings and general hospital medical emergency departments. Successful implementation of the 1998 mental health plan, therefore, necessitates the development of an effective, multifaceted CR/ES system that integrates hospital and community-based services.

Expanding on the American Psychiatric Association 1982 Task Force definition of a psychiatric emergency, a mental health crisis is defined in this document as:

- an acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention;
- which involves an element of unpredictability that is usually accompanied by a lack of response to social controls; and
- the crisis may be defined as such by the client, the family or other members of the community, including family physicians or police.

The goal of a mental health CR/ES is to: Facilitate stabilization of the individual to the point where:

a. risk of harm to self/others is minimized;

b. the person has returned to a level of functioning that does not require continued provision of an urgent/emergent level of care; and

c. the individual can follow through with a course of treatment in a community-based setting.

Although this goal may be achieved in a variety of ways, crisis interventions within a CR/ES emphasize direct engagement, both with the client and with social supports and community service providers, to create a viable followup care plan.

The target population for a CR/ES is etiologically and symptomatically heterogeneous. It may include individuals affected by a serious and persistent mental illness. However, individuals who are not affected by chronic major psychiatric disturbances may also present with a crisis that meets the definition presented above. Individuals who do not satisfy the conditions of the definition for a mental health crisis may nevertheless present to a mental health crisis/emergency service provider. As there is no way of determining a priori that they do not satisfy the criteria for a mental health crisis, they must be provided with some form of initial response. Finally, police or physicians effectively designate a person as a member of the target population for crisis/emergency services when they invoke Section 28 or Section 22 of the *Mental Health Act*. In light of these factors, the target population for a crisis/emergency response must be regarded as a broadly heterogeneous collection of individuals who experience a mental health crisis. Members of the target population may define themselves as service recipients or they may be designated by others as appropriate recipients of services. The seriously and persistently mentally ill only represent a subset of this target population.

Because the target population for a CR/ES includes an etiologically and symptomatically diverse group of individuals, the crisis/emergency

services that meet their needs must be correspondingly diverse. In order to provide for the urgent/emergent assessment and crisis intervention needs for the target population, a continuum of five core program components is required:

- *Crisis lines* — A telephone service provided by a trained volunteer which delivers immediate support to individuals in need by means of active listening or referral to appropriate agencies.
- *Mobile crisis outreach* — A service in which first-line responders provide outreach to individuals in the community with acute mental health emergencies.
- *Walk-in crisis stabilization service* — A service which enables individuals to present with a mental health crisis and receive appropriate assessment and access to followup care.
- *Community crisis stabilization services* — A range of services that provide community-based support for individuals in a mental health crisis. Settings include: crisis residences for crisis intervention and residential treatment, structure, supervision, intensive case management and connection to followup services; home stabilization, where mental health acute care patients are provided treatment within their own homes by outreach nurses; and crisis housing (hotels, boarding houses), where an individual remains until stable and is provided with 24-hour observation, support, intensive case management, assistance and connection with followup services.
- *Hospital-based psychiatric emergency services* — This includes a psychiatric emergency service which provides specialized emergency mental health assessment, treatment and management services to people referred via a hospital emergency department and a brief stay unit, an inpatient psychiatric unit that specializes in the assessment and treatment

> of mental health emergencies. It maintains a brief length of stay (average length of stay is three to five days) and has the capability to detain and treat patients on an involuntary basis. The focus of the brief stay unit is on intensive crisis management.

The five core CR/ES components deliver a range of functions that are essential to a crisis/emergency response service. It is important to recognize that while the functions will remain constant in a comprehensive system of crisis/emergency response, the service delivery structures that provide these functions may vary from one community to another.

The standards laid out in this document refer to the core functions of a CR/ES system. They do not specifically dictate which structures must be put in place. The standards proposed are intended to represent a realistic level of practice a system should be seeking to attain within the limitations of available resources. The term "target standards" is used in the document to distinguish the proposed standards from "optimal standards" (attainable with unlimited resources) or "minimal standards" (a level of care below which practice would be unacceptable and immediate remediation would be required).

In addition to meeting the principle goal of a system of crisis response/emergency service, described above, the system of five core components is intended to achieve several other critical objectives, including the following:

- To extend the reach of the mental health system to those individuals or groups within the target population for mental health services who have traditionally not accessed or benefited from needed services. This may include the psychiatrically disabled and socioeconomically disenfranchised individuals found in the downtown core of major cities.
- To provide clinically appropriate crisis interventions for individuals who are not appropriate for referral to other mental health services.

- To address well-documented quality of care issues in psychiatric emergency setting by providing scope and sanction for a system of crisis/emergency response services that stresses biopsychosocial assessment, crisis intervention, firm linkage with followup care providers and the promotion of safe outcomes.

The main body of this document consists of a detailed discussion of the five core program components, with a delineation of essential functions and associated target standards for each component. Following this is a series of appendices, including:

- a discussion of issues around the implementation of crisis response/emergency services within First Nations and other aboriginal communities;
- descriptions of existing programs within British Columbia that perform the essential functions and achieve the standards laid out in this document;
- discussion of innovative programs within the CR/ES, including a detailed discussion of observation units, which are currently being implemented under a major initiative of the Ministry of Health Services; and
- issues around evaluation of services.

The last appendix (Appendix E) contains a discussion of issues arising in the consultation forum on provincial best practices in mental health, held on November 4 to 5, 1999 in Richmond, British Columbia. Co-chairs from the seven best practice committees presided over sessions attended by the B.C. Mental Health Plan Implementation Steering Committee, Ministry of Health representatives (including ministry best practice working group support/ liaison personnel), delegations representing each of the 18 health care regions in British Columbia and a number of guests selected on the basis of their

extensive knowledge and expertise in specific areas of mental health service delivery. In the course of four sessions focused on crisis/emergency response, a host of issues were raised. These issues are presented in the appendix, accompanied by commentary which represents the CR/ES best practice committee's response to the issues.

Footnotes

[1] Ministry of Health and Ministry Responsible for Seniors (2000): *B.C.s Mental Health Reform — Best Practices*, Victoria, Province of British Columbia.

Appendix 1.6: Caring and Learning Together: Vancouver/Richmond Health Board

The Caring and Learning Together Program, funded by the Vancouver/ Richmond Health Board as a result of *The Way Home* report, was developed, implemented and evaluated in 1998/1999 by Educare Geriatric Resource Systems Inc. The goal of the program is to enhance the abilities, skills and confidence level of formal and informal caregivers in providing home-based care to geropsychiatric clients.

The program outcomes are articulated as:

1. Increased abilities, skills and confidence of formal and informal caregivers in providing care.
2. Improved relationships between formal and informal caregivers.
3. Decreased family burnout by increasing family's ability to cope with the care of their loved ones.
4. Enhanced quality care to clients by reducing home support staff turnover and providing staff consistency.
5. Decreased need for crisis interventions.

6. Increased public participation and advocacy.

Both quantitative and qualitative evaluation tools and focus group results show that home support workers and family caregivers are more knowledgeable, more confident, able to put into practice their new skills, feel more empathic towards the role of their counterparts and feel better able to cope with their caregiving responsibilities.

In anticipation of potential barriers to participation, respite and transportation are offered to family caregivers and home support agencies were reimbursed for staff replacement for home support workers. A certificate of completion is granted to all participants at the completion of the program. This concrete support of the program participants is essential to the success of the program, particularly with regard to home support worker participation.

Efforts are made to ensure that participants were appropriately linked with existing community services and with guest speakers from Continuing Care, mental health and community caregiver support organizations. Continued efforts will need to be made to reinforce these important links.

The program is broken down into eight sessions (three hours per week) as follows:

Week 1 - Introduction and Person

Week 2 - Normal Aging and Structure and Function of the Brain

Week 3 - Dementia, Delirium and Anxiety and Panic Disorders

Week 4 - Depression, Bipolar Disorder and Schizophrenia

Week 5 - Communication

Week 6 - Behaviours

Week 7 - Caregiver Well-being and Community Services

Week 8 - Review and Summary

Appendix 1.7: About Mheccu (Mental Health Evaluation and Community Consultation Unit)

Mheccu is a UBC-based organization dedicated to pursuing mental health research, education and training and delivery of mental health services to the people of British Columbia.

Mheccu's integration of research, education and training and service delivery means that:

- research directly linked to community services is more likely to be well informed and more likely to be used by service providers, consumers and families; and
- community services draw upon relevant and accessible academic research to better integrate the most up to date research into their practice.

Mission

To foster and facilitate exemplary practices in prevention and treatment services and supports for people with mental health problems and disorders and for their families and caregivers.

Mheccu's activities focus on three general areas:

- mental health service delivery;
- research and evaluation; and
- education and training.

For Further Information

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APPENDIX 1.8

Elderly Service Benchmarks

Appendix 1.8: Elderly Service Benchmarks[1]

Benchmarks Assumption

The target group used for the development of the *BC Elderly Service Benchmarks* is defined as the 15 per cent of all elderly people who require specialized geriatric treatment. This percentage is considered to be conservative in reflecting the more severe problems; it is expected that, as the number of elderly continues to increase, especially those over 85 years, the benchmarks will need to be adjusted upward to reflect the increased need for services. Benchmarks have been established only for the services considered to be core services, not all existing services.

Footnotes

1 Joanne Lamperson (1994): *Elderly Services Benchmarks for the Province of British Columbia,* Victoria, Mental Health Division, Ministry of Health, Province of British Columbia.

APPENDIX 1.9

St. Vincent's Hospital Model of Care

Appendix 1.9: St. Vincent's Hospital Model of Care: Excerpt: Adult Best Practices: Inpatient/Outpatient Services[1]

Geriatrics

It is desirable to have a specialized unit, designed and staffed for this patient population, rather than mixing this patient population with others. If there is a need to mix inpatient beds with another program in order to have a viable unit, geriatric medicine is preferable to most adult psychiatry because of the frail nature of this population.

Program Description

Patient Population

- complex, co-morbid — combining two or more conditions:

psychiatric (dementia and depression) or medical/psychiatric (Parkinson's/delirium) — often have complicating chronic medical conditions that need ongoing medical care;

- frailty;
- generally over 65 years of age with a psychiatric disorder that meets the criteria specified in DSM-IV. The disorder is:
  - a psychiatric illness arising in later life;
  - a psychiatric illness first arising in the adult years, but continuing into later life;
  - results from neuro-degenerative disease arising in the pre-senile or geriatric age range, for example:
    - depression;
    - dementia with psychiatric overlay — agitation, aggression;
    - delirium;
  - movement disorders — Parkinson's;
  - behavioral disorder — importuning, sexual inappropriateness, aggression, agitation;
  - psychosis;
  - substance abuse.

Principles

- multidisciplinary team requiring specialist training — geriatric psychiatrist, nursing, neuropsychiatry;
- biopsychosocial environmental model;

- case management (GP, LTC, MH) to follow the patient through the system;
- critical mass of patients/beds, to ensure critical mass of specialized staff and expertise;
- seamless system from community to hospital;
- integrated hospital and community:
  - integrated with geriatric medicine in acute care;
  - program located in an acute hospital setting, with anesthesia and access to a variety of subspecialties;
  - ability to certify; and
  - inpatient unit is one component of a comprehensive and co-ordinated program, rather than a stand-alone unit.

Hospital Components

- inpatient;
- outpatient clinic-geri-psychiatrist (assessment and followup);
- ECT — inpatient and outpatient;
- consultation and liaison to other acute units;
- teaching of medical, nursing and other students;
- education and consultation to nurses in long term care facilities and other hospital units.

Community Components

- mental health teams;
- GPs;

- psychiatrists in private practice;
- LTC/ECU beds;
- home-based treatment (outreach);
- day programs;
- alternative housing, residential and support.

Integrated Components

- followup care — GP, psychiatrist or mental health team;
- joint educational rounds;
- joint care rounds;
- integrated with LTC/ECU;
- centralized intake (need for differentiation of various components, so when and where to refer is clear);
- outreach — community, home and long term care facilities;
- joint utilization rounds (Kelowna).

Examples of Best Practices

- Geriatric Psychiatric Outreach Team — Vancouver General Hospital;
- Capital Region — Eric Martin Pavilion;
- St. Vincent's Hospital.

Historical Systemic Barriers to Best Practice Models

- different staffing models, community and hospital — generic vs. discipline specific;

- transfer of information, confidentiality issues, complete and accurate information;
- followup care recommendations often not adhered to;
- not enough education of multidisciplinary team (e.g. GPs, nursing in other acute inpatient units and long term care facilities) to know when to refer — depressed residents in long term care often not identified, only aggressive residents;
- lack of emergency services specifically for the elderly;
- lack of acceptance/availability of ECT;
- ageism — reluctance to treat the elderly;
- lack of long term care/ECU beds in the community;
- community facilities close the door when a patient is transferred to an acute care bed;
- barriers to discharge/care plan not transportable, staffing levels and policies (e.g. no restraint) of long term care facilities;
- lack of/minimal access to diagnostic testing on an outpatient basis (e.g. CT scan, MRI);
- collective agreements impede integration.

Goals and Objectives

- assessment, diagnosis and treatment — development of a practical/ workable treatment plan;
- discharge to place of residence — home, long term care;
- evaluation of outcomes;
- education of providers and families.

Access Criteria

There is a need to differentiate between secondary and tertiary geriatric psychiatry units. Both have specialized multidisciplinary assessment (e.g. nursing, psychiatry, neuropsychology, specialized medicine, rehabilitation therapy, radiology, laboratory).

Secondary Geriatric Psychiatry — Regional Resource

- transfers from other hospitals in the region;
- admissions from long term care/ECU facilities in the region, after community resources have failed;
- those who cannot be successfully treated in a secondary inpatient unit may be referred to tertiary inpatient;
- admission through an emergency department, referred by a GP and screened by a psychiatrist.

Tertiary Geriatric Psychiatry — Provincial Resource

- high degree of complexity and co-morbidity;
- academic (research);
- support to secondary geriatric services mental health team and acute psychiatric units:
    - wait listed (not admitted through emergency);
    - transferred from other acute psychiatric units.

a) Eligibility Criteria for Client Placement in Inpatient Unit

- patient requires specialized diagnosis and treatment in an inpatient setting;
- residential facilities unable to cope despite adequate community support;

- agreement to return patient to their place of residence after inpatient treatment — acute care, long term care, ECU or home.

Excludes

- those suitable for treatment in a general psychiatric unit;
- healthy schizophrenics over 65;
- elderly depressed patients not complex/co-morbid, not requiring specialized treatment;
- patients who are acutely medically or surgically ill, who would normally be admitted through emergency into an ICU, acute medical or surgical bed (e.g. exhibiting delirium).

b) Screening and Assessment Tools Available to Assist Client Placement

- nursing assessment tools: Geri-Snap — SABRE, sleep chart, movement chart;
- physician assessment (e.g. MMSE/3MS, HAM-D/HAM-G, ADAS-COG AIMS, CGI [under review]);
- ADL/IADL-Barthol.

Discharge Criteria

- improvement in assessment tools (e.g. Geri-Snap);
- workable treatment plan;
- treatable component treated/treatment plan successful and can be continued on an outpatient basis, discharge planning complete — community resources set up.

Procedures to Ensure Continuity of Care When Clients are Discharged from Service

- transferral of information to referral sources — discharge checklists (Kelowna/St. Vincent's);
- consults, lab, nursing care plan, discharge summary, etc.

Standards

Staffing Standards — Inpatient-closed Unit

- sufficient beds to ensure critical mass of staff and expertise;
- geriatric psychiatrist — average of one session per bed per week, 24-hour;
- on-call coverage by a psychiatrist;
- intake nurse;
- nurse clinician for education and consultation, CNS shared community/hospital/long term care;
- nurses with specialized training in geriatric psychiatry;
- safe environment —- century tub, dining room, lounge, ability to secure the unit for wandering patients;
- OT, ADL, safety assessments and home visits;
- PT — chest physio, falls protocol;
- SW — discharge planning, link with referring facilities;
- pharmacy, pastoral care and clinical nutrition staff;
- GP to follow up with medical care;
- access to consults — anesthesia, cardiology, neuropsychology, neurology, surgery, geriatrician, etc;
- basic laboratory and radiology;

- access to specialized testing — EEG, CT scan, MRI;
- access to speech/audiology, ENT, dental, ophthalmology.

Staffing for a 20-bed Unit

- clinician days — one registered nurse to four patients, plus one care aide, seven days a week;
- unit clerk, Monday to Friday afternoons — one registered nurse to five patients, plus one care aide (12 p.m. to 8 p.m.), seven days a week;
- nights — one registered nurse to 10 patients;
- OT, ADL, safety assessments and home visits — 1.0 FTEs per 20 beds;
- PT — chest physio, falls protocol — one FTE per 20 beds;
- pharmacy and clinical nutrition staff;
- general practitioner to follow up with medical care-internal (five sessions per 20 beds) for tertiary or family physician (for secondary), if prepared to follow the patient and work into the schedule (e.g. diagnostic rounds);
- access to specialists for consults — anesthesia, cardiology, neuropsychology, neurology, surgery, geriatrics, etc.;
- basic laboratory and radiology;
- access to specialized testing — EEG, CT scan, MRI;
- intake registered nurse (0.5 for 20 beds);
- outpatient ECT — 4.5 RN/RPN for pre- and post-ECT care, for 15 patients per week including home visits;
- outreach/home assessment — psychiatrist, registered nurse/ registered psychiatric nurse with social worker/occupational therapist/ neuropsych backup;

- outpatient — geripsychiatrist with access to social worker, neuropsychiatry, as required.

Utilization Standards

Inpatient unit admission and discharge criteria:

- admission — previous attempts to resolve on an outpatient basis have not been successful;
- discharge — treatable component treated/treatment plan successful and can be continued on an outpatient basis; discharge planning complete; community resources set up;
- ALOS, CIHI by CMG, depend upon case mix (e.g. depression with course of ECT — 28 days);
- psychiatry utilization tools — Interqual;
- RIW-3.0-4.0 — (tertiary) based on direct admission to service, not transfer from another service after primary problem resolved;
- indicators — case mix, actual to expected length of stay, RIW.

Standards for Service Linkages

Referral, Exchange of Information, Transfer of Responsibility for Care

Practice is to send all relevant information to and from:

- sending agency — general practitioner/mental health therapist/ psychiatrist: reason for/expectations of inpatient admission, copies of admission or discharge summaries, as well as reports of relevant investigations;
- geriatric inpatient unit to send discharge summary, relevant lab and radiology reports, all assessment, treatment and discharge plans from occupational therapist, PT and dietitian, as well as nursing care plan, assessment tools and nursing transfer summary.

Client Followup

- followup by GP for medical issues — by psychiatrist, GP or mental health team for psychiatric issues;
- invite community team to care rounds, participation in ward rounds (assessment, diagnosis and treatment plan) and discharge planning;
- invite attending GP to participate in discharge planning;
- inpatient geriatric psychiatrists often work part time on the community mental health team.

Epidemiology Figures

- prevalence of dementia;
- prevalence of psychosis;
- prevalence of depression.

References

- APA Clinical Practice guidelines, dementia, depression.
- CCHSA standards for mental health.
- Performance indicators for mental health.
- C5R — Canadian Consortium of Centres for Clinical Cognitive Research.
- Canadian Academy of Geriatric Psychiatry.

Footnotes

[1] Ministry of Health and Ministry Responsible for Seniors (2000): *B.C.s Mental Health Reform — Best Practices*, Victoria, Province of British Columbia.

Appendix 1.10: Communication from Margaret Neylan

The following excerpt from a letter written by Margaret Neylan (former Chair, British Columbia Seniors Advisory Council) is reproduced here because it speaks to issues that the working group felt to be particularly important to emphasize.

Re: Best Practices in Mental Health for the Elderly

"In addition this principle [of comprehensive services] needs to elaborate that the mentally ill elderly is capable of enjoyment with some quality of life experience. This experience may be sporadic but is important and will not happen unless the staff believe it is important and provide opportunities. From my five years of experience visiting a relative in a special care unit I was impressed by these "special moments." The staff recognized their importance and encouraged events that elicited them. Examples — active music "therapy" with a music student from the Cap College Program. She brought a guitar, sat on the floor and strummed until a resident showed interest, then moved towards a song that was indicated. The enjoyment of those one to one and a half hour sessions was obvious. There was increased animation/relaxation/smiles and more and more joined in singing or humming. Fresh garden flowers were an opportunity to smell and to enjoy the color. One needed to avoid poisonous things of course. But the thorns on roses were readily remembered and avoided in handling. I guess my plea is to look for human enjoyment in spite of the distractability. These experts helped families as well as the residents. So social, as well as medical, models are needed. By the way, relatives paid for the music student. In some sense this is health promotion.

"The other concept missing altogether is that of a healing milieu. This is the context for the delivery of individual care. It is a matter of the physical and the social aspects. In the physical there are many aspects: architecture, interior design (i.e. color, pictures, furniture, etc.) but also access to

APPENDIX 1.10

Communication from Margaret Neylan

> a garden and to pets and people. The social side is founded on the relationships among staff and visitors and volunteers. Creating positive outlook and mutual respect and communication is demanding work. Like a parent's work, it is ongoing, always changing and often unrecognized. But it is evident to any skilled observer: lack of a therapeutic milieu leads to tension, conflict and often unfortunately to abuse, disrespect and indignity."

April 6, 2000

APPENDIX 1.11

Working Toward Quality of Life in Nursing Home Culture

Appendix 1.11: Working Toward Quality of Life in Nursing Home Culture

Prepared for Older Adult Working Group, Mental Health

December 1, 1999 - Draft 2

By Elisabeth J. Drance, MD, FRCPC

We are fortunate to have very dedicated people working for the good of our older population in nursing homes. People all over Vancouver are caring for our frailest elders with very limited resources. Unfortunately, nursing homes were created, from the earliest times, as extensions of acute care hospitals. They have focused on the physical needs of their residents and on providing them with numerous therapies, including rehab therapy, pet therapy, horticultural therapy, etc. However, despite the best of intentions, we have lost the concept of nursing "home". We are now having to struggle to find ways to combine the best of medical care and a commitment to creating a person-centred environment which provides purpose, meaning and pleasure to its inhabitants. Observations to the barriers which prevent this from happening include the following:

Our elders living in nursing homes are:

- increasingly frail;
- increasingly cognitively impaired and, as a result, increasingly sensitive

> to their environment and their interpersonal interactions — often responding with behaviours which are labelled as "problems" when it is sometimes our way of caring for the person which is the major aggravant to the behaviour.

We are struggling to find ways to involve them in directing their own care at whatever level they are able to do so.

Despite most nursing homes working in a medical model, we do not always give good medical care to our elders in nursing homes. Nursing homes need to focus on the potential for "growth" in their residents. Currently, there is an emphasis on the person's deficits and their decline. Because of this, their personhood is often underemphasized and their strengths and abilities missed.

We need to increasingly focus on the home in nursing home. Sometimes, we acknowledge it in our language, but we do not seem to acknowledge the value in moving in that direction in terms of the behaviour and quality of life of the people living in long term care settings. Sometimes, we do not know how to begin the shift.

We fail, as a society, to adequately fund the care of our elders in nursing homes.

We fail as citizens and as health care professionals to help the governing bodies understand the value of funding adequate care for our frail elders.

We have not chosen a paradigm of care as a vision for our region. Many such paradigms exist — whether it is the creation of the prosthetic environment of Gentle Care, the biodiversity and respect of the Eden Alternative or the model of Ability Enhancing Care of Dawson, Wells and Kline.

We need to create incentive for facilities to begin to examine other modes of operating which move in the direction of person-centred care. We need to look at tying the funding of nursing homes with their ability to demonstrate their model of person-centred care, whatever that may be.

By person-centred care, I am referring to the bringing of decisions regarding an individual's care as close to that individual as is possible. It is the recognition that the person is an individual with unique values and needs. It focuses on the need to know those values and needs first and foremost when providing them with care. A careful integration of the person's physical needs and their individuality make up a truly person-centred care plan.

We are failing the families of the elders living in our nursing homes.

- We need to incorporate families as meaningful members of the caregiving team.
- Family members are often seen as "things we have to endure", rather than as people with knowledge and needs.
- We perpetuate an us vs. them model rather than a we together model.
- We need to acknowledge their abilities.
- We need to acknowledge their needs.
- We often do not provide them with support during key transition times for them:
  - transition of loved one into facility;
  - changes in levels of functioning and care settings;
  - transition into palliative care;
  - death of their loved one.
- Professional caregivers become defensive when families point out their concerns or observations instead of using them to learn what we could change or do better.

We need to address the needs of our paid caregivers in the nursing home setting:

- From management to nurses to care aides to recreation staff

to housekeeping staff to dietary staff, we need to provide each of them with a clear set of expectations with respect to person-centred care and support for carrying out that type of care.

- Management and decision making structures are often hierarchical and ignore the fundamental principle, "Do unto your employees as you would have them do unto the residents". We need to flatten the power structure and emphasize shared decision making throughout the facility.

Administrators

- In private facilities, the tension between earning money for the parent company and providing excellent care for people is enormous. This often prevents administrators from trying creative strategies or thinking outside the box.
- We need to provide them with a clear set of expectations with respect to person-centred care.
- We do not award funding for a facility based on its ability to create a person-centred care environment.

Directors of Care

- Many come out of acute care settings where the medical model of care is essential and focus on "treatment" and "therapy" is the key goal.
- Many have been in the system long enough to "know" the medical or hospital model of care with comfort. They run efficient, system-oriented facilities.
- We need to provide them with a clear set of expectations with respect to person-centred care.

Physicians

- Medical coordinators of facilities are given very little compensation

for their role as a team member. They cannot participate in truly meaningful ways to create culture change.

- Physicians receive little training about the difference between hospital care and nursing home care and the role that the environment has to play in their patients' well-being.
- Family physicians are woefully inadequately compensated for caring for the increasingly frail nursing home populations, making visits to the facility rare and their involvement pitifully limited. Family physicians increasingly do not follow long-time patients into the nursing home because they cannot afford to do so.
- Physicians often do not know how to be involved as a team member in the care of their elderly patients in nursing homes. We need to work toward better education of physicians in the area of nursing home work.

Nurses

- Nurses are expected to be the leaders of the care team, but are not trained for that role in a person-centred paradigm of care.
- Nurses spend inordinate amounts of time administering medications — and have very little time to do skilled nursing assessments when a resident is having physical and behavioural symptoms.
- Training of nurses in a person-centred model of care or in use of a model for assessing behavioural symptoms is totally inadequate when the system of care does not support the implementation of that knowledge. Education, while essential, is inadequate to create culture change.
- We need to work at inspiring nursing students to enter the specialty of nursing home work, by creating a work setting which is both supportive and clinically challenging.

Social Work

- In nursing home culture, the key role of social workers in providing emotional support to residents and their families and in assisting in their adaptation to nursing home life has often been missed.
- Social workers can be key in helping promote a person-centred environment by providing the staff with lots of personal information on admission.
- Family councils must be established in each facility. This is most suitably the responsibility of the social worker.
- Social workers need to be better integrated into the care team.

Direct Care Staff (including care aids, dietary/housekeeping)

- We fund woefully inadequate numbers of care staff for the complexity of the resident population in nursing homes.
- Direct care staff need to be trained in a person-centred model of care. They learn to carry out tasks instead of assisting residents to function at their highest level possible.
- Direct care staff need to be well integrated into the caregiving team. Often, they do not attend care conferences, nor are they involved in decisions to do with the people they care for. Often they receive little to no information about the people they are caring for and communication about changes in medication or changes in condition are inadequately communicated.
- Direct care staff often feel disempowered and unappreciated in their roles.
- These factors have led to the increasing prominence of union activity as a way to solve problems in the nursing home workplace.

APPENDIX 1.11

Working Toward Quality of Life in Nursing Home Culture

Mental Health Staff

- With the increasing complexity of older adults in nursing homes, we are seeing increasing behavioural symptoms, especially related to dementia and depression.
- Because of the lack of person-centredness, the inadequate numbers of staff and the sense of powerlessness amongst nursing home staff, mental health teams are often asked to solve the problem of a person's challenging behaviour. It is very challenging, as an outsider, to review a situation and see that it is, at least in part, environmental issues which are driving the behaviour. We often want to see these issues addressed prior to instituting pharmacotherapeutic treatments. However, this can be difficult to do unless the nursing home shares this view.

Revised December 6, 1999.

APPENDIX 1.12

The Eden Alternative: One Paradigm for Change in Long Term Care

Appendix 1.12: The Eden Alternative: One Paradigm for Change in Long Term Care

For more information about the Eden Alternative, visit their web site at www.edenalt.com or read *Life Worth Living* by Dr. William Thomas. The book provides practical information and some initial statistics and addresses some of the problems long term care facilities face. This book is an introduction to the principles and practices which underlie the Eden Alternative approach to long term care.

What is the Eden Alternative?

Eden is a paradigm of care for elders in nursing homes which balances care for the human body and the human being:

- Works towards the eradication of the three plagues of nursing home life.
- Transforms the nursing home from an institution to a human habitat.

- Focuses on growth of residents, families and staff.

What are the Three Plagues of Nursing Home Life?

1. Loneliness.
2. Boredom.
3. Helplessness.

How can the Three Plagues be Addressed?

Through the creation of a human habitat.

What is a Human Habitat?

A setting which:

- Brings decision making as close to the resident as possible.
- Provides continuous opportunities for companionship — animals, children, plants.
- Provides continuous opportunities for elders to give, as well as receive, care.
- Provides continuous opportunities for spontaneity and variety.
- Provides “care”, rather than “treatment”.

How is the Eden Alternative Implemented?

- Over years — Vision, education, implementation.
- Leadership is key — vision, empowering elders, families and staff.
- Requires courage and conviction.

Eden Alternative's Ten Principles

1. Understands that loneliness, helplessness and boredom account for the bulk of suffering in a typical nursing home.
2. Commits itself to surrendering the institutional point of view and adopts the human habitat model that makes pets, plants and children the pivots for daily life in the nursing home.
3. Provides easy access to companionship by promoting close and continuing contact between the elements of the human habitat and residents.
4. Provides opportunities to give, as well as to receive, care by promoting resident participation in the daily round of activities that are necessary to maintain the human habitat.
5. Imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place.
6. Recognizes that meaning is the food and water than nourishes the human spirit. It strengthens us. The counterfeits of meaning tempt us with hollow promises. In the end, they always leave us empty and alone.
7. Recognizes that medical treatment should be the servant of genuine human caring, never its master.
8. De-emphasizes top down bureaucratic authority in the home and seeks instead to place the maximum possible decision making authority either with the residents or in the hands of those closest to the residents.
9. Recognizes that human growth must never be separated from human life.

10. Is blessed with wise leadership that places the need to improve residents' quality of life over and above the inevitable objections to change. Leadership is the life blood of this process and nothing can be substituted for it.

APPENDIX 1.12

The Eden Alternative: One Paradigm for Change in Long Term Care

Some Definitions to Ponder

a) Loneliness: The pain we feel when we want, but cannot have, companionship.

b) Helplessness: The pain we feel when we always receive care and never give care.

c) Boredom: The pain we feel when our lives lack variety and spontaneity.

APPENDIX 1.13

Description of On-lok, Choice and SIPA

Appendix 1.13: Description of On-lok, Choice and SIPA

This summary was prepared for the Vancouver/Richmond Health Board for their review of possible programs for the frail elderly .

On-Lok was the first integrated, capitated model of care for the nursing home eligible frail elderly population. The program began in San Francisco's Chinatown with a catchment area of 2.5 square miles; it has since expanded to cover 10 square miles with an enrollment of 433 clients. Integral to the On-Lok model is the day health centre which serves as the primary delivery site for monitoring clients, controlling costs and services and providing some stimulation to clients who would otherwise be isolated and/or homebound. Other program components include: in-home services, skilled nursing, inpatient medical services and transitional housing. As a way to reinforce the integration of services, participants in On-Lok must agree to go under the care of the program's physicians. The success of On-Lok has lead to replications of the model called PACE (Program of All-inclusive Care for the Elderly).

These programs are being implemented in various locations in the United States, however, none of them have yet achieved the success of On-Lok.

The Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) in Edmonton, Alberta, is based on the American PACE model. Individuals eligible for the program include those at risk for placement in long term care, high users of hospital or health centres and those for whom alternative, less comprehensive services have failed.

Its core program elements include: a day health centre which all clients must attend at least one day a week to receive services; a health clinic where each client is assigned a clinic physician to address all their medical needs; home support services, which may include meal delivery, personal care adaptation of the home environment and home making services; transportation to and from the day health centre and other appointments; subacute care for treatment, respite, night care or a holding bed; and emergency response provided by an on-call nurse for off-hours, nights and weekends when the day health centre is closed. The program provides 24-hour care for clients through a multidisciplinary team of professionals using case co-ordination.

The Capital Health Authority funds three CHOICE programs. Each site has the capacity for 100 clients.

The SIPA Demonstration Program (Systeme de Services Integres pour Personnes Agees en Perte D'Autonomie) in Montreal, Quebec, will include two sites, each site maintaining two interdisciplinary teams to serve a total of 600 patients (150 patients/team).

Admission into the program includes not only the frail elderly eligible for nursing homes, but also the frail elderly with disabilities who require help to remain in their own homes but can also benefit from the program. The SIPA model is different than the other Canadian programs for the frail

elderly in that it will take on full clinical responsibility for its clients based on capitation (capitation will be simulated until December 31, 1999 — a rate has not yet been defined). Another difference between SIPA and CHOICE is that clients will be encouraged to remain with their family physicians to ensure continuity of care.

Program components include everything from alternative housing, primary and secondary medical care, medication, equipment and home support. This model will not rely on the day health centre as the hub of the program. SIPA will use an interdisciplinary team to provide 24-hour care to clients. The staffing mix is not yet known.

Appendix 1.14: Vancouver/Richmond Evaluation Working Group Tables

For each one of these, the evaluation working group drafted a definition and some examples of corresponding objectives/indicators. The age-based working groups critiqued the draft from their own perspectives and all agreed to the following six areas for system performance evaluation (see Table 1 on page 91).

The evaluation working group then compared the six conceptual areas of its framework with the goals of the Vancouver/Richmond Health Board, the 'domains' of the performance indicators framework developed by the Adult Mental Health Division of the Ministry of Health and the 'dimensions' used by the Canadian Council of Health Services Accreditation in its AIM 2000 project.

While there was not a perfect match, it was possible to relate these frameworks to one another in a way that makes it possible to cluster indicators under comparable headings (see Table 2 on page 92).

Table 1: Areas of System Performance Evaluation*

Goal	Definition	Examples
Efficiency/ Appropriateness	Appropriateness, a common indicator of service efficiency, means delivering the right kind and intensity of service at the right time and place for the right person.	Alternative level of care days Least restrictive care environment
Outcome/ Effectiveness	Outcome effectiveness refers to the attainment of individual, program and/ or system outcome goals. Negative outcomes, such as side effects, are also included in this domain.	Improved quality of life Decreased mortality rates Unusual occurrences
Accessibility	Accessibility includes elements of availability, adequacy, and responsiveness. It refers to the ability of a population group to obtain needed services quickly and conveniently.	Treated prevalence Waiting times Culturally competent care
Continuity of Care	Continuity of care as experienced by individual clients and family members is typically facilitated by systems integration, both within the mental health sector and between mental health and other sectors.	Successful referrals between hospital and community mental health services Transition to/linkage with primary care, continuing care, forensic services, etc. Single case manager, shared charts
Person-centred	Person-centred refers to client and family participation in individual care planning and to public participation in overall systems management.	Setting of goals with client complaint mechanism Client and family participation on committees
Positive Work Environment	A positive work environment is an environment of trust, adequate support and learning.	Staff turnover rates Opportunity for staff education

Note to Table 1:

* The Community Health Services branch of the Vancouver/Richmond Health Board has decided to use this same basic framework, but they have added a seventh goal of accountability. The evaluation working group concurred with the view of the Canadian Council of Health Services Accreditation that the purpose of the entire framework is to ensure accountability, so accountability is not needed as a separate goal. However, financial indicators can, and most likely will, be included within the general framework.

APPENDIX 1.14

Vancouver/ Richmond Evaluation Working Group Tables

Table 2: Proposed Vancouver/Richmond Mental Health Evaluation in Relation to Other Frameworks Considered

Proposed Vancouver/ Richmond Mental Health Evaluation Framework	Other Frameworks Considered		
	Vancouver/Richmond Health Board 'Goals'	Ministry of Health, Mental Health Services Division 'Domains'	Canadian Council of Health Services Accreditation 'Dimensions'
Accessibility	Quality	Access/Responsiveness	Responsiveness
Appropriateness (Efficiency)		Quality/Appropriateness	
Continuity of Care	Integration		System Competency
Outcome Effectiveness	Outcome	Outcome	
Person-centred Individual Choice	Public Participation	Participation	Client/Community Focus
Positive Work Environment	Work Environment Learning and Growth		Work Life

A comparison of this framework with the Ministry for Children and Family Development is available on request.

APPENDIX 1.15

Excerpt: *Community for Life*

Appendix 1.15: Excerpt: *Community for Life*[1]

Principles

Principles also establish expectations for how services will be designed, funded, operated and evaluated. It is particularly important to have clearly defined principles in a decentralized health system such as our own, in which each health authority is responsible for delivering its own services.

Clients Come First

Clients make their own health decisions, with support from family, friends,

other caregivers and service providers. Clients have full information about their situation and their options for care. They have as much autonomy as possible to select the type of care they receive (consistent with cost effective and high quality care) and they have assurances that the system will treat them fairly.

Support for Family, Friends and Other Caregivers

The system recognizes that the network of family and friends is vital to clients. Efforts are made to help support these caregivers and avoid their becoming exhausted.

An Individual Approach

Clients are valued members of their communities, each with individual abilities, behaviours, values and life experiences that are recognized and encouraged; clients are not individuals with problems and limitations to be managed. The system pays particular attention to each client's previous roles in life and to culture, values and self-identity.

Health is the Goal

The system plans, develops, funds and manages services to contribute to the health of all British Columbians.

Focus on Wellness and Prevention

All services emphasize promotion of health and prevention of problems or crises.

Freedom to Live Normally

Community care providers and residential facilities give clients the freedom to live as normally as possible.

Community Development

Services both build on, and develop, the ability of communities to address their own health issues.

Accessible and Flexible Services

Clients and families have reasonable and equitable access to services, regardless of where they live in the province or their ability to pay. Their needs are met in a flexible, timely and responsive manner.

Providing Care Close to Home

Every effort is made to deliver services as close as possible to clients' home environments (consistent with cost effective and high quality care).

Continuum of Services

When moving between different services providers, organizations and geographic locations, clients and families do not "fall through the cracks." They experience smooth transitions.

Accountability

The system monitors and evaluates services on the basis of how they improve quality of life and achieve clients' goals, as well as by measuring outcomes and standards of service excellence.

Vision

Individuals have the support and health services they need to live fully and independently or interdependently as valued members of their community.

APPENDIX 1.15

Excerpt: *Community for Life*

A Vision for the Future

During our first phase of consultation, the steering committee invested a significant amount of time asking stakeholders what they thought Continuing Care should, and could, consist of in the future. Participants also had opportunities to provide input on a consultation document outlining ideas for the future system. Based on this extensive consultation, the steering committee developed a vision of an achievable future for Continuing Care.

Values

Values are core beliefs that determine how a system develops and how it is managed. Over the course of the review, the steering committee came to agreement on the values that should guide the future of Continuing Care.

People are valued. Therefore, the Continuing Care system:

- respects, recognizes and supports clients;
- respects, recognizes and supports family, friends and other caregivers;
- respects, recognizes and supports service providers.

Adopting a New Culture

Adopting the desire vision, values and principles will point the Continuing Care system towards a new culture. The system's culture must place great importance on viewing clients as decision makers and as valued members of their communities. It should also emphasize:

- caring relationships over service provisions;
- flexibility over rules;
- wellness over illness; and
- risk taking over rigid safety concerns.

The envisioned culture is one in which the system and its clients share the same values and in which a range of coordinated services is available. The culture would recognize that health care reform is an ongoing reality and that resources must be carefully managed in order to revitalize, focus and sustain Continuing Care.

Footnotes

[1] Continuing Care Review Steering Committee, Ministry of Health Services and Ministry Responsible for Seniors (1999): *Community for Life: Review of Continuing Care Services in British Columbia,* Victoria, Province of British Columbia.

Appendix 1.16: Interdisciplinary Teamwork in Psychogeriatrics

The following depiction of interdisciplinary practice was prepared by Linda Myers, Psychogeriatric Services Manager, Kelowna Mental Health Centre, Okanagan Similkameen Health Region.

Definitions

Psychogeriatrics

"Psychogeriatrics is a specialty field concerning the study of elderly people who present clinically with dementia, behavioural disturbances and/or psychiatric manifestations. Their etiologies may be attributed to such factors as medical problems, organicity, functional disorder, environmental needs and social deprivation" (Cyr, 14).

Psychogeriatric Assessment

A comprehensive psychogeriatric assessment is inclusive of a holistic approach that promotes "harmony in the person's whole self including the mind and body and the interaction within the environment" Kutlenios (1987).

The Ontario Psychogeriatric Association (OPGA) specifies that "assessment embraces the domains of physical and mental health, social and economic status, behavior and self-care abilities, and the individual's physical environment" (Cyr, 15). The OPGA recommends that this assessment take place "in the client's residence, if possible, and be conducted by a multidisciplinary team of health professionals" (15).

Team

According to the team definition of Katzenbach and Smith 1994: "A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable" (45).

Multidisciplinary vs. Interdisciplinary Team

The words multidisciplinary and interdisciplinary are often interchanged as though they are one in the same. However, in psychogeriatric practice, the distinction between the two is very important.

"In the *multidisciplinary* approach, each discipline provides vital information toward decision making about the patient's care. But in general, only one person, such a physician or nurse case manager, makes the treatment decisions. Although the multidisciplinary approach is clearly superior to input from only a single health professional or a single discipline, receiving input from a variety of disciplines is merely the first step. The second is combining that input into a common decision making process. Hence, the birth of the interdisciplinary team"(Siegler, 16).

The *interdisciplinary* approach "recognizes that many clinical problems outstrip

the tools of individual disciplines and entails several health care providers simultaneously and cooperatively evaluating the patient and developing a joint plan of action…But nowhere in health care is this strategy more common or more effective than in the care of multiply impaired older patients" (vii).

Why Teams in Geriatrics?

"One of the major ways in which the practice of geriatric medicine differs from medical care of other age groups is that it deals with a more complex set of health care problems — multiple illnesses, multiple disabilities, multiple medications, multiple procedures, and multiple disciplines brought to bear on one problem" (16).

What is Interdisciplinary Care?

"Interdisciplinary work sees individuals involved in interdependent goal-setting, sharing responsibility, respecting and relying on each others' competence and being involved in evaluation of the outcome. While no comprehensive evidence-based analysis of the value of interdisciplinary work has been reported, it seems to offer greater potential to address a broad range of patient and health professional needs" (Yaffe, 156).

Psychogeriatric Program Evaluation

"The Department of National Health and Welfare (1988) has made reference to the importance of program evaluation in the provision of good psychogeriatric care. In the development and implementation of a model of psychogeriatric care, it is imperative to develop a program evaluation framework concurrently. Without process and outcome program evaluation

data, both qualitative and quantitative factors constraining effective and efficient service delivery may never be identified or documented” (Cyr, 18).

Advantages to Interdisciplinary Psychogeriatric Practice

Kelowna Mental Health Centre Experience

- Recruitment of diversified skills within and between disciplines.
- All professionals on the team are valued and respected.
- High leadership skills from individual members area of expertise.
- Team decision making for complex care situations.
- Standards of care are upheld by a team standard.
- Shared vision, principles of care and values.
- Team members monitor each other's performance, since each team member's performance reflects on the “team's performance”.
- Ability to provide care management or case co-ordination through care transitions (high risk points to client function).
- Collaboration with service provider partners (necessary to ensure support for common client goals despite multiple provider interventions).
- Ease in partnering with other primary service providers to co-ordinate more effective outcomes for the client. This is necessary to prevent situations where for example, the home care nurse, mental health occupational therapist and home support worker all schedule appointments with the client on the same day and at the same time.
- Education and consultative services to support and increase the community's and primary providers' capacity to assist the target population.

- Care complexity requires team members to collaborate with health care providers across the continuum of services for the target population. Thus, team members recognize gaps in service and provide advocacy via their interdisciplinary team.
- Efficient use of consultative services of a psychiatrist (the psychiatrist does not have to co-ordinate or navigate the health care services that are necessary to ensure efficacy in complex situations.
  For example, medication might not be taken unless transportation, monitoring or financial issues are addressed).
- Health care cost saving (see below).

Case Example

An elder male client of the Kelowna Mental Health Centre with a diagnosis of bipolar illness, alcoholism and possible early dementia had been admitted to acute psychiatry three to five times per year and, additionally, received emergency room services six to seven times per year for his psychiatric distress.

When his medication was managed by the community mental health clinic (IM medication for his psychosis and psychiatric appointments at the mental health centre), he had no further admissions to the hospital. However, the emergency room visits continued.

When a supported housing arrangement and elder outreach services were added, the client, family caregiver and informal service provider were supported by a team approach.

There have been no further hospitalizations or emergency room visits to date (two years in July 2001).

APPENDIX 1.16

Interdisciplinary Teamwork in Psychogeriatrics

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APPENDIX 1.17

Excerpt: *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*

Appendix 1.17: Excerpt: *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*[1]

Underlying Principles of Psychogeriatric Care

Geriatric psychiatry (or psychogeriatrics) has developed in response to the expanding needs of an increasing and hitherto neglected patient population and is now an important component of the health and social services. It a body of knowledge on the psychodynamics and psychopathology of old age, special expertise in the pharmacological and psychosocial treatment and management of the mentally ill elderly and a unique organization of services. It represents an innovative use of existent resources, rather than a new specialty, for it has had contributions from many fields and disciplines.

At present, specialized psychogeriatric services are very thinly scattered across the country. They cannot begin to treat more than a fraction of the elderly people with mental disorders. The majority are managed by family physicians, public health nurses and community support personnel. However, the underlying principles of the specialty can and should be applied by all who plan and direct the management and treatment of mental illness in the elderly.

Psychogeriatric care makes use of a variety of professionals, community resources and support personnel. Community outreach is fundamental, with home assessment of patients and consultation to long term care facilities. A broad framework and a multidisciplinary team are used for assessment, treatment and planning. Continuity and co-ordination in service provision are emphasized.

The aims of psychogeriatric management and treatment include the reduction of distress to patient and family, the improvement and maintenance of function and the mobilization of the individual's capacity for autonomous living. These should be the goals for all patients, whether living at home or in institutions: a degree of autonomy should be possible in all settings. Independence should be maximized and maintained at the highest level that can be reached. In doing so, only services which are truly necessary should be offered, as it is easy to create dependence.

Much of the content of the management plan is determined by nonclinical factors, such as the person's level of functioning, support systems and living environment. The domestic situation can constitute a resource or a focus of need. Both possibilities must be taken into account in planning for the patient.

The possibility of rehabilitation should never be dismissed on the basis of age alone, even when the patient is very old. While many elderly patients require long term or ongoing care, appropriate treatment and rehabilitation services

allow many to regain their health and autonomy. Rehabilitation services also have an important role in the maintenance of optimal function in those who cannot progress as far. Care for the caregivers is a fundamental principle. Families who look after elderly mentally relatives need support, advice and assistance to enable them to provide the best care possible and to maintain their own morale. This is also true of caregivers in institutional settings, though the supports needed will differ.

Resources for Patient Care

The resources required to address the special needs of the elderly psychiatric patient are described under two major headings: Psychogeriatric Services and Support Services.

A. Psychogeriatric Services

1. Essential Functions

Since specialized psychogeriatric services are not yet widely available, it is necessary to assign priorities for existing or developing resources. Essential roles and functions are summarized here.

a) Diagnosis of difficult cases: Geropsychiatrists and specialized units offer diagnostic services for patients presenting special difficulty to referring physicians. The patient is referred back to the family physician for treatment, though the team may offer assistance where necessary.

Footnotes

[1] National Department of Health and Welfare (1988): *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders,* Ottawa, Ministry of Supply and Services, 14.

Appendix 1.18: Excerpt: *Supportive Housing Review*[1]

The Role of Supportive Housing

The committee finds that the role of supportive housing in a community is best expressed in terms of the social model of health, that is, health is primarily a function of being a participating and respected member of the community. To maintain and improve the health of our elderly citizens, we must look at their place in the community and support them as adults who still have a positive role to play. In order to give this support, we need to look first at the environment they live in to see how it helps or hinders them in carrying out their daily activities both inside and outside the home.

The following aspects need to be considered:

- physical structure of the community (sidewalks, streets, steps, etc.);
- suitability of the home environment (safety, accessibility and ease of use);
- possibility of maintaining active social and cultural connections; and
- availability of services, such as transportation, shopping, banking and medical care.

There are many ways of making environments more enabling for individuals in the community, one of which is to combine housing, social opportunities and services in a supportive housing setting.

After studying the information gained through research and consulting with people across British Columbia, the committee concludes that:

- supportive housing is a practical housing option that can help seniors maintain their independence and links to the community;

- supportive housing should be available alongside other housing options in every community; and
- a supportive housing environment promotes health by minimizing environmental demands, providing social opportunities and making specific services available as needed.

Good supportive housing can also help to reduce specific health problems associated with social isolation, such as depression, inadequate nutrition and poor hygiene. It can prevent accidents and provide short-term and long-term assistance to prevent temporary or minor illnesses from escalating. However, it is important to emphasize that supportive housing is not a substitute for long term care and there will continue to be a need for high quality hospital and residential care.

In recognizing and promoting the valuable role of supportive housing, there is a danger that individuals who need residential care might be kept inappropriately in supportive housing developments that cannot meet their needs or that medical services might be offered in an unlicensed and inadequate environment. In other words, the purpose of supportive housing is to help individuals maintain independence, not to provide care. Mechanisms for timely transition from housing to care when required must be developed.

Supportive housing should be widely accessible to seniors in the province. It should be:

- affordable for seniors at all income levels, not only for those with higher incomes, as is the case with most existing developments; and
- available within local communities, so that residents are able to maintain their family and social connections.

Finally, the committee finds that local groups and individuals are most aware of the needs and preferences of their older citizens and the form of supportive

housing that would best meet their needs. The committee has, therefore, not set out to prescribe a single model for the whole province, but recognizes that there could be a variety of supportive housing developments, each suited to local characteristics and conditions.

Key Policy Issues

The committee found that there are several key policy issues that need to be further explored:

Supportive Communities

Factors in the environment can limit the ability of seniors (and others) to function independently and remain part of the community. To make a community more supportive for a senior, we need to:

- look at the person's residence to remove hazards and barriers to mobility;
- ensure that the senior has easy access to community resources and services; and
- enable the person to maintain a social life in whatever way they prefer.

Improving the existing environment of seniors to accommodate their needs should be the first step. If needed improvements cannot be done successfully, moving to housing with fewer barriers in or near a more supportive community should be considered. A move to a supportive housing development may be the best alternative in some situations.

Role of Health Care and Home Support Services

Several aspects of the link between supportive housing and health care need to be examined:

- Support services may be offered to help people remain in regular housing, but they may also be provided in types of housing that are in themselves more supportive. Health professionals should be able to consider client needs holistically: looking at health, social and housing needs together. Referrals to supportive housing should be a viable option.
- Health services, whether temporary or long term, need to be flexible and provided in a timely way in response to a person's changing needs, wherever they live. There is a need to review the way in which these services are now being provided. In particular, we need to look at the current licensing and regulatory system which, we were repeatedly told, creates barriers to effective, affordable supportive housing.
- In many communities, it is possible to combine supportive housing with an assisted living development or a care facility on the same site. This, sometimes called the campus model, has many advantages: It makes it possible to share amenities such as dining room, bathing and emergency response and if a person, or one member of a couple, does require residential care, there is no necessity for a disruptive move. Current admission and wait list procedures, and policies about providing care services outside of facilities, need to be examined to make these shared developments work smoothly.
- The literature review suggests that supportive housing can reduce public costs by preventing or delaying a move to a care facility. In order to find out to what extent this would be true in British Columbia today, further research is needed. The research needs to take into account factors such as changes in health care delivery and the size and characteristics of the senior population. Those who took part in the Capital Region focus group also felt that

> supportive housing could be an option for some seniors who now live in facilities, but who no longer need all of the medical services being provided. It seems likely that good supportive housing could, for some, be an alternative to long term institutional care and this question should also be part of further research.

Consumer Protection

The statutes that regulate the relationship between residents and providers of independent housing recognize residents as consumers who are making a housing choice using the resources available to them.

The *Residential Tenancy Act*, for instance, sets out the right and responsibilities of landlords and tenants and a procedure for resolving disputes. The key tenant protections are rights of quiet enjoyment and security of tenure. However, the Act was not written with supportive housing developments in mind and its application to them needs to be reviewed.

On the other hand, the licensing model used to regulate care facilities was also not developed to apply to supportive housing. One of the objectives of supportive housing is to help seniors maintain their independence. For that reason, a type of consumer protection model would appear to be more suitable for ensuring the protection of rights than one that directly regulates operators with little involvement of the residents.

It should be recognized that some residents are more dependent on supportive housing operators than occupants of housing where no services are provided. Others might need more support because of health considerations. More protective measures may, therefore, be justified, but it is important to make sure that the degree of regulation recognizes the professionalism of the housing providers and does not reduce the autonomy of the residents.

Another consumer protection issue is that, where large sums of money are paid in advance (e.g. life leases or advance fees for support services), it is essential

to ensure that these funds are protected. They must be used for their intended purpose to benefit the resident and be subject to fair refund policies.

Aging in Place

The principle of aging in place means that seniors should be able to stay in their preferred living environments for as long as possible. This principle must be kept in mind when a senior is considering a move to supportive housing and what to do if their health fails while they are living there. Adjusting services to changing needs would be more helpful than requiring a person to move to new settings (i.e. care facilities), where the services are provided centrally. Moving to a new location demands changes in lifestyle and disturbs links with the larger community. These changes can seriously affect how individuals feel about themselves and reduce their sense of well-being.

However, if seniors are to age in place, all the necessary support services must be available. Each supportive housing operator will have to decide what type of supports to offer and whether and how they should require residents to leave if their needs go beyond those that can be met by the operator and through home care. Some providers may aim to maintain an environment that is primarily housing by establishing a clear requirement that a person must move if care needs increase beyond a certain point. Others may choose to support residents to a much greater degree. In either case, the consumer is entitled to a contract that clearly specifies the provider's exit policy. "Campus" models are one solution to the issues raised by the concept of aging in place.

Affordability

Affordability, or cost to the occupant, is perhaps the major barrier preventing access to supportive housing. With a few exceptions, the monthly charges for congregate supportive housing in British Columbia begin in the $1,200 range.

It is estimated that the total incomes of about 43 per cent of elderly British Columbians fall below this level. Many more would have to spend very high proportions of their incomes to obtain supportive housing at this lower end of the market. For instance, if we assume that supportive housing costs should not exceed two-thirds of income, 66 per cent of seniors could not afford to pay even the median cost of a studio suite in congregate housing ($1,470).

Three quarters of seniors in British Columbia are homeowners and many could use their equity for supportive housing. However, a large segment of the elderly population still could not afford it. This group includes renters, whose incomes tend to be lower than homeowners' incomes, and owners with limited equity or monthly incomes too low to pay for services.

If the benefits to seniors of this form of housing are to be realized, ways to make it more affordable for lower- and middle-income seniors need to be explored. This exploration includes finding ways to lower the cost of development and looking at what income support is available to seniors.

Planning and Development Assistance

The consultations indicated that many individuals and groups are interested in developing affordable supportive housing in their communities. Although many of these individuals and groups are capable and dedicated, they need additional resources, advice and help in planning and developing their projects, rather than having to "reinvent the wheel." Many local governments are also looking for information and guidance on building and planning decisions in order to assist supportive housing initiatives and address community concerns.

Emergency Housing

Gaps have been identified in the services available for elderly people who find

APPENDIX 1.18

Excerpt: *Supportive Housing Review*

themselves without housing because of emergency situations resulting from abuse, mental illness or personal crisis.

Seniors sometimes find it difficult to access shelters and other assistance that are intended primarily for other groups. Most elderly persons in these situations could be helped if resources were available or mandates broadened to provide limited assistance that meets their immediate needs.

Footnotes

1 The report, *Supportive Housing in Supportive Communities: The Report on the Supportive Housing Review*, was released in 2000 by the then Ministry of Social Development and Economic Security and the Ministry of Health and Ministry Responsible for Seniors, Province of British Columbia. The report contains recommendations based on a year-long review to identify barriers to supportive housing and to clarify government's role in encouraging its development. A copy of the report is available at http://www.hlth.gov.bc.ca/cpa/publications/housing.pdf.

APPENDIX 1.19

Goal Attainment Scaling at the Elderly Outreach Service

Appendix 1.19: Goal Attainment Scaling at the Elderly Outreach Service: Results of a Pilot Project

By David J. Evans, MD, CCFP

Background

Number	Psychiatric Diagnosis
30	Dementia
4	Cognitive impairment
7	Depression
1	Dysthymic disorder
4	Personality disorder
2	Delusion disorder
3	Alcohol abuse
1	Alcohol dependence
0	Other

Figure 1: EOS G.A.S. Pilot Project Client Information

Goal Attainment Scaling (GAS) is a procedure for setting individualized treatment goals and measuring the outcome of interventions. Procedures and statistical rationale are well described in the literature[1,2,3]. Client outcomes are reflected in a t-score that indicates success at meeting treatment goals. GAS was developed for mental health programs in the 1960s and has been adopted by geriatric and other interdisciplinary programs treating patients with complex interrelated problems[4,5,6].

Goals can be categorized by the "problem" or goal area that is being addressed by the intervention. These goal areas can then be sorted by type of problem into a broader category or domain consistent with domains used in outcomes literature. Success at meeting goal area and domain goals can also be shown using GAS data.

Procedure

One working group at the Elderly Outreach Service, consisting of a family physician, two nurses and a social worker, collected outcome data on clients they assessed between January 1 and March 31, 1998. This was preceded by six months of self-training and interdisciplinary practice using GAS procedures. The group worked in an interdisciplinary mental health service for seniors with late life mental health problems in the Capital Regional District, Victoria, British Columbia. Other disciplines contributing to assessment, goal setting and treatment included occupational therapy, neuropsychology and geriatric psychiatry.

Symptoms, signs, level of function or other parameters for each problem were documented on a GAS worksheet and assigned a "-1" scale score. The improvements or changes expected as a result of intervention were noted and assigned to a score of "0". Client status if improvements exceeded, or greatly exceeded, expectations were scored as "1" or "2", respectively. A significant deterioration was scored as "-2". GAS scores are calculated from the above and the formula can be written as:

$$50+\frac{10\text{ (total score in all goal areas)}}{\text{square root }[.7(\text{number of goal areas}) + .3(\text{number of goal areas squared})]}$$

Goals were set at the initial case review after a comprehensive psychogeriatric assessment by a member of the group. Subsequent reviews were booked as needed to review further assessments, set new goals, revise treatment plans and monitor goal attainment. Review meetings were held weekly.

Data were collected at case closure or at six months, whichever came first.

The average scale scores of goal areas and domains were calculated as outcome indicators for success at interventions for specific types of problems. Averages for GAS scores, total scale scores and number of goal areas were also determined. These summarise client specific information.

Results

Of the 49 clients assessed, only four did not have problems deemed to be amenable to interventions. Ninety per cent of those assessed needed service, indicating well targeted program referrals. Just two clients had their intervention plans terminated. This occurred when the viability of interventions was eliminated by unforeseen developments, such as death or hospital admission due to unrelated problems. Over 95 per cent of the clients completed the program or had six months of service resulting in GAS data reflecting outcomes of intervention. The average age of the 43 clients reviewed was 84.6 years, with a range from 67 to 102 years. There were 27 women and 19 men. Nineteen were married, with three married couples included in the sample. Eighteen clients were widowed and almost half (21) lived alone.

Psychiatric diagnoses are summarised in Figure 2. Dementia was the most common psychiatric diagnosis, evident 70 per cent of the time. Cognitive impairment (not meeting criteria for dementia) was evident in nine per cent. Depression or dysthymia was present in 19 per cent of cases. Nine per cent had an axis II diagnosis and seven per cent had alcohol problems. Two diagnoses were present in eight patients (19 per cent), with cognitive impairment or dementia common to all eight.

Interpretation

The team had good success at meeting intervention goals for most clients

in most goal areas and all domains. GAS scores are meant to produce t-scores describing a bell curve centred around 50 with one standard deviation between 40 and 60.

We took a pragmatic approach to understanding our outcome scores. Most clients had two to six goals (average 3.84). If no changes occurred, outcomes scores would usually be between 35 (six goals) and 38 (two goals). Success at meeting half the goals would result in scores from 42 (six goals) to 44 (two goals). If half the goals were met and half exceeded expectations, scores would be from 56 (two goals) to 58 (six goals). If all outcomes exceeded expectations, scores would range from 62 (two goals) to 65 (six goals). If all goals were met as expected, the score would be 50. Outcome scores from 44 to 56 were identified as having significant improvement within a range of expectations. Only 23 per cent of clients scored less than 44, indicating little or no improvement, whereas 74 per cent scored between 44 and 56, indicating goals were substantially met. Two per cent exceeded expectations for success at meeting identified goals. The distribution of scores was narrower than expected for a t-score and skewed to the left.

Scores are reflective of success at meeting what we feel were realistic goals reflecting improvements of significance to our clients. Our tendency to keep the case open until the goals were met may be the reason for the narrow distribution of scores. Scores lower than expected may reflect poor outcomes, but perhaps reflect unrealistic expectations of treatment efficacy in a difficult to treat client population. This may account for the observed skew to the left.

The number of interventions in specific goal areas should be reviewed before making generalizations about treatment efficacy. One or two interventions may produce scores that are noticeably high or low, but after many interventions in any goal area the average scores should be near zero. Variations suggest the need for clinical case reviews to determine why expectations are being

consistently exceeded or unmet. Frequency of service in goal areas indicates common problems requiring intervention and could be monitored as a clinical indicator as well.

All domain scores (the averages of the scale score achieved) were reasonably close to zero (the score achieved if goals were met). This indicates relative efficacy of intervention in very different types of problems. Most clients had problems in different domains. Effective treatment in one area is often dependent on success in another area. This supports the need for an interdisciplinary team approach to service to this client group.

A relatively low intervention rate for "mental health" domain problems is indicative of the preponderance of clients with dementia served. Their care and support needs tended to be more amenable to improvements than their cognition. They required "function" and "health service" domain interventions to compensate for dementia-related self-neglect. "Social" domain interventions included stress relief to burdened caregivers and assistance with future planning. Caregiver education regarding diagnosis and caregiving responsibilities was the most common goal area identified.

Future Plans

The team feels that in presentation of this data we should make the context clear. The elderly outreach service sees a complex client population referred when the primary care system is not able to provide the services required. Thorough assessment and communication with referring agents is always done. Other clinical services provided by the program include neuropsychology assessments, geriatric psychiatry consultations and services to nursing home residents. Nonclinical services include education, program and community development and advocacy for frail seniors. The data presented reflect client demographics and clinical service outcomes for community clients served by one of two working groups of a larger, diverse team and cannot

be held to represent services and outcomes of the entire program.

The group that piloted GAS procedures and data collection intends to continue with both. The procedures are felt to facilitate teamwork and improve client tracking. The data provide important indicators of service. A report regarding facility interventions is planned, pending the recruitment of a sufficient sample size. This report will be included in the program review document to be published in 1999. We are pleased to share our experience with other programs and interested parties.

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Appendix 2.0

Literature Reviews

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Appendix 2.1: Inpatient Services Literature Review

The elderly patient has a combination of psychological, physical and social needs. Geriatric psychiatry needs to promote integrated approaches to individual assessment, management and followup, with the collaborative efforts of health, social and voluntary organizations and family carers. Rehabilitative measures are an integral part of geriatric psychiatry and there is an emphasis on interdisciplinary services, education and research.[1]

Geriatric psychiatry patients receive care in a variety of inpatient settings including:

- general hospital nonpsychiatric units;
- general hospital psychiatric units; and
- psychiatric hospitals.

Some of the more common reasons for hospitalization include depressive disorders, dementia, delirium or organic disorders.[2, 3] Patients from residential care are predominantly admitted because of aggression.[4] There has been a distinct upward trend since the 1980s of admission for the 85 and over group with functional psychoses and general clinical disorders, with a more pronounced trend in British Columbia among women.[5] In one study, there were significant proportions of the admissions with chronic or relapsing disorders that commonly first appear in earlier years.[3]

The Royal College of Psychiatrists recommends that clinical services for old age psychiatry should include, for dementia care, acute inpatient beds to allow for assessment, investigation and treatment of patients with problems too severe to be responsibly managed elsewhere.[4]

There are identified beneficial effects of geropsychiatry units for older patients with psychiatric disorders, including:

- holistic approach to care;
- social, functional, medical, psychiatric (including dementia workup, objective testing of cognitive function and affective state) and other interdisciplinary (nursing, social work, dietary, etc.) assessment and treatment;
- provision of a rehabilitation model which supports patients in attaining optimal function;
- environment (physically separate and secure) and staff more appropriate for management of problematic behaviour;
- psychiatrist/admitting physician; and
- nurses proficient in medical, psychiatric and gerontological care.[1,6,8]

This often results in more efficient and effective therapeutic interventions and improved quality of life.[1] One study found that overall psychiatric functioning and problem behaviour of nursing home residents, with or without dementia, improved in hospital, without worsening of either medical side effects or cognitive functioning. This may be suggestive of the lack of adequate psychiatric assessment and treatment in the nursing home.[4] However, psychiatric hospitals do have limitations of high cost, short length of stay, risk of nosocomial infections and the inherent difficulty of treating a behavioural problem outside the home milieu.[7]

Although there is no direct reference to homogenous populations, there are a lot of references/literature on improved social, recreational and therapeutic activities directed to patients on special wards, with individualization of the treatments and activities. For example, a specialized delirium ward identified the increased recognition of dementia.[20] Also, a dementia care unit identified a continuous process of reflection and change for staff, with staff ownership and skill development as important features.[21,22]

There are guidelines for a variety of treatments, including the management of agitation[9], dementing disorders[10], pain[16] and depression[12]. Non-pharmacological principles for managing patients with agitation include such things as:

- communicate in calm, friendly manner;
- maintain patient self-esteem;
- compensate for sensory (eyeglasses, hearing aids) and cognitive (e.g. simple tasks) deficit;
- provide patient with sense of control, basic health needs (nutrition, sleep, exercise) and a safe, pain free or pain reduced environment;
- monitor appropriate level of environmental stimulation; and
- manipulate situations to avoid triggers.

Pharmaceutical treatments include the newer antipsychotics, which are better tolerated, with less sedation and other side effects.[12] The use of restraints to manage behaviour is not strongly supported, as numerous studies have shown that use of restraints neither decreases falls nor ensures freedom from injury (which is often severe if person restrained). There are identified restraint alternatives (environmental manipulation, increasing staff attention, use of cushions or pads, enhanced physical therapy and recreation activities) and the need for assessment and monitoring in the event restraint usage is necessary.[13] Lack of consideration for the physical needs of the elderly is risky and, in planning, one must never underestimate the present and future physical needs.[18] There is a need for an adequate number of staff for a ward in areas accommodating larger number of patients (day rooms, corridors) and during busy times (meals, personal care, etc.).[14] One study suggests that some predictors of higher level of care include age, severity of dementia, somatic disorders, activities of daily living, dependency and marital status. Management of behaviours requires high patient-to-staff ratios[15] and there

is some evidence that residents on units with a higher ratio of licensed personnel had fewer instances of disturbing behaviour.[16] Education of staff in relation to the patients' illness and how to deal with both behavioural problems and physical health is important.[4]

Some studies have looked at the length of stay for geriatric psychiatry patients. One study showed those admitted to general hospital had shorter lengths of stay, higher rates of discharge to nursing homes and lower rates of discharge to self-care than those treated in psychiatric hospitals, with better followup care for those discharged from the psychiatric hospitals.[3] Another study attempted to identify predictors of length of stay, identifying psychiatric factors (major depression) being a major predictor and carer stress as the main social predictor. The findings suggest that closer attention may be required to the efficacy of treatment approaches to major depression. As well, the use of the clinical path models and defining multidisciplinary staff responsibilities, time lines and patient outcomes was found to reduce length of stay by 39 per cent in older patients with depression. The social bed day delays were due to difficulties in placing behaviourally disturbed patients with dementia and it was felt the main reason was the lack of long stay psychogeriatric beds in the catchment area.[3]

Discharge planning is considered an important piece of care (and important in successful discharge) and partnership agreements between hospitals and nursing homes can assist with delivering a quality of care at least as good as hospital treatment, if the transfer/discharge is handled properly.[17] Social workers are important in discharge decisions and significantly more influential when discharge is to a nursing home. Caregiver involvement is also essential to caregiver satisfaction, especially when the patient is suffering from dementia.[18]

A Continuum: Veterans Health Administration, Washington, D.C.[19]

The veterans administration is attempting to provide a continuum of care, including:

- a range of facilities (retirement centres, state domiciallaries, private nursing home with psychogeriatric settings and intermediate to highly staffed hospital settings);
- moderate to intensive treatment and rehab in special clinics and hospital settings;
- education of staff, including expertise on staff, access to specialized consultation for treatment/rehabilitation/provision of care planning;
- core interdisciplinary staff for a program, including a geriatric psychiatrist, geriatrician, psychiatric social worker with training/ special expertise in gerontology, clinical nurse specialist or nurse practitioner with training in psychiatric nursing and geriatrics/ gerontology and a geropsychologist (or psychologist with training in gerontology);
- psychogeriatric assessment, including neuropsychological testing;
- levels of care for all services (community and institution) decided by level of intensity of intervention required;
- the presence of multiple physical and mental comorbidates, including substance use disorder;
- associated sociocultural and psychosocial problems and spiritual injuries, such as bereavement and social isolation;
- special issues of geriatric psychopharmacology; and
- need for outreach.

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Appendix 2.2: Education Literature Review

The literature on education that is relevant to best practices in elderly mental health care falls into a number of different categories. Medically oriented journals and other publications contain literature that is primarily oriented to development of clinical expertise or of clinical disciplines. Examples from the selected bibliography (see below) are:

- generic (not discipline specific): 6, 14, 20, 26;
- nurses: 5, 7, 11, 13, 15, 16, 17, 23,, 24, 25, 27, 30;
- occupational therapists: 3, 9;
- social work: 21; and
- physicians: 6, 19, 20, 22.

Articles on providing home support workers with both general and specific information about elderly clients with dementia or other psychogeriatric issues are also common[2,18,24].

A much wider selection of literature is aimed at family, informal community caregivers, volunteers and the like. For example, books such as those by Nancy Mace and Peter Rabin (*The 36-Hour Day*) and Diana Friel McGowin (*Living in the Labyrinth*) provide very personal pictures of the experience of Alzheimer Disease[3]. An enormous number of videos, pamphlets and books in this literature category are published, produced or made available by such organizations as the Alzheimer Society. While professional service providers often find this literature poignant, if not illuminating in various ways, the primary purpose is to make both general experiential, as well as technical

and medical information, comprehensible to nonprofessional individuals who may have some type of personal experience with one or another of the mental health problems that are covered.

Given that the literature is so extensive and diverse because the audiences are so different, no attempt will be made here to provide a comprehensive bibliography. Rather, readers are encouraged to search out specific topics to suit their needs on their own. The following items are, therefore, only a tiny sampling of the available and relevant literature.

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Appendix 2.3: Family Support and Involvement Literature Review

As a result of the work done to estimate the monetary value of the work done by caregivers (Arno, Levine & Memmott, 1999), we have come to recognize that without them the current care system would be under extreme and possibly overwhelming pressure. The same can be said for the subgroup of caregivers we are talking about. We know that difficult to manage individuals also put a tremendous burden on the formal caregiving system. It is our belief that, with adequate and appropriate supports, many informal caregivers can adequately manage the care of individuals displaying difficult behaviours.

The most important need of this group is prompt and effective support. It is now understood that the health of the caregiver is an important concern, with research showing that caregivers often experience serious physical and mental health problems (e.g. Cohen, 1998; Hills, 1998; Murray, Manela, Shuttleworth & Livingston, 1997; Schwarz & Roberts, 2000; Levine, 1999; Gibbons, 1999; Lauzon, 1995). There is a need for more research in the area of caregiver support to verify the reliability of instruments used to measure caregiver burden, especially with diverse populations (Vrabec, 1997; Calderon & Tennstedt, 1998). Toseland and McCallion (1996) provide a particularly informative perspective with respect to trends in caregiving intervention research.

We strongly support the following components of the *Family Support and Involvement Best Practices Report*[2]:

- provision of professional counselling for family members in need, including assistance in accessing services;
- partnerships among families, consumers and professionals in the treatment plan;
- respite care;
- inclusion of families in the planning and evaluation of services; and
- training for mental health professionals.

From the above list we think it is crucial that formal caregivers receive specific and ongoing systematic training in how to work with informal caregivers (Summerton, 2000; Chang, 1999). This should include the counselling skills necessary to consider the changing needs of informal carers (Keady & Williams, 1998; Kellett, 1999). Research is needed in the area of male informal caregivers, if formal caregivers are to provide appropriate supports (Siriopoulos, Brown & Wright, 1999).

Specially designed respite and day programs must be readily accessible and individualized (Campbell & Travis, 1999) and should include inhome respite similar to the program currently offered in Vancouver by the Victoria Order of Nurses. Further study is needed to determine why individuals do not take advantage of respite services that are available (Strang & Haughey, 1998; Strang & Haughey, 1999).

Other innovative approaches, such as telephone- and telecommunications-based interventions, have also been studied (e.g. Davis, 1998; Wright, Bennet & Gramling, 1998; Friedman, Stollerman, Mahoney & Rozenblyum, 1997) .

The working group recognizes that providing these necessary components becomes challenging in a rural setting. However, recognition of the specific challenges faced by rural professionals is reflected in a few journal articles (e.g. Hayes, 1999; Cuellar & Butts, 1999; Bowen, 1999).

Just as the physical design of a care facility can assist in providing care, so can the physical design of the home (Olsen, Hutchings & Ehrenkrantz, 1999).

If we are going to provide care successfully to this group of individuals, more research is needed in providing support for informal caregivers and care for the client. Research could include the provision of caregiver outreach services similar to those provided by the Mobile Outreach to Caregivers Program[2] (available at http://www.hc-sc.gc.ca/seniors-aines/pubs/innovations/innovat_e.htm).

The coping strategies used by informal caregivers that did not develop or experience burnout are identified in one study (Almberg, Grafstrom & Winblad, 1997). Further study is needed to determine if intervention could have changed the coping strategies of those informal caregivers that did experience burnout.

Work has been started in Europe on developing a first stage assessment tool that can be used to identify carers who require more in-depth consideration

of their support needs (Nolan & Philp, 1999). This is an important step in targeting resources to those most in need and providing preventative support — that is, providing the assistance before a crisis occurs (Hunter, McGill, Bosanquet & Johnson, 1997).

More importantly, a review of interventions to help support the carers of people with Alzheimer-type dementia concluded that it was not possible to recommend either wholesale investment in caregiver support programs or withdrawal of the same. The report goes on to make recommendations concerning future areas of research in order to clarify this important issue (Thompson & Thompson, 1999).

All of the interventions and supports listed above need to be done in concert with the various nongovernment agencies concerned with the people we are talking about. This includes the Alzheimer Society of BC their branches, Caregivers Association of BC, Advocates for Care Reform and similar organizations.

Footnotes

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APPENDIX 2.3

Family Support and Involvement Literature Review

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APPENDIX 2.4

Rehabilitation Activities — Psychosocial and Functional Literature

Appendix 2.4: Rehabilitation Activities — Psychosocial and Functional Literature Review

Introduction

Rehabilitation Activities — Psychosocial and Functional

Geriatric psychiatric disorders usually occur in the context of medical illness, disability and psychosocial impoverishment (Klausner & Alexopoulos, 1999). In the past, the management of psychiatric conditions in older adults was

sometimes based on misconceptions of the relations between the aging process and mental illness that led to a purely custodial approach to care without regard to rehabilitation or active treatment (Kim & Rovner, 1996). However, it is now understood that the identification of treatable aspects of the situation and the provision of interventions that support autonomy, are fundamental to meeting the needs of older adults with mental disorders. Although many older clients may be suffering from chronic, multiple or degenerative conditions that seem to be intractable, parts of the problems (e.g. adjustment to certain deficits, caregiver stress) can often be addressed that result in significant improvements for the person and/or their family (Zarit & Zarit, 1998). In this context, psychosocial rehabilitation can be viewed as supporting autonomy. Psychosocial rehabilitation in geriatric psychiatry promotes optimal performance in areas of cognition, interpersonal skills, self-care, leisure and utilization of community resources (Butin & Heaney, 1991) and is based on the premise that success in these areas is crucial to mental well-being.

Psychosocial rehabilitation models for use with elderly psychiatric patients have uniformly demonstrated positive impacts of the patients' well-being (e.g. Roth, 1994; Klausner & Alexapoulos, 1999; Bach, Bach, Bohmer, Fruhwald & Grilc, 1995; Butin & Heaney, 1991; Larkin, DelGrosso & Robbins, 1992). Various approaches have been incorporated into these psychosocial rehabilitation programs, including behavioral approaches, cognitive-behavioral approaches, family systems perspectives, psychotherapy (family, individual and group), biofeedback and psychosocial educational skill building. There is ample evidence to support the use of these therapeutic strategies with older adults (e.g. Dick, Gallagher-Thompson & Tompson, 1996; Knight, 1996; Gilleard, 1996) though there is less literature discussing or evaluating the educational components of these programs (Kelly, 1993). The identification of common problems and needs, the co-ordination and collaboration between available services/programs and the articulation of ways to assist clients in identifying

their own needs have been viewed as central to rehabilitation process. Of utmost importance is the emphasis on supporting autonomy through minimum intervention whenever possible as this supports continued independence, maximizes the choices of the older adult and assures they have the opportunity to make decisions consistent with their own values (Zarit & Zarit, 1998).

The American Association of Retired Persons (AARP) recommends that "we view mental health care — just as we view physical health care — along a continuum from promotion of good mental health to treatment of serious illness" (AARP, 1994a, 2). This reflects the philosophy that one of the goals of mental health services is to help older adults find pleasure and meaning in their lives, use appropriate supports and retain or assume as much control over their lives as possible (Waters, 1995). There are many circumstances under which elderly persons may come into contact with the mental health care system. Some will have long-standing mental health problems. Others will have conditions that manifest in late life (e.g. dementia) and others will benefit from short-term interventions designed to enhance competence, self-esteem and a sense of well-being, typically in relations to life adjustment (e.g. with certain medical conditions, facing a particular stressful circumstance). Since there is ample documentation that most older adults do not use traditional mental health settings, in part because of the stigma many older adults attach to mental health care (Gatz & Smyer, 1992; Kent, 1990), psychosocial rehabilitation programs designed to help older adults cope with transitions and losses (e.g. Perlstein, 1992; Stroebe, et al, 1993; Reiss & Gold, 1993; Sotile & Miller, 1998) of an educational or short-term nature may be provided as workshops or in collaboration with agencies in a variety of settings, including doctor's offices, seniors' centres, neighborhood or community centres, religious organizations or educational institutions. This integration of mental health services within community-based agencies ensures appropriate access to appropriate services.

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Appendix 2.5: Environmental Milieu (Housing) Literature Review

Housing is both a fundamental right and a critical determinant of a person's health. In this review we are less interested in the housing, per se, than in the environmental milieu (the psychosocial interactional environment) in which

clients live and care is provided. An underlying assumption of this review is that a strong emphasis on psychosocial rehabilitation principles should underpin all services provided to elderly persons with mental health problems, wherever they reside.

The majority of older adults with mental health problems live in their own homes, with or without family, or in long term care facilities. They receive home supports and institutional care through continuing care services. A smaller number, primarily those with chronic mental illnesses, live in supported housing, such as mental health residential facilities. Literature pertaining to each of these housing options will be reviewed. Issues related to the environmental milieu in which elderly people with mental health problems live will then be discussed. Finally, the role of mental health services in fostering environments conducive to good mental health and quality of life will also be presented.

Independent Living

The essential mental health services required to address the needs of elderly persons with mental health problems living in their own homes are well described in the "Guidelines" as: diagnosis of difficult cases; development of treatment plans; assessment relating to legal matters; consultation to community resources; education and training (Health and Welfare Canada, 1988, 15-16; See Appendix 1.17: Excerpt: *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders*). These services are best delivered by interdisciplinary outreach teams that can visit clients in their own environment, where they are most likely to function at an optimal level.

Health and Welfare Canada (1993) has developed guidelines for services specifically for elderly people with mental health problems living in their own homes. They outline the continuum of generic and specialized services to meet the mental health needs of elderly persons living

at home and discuss the many issues involved in delivering services.

A particularly vulnerable subpopulation is that of marginally competent people living alone, sometimes “at risk”. Ongoing assessment of the balance between their desire to remain at home and potential safety issues is a complex task that needs to be undertaken. The home support services provided to these individuals are crucial to facilitating their autonomy. A high importance is necessary in addressing the needs of these clients.

The Vancouver Older Adult Mental Health Working Group, in *Redesigning Vancouver Older Adult Mental Health Services* (2000), has identified a broad range of issues and strategies related to home support services for individuals living in the community in their own homes. The need for home support services that focus on the psychosocial needs of clients and the need to supervise clients who are taking medications stand out as especially pertinent issues.

Table 2.5.1 (on page 145) summarizes the key issues with respect to home support services as identified in *Redesigning Vancouver Older Adult Mental Health Services* (2000).

Supported Housing

The best practices for supported housing and residential housing have been well documented in the best practices Housing report[1]. Although this report focuses primarily on younger adults with mental health problems, it is equally applicable to elderly persons with mental health problems who are “aging in place” in these settings.

This report also acknowledged the specialized service needs of elderly persons with mental health problems. Page 46 of the report identifies the following issues as key with respect to the elderly:

Table 2.5.1: Community Services

Least restrictive — *Individuals living in the community who can and would like to continue to live independently, but who require support to do so.*

Issue	Strategy
Home Support Services Home support services raises a number of issues for older adults: • Lack of knowledge on the part of home support workers of the older adult population. • Frequent change of workers. • Limited recognized task base that does not include the provision of social support when, in fact, many older adults lack family or other forms of social support. • Lack of a system-wide process to deal with the growing number of individuals referred for home support whose needs span the mental health and community home support mandates. • Lack of venue for policy discussions to take up regional issues.	• Develop a consistent yet flexible client-directed process between mental health and CHS and CHA's to more effectively process referrals for individuals whose needs span both areas of service. This includes access to service appropriate to needs and to consider system-wide funding issues that arise in the provision of service. • Establish a continuous, system-wide policy review process to ensure that home support services to older adults with mental health problems meet their needs; that the same services are accessible to older adult clients across the region; and to consider system-wide funding issues that arise in the provision of service. **Reallocation** • Enrich and increase current educational opportunities for home support workers who have an interest in specializing in home support for older adults.Training opportunities to include working with older adults who misuse drugs and alcohol. • Increased flexibility in the provision of home support, e.g. visits of less than one hour. • Allow increased hours based on client's need for social time and/or for an identified need to monitor client's well-being. **Increased capacity** • Possible increase in home support workers to provide services noted below.
Medication Monitoring • Arrangements for ongoing medication support are limited. Without this support, many older adults are often unable to live independently/ safely in the community and must move to a more supervised setting.	**Co-ordination** • This is a significant issue that requires a review by a special task group/committee.

Issues

- Planning for elderly services must differentiate the needs of individuals who have a mental illness and are aging in place from those of individuals with psychogeriatric concerns.
- Elderly people with mental illness in continuing care facilities may be victimized or may be aggressive themselves and put others at risk.
- Continuing care facilities are too large to appropriately serve individuals with a mental illness and staff do not have the specialized training and knowledge to serve this population.
- Elderly people with mental illness are sometimes not accepted for admission to continuing care facilities because of their behavior.
- Elderly people in mental health housing do not receive adequate support to age in place and suffer unnecessary housing disruptions.
- Elderly people are frequently sent to hospital and remain there because of a lack of short-stay crisis beds to deal with psychiatric and medical concerns.

Suggested Actions

- Make funding available to develop smaller, homier facilities that could serve elderly individuals with a mental illness (e.g. the Adards Home model in Tasmania).
- Provide training and education for staff in continuing care facilities to support their knowledge of mental illness and their ability to manage behaviors.

- Develop supported housing options specifically for seniors with design features that will promote and support aging in place.
- Health authorities develop a short-stay crisis capability specifically for the elderly.
- Health authorities review the level of home support available to older persons to ensure that they are maintained in their own homes as long as possible.
- Health authorities promote aging in place by ensuring funding to provide added care services during serious illness and to provide palliative care.

In the strategic plan for housing services, the Vancouver/Richmond Health Board (2000) describes a range of residential housing options (e.g. supported housing, residential services, emergency/crisis stabilization housing) to address the various needs of subpopulations of seniors.

Of particular interest are supported hotels to serve individuals who by virtue of lifestyle and personality factors (e.g. alcoholics), do not fit into generic housing services. Table 2.5.2 (on page 148) is excerpted from the Vancouver Older Adult Working Group document *Redesigning Vancouver Older Adult Mental Health Services* (p. 28).

The supportive housing needs of seniors generally have been addressed by the Supportive Housing Review Steering Committee, which is made up of provincial, municipal and regional and health authority representatives (Ministry of Health and Ministry Responsible for Seniors, 1999).

This committee, using input from consumers, health care professionals, senior citizen counsellors, representatives of local government planning departments,

Table 2.5.2: Housing

Issue	Strategy
Supported Living — Individuals living in BC Housing or other nonprofit housing.	
Home Support Service • Lack of continuity of staff. • Lack of flexibility in buildings. • Lack of meal service. • Lack of ongoing medication administration or followup.	**Reallocation** • Utilize block hours for service, i.e. specific home support staff attached to buildings who are known to tenants, caretakers and other service providers. • Block hours allow home support workers to provide service based on the changing needs of tenants. **Increased Capacity** • Enrich services available to older adults by forming partnerships to provide on-site services, e.g. community kitchens, bridging to social activities, mental health outreach, medication followup.

community-based organizations and housing providers, found that "the role of supported housing in a community is best expressed in terms of a social model of health, that is, health is primarily a function of being a participating and respected member of the community" (p. 17).

Key policy issues identified by the Supportive Housing Review Steering Committee (see Appendix 1.18: Excerpt: *Supportive Housing in Supportive Communities: The Report on the Supportive Housing Review*, available at http://www.hlth.gov.bc.ca/cpa/publications/housing.pdf) are relevant to the needs of elderly persons with mental health problems living in the community. The policy issues examined were: factors that make a community more supportive to seniors; the links between supportive housing, health care and home support services; consumer protection; aging in place; affordability; assistance required by individuals and groups to develop supportive housing; and emergency housing.

Gnaedinger & Schiff (1997) investigated in a national study the extent to which municipal housing providers are concerned about tenants with

dementia, the steps they are taking to address their concerns and the barriers they face in making policy and physical environment changes. They found housing providers are aware and concerned about tenants with dementia and make efforts to maximize their quality of life, while ensuring safety and security.

Facility Care

When elderly persons with mental health problems cannot continue living in their own home, housing/care is best provided in the long term care facilities available to all older persons requiring care through Continuing Care.

Guidelines for establishing standards for services to elderly people with mental health problems in long term care facilities have been developed by Health and Welfare Canada (1988, p. 17). The needs of many of these individuals can be met in a long term care facility quite well if an adequate number of appropriately trained staff are provided.

The Vancouver Older Adult Mental Health Working Group, in *Redesigning Vancouver Older Adult Mental Health Services* (2000), has identified a broad range of issues and strategies related to services for individuals living in long term care facilities. Table 2.5.3 (below) is extracted from this document (pp. 28-30).

Table 2.5.3: Facility Placement — Nursing Homes

Issues	Strategy
Facility Placement • Elderly residents in mental health facilities are unable to age in place because of limited accommodation appropriate to their needs. • Current staffing ratios do not allow for adequate and flexible staffing to meet the needs of older adult residents. • Physical plant barriers make care difficult and/or unsafe. • Funding is inadequate for costs such as incontinence supplies.	**Reallocation/Increased Capacity** • Review existing facilities to identify additional facility that could be renovated to meet the needs of older adults, thus deferring placement into the long term care system. • Develop and fund flexible staffing models to provide care as needed in mental health facilities. • Ensure that the funding structure for mental health facilities is equivalent to the continuing care system for incontinence and other needed care supplies

Table 2.5.3: Facility Placement — Nursing Homes continued

Issues	Strategy
Nursing Homes • Increasingly frail, cognitively impaired people require nursing home care. Of the seven per cent of older adults who currently live in long tern care nursing homes, many have some dementia or depression and/or behavioural problems that require psychiatric assessment and treatment.	• Improve staffing levels to reflect increasing complexity of elders in long term care. • Alter care leveling to reflect group of people between ICIII and EC who require increased sophistication of care by virtue of their behaviour. • Establish base-line competencies and standard education/certification for care aides that reflects person-centred care/mental health issues. • Encourage gerontology certificates for nurses in residential care. • Improve training health care team re: mental health issues and issues of person-centred care. • Provide staff with work environment which supports and reinforces information learned. • Encourage development of care in facilities which brings decision making re: care as close to the resident as possible.
• Need for creation of homey environment, reducing boredom, loneliness and helplessness.	• Focus on person's remaining abilities. • Create a biomedical-diverse environment that incorporates community and family members in its day to day functioning • Individualize care strategies. • Encourage staff's knowledge of the people they are caring for. • Involve families actively in care planning throughout stay in nursing home. • Support families' emotional needs throughout relative's stay in nursing home. • Diversity of cultures amongst care staff and residents creates challenges for mutual respect and understanding.

Some individuals may have very challenging behaviours (sexual inappropriateness, aggression, wandering) that are difficult to manage in most congregate settings. These individuals may require extra support by trained staff and a specially designed environment in order to be cared for in generic long term care facilities. The need for modification in long term care facility design for elderly persons with a dementia have been well documented (Health and Welfare Canada, 1987; 1991; Tooth, 1989). The behaviours that facility staff find most difficult to manage in congregate settings have been identified in a study by Dr. Gloria Gutman (1995) and strategies for caring for this special group are suggested in the report. In some instances, specialized tertiary care resources may be needed to house very behaviorally complex individuals (discussed under tertiary care in this document). An enhanced special care unit for severe behavioral disorders related to dementia has been described in the *Strategic Plan for Housing Services* (Vancouver/Richmond Health Board, 2000).

Environmental Milieu Promoting a Culture of Caring

It has been suggested that the psychosocial environment of some long term care facilities and boarding homes is not conducive to meeting the mental health needs of elderly people and can, in fact, promote mental health problems. Social isolation in long term care facilities is eloquently described by seniors who participated in a British Columbia research project about living in these facilities (Association of Advocates for Care Reform, 1997).

Dr. Liz Drance (see Appendix 1.11: Working Towards Quality of Life in Nursing Home Culture) has identified barriers to developing person-centred care in long term care facilities that arise from the acute care/medical model from which facilities have evolved. She suggests that only when the client is first understood as an individual with unique needs and values can we hope to provide person-centred care. She makes a number of suggestions to foster a culture of caring

that facilitates optimal mental health and quality of life in facilities: shift to a person-centred model of care; focus on clients' strength and assets rather than deficits; and address the needs of families and paid caregivers in order to create a person-centred environment.

It seems evident that a major shift away from a biomedical approach to caring for elderly people with mental health problems and towards a psychosocial approach must be undertaken. This would necessitate significant training of service providers (e.g. general practitioners, health care professionals, paraprofessionals) in terms of knowledge and skills. It will also require an expansion of the range of services provided to clients in their homes and in facilities such that their psychological and social needs are identified and addressed. This will necessitate the inclusion of a wider variety of disciplines and perspectives than is presently the case to provide care, to train staff and to develop programs.

In an effort to create a more person-centred system, the Continuing Care Division, which provides in-home support and facility care to the elderly, has recently reviewed their services in British Columbia. Some of the challenges in the current system that were acknowledged by the Continuing Care Review Steering Committee were: an inflexible philosophy and approach; barriers to empowering clients and caregivers; inadequate staff numbers; insufficient education and training for service providers; and insufficient support for caregivers (see Appendix 1.15: Excerpt: *Community for Life*).

In order to promote and foster a culture of caring for individuals both living in the community and in facilities, the steering committee identified a guiding vision, values and principles for continuing care services (see Appendix 1.15). The vision identified is: "Individuals have the support and health services they need to live fully and independently or interdependently as valued members of their community" (p. 24). In the new continuing care system, people are valued;

therefore, providers are respected, recognized and supported by the system. The guiding principles that establish expectations for how continuing care services will be designed, funded, operated and evaluated were also identified by the steering committee (p. 25).

If the new culture envisioned by the Continuing Care Review Steering Committee is adopted, it will promote positive mental health for all seniors and will facilitate and enhance the care of clients/residents with mental health problems. Of particular importance in enhancing the feasibility of maintaining psychogeriatric clients in their homes are the following priorities for action that have been set out in the continuing care review document (p. 30):

- Acknowledge and support caregivers in the community.
- Support service workers in their jobs.
- Ensure each community has a range of flexible housing options, including supportive housing.

Role of Mental Health Services

The role of mental health services is to provide direct and indirect services to clients and their caregivers and care providers so that clients can be maintained optimally in their homes, be they residing in their personal dwelling or a long term care facility (Health and Welfare Canada, 1990).

The *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* (Health and Welfare, 1988) identifies housing as a support need of psychogeriatric clients that is met in a variety of ways and is supported by mental health services directly and indirectly, (Health and Welfare, 1988, p. 18).

Some examples of how mental health can support the living situations of elderly people with mental health problems are as follows:

> *Mental health consultation should be provided to agencies and facilities to assist them to develop the appropriate environment and culture to meet the needs of psychogeriatric clients — this may relate to facility design, program design, etc.*
>
> *Mental health should provide specialized core and illness/issue-specific education and skills training for those who care for psychogeriatric clients (e.g. physicians, other health care professionals, paraprofessionals-professionals).*
>
> *Mental health should also provide specialized assessment and treatment to psychogeriatric clients and assist in developing individualized care plans with caregivers and care providers.*
>
> *Family caregivers should be provided with counselling, education and support groups to enhance their ability to care for psychogeriatric clients at home.*

To conclude, living in an environment that facilitates optimal mental health, quality of life and a "life", rather than remaining alive, is imperative to elderly people with mental health needs. It is possible to provide a positive evironmental milieu in a variety of settings. Mental health clinicians and services have an important role in developing and supporting such environments.

Footnote

[1] Ministry of Health and Ministry Responsible for Seniors (2000): *B.C.s Mental Health Reform — Best Practices*, Victoria, Province of British Columbia.

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Appendix 2.6: Quality Improvement Literature Review

Quality Improvement (QI), as defined by D.M. Berwick and supported by the Canadian Council Health Services Accreditation, is:

> An organizational philosophy that seeks to meet clients' needs and exceed exceptions with a minimum of effort; rework and waste, by using a structured process that selectively identifies and improves all aspects of care and service on an ongoing basis.

- Quality improvement encompasses all systems of heath care and focuses on changing PROCESS to improve patient/client outcomes.
- Reasons for becoming involved with improving care include:

- Studies currently documented that physicians and other health care practitioners frequently miss problems in older adults, e.g.:
  - malnutrition in nursing homes;[1,2]
  - delirium by E.R. physicians;[3]
  - moderate impairment in cognition, nutrition, vision and continence in 46 to 73 per cent;[4]
  - undernutrition by 65 per cent;[5] and
  - inappropriate use of major procedures.[6,7]
- Health care budgets being restricted and seniors at risk.[8]
- Many TQM (Total Quality Management) techniques developed, refined and available.[9, 10, 11, 12]
- Similarities between techniques and philosophy of TQM and modern geriatric care (e.g. client-focus/driven; interdisciplinary care).[13, 8]
- Important characteristics in Quality Improvement include focuses on:[8]
  - systems rather than individuals;.
  - improving mean functioning rather than punishing outliers;
  - interdisciplinary team problems solving; and
  - data, rather than opinion or tradition to drive decision making.
- Some conditions amenable to QI from survey of practicing geriatricians (prioritized out of top 10), include:[14]
  - dementia (home care #3; office practice #3; hospital #9; nursing home #8);
  - depression (home care #8; office practice #2; nursing home #6);

  - polypharmacy/compliance (home care #3; office practice #7; hospital #3; nursing home #5).

- Critical factors for successful implementation of Quality Improvement programs (prioritized) include:[14]

  1. To Improve Care
     - Leadership.
     - Building local commitment.
     - Incorporating patient preference into program, design and decisions.
     - Using outcome to improve processes.
     - Management and planning.
     - Developing and using practice guidelines.
     - Team member selection.
     - Team building (QI teams).
     - Access to statistical resources.
  2. Special Training
     - Using outcomes to improve processes.
     - Team building.
     - Leadership.
     - Management and planning.
     - Incorporating patient preference into program, design and decisions.
     - Developing and using practice guidelines.

- Access to statistical resources.
- Building local commitment.
- Team member selection.

- Suggestions for promoting effective quality improvement include:[8, 14]
  - Co-operative effort among relevant professional organizations to develop and disseminate QI.
  - Establish cadre of experienced QI practitioners to lead above.
  - Include training re: QI in professional education programs.
  - Maintain clearing house of successful programs.
  - Conduct QI research.
  - Develop validated needs assessment protocols.
  - Consider electronic list server or chat room to enhance interaction.
- Some effective examples of quality improvement activities include:
  - Identification of only seven per cent of targeted geriatric conditions (cognitive impairment depression and recent weight loss) recognized in OP; department; education and information instituted; increase of newly-identified problems in 30 to 55 per cent of cases.[15]
  - In rural family practitioners' offices, increase of 40 to 100 per cent of newly-identified problems using same intervention (education and information).[16]
  - Short-screening instrument for identifying eight geriatric problems in office settings.[17]

- Targeting older medical outpatients for comprehension geriatric assessment and treatment using the pre-screening instrument.[18, 19]
- Identification of group of frequent users (abusers) of OP; innovative, nontraditional program; decrease repeat hospital admission and emergency care use; decrease total cost of care; and increase patient and physician satisfaction.[20]
- Nursing homes have demonstrated multiple improvements, such as:
  - Feedback system for physicians, reducing both psychotropic drug and inappropriate medication use.[2]
  - Monthly monitoring by interdisciplinary liaison, with comparison to other facilities.[21]
  - When quality indicator deviates, further information caught (although there may be many causes, one or two indicators of causation will account for majority).[11]
  - Team approach successfully reduced physical restraint usage (from >40 to <5 per cent).[22]
  - Development of Geronto (diagram of a person) allows rapid interdisciplinary communication (done in French nursing homes, but has been successfully utilized in subacute care unit).[23]
  - The Eden Alternative, with animals, plant and team approach to problem solving, has been associated with decreased infections, decreased deaths, decreased staff turnover, high level of quality of life and less depression.[24]
- The underlying principles of Quality Improvement, as supported by council, include:

- Knowing whom we serve — our client.
- Concentrating on what we do to achieve intended results — our processes and outcomes.
- Involving those who carry out processes — our teams (interdisciplinary and front line).
- Encouraging, facilitating and guiding as major role of leaders.
- Continuously striving to make things better — CQI.

- The dimensions of quality (as proposed by the CCASA AIM 26 2000 Project) include:
  - responsiveness;
  - system competency;
  - client/community focus; and
  - worklife.
- The Canadian Council provides the following direction in relation to Quality Improvement activities:[25]
  - Board's role to provide direction re:
    - where to focus;
    - what should be monitored corporate-wide;
    - where the information should go; and
    - how the information should be used.
- The board works with management to set up an accountability framework to:
  - Ensure there is a reporting system.

- Ensure that there are adequate information systems.
- The following is included in a reporting system:
  - Processes are selected in priority order for monitoring and improvement.
  - Indicators (measures) of performance are identified.
  - Efforts are made to improve the selected processes.
  - Quality improvements are maintained through ongoing monitoring, evaluation and implementation of necessary change.
- Assessing and actioning risk is very important with risk defined as:
  - Exposure to any event which may jeopardize the client, staff, physician, volunteer, reputation, net income, property or liability of the organization.
- Assess risk with the following criteria:
  - How serious is the risk?
  - How many people are affected?
  - How often does it occur?

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APPENDIX 2.6

Quality Improvement Literature Review

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APPENDIX 2.7

Service and Program Evaluation Literature Review

Appendix 2.7: Service and Program Evaluation Literature Review

Canada's population is aging and a disproportionate number of people over the age of 65 suffer from mental illness, particularly from dementia and depression. This vulnerable population often has concurrent social, physical, intellectual, functional and environmental needs, in addition to its mental health needs.[1-8] It is essential to ensure that the limited mental health resources available for the elderly are adequately meeting their needs and those of their families and of the community. However, the diversity of mental health services available for the elderly, ranging from specialized psychiatric inpatient units to community outreach programs, and the lack of systematic evaluations of these services, make it difficult to draw any definitive conclusions as to their effectiveness.[9-16]

To evaluate any program it is important to have a clear idea of what the program set out to do: without identifying specific, measurable goals, outcome evaluation becomes difficult and the validity of the results may come into question.[17] When evaluating program or patient outcomes, one must also identify from whose perspective those outcomes are being measured;

the care provider, the patient, the patient's family and the community all have an interest in and a perspective on the outcomes of a given health care service.[8,12,15,18-22] The decision to use self-reporting, professional reporting, performance-based measures, objective data (such as hospital admission rates or length of stay) or a combination of these, will depend on the way in which the outcome data is to be used, as well as on the clinical setting and on the feasibility of administering the test or collecting the data.[18,23] Having patients identify and/or prioritize variables to be measured and making use of multidisciplinary collaboration in selecting or designing an outcome assessment tool can help maintain a relevant focus to the evaluation; the variables clinicians use to make judgments may differ from those variables which influence patients' self-perception.[18,20,24]

One of the problems cited both in evaluating individual services and in attempting to compare different programs is the lack of consistent and clearly defined outcome criteria, without which meaningful outcome evaluation is impossible.[10,14,15,25] Commonly-selected variables include hospital and long term care facility admission rates; caregiver and referring agent satisfaction; caregiver stress or burden; patient physical, cognitive and functional impairment; quality of life and cost.[6,7,11-14,16,21,25-30] One of the easiest variables to measure and to document quantitatively is hospital and long term care admission rates, but these are as much related to the ability and the availability of a caregiver in the community as they are to the involvement of a geriatric psychiatry service.[29] A 1993 study on outcomes in a geriatric outpatient setting found that social factors, particularly caregiver burden, were better predictors of admission than were the physical or mental health or degree of disability of the patient.[31]

Most geriatric psychiatry programs serve primarily elderly people living in the community, which means relying on informal caregivers, often spouses or children.[15] The relationship between the depressed elderly patient

and their caregiver has been shown to be directly related to prognosis — a poor relationship predicts a poor outcome.[26,32] Thus, to evaluate the effectiveness of these programs, it is necessary to recognize the tremendous impact of psychiatric illness or dementia on the patient's family or caregiver, and to measure caregiver outcomes in addition to patient, program and system outcomes.[15,19] Caregiver perception of the usefulness of the service, caregiver satisfaction and level of caregiver stress are all factors that have been considered, but the data is inconsistent. Potter, et al, in 1993 demonstrated that caregiver burden was an important predictor of patient outcome. Gilleard, et al, in 1995 demonstrated that it was not. In 1996, Melzer, et al, found that there was no correlation between two accepted methods of measuring caregiver burden. This illustrates one of the difficulties of evaluating geriatric psychiatry services: there is no universally accepted way of determining what to measure or how to measure it, making it exceedingly difficult not only to evaluate a program, but also to evaluate a program evaluation!

Banerjee and Dickenson (1997) reviewed evidence-based health care in old-age psychiatry. They noted there has been a tendency for drug studies to focus on younger adults and, even if done in seniors, studies are done in uncomplicated patients, seldom seen in real clinical settings. They also note nondrug therapy is seldom analyzed. They speak to the importance of looking at effectiveness, not just efficacy in therapies, and support the Cochrane Collaboration efforts in this regard.

We clearly need more research in all aspects of mental health care for the elderly. Perhaps a simple place to start in British Columbia is to be able to define our own present practices in common language so we can begin to cross compare amongst ourselves and with the "written evidence".[36]

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Annotated Bibliography

"Outcomes in a Geriatric Psychiatry Outpatient and Outreach Service: What are Appropriate Variables for Measuring Outcome?"

#2: *Greenwald, B.S., Kremen, N. and Aupperle, P. "Tailoring adult psychiatric practices to the field of geriatrics". *Psychiatric Quarterly* 63:4 (1992): 343-363.

*The aging of the American population and the high incidence of mental illness among the elderly have contributed to the recent development of the subdiscipline of geriatric psychiatry. Greenwald provides an overview of the interface between medicine and psychiatry in the elderly, including delirium, dementia, depression and geriatric psychopharmacology, noting that depression and dementia are the two most commonly encountered conditions in geriatric psychiatry [*Greenwald 1992]. Jenicke's article reviews pertinent aspects of diagnosis and treatment in geriatric psychiatry [*Jenicke 1996], while Roughan focuses on the interplay between sexism, ageism and mental illness in elderly women [*Roughan 1993]. The situation in Canada is comparable to that in the United States and the fact that the mentally ill elderly

often have concurrent social, physical, intellectual, functional and environmental needs underlines the importance of a multidisciplinary approach [*LeClair 1997].

#5: Wasylenki, D. "The psychogeriatric problem". *Canada's Mental Health* 30 (1982): 16-19.

Canada has one of the highest rates of institutionalization in the western world and many of those placements are inappropriate. There is a need for more and better community and home care services. Elderly people generally prefer to be treated in their homes and displacing them can lead to confusion, anxiety and depression. Depression is the most common functional disorder in the elderly population and left untreated it is a common precipitant of decline in physical health and a common cause of premature admission to long term care facilities. Dementia is also common in the elderly and, although it is not treatable, its severity is frequently determined by the interaction of physical, social and psychological factors.

#6: Harris, A.G., Marriott, J.A.S. and Robertson, J. "Issues in the evaluation of a community psychogeriatric service". *Canadian Journal of Psychiatry* 35:3 (1990): 215-222.

A hospital-based community psychogeriatric outreach outpatient service in Hamilton conducted an evaluation over a two-year period. Demographic and diagnostic data collection revealed a 2:1 female:male ratio and a significantly greater proportion of widows than of widowers. Nearly half of the patients suffered from organic mental disorders and approximately one-third suffered from affective disorders, particularly depression. A poor response rate for the user survey made it difficult to evaluate, but the majority of patients, families and referring family physicians who responded were satisfied with the service.

#7: Bedford, S., Melzer, D., Dening, T., Lawton, C., Todd, C., Badger, G. and Brayne, C. "What becomes of people with dementia referred to community psychogeriatric teams?" *International Journal of Geriatric Psychiatry* 11 (1996): 1051-1056.

Four multidisciplinary community psychogeriatric teams in Cambridge, England, selected survival, institutionalisation, key worker assessments of avoidable admissions, appropriateness of placement, unmet needs, carer stress and staff perception of global outcome for patients and carers as outcome measures for their programs. They found that demented patients were more dependent, received more community services, had more unmet needs and had higher rates of institutionalisation than did patients without dementia and carers of patients with dementia were perceived to be under more stress than others.

#8: Rogers, J.C., Holm, M.B., Goldstein, G., McCue, M. and Nussbaum, P.D. Stability and change in functional assessment of patients with geropsychiatric disorders. *The American Journal of Occupational Therapy* 48:10 (1994): 914-918.

The most common reasons for psychiatric admission for the geriatric population are depression and dementia. The ultimate outcome is in part dependent on diagnosis, but regardless of the disease, a major goal following psychiatric admission in the geriatric population is a return to independent community living. A comparison of patient self-ratings, informant (caregiver) ratings and performance test scores for patient functional assessment revealed that while patients tend to overrate their abilities, there is good correlation between informant rating scores and performance test scores. Caregivers of patients with dementia or major depression are able to accurately assess the patients' functional ability and their input may be useful in planning patient management.

#9: Cole, M.G. "Effectiveness of three types of geriatric medical services: lessons for geriatric psychiatric services". *Canadian Medical Association Journal* 144:10 (1991): 1229-1240.

Due to the lack of controlled clinical trials evaluating the effectiveness of geriatric psychiatry services, Cole reviewed evaluations of geriatric medical services and drew parallels between the two, based on the similarity of their patient populations. The only services which had clearly positive outcomes were external services that provided continuing care. By analogy, geriatric psychiatry programs should concentrate their resources on community-based services and continuing care.

#10: Burvill, P.W., Stampfer, H.G. and Hall, W.D. "Issues in the assessment of outcome in depressive illness in the elderly". *International Journal of Geriatric Psychiatry* 6 (1991): 269-277.

The focus of outcomes measurement in geriatric psychiatry needs to shift from the descriptive to the quantitative and statistical, with an emphasis on precisely defined outcome criteria and the use of standardized instruments. Relapse and chronicity in depression highlight the problems of determining the length of followup and defining a positive outcome; a comprehensive range of outcomes is needed to distinguish between patients with different duration and severity of symptoms and frequency of relapse.

#11: Houston F. Two year follow-up study of an outreach program in geriatric psychiatry. *Canadian Journal of Psychiatry* 28 (1983): 367-369.

A psychogeriatric outreach program in Hamilton, Ontario, mailed questionnaires to its referral sources and monitored the hospital admission rates of its patients over a two-year evaluation period. The majority of the referring sources felt that the assessment provided by the team had been helpful for the patient or for themselves and fewer than 25 per cent of the patients in the outreach program were admitted to hospital.

#12: Seidel, G., Smith, C., Hafner, R.J. and Holme, G. A psychogeriatric community outreach service: description and evaluation. *International Journal of Geriatric Psychiatry* 7 (1992): 347-350.

Evaluation of a psychogeriatric community outreach team in Australia was based on changes in patient behavioural disturbance and carer and referring agent perception of the usefulness of the service. Carer and referring agent scores correlated highly, with 80 and 87per cent of the respective groups finding the service helpful or very helpful. Behavioural disturbance scores improved significantly in the majority of patients for whom it was a problem; this measure was only used on those patients living in long term care facilities.

#13: Draper, B. The effectiveness of services and treatment in psychogeriatrics. *Australian and New Zealand Journal of Psychiatry* 24 (1990): 238-251.

There is an increasing demand in Australia for specialized psychogeriatric services, but little formal evaluation of these services is available. Integrated programs with a continuum of care from community-based services to inpatient hospital care offered elderly patients the best outcome. Three important factors were found to be common to most community services: 24 hour service, continuity of care and availability of day care. However, outcomes are often measured in terms of acute and long term hospital admissions; this is an inadequate measure of outcome for psychogeriatric services. Early intervention, respite care, ongoing provision of help to families and patients, and prevention of secondary emotional disabilities are all important features of a psychogeriatric service.

#14: Warrington, J. and Eagles, J.M. Day care for the elderly mentally ill: Diurnal confusion? *Health Bulletin* 53:2 (1995): 99-104.

There is little evidence of the effectiveness or efficiency of day care for the elderly mentally ill for patients, caregivers or their communities. This stems both from the fact that little research has been done and from the poorly-defined goals of day care programs, making outcome evaluation difficult. Suggested outcome goals include prevention of physical and mental deterioration, respite for caregivers, aftercare for recently discharged inpatients and the saving of hospital beds. While there is some evidence that behavioural modification and reality orientation in day care programs have decreased problem behaviour in the demented elderly,

there is no evidence that day care is effective for the elderly functionally ill. One of the more widely-accepted goals of day care programs is to prevent institutionalisation, but there is considerable evidence that this is not the case.

#15: Stolee, P., LeClair, J.K. and Kessler, L. "Geriatric psychiatry outreach services: Principles and practice in Canada". *The Gerontologist* 30 (1990): 10A.

The Canadian consensus statement on geriatric psychiatry emphasizes the need for a comprehensive approach in terms of target population, method of mental health consultation and location of service delivery. In spite of this recommendation, many existing geriatric psychiatry programs are targeted at one component of the system, such as community caregivers or patients in long term care facilities.

#16: Kujawinski, J., Bigelow, P., Diedrich, D., Kikkebusch, P., Korpan, P., Walczak, J., Maxson, E., Ropski, S. and Farran, C.J. "Research considerations Geropsychiatry unit evaluation". *Journal of Gerontological Nursing* 19:1 (1993): 5-10.

Studies have demonstrated that elderly inpatients on specialized geriatric medicine wards have better outcomes than do similar patients on regular medical wards, but no studies have evaluated the effectiveness of geriatric psychiatry wards. Evaluation of 57 patients on a geriatric psychiatry inpatient unit, of whom the majority were female, suffering from major depression, and had concurrent, multiple medical diagnoses, showed improvement in cognitive and functional status in the majority of patients following discharge. The Mini Mental Status Examination and the Geriatric Psychiatry Nurse Rating Scale were used to monitor the outcome variables.

#17: Health Services Research Group. "Program evaluation in health care". *Canadian Medical Association Journal* 146:8 (1992): 1301-1304.

Systematically collecting information about a health service program allows physicians and others to demonstrate which services are effective and efficient, both in terms of whether the program is having its desired effect and whether it is doing so at a reasonable cost. One of the challenges of evaluating a program is having a clear idea of what the program set out to do: without identifying specific, measurable goals, outcome evaluation becomes difficult and the validity of the results may come into question.

#18: Feinstein, A.R. "Benefits and obstacles for development of health status assessment measures in clinical settings". *Medical Care* 30:5 (1992): MS50-MS56.

Decisions as to who will choose what to measure, who will measure it and how it will be measured all make the process of developing a health measurement scale a difficult one. By identifying a specific purpose, avoiding excessive numbers of variables and allowing patient and multidisciplinary participation in the selection and design of the scales, these difficulties can be minimized.

#19: Agbayewa, M.O. "The Relevance of Outcome Measurement for Clinicians". *Canadian Psychiatric Association Bulletin* April (1997): 41-42.

Measuring outcomes can demonstrate the effectiveness of an intervention, measure patient progress, identify factors that influence outcome and contribute to an understanding of a disease and its treatment. To evaluate the effectiveness of treatment, one must evaluate the patient's subjective experience in terms of their quality of life and level of functioning within their environment. Similar factors can be applied to caregivers, as many patients present to a psychiatrist not because of their subjective distress but due to the caregiver's or family's inability to cope. Regardless of what it is measuring, a good tool will be valid, reliable, sensitive and usable.

#20: Elbeck, M. and Fecteau, G. "Improving the validity of measures of patient satisfaction with psychiatric care and treatment". *Hospital and Community Psychiatry* 41:9 (1990): 998-1001.

In order to address the problem of validity in patient satisfaction surveys, a series of focus groups with inpatients in a provincial psychiatric hospital asked participants about what they felt constituted ideal care. A second group of patients prioritized the items generated by the focus groups and identified interpersonal relations with staff and the preservation of individuality as important factors. A survey was constructed based on these results. Using focus groups allowed the unit to develop a scale tailored specifically to the perspectives of the patient population instead of having patients rate aspects of their care that health care professionals felt were important.

#21: Melzer, D., Bedford, S., Dening, T., Lawton, C., Todd, C., Badger, G. and Brayne, C. "Carers and the monitoring of psychogeriatric community teams". *International Journal of Geriatric Psychiatry* 11 (1996): 1057-1061.

A substudy on the carer interviews from the 1996 Bedford study (see above) showed that while more than half of the carers showed signs of probable or definite psychological distress according to the general health questionnaire, only a small fraction of these were identified in the key worker assessment of carer stress. More than half of the carers felt that they had unmet needs and almost half felt the services offered by the psychogeriatric team were of poor

or moderate quality. As informal caregivers provide the bulk of support for elderly people with psychiatric disorders, their view on the services they receive are a critical element in evaluating the effectiveness of a program; it is, therefore, important to address the question of the validity of key worker assessment of carer stress.

#22: Tourigny-Rivard, M.F. and Drury, M. "The effects of monthly psychiatric consultation in a nursing home". *The Gerontologist* 27:3 (1987): 363-366.

Consultation by a geriatric psychiatrist in a Canadian nursing home over an 18-month period was useful to nursing home staff in that it increased their understanding and acceptance of psychiatric illness in the residents and increased the frequency of therapeutic programs offered at the home. However, few depressed patients referred to the consultation service showed substantial clinical improvement. Positive changes were primarily due to consultant-staff interaction, not consultant-patient interaction.

#23: Studenski, S. and Duncan, P.W. "Measuring rehabilitation outcomes". *Clinics in Geriatric Medicine* 9:4 (1993): 823-830.

The decision to use self-reporting, professional reporting, performance-based measures, objective data (such as hospital admission rates or length of stay) or a combination of these, will depend on the way in which the outcome data is to be used as well as on the clinical relevance of the measure and feasibility of administering the test or collecting the data. Having patients and caregivers identify and/or prioritize variables to be measured and making use of multidisciplinary collaboration in selecting or designing an outcome assessment tool can help maintain a relevant focus to the evaluation.

#25: Ramsay, M., Winget, C. and Higginson, I. "Review: Measures to determine the outcome of community services for people with dementia". *Age and Ageing* 24 (1995): 73-83.

A health care outcome is any result which is attributable to a health services intervention, but for it to be useful, it must be related to an achievable objective of the service being evaluated. Community services for dementia have often used admission to residential homes and hospitals as an outcome measure, but numerous studies have shown that such services do not reduce admission rates. This does not mean that they have no value, but rather that alternative objectives need to be explored and measured. Based on the goals of community services reported in the literature, there are a number of domains that ought to be covered in outcome measures for dementia. For patients these include personal self-care, activities of daily living, physical health, psychological well-being, cognitive decline, inappropriate behaviour, social functioning and satisfaction. For caregivers, physical health, psychological well-being, social resources, knowledge and skills, co-ordination and communication and satisfaction are all important.

#26: Gilleard, C.J. "Predicting the outcome of psychogeriatric day care". *The Gerontologist* 25:3 (1985): 280-285.

Four Scottish psychogeriatric day hospitals conducted a prospective study using a multivariate approach to evaluating the effectiveness of their program. Outcome measures selected, measured six months after patients' initial attendance, were: whether the patient was still attending, whether the patient was living at home or in long term care, the number of social service agencies currently in contact with the patient, caregivers' self-rated health status, the extent to which caregivers received additional help from other family members and the perceived disadvantages of having their dependent attend a day hospital. Results of the study showed that major self-care impairment, a high level of professional care input and a poor pre-morbid social relationship between the caregiver and the patient were all independent predictors of patient entry into long term care facilities. The level of stress reported by caregivers did not independently influence placement outcome and the more community support a patient received, the more likely they were to be institutionalised.

#27: Knight, B., Reinhart, R. and Field, P. "Senior outreach services: A treatment-oriented outreach team in community mental health". *The Gerontologist* 22:6 (1982): 544-547.

A geriatric psychiatry outreach team in California was developed based on the belief that a strong commitment to maintaining independence and provision of active treatment could reduce institutionalization among the elderly mentally ill. The team's goals included prevention of institutionalization by means of early assessment and intervention, co-ordination of community support services and increasing accessibility of services.

#28: Levy, M.T. "Psychiatric assessment of elderly patients in the home: a survey of 176 cases". *Journal of the American Geriatrics Society* 33:1 (1985): 9-12.

One hundred and seventy-six elderly patients referred for psychiatric evaluation were assessed at home. Home assessments were found to be useful because they enabled the clinician to directly observe the patient's living conditions and to develop a rapport with the patient in a familiar, nonthreatening environment. Home assessment resulted in ongoing home management in the majority of patients and in acute medical or psychiatric hospitalization, placement in a facility or no intervention in the others. As in other studies of the elderly mentally ill, the most common diagnoses were dementia and major depression.

#29: Warfon, M.F. and Shulman, K.I. "Community psychiatric services for the elderly: The Sunnybrook experience". *Canada's Mental Health* 35 (1987): 2-6.

A community outreach service for psychogeriatric assessment and treatment in Toronto provided home assessment, support for patients and caregivers, including telephone contact, information about resources and ongoing monitoring. The average length of service provided was six months and 60 per cent of cases were closed over a three-year period. Outcomes were measured in terms of admissions to long term care and acute medical and psychiatric hospital admissions: approximately 30 per cent of patients moved into long term care and 30 per cent required hospital admission. The difficulty of using admission as an outcome measure is that it may be as much related to the ability and/or the availability of a caregiver in the community as it is to the involvement of a psychogeriatric service.

#30: Wasylenki, D.A., Harrison, M.K., Britnell, J. and Hood, J. "A community-based psychogeriatric service". *Journal of the American Geriatrics Society* 32:3 (1984): 213-218.

Evaluation of a community psychogeriatric service in Ontario showed a high rate of satisfaction amongst consultees, most of whom felt that the service's recommendations were realistic and felt that they had acquired new information or a new skill as a result of the intervention. The majority of the consultees were nurses, either working in the community or in long term care institutions. Rates of institutionalization and change in mental functioning were also measured. Fewer than 20 per cent of patients were institutionalized and 80 per cent either maintained or improved their mental functioning. Of those whose mental functioning deteriorated, three quarters suffered from dementia.

#31: Potter, J.F. "Comprehensive geriatric assessment in the outpatient setting: population characteristics and factors influencing outcome". *Experimental Gerontology* 28 (1993): 447-457.

This prospective study of functional outcomes in the elderly assessed social, cognitive, affective, functional and physical health domains at presentation and at six and 12 months followup. Although primarily a descriptive study, it found that neither degree of disability nor measures of physical or mental health or functional ability were good predictors of long term care use. Social factors, particularly caregiver burden, were the only predictors of long term care admission, emphasizing the importance of addressing caregiver needs and the caregiver-patient relationship as a part of comprehensive geriatric assessment.

#32: Hinrichsen, G.A. and Hernandez, N.A. "Factors associated with recovery from and relapse into major depressive disorder in the elderly". *American Journal of Psychiatry* 150 (1993): 1820-1825.

Major depression is a common, treatable illness in the geriatric population, but it frequently

follows a remitting and relapsing course. All of the predictors of poor prognosis for complete recovery are directly related to the caregiver and their relationship with the patient; the demographic and clinical characteristics of the patient are did not predict recovery or relapse. This confirms the need for the clinician to be aware of caregiver concerns when treating a depressed elderly patient.

#33: Grams, G.D., Herbert, C., Hefferman, C., Calam, B., Wilson, M.A., Grzybowski, S. and Brown, D. "Haida perspectives on living with non-insulin-dependent diabetes". *Canadian Medical Association Journal* 155:11 (1996): 1563-1568.

Members of the Haida people participated in focus groups to explore their perspectives on non-insulin-dependent diabetes, which is increasingly prevalent in aboriginal communities. Six themes recurred in the discussions: fear; grief and loss; the loss of and desire to regain control; food and eating; physical and personal strength; and traditional ways.

#34: Grams, G.D. Rudiments in the process of conducting qualitative research: a working guide to "grounded theory". Unpublished working paper: University of British Columbia, July 1996.

This introduction to grounded theory and qualitative research provides a simplified, step-by-step explanation of how to proceed with the study design, data collection and data analysis stages of a qualitative research study, as well as guidance on how to present the final product of the study.

#35: Banerjee, S. and Dickinson, E. "Evidence Based Health Care In Old Age Psychiatry". Int'l J *Psychiatry in Medicine* 27:3 (1997): 283-292.

The purpose of this article is to present the current status and future needs of old age psychiatry in relation to evidence-based health care. The opportunities and difficulties of evidence-based medicine as applied to old age psychiatry are described. Depression is used as a specific example. The role of the Cochrane Collaboration and of clinical guidelines in dealing with these difficulties are discussed. There has been a tendency for drug studies to focus on younger age groups and to exclude patients with comorbidity or polypharmacy. Aspects of clinical management separate from drugs are given insufficient attention. The generalizability of current studies is a problem in old age psychiatry. Psychiatry is no less part of medicine than any other specialty. Increases attention to studies of effectiveness, as opposed to efficacy, is indicated. The Cochrane Collaboration

is an international network which promotes and conducts systematic reviews of the effectiveness of health care. Systematic reviews can increase the generalizability of the current knowledge base and better define the needs for future research.

Appendix 2.8: Health Promotion Literature Review

Mortimer (1995) argues convincingly that preventive interventions may well be possible for dementing illnesses. Nolan and Blass (1992) suggest a set of preventive interventions for dementia designed to maximize brain reserve and minimize brain damage. When dementia is viewed as the net result of a lifetime of growth and degeneration of the brain, prevention of dementia must be approached from a lifespan perspective and, as yet, there have been no systematic investigations of long-term effects of such interventions. However, the effectiveness of preventive interventions has already been clearly demonstrated (Gallagher & Thompson, 1981, 1983) for other mental health disorders, such as depression. These, and other preventive efforts, illustrate that the emotional and economic impact of successful preventive interventions can be profound for older adults in an aging society (Smyer, 1995).

Although the traditional public health perspective on prevention (i.e. primary, secondary, tertiary prevention) can be adapted for mental health, this framework is limited in that it is far more difficult to define a "case" in mental illness than in relation to physical disease. Further, social context plays an extremely important role in the prevention or presentation of a mental illness. In response to these limitations, Mrazek and Haggerty (1994) suggested a new spectrum of mental health interventions for mental disorders. This spectrum includes three major classes of intervention: prevention, treatment and maintenance. The two latter issues have been addressed elsewhere in this document.

In Mrazek and Haggerty's (1994) conceptualization, three types of prevention efforts are identified: universal prevention, selective prevention and indicated prevention.

In the mental health intervention spectrum, universal preventive interventions are targeted to the general public or a whole population group that has not been identified on the basis of individual risk....Selective prevention interventions for mental disorders are targeted to individuals or a subgroup to the population those risk of developing mental disorders is significantly higher than average....Indicated preventive interventions for mental disorders are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder but who do not meet DSM-III-R diagnostic levels at the current time....Indicate preventive interventions are often referred to by clinicians as early intervention or an early form of treatment (Mrazek & Haggerty, 1994, pp. 24-25).

According to Smyer (1995), this conceptual framework on preventive intervention is not sufficient for the development of an effective program on preventive intervention. In addition, it is necessary to include a component that reflects the interaction of the individual and their environment in producing a profile of risk for the development of the mental disorder. This then addresses the individual's level of vulnerability (i.e. genetic influences, acquired biological vulnerabilities and psychological factors that affect the individual's risk for the disorder) and stressors (both psychosocial and environmental). Greater vulnerability or greater stress or both affect the individual's risk of developing the disorder. In addition to addressing the individual's vulnerability and the interpersonal, societal and physical environments, Gatz, Kasl-Godley and Karel (1996) note that protective factors, whether biological, psychological or social, must also be included when considering the risks and probabilities of developing a mental disorder.

In identifying the necessary framework within which to consider interventions to prevent mental disorders among older adults, Smyer (1995) notes that there is still much work to be done in targeting the concerns of older adults. For example, our understanding of modifiable risk and protective factors for the development of mental disorders in late life must be expanded. Smyer (1995) notes that an initial focus on risk reduction — targeting known risk and protective factors — is the best available theoretical model for the development, implementation, and evaluation of interventions to prevent the onset of mental disorders in older adults. Few well-developed, large scale, developmental epidemiological preventive intervention studies are available to guide the way. However, preventive intervention research is not totally lacking and smaller scale, targeted preventive interventions can be highly effective. The profound impacts that successful preventive interventions can have in terms of quality of life, as well as reduction of costs of care, should no longer be denied to older adults within our aging society.

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Appendix 3.0

Examples of Best Practices in Elderly Mental Health Care

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Appendix 3.1: Abbotsford Mental Health Centre

Dianne Liddle, Site Coordinator

What we do well here in Abbotsford Mental Health Centre:

- Lead and facilitate a very successful seniors ladies support group.
- Offer the stress management classes to the E.C.M. Respiratory Rehab Program.
- Provide training assistance to peer support for seniors.
- Provide lectures and education to the caregivers support group.
- Committee membership on Community Network Response to prevent elder abuse.
- Liaise with Continuing Care Division.
- Partnership with Alzheimer Resource Centre, providing co-facilitation in offering an early stage memory loss group.
- Offer a psychoeducational, time-limited geriatric life skills group consultation with case conferencing, etc., to long term care facilities.

We also provide input to discharge planning at the hospital.

What we need are more general practitioners to provide primary care on an outreach basis and psychiatric consultation for long term care facilities.

Appendix 3.2: Salmon Arm Mental Health Centre

Dustine Tucker, MSW, Coordinator Elderly Service Program

Like everyone, we also have major concerns about environments in care facilities. We (Vernon coordinator Ken Green) have recently been discussing

this as we attempt to create a nurses' network for facility nurses who are interested in learning more about mental health needs of the elderly. We think it would be useful to have regional committees throughout the province that assisted facilities in creating more responsive environments, particularly in regards to mental health. These committees could also show some leadership in assessing community housing needs of the elderly who have special needs.

Our team in Salmon Arm has tried some very simple ideas to create a bridge between community and facility living, with little or no success. We have a team of life skills workers (who technically work for Continuing Care) and have tried to convince their managers to allow them to visit a senior who has recently moved to a facility so that they can communicate their needs to staff, follow through with simple adjustment problems and alleviate the person's fears of being abandoned and without some continuity in their day to day lives. We feel some short-term involvement would have long term benefits. However, this is considered "double dipping" in the health care system.

We are attempting to offer a form of assertive management in how our services are setup. We have case managers who have, on average about 30 to 40 persons on their caseloads. They set up a plan of care, which is then carried out (in addition to themselves) by our life skills workers and our evening and weekend nursing services. We meet every morning as a team to discuss the "hot spots" gleaned from the evening registered nurse notebook and whatever came up the day before. This meeting is pivotal in keeping on top of a potential crisis or following up after one has occurred. Most of our work happens in the home. I should also mention that we have begun to do more work with groups of clients. Our afternoon registered nurses often pick up two to four lonely people and take them for a coffee or drop them off at the movies. We just felt it was silly to have two workers picking up people for coffee and ending up in the same restaurant and then having to ignore each other to preserve confidentiality. Anyway our clients seem to link up well and feel like they have a friend to do things with.

We try to respond to an emergency, if at all possible. Our after hours registered nurses have been invaluable in this regard. All case managers carry a cell phone so anyone on the team can reach us for emergency situations. Our team nurse (days) also attends all the hospital discharge rounds. Our team meets every other Wednesday with community care nurses (Continuing Care, home care nurses) to discuss clients we have in common and to pass referrals back and forth. Dr. Gail Ayotte, Regional Consultant re: Mental Health in the Elderly, also attends this meeting. This meeting has been critical in ensuring we aren't stepping on each others' toes.

We agree about training for emergency room staff. We spend a lot of time with our clients in emergency to ensure that hospital staff have lots of information about our clients. We have been known to be a little pushy around asking for urinary tract infection tests, etc. We are quite alarmed at the lack of knowledge some physicians have about psychotropics in the elderly and we spend over 50 per cent of our time dealing with medication problems. We have no psychosocial rehab program, to date, in our area, but having one would be heaven. We would like to see rehab programs that give adequate times for people to recover from a major health crisis. The extreme emphasis on early "supported" discharge sets people back so that it makes it very difficult for them to ever reach their highest level of functioning. If this were in existence, it would certainly reduce the psychosocial problems they experience after such a discharge.

Appendix 3.3: Upper Island Geriatric Outreach Program

The philosophy of the Upper Island Geriatric Outreach Program has been developed within a framework of a biopsychosocial ecological model. This model recognizes the dynamic interaction between individuals and their environment and the influence of both biological and psychosocial factors upon health status. The philosophical objectives in the framework are to:

- Foster the development of a community environment in which integration of services and linkage between formal and informal supports is a recognized and accepted model for quality health care and health promotion.
- Foster an environment conducive to growth and change so as to support the attitudinal shifts necessary for effective health promotion and maintenance of optimal functioning level.
- Acknowledge that there are often equally valid alternative approaches to management of health problems and that the role of the health care professionals may be one of providing choices, rather than answers, for their patients.
- Providing efficient assessment protocol, which includes diagnosis, treatment, rehabilitation, prevention and health promotion.
- Recognize that the efforts of the patient's own support systems can be greatly enhanced by professional assistance.

Statistical Information

April 1, 1999 - March 2, 2000

Total referrals:	511
Assessment/reassessment of clients:	609
Direct contact (client/family):	4,178
Case management conferences:	11,422
Liaison meetings:	266
Consultation to agencies:	138

Appendix 3.4: Upper Island/Central Coast Community Health Service Society

Enhanced Case Management Project Interim Evaluation Report[1]

The Enhanced Case Management Project, an initiative of the Comox Valley Community Health Council, St. Joseph's Hospital in Comox and the Upper Island/Central Coast Community Health Service Society, is funded by Health Canada's health transition fund for one year, in the amount of $129,448. This budget covers the costs of staffing, benefits, travel, office furniture, equipment and supplies, telecommunications, education, evaluation and dissemination of results.

The short-term objective of the project is to improve the amount, quality and co-ordination of support to seniors with dementia living in the community, and their family caregivers, through education and collaborative case management. The longer-term objective is to reduce demands on the medical system, such as doctors' visits and hospital admissions due to family crises, among clients with a dementia who live in the community.

The project was officially launched at the end of January 1999 and is on track. Course curricula have been developed and materials distributed. Continuing Care case managers, home support supervisors and home support workers are all receiving education on dementias and dementia care from an instructor/specialist in dementia care and are proactively increasing their collaboration.

By the end of June 1999, seven case managers and home support supervisors had each attended seven formal education sessions and most had participated in at least two case consultations with the instructor/specialist. Forty-five self-selected home support workers had attended two formal education sessions and many had become directly involved in care planning for clients with a dementia.

Results of evaluation to date reveal:

a) Case managers, home support supervisors and home support workers have all increased their knowledge of dementias and dementia care, appreciate the opportunity to learn to improve their capability and are aware that by increasing the specificity of their knowledge they can more efficiently provide service.

b) Home support workers report increased confidence in their ability to work with clients with a dementia.

c) There is an increase in team work (between home support and Continuing Care) resulting in "better care plans" and more information, from many perspectives, being imparted to families.

d) The instructor/specialist is receiving an increased number of consultation requests from providers and volunteers, both within and outside of the Upper Island/Central Coast Community Service Society.

There have been a number of unanticipated, positive developments to date, as well:

a) It was anticipated that approximately 30 home support workers would self-select to participate in the project. At last count, there were 45, with another 27 home support workers requesting copies of the educational materials. (Word of mouth has created this demand.)

b) Family caregivers have already requested over 70 copies of the caregiver's manual produced as part of this project.

c) Home support workers are meeting case managers and are being consulted about their clients. There is clearly increased collaboration and a "team feeling" among home support supervisors, home support workers and case managers that was not there before.

d) Psychogeriatricians are now consulting case managers about their clients and including them in initial assessments.

Plans for the continuation of the project include more formal education sessions with all groups, to be completed in November 1999, and further evaluation activities in December 1999 and January 2000.

Footnotes

[1] Taken from: Interim Evaluation Report on the Upper Island/Central Coast Community Health Service Society's Enhanced Case Management Project. Funded by the health transition fund of Health Canada. By Nancy Gnaedinger, Consultant in Gerontology, Victoria.

Appendix 3.5: Port Alberni Mental Health Services

Dr. B. Booth, Psychiatrist, and Linda St. Claire, Geriatric Team Nurse, Port Alberni Mental Health Services

We consider our team exceeds expectations in that we are able to tailor our services to the ever changing needs of our community, facilities and hospitals. We are able to assess the needs in all these areas and deliver service to those with the greatest needs maintaining a balance with the other areas. We have the advantage of being a small town with few resource staff and frequent contact with all of the service providers. Our team is also proud of its communication with local physicians. This is facilitated by daily rounds and all of the geriatric consult clients in the acute care hospital.

There is no dedicated clerical support for the geriatric program.

There is a great and constant need for transitional housing from hospital to long term care homes or back to the client's home. This area lacks tertiary care resources and beds.

Training is needed for long term care workers and home support workers to assist them to understand the unique needs of the mental health elderly.

Staff limitations curtail meeting more with other agencies than we already do. Hospitals need to put back rehab programs that improve elderly clients' functioning or the government needs to put funding into more rehab type day programs.

There is no relief for sick or vacation for any member in the geriatric program.

Continuing education for all team members is crucial and needs to be supported in this rapidly changing field.

Acute care staff need more training in geriatric psychiatry, as most of the acute care beds are now filled with elderly clients.

Our local hospital has an ECT program.

Our hospital does not have a day program for any clients — adult or senior.

Psychiatry has one geriatric bed.

Appendix 3.6: Penticton

Janice Richards, Coordinator, Penticton Elderly Outreach Team

In smaller centres, we frequently encounter situations where appropriate services are not always available to elderly clients with mental health complications on an emergency/acute care basis. Provision of added "at home" service is the only viable alternative while waiting for appropriate acute and/or long term care placement to become available. Our community has developed an effective community living support program, which provides a practical component to the implementation of treatment and management plans in the community. Services are provided by the community mental health workers under the supervision of mental health clinicians. We have found this

to be a valuable tool to assist in our mandate to promote independence and self direction for our clients and would support this type of program as an integral component to the goal of best practices to provide "comprehensive care that strives to meet the constellation of needs unique to each individual".

Our team would like to see the needs of a specific group addressed. That is those individuals who have suffered life-long serious or persistent mental illness and who have aged to the point where they no longer fit into existing adult rehabilitation programs. Under the present division of adult and elderly programs, this population is often unable to access more appropriate "seniors" programs due to a lack of resources to provide support to this specific segment of the population within either adult or elderly mental health programs.

We believe that our services are most effectively and efficiently delivered under the umbrella of mental health services and are very concerned that the elderly have been left out of the overall mental health planning. We wish to stress the importance of maintaining adequate and separate funding resources for this substantial population. Our program is delivered in a community which has roughly double the provincial average population of elderly residents and demographics indicate that this population will continue to increase relative to the adult population.

Appendix 3.7: South Health Area, Duncan Mental Health Centre

Jean Haley

Crisis response in our community is carried out by the elderly team, except in the emergency department where clients are assessed by the psychiatric emergency response team. We also use the enhanced psychogeriatric care dollars to assist facilities to cope with clients in crisis. Crisis intervention is time consuming and, to be effective, requires adequate staff and resources.

APPENDIX 3.7

Duncan Mental Health Centre

Perhaps mental health should have its own home support budget with health services workers trained to care for this more difficult to manage population.

Staff and services are needed on a per capita basis. There is an integrated intake system in Duncan. All referrals for the elderly are done through the Continuing Care central intake. Mental health receives a full package of information about the client. When receiving the intake, this saves time and confusion for the client or family.

We recently provided a 12-hour course to 18 health service workers to increase their knowledge/skills to care for psychogeriatric clients. This included care planning sessions. The results were encouraging, with health services workers feeling empowered to suggest strategies of care and feeling comfortable performing activities that were not "tasks".

This type of initiative requires money to be ongoing, but so far has been worthwhile.

APPENDIX 3.8

Chilliwack Mental Health Centre

Appendix 3.8: Chilliwack Mental Health Centre

Dr. Katie Wilson

In Chilliwack, we are, on occasion, using a respite bed in a long term care facility for further assessment and treatment. This particular facility is adjacent to the hospital and adult day care. We are able to involve all community team members and to do discharge planning.

We do rely on added care, since there are no extra resources allocated for this treatment.

It is well received by staff, who find it challenging and rewarding.

Appendix 3.9: Creston Community Outreach Program

O. G. Deatherage, Clinical Psychologist

We believe that the Creston Community Outreach team in several ways approaches being an example of the model presented in the first draft of this document. Our program team includes several part-time members, including a nurse, clinical counselors, clinical psychologists, general practitioner specialists and a geriatric psychiatrist. Clients of the program can receive services in their homes, in facilities, in our offices or in hospital and families can be included. Services include assessment, counselling, group therapy, planning, outpatient ECT, followup, consultations, support for community agencies in facilities and education and training for community professionals.

Appendix 3.10: Castlegar Mental Health Services

Martha Fish

I am responding from the point of view of a social worker in a rural community mental health setting — West Kootenays/Boundary area: total population approximately 80,000.

In Trail and Castlegar, our mental health geriatric assessment team was established in 1992 and includes a mental health social worker in each community, with a total of 1.5 FTEs. We have a geriatric psychiatrist one session every two weeks and a physician one session per week. We have nursing input from long term care nurses working as part of our team.

In the Nelson elderly outreach team, founded in 1992, which covers the Slocan Valley, we have a mental health social worker and two mental health nurses, with a total FTE of 2.0, plus a geriatric psychiatrist one session/week.

APPENDIX 3.10

Castlegar Mental Health Services

Our resources are slim and focus tends to be on assessment and consultations, with very limited treatment or case management ability. However, in Nelson, there ongoing group treatments are being provided. Crisis lines are provided in our area and work very well. In Trail, the crisis line is used for first line for emergency after hours response and for the gatekeepers' program identifying elder abuse. In that case, a member of the public calls the crisis line, who contacts the appropriate investigator. Our psychogeriatric outreach teams do some crisis response, but cannot provide dedicated emergency mental health services. We believe the solution is increased training of emergency mental health staff in psychogeriatric issues. We would like to see more access to provincial consult services, including ethicists, specialized psychiatrists, etc.

APPENDIX 3.11

Vancouver Hospital Geriatric Psychiatry Outreach Team

Appendix 3.11: Vancouver Hospital Geriatric Psychiatry Outreach Team

Population/Client Profile

- Age: 65 with exceptions, average age 76.
- Diagnostic Groups: Delirium 2.2%, cognitive impairment NYD 15%, dementia 39%, bipolar disorder 2.2%, dysthymia 1.2%, major depressive episode 16.8%, substance abuse disorder 4.8%, other 19.8%.
- Living Situation: With spouse 27.5%, alone 41.3%, family/friend 10.8%, institution 12%, other 8.4%.

Capacity

- 1998 New: 167 admissions (147 new, 11 readmissions, six group only).
- Active patients: Total caseload at a point approximately 150; each case manager, registered nurse and social worker carries about 40 cases. Doctors carry some patients alone; numbers vary according to doctor (six to 24).

Types of Service Provided

A. Patient Services

- Initial assessment with treatment recommendations.
- Liaison with patient's family doctor.
- Second opinions.
- Followup therapy, as needed.
- Suggestions for referral to other appropriate services.
- Family work, where needed.
- Caregiver group.
- Neuropsychological.
- Socialization group.
- Committals.
- Medical/legal assessments.

B. Educational Services

1. Continuing undergraduate and post graduate education.
2. Continuing education sessions.

Administrative Structure

- Interdisciplinary team.
- Reports to Department of Psychiatry.
- Have patient data base to describe demographics and diagnostic data.

APPENDIX 3.11

Vancouver Hospital
Geriatric Psychiatry
Outreach Team

Staffing

- 1.6 registered nurse FTE
- 1 social worker
- 1.0 neuropsychologist
- 15 sessions shared among three psychiatrists (one session = 1/2 day)
- 1 secretary

Outcome Measures

- Time on waitlist (average 19 days).
- Goal attainment scaling ®®.

Future Program Initiatives

- Increasing sophistication with goal attainment scaling.

APPENDIX 3.12

Vancouver Hospital
Community Consultation
Liaison Service

Appendix 3.12: Vancouver Hospital Community Consultation Liaison Service

Peter Chan, MD, FRCPC

The Geriatric Consultation Liaison Service at Vancouver General Hospital provides consultation primarily to the family practice units within the hospital to those over the age of sixty. While it is well recognized that there are many seniors who are admitted acutely in other medical/surgical units, the focus for subspecialty consultation is in the family practice units owing to the often very frail, usually demented, elderly (average age 79) clientele who are admitted with functional decline and inability to cope at home. Beyond the assessment and management of common syndromes such as delirium, dementia, depression, and associated behavioural manifestations, psychiatric consultation incorporates the interdisciplinary assessments from such services

as occupational therapy, physiotherapy and social work. Because questions are often raised in regards to the patient's ability to cope, as influenced by cognitive factors affecting insight, judgment and executive functioning, a large part of the consultation service time is devoted to assessing competency of managing financial and personal affairs in these individuals. The result of this assessment may include recommendations for further mental health followup by the community mental health teams' day hospital programs, senior's peer support programs or to the Senior's Well Aware Program, if there are alcohol and drug abuse issues. The possibility of transfer to a more specialized psychogeriatric units located within the hospital (STAT Centre) or other hospitals such as Valleyview may also be facilitated. While there is a single psychiatric consultant for the service, the ideal service would incorporate a nurse clinician who can help directly with psychiatric issues that arise during nursing care, and to provide a link to community resources. At this time, the psychiatrist does work with close contact to the family practice gerontology nurse who has some understanding of psychiatric issues, but comes primarily from a geriatric medicine background. Being in a teaching hospital, opportunities are provided for students, residents, family practice fellows and psychiatry fellows to experience being on the consultation service. As the subspecialty consultant is working with five other general consultation liaison psychiatrists, there is opportunity to provide second opinions of patients in non Family Practice units and to reciprocally share information and knowledge with those who work in the more specialized medical/surgical units/intensive care units within the hospital.

Appendix 3.13: Victoria — Elderly Outreach Service

Giuseppe (Joe) Scaletta, MSW, Coordinator

The Elderly Outreach Service (EOS) is an interdisciplinary community mental health program for seniors that started as a project in 1989. The program

provides comprehensive, coordinated and prompt interdisciplinary assessment, consultation and short-term treatment to individuals aged 65 and older experiencing an age related mental health problem. In 12 years, the program has responded to over 8,000 referrals of seniors experiencing mental health problems. EOS was the first program of its type in British Columbia and was the model for similar programs in over 50 communities in the province.

Education to seniors, both formal and informal caregivers, is an integral part of the program mandate. Team members have presented hundreds of educational sessions over the years. The program initiated and has co-sponsored (with the Alzheimer Society) conferences in dementia care. The seventh annual conference, "Exploring the Spectrum of Dementia: Diagnosis to Care", is scheduled for February 11 and 12, 2001, with an anticipated registration of 300 people. The program has hosted many student practicum placements from universities in British Columbia and other provinces. EOS staff presented our use of Goal Attainment Scaling (GAS) to many mental health programs in Edmonton. Seven of the program areas in Edmonton adopted the use of GAS following the presentation.

Community linkages are vital to the work of EOS. Linkages have proactively been established with hospital based programs, nonprofit agencies (such as the Alzheimer Society), long term care services and any service that works with seniors. Active community involvement in an advisory committee has been in place since the outset of the program. Community initiatives include the establishment of a dementia-specific day centre, a caregiver counsellor position for caregivers of those with dementia, establishment of a video library on seniors' mental health issues, numerous educational sessions for formal and informal care providers as well as the annual conference on dementia care. In a survey of referral agents, over 90 per cent of respondents indicated that they were satisfied or very satisfied with the program.

EOS was surveyed and accredited by the Canada Council on Health Services Accreditation in November 1996 as a Ministry of Health, mental health program, and in February 2000 as part of the Capital Health Region accreditation.

Ongoing quality improvement is an important part of the program. Clinically, Goal Attainment Scaling is used to track outcomes in service provision and to show that clinicians are meeting clinical goals set for/with clients. All cases are presented at interdisciplinary clinical meetings to ensure that each client has the benefit of an interdisciplinary assessment. Other quality improvement measures include tracking service delivery in each community in the region to ensure equitable access to the service.

Team disciplines include:

Geriatric Psychiatry	0.9 FTE
General Practice Physician	1.8 FTE
Nursing	4.0 FTE
Social Work	2.0 FTE
Occupational Therapy	1.0 FTE
Psychology	1.0 FTE
Neuropsychology	1.0 FTE
Administrative Support	2.6 FTE

EOS: Statistical Information for 1999

Referrals: 732

Cases closed during 1999:	628
Total cases open during 1999:	766
Total cases with diagnosis of dementia:	612 (80% of cases open during 1999)
Clients with dementia who lived alone:	172 (28% of those with dementia)
Average length of stay:	137 days

The trend for the program over the past several years is that it is seeing an older population and an increasing number of people with dementia.

Appendix 3.14: Prince George

Karla Staff, Coordinator, Elderly Services Program

Team Composition

Regular Staff

Program co-ordinator

Regional outreach; assessments/case manager

Substance misuse specialist; assessments/case manager

Supportive housing; assessments/case manager

Life skills paraprofessionals

Sessional Consultants

Clinical director (psychiatrist)

Family physicians (2)

Psychologist

Other consultants as required

Range of Services

Clinical Services

In-home assessments

Case management

Other Features

Regional liaison nurse

Supportive Housing Program

Therapeutic interventions

Medication reviews

Competency assessments

Abuse investigations

Life skills options

Alcohol misuse specialist

Community education/development

A unique feature of our program is our Substance Abuse/Misuse Program, one of four funded programs of this type in British Columbia. Substance abuse/misuse is an area that is generally recognized as a frequent problem with elderly people, but it is generally poorly addressed in mainstream services and poorly diagnosed in health services. Statistically, the North has a higher rate of substance abuse/misuse for all ages and has a proportionally higher ratio of males to females, especially single older males. In our experience, we have found this population to be generally underserviced and as a consequence to end up in health services for lack of other options.

Our Supportive Housing Program provides 12 hours per day of paraprofessional support in a senior's apartment building. Individuals receiving this support are cognitively impaired but ambulatory seniors who may be alcohol using and may have other concurrent mental health diagnoses. The goals of this program are to stabilize housing, improve nutrition, increase appropriate access to health services, monitor mental health symptoms/ episodes and reduce isolation through social support. Outcomes to date include: 13 of 23 units are occupied and a waitlist system has been established; gains for all clients have been noted and families are pleased with the supports that are offered; clients have become integrated in community activities; improved or re-established nutrition for some; successful interventions for depression, delirium and behavioural problems.

Life Skills for the Elderly is designed to maintain/optimize skills in self-care, community access, socialization and problem solving. Workers in this program

APPENDIX 3.14

Prince George

do "with", not "for" clients. Outcomes that have been noted are the reduction of risk, emergency hospitalization and isolation. The use of paraprofessionals in this program is more cost effective, as well as extending outreach, treatment and case management into the community.

Provision of regional outreach is accomplished both with visits from Lower Mainland specialists (two to four visits per year) and by regular visits from the team nurse and/or other team members. The program averages 1.5 visits per month (approximately 10,000 km per year). The objectives of regional outreach are to provide access to psychogeriatric treatment to elderly people in remote locations, to improve care for the elderly through education, consultation and family support, to improve quality and consistency of psychogeriatric care in facilities and to reduce the need to rely on more expensive visits from fly-in consultants. In our experience with this program, we have found the small communities to be receptive; as general practitioners become familiar with the program, referrals have increased quickly.

APPENDIX 3.15

Vancouver Community Geriatric Mental Health Services

Appendix 3.15: Vancouver Community Geriatric Mental Health Services

The Geriatric Program is a specialized service of the Vancouver Community Mental Health Services. The program developed in late 1990 provides assessment and ongoing psychiatric treatment to individuals age 65 and older who have serious mental illness complicated by co-existing physical illness. These individuals may not have had any mental health problems previously but with age have developed depression, dementia, delusions or delirium requiring psychiatric assessment and treatment.

The program also provides services to those age 65 and older who have had life long serious mental illness and now have developed physical illness that complicates their psychiatric treatment such that they require the specialized services of the Geriatric Program.

Individuals under age 65 who present with age related "geriatric mental health problems" are considered for acceptance into the program on an individual basis.

Location

The geriatric program services operate from the eight mental health teams based in the six geographical Community Health Areas designated by the Vancouver/Richmond Health Board.

Staffing

There are a total of 25.4 full time staff which consist of a mix of nurses, social workers, occupational therapists, health care workers, and rehab workers for clinical care. They are supported by 5.05 FTE physicians which consist of a mix of psychiatrists, geriatricians and family practice physicians. The staff are distributed throughout the eight teams with the majority of teams having two clinical staff and six physician sessions.

Types of Services

The teams provide:

- Assessment for consultation and for ongoing support and medical management.
- Counselling.
- Management of medications in close collaboration with the individual's family physician.
- Assistance in getting admitted to hospital if required.
- Assistance with obtaining services provided by Community Health Services.

- Education for the client and the family.
- Support groups for the clients.
- Brokerage to assist the clients in obtaining other needed services.
- Services are provided on an outreach basis with staff going to the clients' home or long term care facility.

Four of the teams are partnership teams with the GPOT and have developed links with the Vancouver Hospital and Health Science Center (VHHSC). The remaining teams have developed links with the Providence Health Care system and the university based VHHSC site.

The GPOT partnership teams have access to neuropsychological testing through the sessions the neuropsychologist has with the GPOT hospital arm of the program. The other teams access assessments through fee for service neuropsychologists.

Additional services provided by the program:

Geriatric Crisis Nurse

This program developed in 1998 consists of a nurse who works out of the Mental Health Emergency Services Program and assists older adults who are experiencing a psychiatric or a behaviour crisis by providing assessment and crises intervention, linkages to other services if required and short-term support. The hours of operation are 11 a.m. to 7 p.m. If the nurse is unavailable, the adult services day -time and after-hours mental health emergency service staff will respond.

Dual Diagnosis Nurse

This program developed in 1994 consist of a nurse who works with the Seniors Well Aware Program (SWAP). The SWAP is a service specifically

for older adults who have drug and alcohol problems and the mental health nurse provides support to the SWAP staff and does joint assessment with the mental health geriatric team staff if a problem with drugs or alcohol requires assessment and evaluation. She only works half time, so can not really carry her own clients except for a very few.

Geriatric Rehabilitation Program

The "Bright Spot" is a small rehabilitation program for clients of four mental health teams. This program which was established in 1996 was funded through the downsizing of the Geriatric Division of Riverview Hospital when eight clients were relocated to housing in Vancouver. The program operates three days per week. Seniors who have a serious mental illness are often at high risk for social isolation, loss of independence and lack of meaningful activities. These individuals are often unable to access mainstream seniors programs such as adult day care programs because of difficult behaviours, paranoid ideas, depressive symptoms or fear of stigmatization. As well those who can and do attend mainstream programs may require additional support and rehabilitation because of their mental illness. The "Bright Spot" has staff specifically experienced in understanding rehabilitation issues for seniors with mental illness. Transportation is available to assist the clients to attend.

Program Stats

Number of clients active in the program as of April 2000 is 597, which represents 15.9 per cent of all adult clients active with the Vancouver Community Mental Health Service.

Number of referrals per year approximately 700 (40% male, 60% female).

Referrals by age group: Under 65 (6%); 65-74 (27%); 75-84 (39%); 85+ (26%).

The median times between referral and face to face contact is seven days.

Accommodations: Private home alone 38%; private home with family 12%; private home with others 1.4%; homeless 1.4%; facility 43%; hospital 0.3%.

Median length of stay is 20 days.

Reason for referral: There may be more than one reason for referral.

Depression	40%
Dementia	41%
Delirium	3.4%
Delusions	13.4%
Paranoia	21.2%
Assaultive behaviour	13.7%
Confusion	11.5%
Other behaviour	29.5%
Self neglect	11.6%
Abuse/neglect	1.4%
Competency only	1.4%
Consultation	1.7%
Other illnesses	4.5%
Continued followup	14%

7% have problems with alcohol abuse.

1.7% have problems with medication abuse

The level of care (reported in a 1998 client survey based on 570 client responses): PC 10.7%; IC1 13.5%; IC11 20.4%; IC111 32.8%; Extended Care 5.3%; 17.5% no information received.

25% have neglect, including self-neglect problems.

36% are not legally capable.

Hospitalizations

April/99 - March/2000 total number hospitalized: 311 clients.

Of these, 14.1% were new referrals and 85.5% were active clients; 26% were involuntary psychiatric admissions; 27.9% were voluntary psychiatric admissions; 27.9% were medical admissions; 17% were urgent medical admissions; 70% were considered an emergency admission; 22% were not considered an emergency.

Community Linkages

The staff of the Geriatric Program work closely with the educator of the Geriatric Psychiatry Education Program (GPEP) funded by the Community Health Services. They are part of the formal education presentation put on for nurses in the long-term residential care program and also participate in informal presentation within the facilities with GPEP and facility staff.

The Geriatric Program staff also present to the homemakers staff and informal caregivers together with the CHS Caring and Sharing Education Program staff providing information on the mental health geriatric services.

The staff work closely with family physicians and with the office of the Public Guardian of British Columbia.

The Director of the program is a member on many committees, which work on issues related to providing services to this aging population.

Accreditation Report

The following is taken from the accreditation report based on a review

of the Vancouver Community Mental Health Services when they were still under the Greater Vancouver Mental Health Services Society (GVMHSS). The accreditation was done December 12 to 16, 1999. The service received a three-year accreditation. Members of the accreditation team visited one of the geriatric programs at a team meeting and accompanied staff on home visits, as well as speaking with clients and family members and other community agency staff who work closely with the staff of the geriatric programs. This was their feedback on the Geriatric Program:

> "This is a strong, enthusiastic, and client-focused team. Members of the team are congratulated on the integrated programs and services they provide and on the strong relationships they have fostered with other health providers.
>
> "Team members are continuously involved in assessing the needs of the community they serve. This assessment is supported through strong linkages and networking with associated agencies, community stakeholder groups and committees.
>
> "Services are well integrated and co-ordinated. Geriatric services staff meet monthly as a program committee across agencies and they use task groups and subcommittees to address specific issues. Minutes from these meetings are distributed to all geriatric program team members.
>
> "There is much informal communication between team members and other health and service organizations in the community. This helps to maintain a strong referral network. Clients are readily referred to other services as required.
>
> "Access to the Geriatric Program's services is well co-ordinated. Appropriate client information is gathered from referral sources. The team is supported in its plan to reinforce the use of standardized requirements for referral. A client information brochure has been developed for the use of all of

the teams. Since the last accreditation survey a geriatric program for referral sources has been developed and is being distributed.

"There is a comprehensive, interdisciplinary assessment and care planning process. The results of the assessment are discussed by the team and with the client and family members. It is especially noteworthy that copies of the assessment are sent to the client's family doctor, GVMHSS staff and the continuing care workers.

"There is an informed consent process that is used for some aspects of treatment and care provision. The geriatric team is strongly encouraged to implement its plan to review the informed consent process to ensure that it conforms with the new adult guardianship legislation and also to ensure that there is standardization in the documentation of informed consent.

"The treatment plan is developed by the team members in collaboration with the client and/or their family members. As appropriate, the family doctor and other care providers are also involved. Each team member is well aware of discipline-specific roles and responsibilities. It is evident that team members respect and appreciate the importance of each discipline's contributions to the overall well-being of the client.

"Evidence-based care and best practice are high priorities for the Geriatric Program. Geriatric physicians meet several times a year. An interdisciplinary best practice group has been formed and the team is strongly supported in its plan for this group to review clinical practice guidelines and new evidence-based literature.

"Expected outcomes of care are developed for each client and are recorded on the client goal setting and tracking sheet, which is being pilot-tested by team members. This is an important initiative which

APPENDIX 3.15

Vancouver Community Geriatric Mental Health Services

demonstrates the geriatric team's clear understanding and use of Quality Improvement principles.

"Other excellent initiatives that show the Geriatric Program staff's involvement in quality improvement include the following: the mutually beneficial partnership that has been formed with the Geriatric Psychiatry Education Program (GPEP); the work that has been done to assist in the development of a pilot project to provide geriatric psychiatry education to home support staff and informal care givers resulting in the Caring and Learning Program; and the development of the position of geriatric crisis nurse to provide after-hours support to clients.

"The knowledge that Canada will very soon be facing vast increases in the numbers of elderly clients is driving the move to develop alternate modes of care delivery to reduce the lead on inpatient beds. Two alternatives for care delivery that strongly support a health promotion and prevention focus to meeting the growing community needs include the following: the plan to develop a second Bright Spot Day Program for the east side to build on the success of the current program; and a geriatric Venture short-term stay program for the frail elderly with mental health needs."

APPENDIX 3.16

Integrated Group Therapy Program, Kelowna Mental Health Centre

Appendix 3.16: Integrated Group Therapy Program[1], Kelowna Mental Health Centre

The integrated group approach is designed to assist clients through a continuum of: treatment of illness, prevention, recovery and sustaining wellness. The health promotion focus of addressing the underlying conditions that lead to illness is an integral part of the program's philosophy.

Therapeutic Activation Group

Target Population

The Women's Therapeutic Activation Group (TAG) is an eight-week program for cognitively intact women age sixty-five or older who experience depression, anxiety, panic or difficulties adjusting to changes associated with aging.

Complicating factors include: transportation, social isolation, losses (spouse, family, friends or pets) physical challenges, physical illness, pattern of refusing health/other services and financial limitations.

All clients enrolled in this program have received service from the formal mental health system for depression either through the acute or community programs or private practice psychiatrists.

Program Structure

- The group has two facilitators: a nurse from the Elder Services Outreach Program and a recreation therapist hired through a mental health funded Canadian Mental Health Association (CMHA) contract.
- Transportation provided via CMHA van — no cost to clients.
- Consistent driver hired by CMHA.
- Located at the Seniors Activity Centre — no cost for space allocated.
- Lunch meal onsite during group session. Therapists and driver are involved with participants during the meal break.
- Funding available for four eight-week group programs per calendar year.
- Group session is 2.75 hours once per week.
- Participants are phoned the evening before each group session.

- Participant binders and resource material are provided at no cost to clients.

Program Content

- Psychoeducational approach/cognitive behavioral therapy.
- Physician lead discussion about medication and side effects.
- Discussion topics include: expectations/rules of group, depression, anxiety, panic: symptoms, causes, coping skills, stress; both general and holiday-related, communication skills, anger management, fear, grief and mourning.
- Tour of senior's centre to facilitate use of and participation in the centre's programs.
- Program content is tailored to common group needs.
- Client goal setting focused on activation and behavioral change.
- Linkage with the weekly support group and other resources.

Linkage of Programming

All graduates of the TAG program are encouraged to follow up on their personal activation goals, such as volunteering. In addition they are encouraged to join the weekly support group ("Primetimers" Group) that has a social and activation focus. The same driver provides transportation at no charge to the clients. The graduates have already formed as a group so the next step of integrating into another group poses a lessor barrier. Approximately 75 per cent of the TAG participants have joined the Primetimers weekly support group.

The mental health nurse and the facilitator of the weekly support group connect by e-mail or phone monthly for two hours to review any client

concerns. The mental health nurse sees any participants at risk of relapse. The nurse will also encourage clients at risk to contact her as required.

Primetimers Weekly Support Group

Background

Its participants named this group. Approximately 30 per cent of the graduates of the Therapeutic Activation Group (TAG) required ongoing case management. The ever-growing caseloads and pattern of repeated depression relapses precipitated the development of the Primetimers weekly social support and activation group. This group has expanded to two weekly groups with approximately 15 participants each.

Developmental Phase

Considerable attention was paid to this phase. It took two days per week over a three-month period for a social worker to: assist in the interviewing for the group coordinator/facilitator through Canadian Mental Health Association; secure a location, at $25 per week, with easy access and equipment storage; confirm the availability of a driver; arrange for a bus and volunteer driver for monthly activities in the community; purchase supplies for the group; and screen/interview all TAG graduates, who had been waitlisted for the startup of this program for up to two years.

18 Months After Startup

- Monthly newsletter by the group members.
- Archives maintained by group members (i.e. photos of events).
- Responsibilities delegated to group members by the coordinator.
- Relapses (depression/isolation) almost nil.

- Socialization/networking — outside the group.
- Monthly outings and celebrations key aspects.
- Evaluations by clients.
- Second Primetimers just began.

Evaluation

What do the participants say?

The feedback from the participants has been very positive. Common themes were: reason to get out of the house; there is meaning in life again; helpful to know I am not the only one with these kinds of problems; it feels like a family; I care about my health more; I do not need to see my doctor as often; I know myself better. An unsolicited letter of thank you from a family member stated: "Thank you for giving me my mother back, she is living life again".

Outcome/Findings

- Less individual case management by mental health nurse.
- Participants have developed a social support network, compared to a previously isolated lifestyle.
- The group participation seems to build tolerance and confidence to socialize in a group and transfers to other aspects of their life (i.e. attending church again).
- The participants report that the periodic followup phone calls from group facilitators translate to feelings of being connected and secure.
- The cost of this integrated program is very low. The Primetimers Group Program costs approximately $13,000 per year for the weekly

program, inclusive of offsite rental space and free transportation, as well as the coordinator's and driver's wages. The Therapeutic Activation Group (eight weeks) costs approximately $2,500 per group, inclusive of a recreation therapist and driver's wages. There is no charge for the use of the meeting space at the senior's centre, where the recreation therapist is employed on alternate days. The mental health nurse's services (co-therapist) are provided through the Elder Outreach Program.

- The costs noted above reflect the lower costs of sustaining wellness — once achieved — through a social and activation model.
- Free transportation is critical to reducing a significant barrier to attendance. Transportation is a major issue for Kelowna's senior population.
- A formal research proposal is pending.

Footnotes

[1] Report submitted to Elder Services (Outreach) Program, Kelowna Mental Health Centre.

9.0 Glossary of Terms and Acronyms

Accountability The definition and measurement of expected outcomes and performance measures; a plan for monitoring service delivery and activity reporting.

Accreditation External, formal review of an agency's performance and adherence to standards of delivering care services. Certification by a national organization whose business is the evaluation of compliance by service organizations, such as hospitals, with pre-set standards of care and/or service.

Acute care (*Also referred to as secondary level care*) Diagnostic and therapeutic health care provided by health care professionals, usually in a hospital setting and for a short duration.

Acute psychiatry (*Inpatient*) Assessment diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit.

Adult Person 19 years of age or older.

Advocacy The act of informing and supporting people so they can make the best decisions possible for themselves or an act or acts undertaken on behalf of others when they are unable to act on their own.

ALOS Average Length of Stay.

Assertive Community Treatment (ACT) Proactive, usually relatively intense case management of individuals living in the community.

BCPGA British Columbia Psychogeriatric Association.

Best practices in mental health Descriptions of what should be done to facilitate change for the better in mental health policies, practices and initiatives.

Biopsychosocial approach/model Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams which may include physicians, nurses, pharmacists, social workers, occupational therapists, dietitians, psychologists, life skills workers and others.

Case management The co-ordination of a client/patient's health care, housing and other related matters. Usually done by one person (the case manager) operating in a team environment who liaises with all others providing services to the individual. Case management provides active outreach, co-ordination of personalized care plans and monitoring of mental health status.

CEO Chief Executive Officer — the head of an organization such as a hospital or health authority.

Clinical practice guidelines Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

Continuing Care *(when capitalized)* Unless otherwise stated or apparent from the text, refers to the system of community-based services and the administrative structure(s) responsible for the administration, organization and delivery of continuing care services.

Continuing care *(lower case)* Refers to the array of community services that include home support services, respite services and residential facility placement.

Crisis stabilization Short-term treatment and stabilization for individuals in psychosocial and/or psychiatric crises as an alternative to hospitalization.

Decompensate Psychotic symptoms return or the person's ability to function is disrupted.

Dual diagnoses Describes the condition of people who have a mental illness and either a mental handicap or substance misuse issues.

ECT Electroconvulsive therapy.

Environmental milieu The context in which an individual lives and which encompasses not only the physical residence but also the social, emotional, psychological and other aspects of day to day life.

Evidence-based decision making A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

Forensic Related to the criminal justice system.

F/P/T Federal/Provincial/Territorial.

FTE Full Time Equivalent — unit used to describe a full-time position.

Functional impairment Reduction in a person's ability to perform usual daily activities.

GAS Global Assessment Scale — a measure used to evaluate functioning.

GPOT Geriatric Psychiatry Outreach Program — multidisciplinary geriatric assessment and treatment program at Vancouver Hospital.

Guidelines A suggestion or set of suggestions that guide and direct action.

Indirect consultation Consultation in which one professional service provider discusses a case with another professional (usually a specialist, such as a geriatric psychiatrist, geriatrician, neurologist, etc.) without the second professional seeing the individual.

Integration Organization of service entities along a continuum designed to ensure that the clients' needs are met in a coherent, unified, holistic and efficient manner.

LPN Licensed Practical Nurse.

Mheccu Mental Health Evaluation and Community Consultation Unit — an organization based at the University of British Columbia dedicated to pursuing mental health research, education and training and delivery of mental health services to the people of British Columbia.

Organic brain syndrome A psychological or behavioural abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

Outreach Services taken to the client/patient at home or in a facility, rather than requiring the person to attend a clinic or hospital.

Primary care Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients/patients. Primary care may include referral to more specialized levels of care, e.g. secondary (hospital or specialist care). Family doctors are often referred to as "primary care physicians."

Psychogeriatric Refers to psychiatric disorders or conditions that are primarily experienced by elderly people and are considered to represent age-related disorders.

Psychosocial rehabilitation Psychiatric rehabilitation services designed to assist a person with a serious mental illness in effectively managing the illness and compensating for the functional deficits associated with the illness.

QA (*Quality Assurance*) An ongoing program to ensure that standards of service delivery are being met.

QI (*Quality Improvement*) A defined process to improve performance on an ongoing basis.

Residential care Provided in community-based facilities that are usually licensed and staffed to provide full-time care, supervision and psychosocial

rehabilitation for people whose social, mental or physical functioning prevents them from living more independently.

Respite Temporary, short-term care designed to give relief or support to family caregivers who are responsible for the ongoing care and supervision of a family member with a serious mental illness. Respite may be provided inside or outside the home.

Secondary level care See Acute care.

Stakeholders Representatives of various mental health care or seniors' organizations.

Standard An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared.

STAT Short-term Assessment and Treatment.

Supported housing A variety of living arrangements (usually self-contained living units) for people who are able to live independently with the assistance of a range of support services.

Tertiary care Specialized therapeutic and/or residential resources required when staff or facilities at the primary and secondary levels of care are not able to manage individuals with complex and/or severe mental health disorders and/or behaviours.

UBC University of British Columbia.

Utilization management Process by which administrators decide on the efficient use of care resources by comparing the observed or reported use of resources with recognized standards or appropriate, timely and cost effective usage.

Values The beliefs of an organization that underlie its principles and actions and form the basis for planning and operating services.

Feedback: Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities

February 2002 Edition

The *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities* document will be periodically updated. To assist in this process, please answer any or all of the following questions and send it to the address shown at the bottom of this form.

Thank you for your assistance.

1. Is this a useful document? Will it assist you in designing, developing and implementing services? Briefly explain your response.

2. Please identify errors or omissions and identify any changes you would like to see made to the next edition.

3. Is there a program that you think may qualify for inclusion in the next edition? In your description, please show links to one or more of the six principles listed in the document.

4. Are the principles and assumptions about care generally appropriate and consistent with the needs of clients and caregivers?

5. Do the descriptions of the service system and the embedded elements of care reflect the "real world" of need for services and resources?

6. Does the document as a whole provide clear and appropriate guidelines for developing exemplary services for elderly people with mental health problems?

7. Has the document captured the salient characteristics of mental health care for elderly persons?

8. Additional comments: (Please attach another page if you need more space.)

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Please return to: Mental Health and Addictions, Ministry of Health Services, 1515 Blanshard Street, Victoria, BC V8W 3C8.

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