THE UNIVERSITY OF MANITOBA

A SURVEY

OF

COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAMS

IN WESTERN CANADA

by Penny MacCourt

A PRACTICUM REPORT

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTERS OF SOCIAL WORK

Faculty of Social Work

Winnipeg, Manitoba

ISBN 0-315-81831-X

Name _____

Dissertation Abstracts International is arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation. Enter the corresponding four-digit code in the spaces provided.

Social Work
SUBJECT TERM

0452
SUBJECT CODE

U·M·I

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Fine Arts 0357
Information Science 0723
Journalism 0391
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION
General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523
Psychology 0525
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
Language
- General 0679
- Ancient 0289
- Linguistics 0290
- Modern 0291

Literature
- General 0401
- Classical 0294
- Comparative 0295
- Medieval 0297
- Modern 0298
- African 0316
- American 0591
- Asian 0305
- Canadian (English) 0352
- Canadian (French) 0355
- English 0593
- Germanic 0311
- Latin American 0312
- Middle Eastern 0315
- Romance 0313
- Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
Philosophy 0422
Religion
- General 0318
- Biblical Studies 0321
- Clergy 0319
- History of 0320
- Philosophy of 0322

Theology 0469

SOCIAL SCIENCES
American Studies 0323
Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
- Accounting 0272
- Banking 0770
- Management 0454
- Marketing 0338

Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Food Science and Technology 0359
- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
- Medical 0760

EARTH SCIENCES
Biogeochemistry 0425
Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

A SURVEY OF COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAMS IN WESTERN CANADA

BY

PENNY MACCOURT

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

ABSTRACT

The growing need for specialized services for the elderly with mental health problems is well documented. There has been a proliferation of community psychogeriatric outreach programs developed to meet these needs, but very little is known about these programs.

The purpose of this research was to develop an ideal model for a community psychogeriatric program, and to compare existing programs in western Canada to the ideal model, and to each other.

Key informants in each of the western provinces, and 3 people prominent in the field of psychogeriatrics, were interviewed. The results of this survey were used in developing a questionnaire that enabled an "ideal model", derived from a literature review, to be compared to existing community psychogeriatric outreach programs, and existing programs to each other. The questionnaire focused on: (1) program context and development, (2) staffing, (3) referral system, (4) services, (5) assessment, (6) program outcomes, (7) client characteristics, (8) catchment area characteristics.

Thirty-one programs were sent questionnaires, and 28 programs participated. Parametric and non-parametric statistics were used to analyze the quantitative data.

It was found that most of the existing services conform to the "ideal model". The research

revealed that psychogeriatric programs in western Canada are not homogeneous. There is variety in all areas surveyed. Funders and catchment area (ie rural or urban) may be the most important differentiating factors, from which other differences arise.

Overall psychogeriatric programs have low penetration rates for mental disorders in general, and for all but one specific disorder. The survey results showed that the rate of cases seen by programs is proportional to the number of staff per elderly people in their catchments. If funders wish to improve penetration rates, to expand the range of mental health problems seen, and to provide more direct services to caregivers, not only will teams have to be larger, they will also have to be multidisciplinary.

The report recommends that programs must be evaluated to determine which service model, discipline mix, and interventions are the most effective in meeting the complex needs of the psychogeriatric client.

ACKNOWLEDGEMENTS

This project could not have been realized without the help of a number of dedicated people to whom the author is forever indebted. Deepest thanks are expressed to each of them for making the process easier, thereby allowing me to learn and to gain satisfaction from the experience.

The author sincerely appreciates the direction and guidance from the practicum committee members. Dr. Don Fuchs, Dr. Barrie Humphrey, and Jeannette Block. Their substantive comments, interest and positive encouragement in the study played a major part in the quality of the completed work.

This practicum was undertaken in Nanaimo, British Columbia. As Dr. Humphrey was the only committee member here, he bore much of the brunt of my learning efforts. He helped me to overcome my number phobia, initiated me into the world of computers, and taught me the mysteries of statistical analysis. He endured the verbal processing which I required to work out my ideas, provided corrective feedback, was always affirming, and led me to achieve a much higher standard than I would have otherwise done.

Thanks must be given to the key informants and survey respondents, who so freely shared their ideas and time. Their willingness to do so, and their interest in the research was very encouraging.

Appreciation must also be expressed to Bev Wilden who helped pre-test the research instruments, and risked our friendship to provide much needed feedback at a critical point in this project.

The psychogeriatric team that I work with also deserves thanks for enduring my brainstorming, and providing encouragement. A special thanks to Mike Provencher for his input into the survey design, both content and format. Linda Inscho must be thanked for her willingness to help me organize and edit the final document under considerable time pressure.

Finally, the author would like to express special thanks to her husband Fergus, for his patience, support and understanding, and for taking over the entire domestic and parenting load, while I developed and completed this project. I thank my children, Noah and Shannon for their tolerance of my preoccupation with the research, and for giving up their computer games while I monopolized the computer.

TABLE OF CONTENTS

Chapter 3

Chapter 4

Chapter 5

LIST OF APPENDICES

LIST OF TABLES

LIST OF FIGURES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

PURPOSE OF THE RESEARCH

The purpose of the research is to describe systematically all Psychogeriatric Outreach Programs in western Canada that provide services to elderly people living in the community, and to compare these to an ideal model developed from a review of the literature.

STATEMENT OF THE PROBLEM

The community psychogeriatric outreach program is a fairly new service model. It has been developed to meet the needs of elderly persons with mental disorders residing in the community, with the objective of reducing or delaying the need for institutional care. The need for such services to this population is growing due to the increasing elderly population, the documented increase in the prevalence of mental health disorders as people age, and concerns about health care costs.(Health and Welfare Canada, 1991e).

No definitive model for the development of community psychogeriatric outreach programs has been documented. In the "Guidelines For Comprehensive Service To Elderly Persons With Psychiatric Disorders" (1988b) general principles for the development of a comprehensive approach for services are provided but no "recipe" is suggested. Shulman

and Arie,(1991) state that "the inherent complexity of the services, the different level of resources and personnel, the local historical antecedents and the special nature of each setting make it impossible to provide a definitive document".

A number of theoretical models for psychogeriatric services in Canada have been proposed by Goldstein, (1980), Wasylenki, (1982), Rodenberg, (1985), Harris et al, (1990), and Shulman, (1991). Shulman and Arie, (1991) have described psychogeriatric services in Great Britain. Houston, (1980), Wasylenki, (1984), Wargon et al, (1987), Harris et al, (1990), and Grauer et al, (1991), have provided the only description of Canadian community psychogeriatric outreach programs in the literature.

Cole, (1989), points out that there is a lack of research into the effectiveness of geriatric psychiatry services. In the current climate of concern for government spending in general, and health care costs in particular, it is important to be able to identify what community Psychogeriatric Outreach Programs actually do, whom they serve, what services are provided to clients, and how different programs/models compare to each other. Due to the relative newness of the field of psychogeriatrics and the paucity of documentation in the literature we know very little about these areas.

As noted above, the number of elderly with mental dysfunction is increasing. Various forms of community psychogeriatric outreach programs have been put into place to serve this group. Additional programs are being planned, and current ones are expanding. Thus

it is imperative that current psychogeriatric outreach services are studied so policy makers and program planners can determine what programs actually do, what types of teams are in place, who refers clients for what reason, how many and what kinds of clients are being served , and what services are provided. Evaluation of program impact, and what components of service are most important in the efficient delivery of services, are important areas for future research.

GOALS OF THE RESEARCH

This practicum was intended to be the first step in laying the foundation for future research by systematically describing all the community Psychogeriatric Outreach Programs currently in existence in western Canada.

The results identify the services currently available to elderly persons residing in the community, suffering from mental disorders. It was possible to identify general client characteristics, and universal characteristics common to all psychogeriatric community outreach programs. The data collected could be used in future research to assess the evaluability of individual programs and the potential for comparison of different programs/models to each other. The data provided information about what disciplines are employed in this field, what services are offered, and who funds community psychogeriatric outreach programs. The results of this research will be of interest at the program planning and policy development level both in designing new programs and in fine tuning existing ones. The following are the objectives that were undertaken to reach

reach the goal;

- To describe programs currently operating in western Canada that provide psychogeriatric services to the community.
- To describe the mandate and objectives of programs.
- To examine whatever documentation (eg program brochure, mission statement, annual report), is currently available about each program.
- To determine what data/statistics each program collects about its services and clients.
- To determine the caseload of programs.
- To identify the reasons for which clients are referred to psychogeriatric programs.
- To identify the referral sources of programs.
- To determine the demographic characteristics of the clients of programs.
- To identify the diagnostic characteristics of clients in programs.
- To identify the disciplines program utilizes.
- To determine how many staff programs have.
- To document the range of services offered by programs.
- To identify the areas assessed in a psychogeriatric assessment.
- To compare program similarities and differences.

OPERATIONAL DEFINITIONS

The following is a list of operational definitions of key terms, used in searching the literature and in designing the research.

The definitions of psychogeriatric, mental dysfunction, and elderly used in "Guidelines for Comprehensive Services to Elderly Persons With Psychiatric Disorders" (Health and Welfare Canada, 1988B), were adopted.

Psychogeriatric, Geriatric Psychiatry: used interchangeably and denote the psychiatric subspecialty which addresses itself to the care of the mentally impaired elderly; denotes a broad specialty area concerned with all aspects of patient care and functioning.

Mental Dysfunction, Mental Impairment, Mental Health Problems, Mental Disorders, Mental Illness: used in a broad sense to refer to the acute or residual effects of a psychiatric disorder, whether it be dementia, a functional psychosis, an affective disorder, or some other condition.

Elderly: people 65 years or older.

Client: recipients of psychogeriatric services.

Community: anywhere an elderly person resides outside of an acute care hospital, or mental hospital.

Outreach Services: services provided outside the doors of the organization.

Services: encompasses patient and non-patient activities, such as consultation, assessment, education, treatment, liaison, referral.

Psychogeriatric Outreach Program: any program that identifies itself as providing mental health services exclusively to the elderly. In the case of institutions, the services are provided outside the institution's physical boundaries.

LEARNING OBJECTIVES

Through completing this practicum, I expected to acquire a broad and in-depth knowledge of how community Psychogeriatric Outreach Programs are providing services in western Canada. As well, I expected to develop expertise in the development, design, and implementation of survey techniques, and in data analysis.

The specific skills I expected to learn were as follows:

Ability to develop, design and implement a survey.

Ability to develop and design a survey instrument.

Ability to analyze data using appropriate statistics.

Ability to relate the results of the analysis to existing studies/literature.

Ability to relate research results to social policy, program planning, areas of future research.

ORGANIZATION OF THE PRACTICUM REPORT

The practicum report was organized in such a way as to identify why there is a need for community psychogeriatric programs, and the current organization of psychogeriatric services in Canada. An ideal model for the delivery of community psychogeriatric outreach services has been developed from the literature review, and compared to existing programs that were surveyed. An analysis of the survey data, and a discussion of the results was undertaken; recommendations for program planning and research were derived from the results.

Chapter 1 is comprised of a literature review that provides,

(1) an overview of the trends that have led to the development of the field of psychogeriatrics;

(2) a statement of the need for psychogeriatric services that identifies the most common psychiatric disorders, and other normative and psychosocial issues that contribute to the need for specialized services;

(3) a rationale for the importance of multidisciplinary community psychogeriatric teams in providing services to address the needs of psychogeriatric clients.

Chapter 2 is comprised of a literature review that

(1) describes theoretical models of how psychogeriatric services should be delivered;

(2) describes Canadian community psychogeriatric outreach teams reported in the literature

Chapter 3 proposes a model for an ideal community psychogeriatric outreach team, derived from the literature review, and to which existing services will be compared. Chapter 4 reports on the methodology for selecting key informants, and the design of the key informant questionnaire. The results of the key informant survey are reported. Chapter 5 reports on the methodology for selecting the programs that were surveyed, the development of the survey questionnaire, and limitations of the research. The results\data

analysis of the survey of psychogeriatric programs, are reported. Chapter 6 discusses the results in relation to the "Ideal Model", the implications of the results for program planning\policy, and points to areas for future research. Chapter 7 provides a summary of the results, conclusions and recommendations. Chapter 8 provides an evaluation of the writer's learning.

CHAPTER 1

LITERATURE REVIEW

Development of the Field of Psychogeriatrics

The purpose of the literature review is to provide an overview of

(1) the development of the field of Psychogeriatrics,

(2) the organization of Psychogeriatric services in Canada. The key components of a community Psychogeriatric outreach program derived from this literature, will be identified.

The literature review will focus on the following areas:

(1) trends that have led to the development of the field of psychogeriatrics;

(2) a statement of the need for psychogeriatric services that identifies the most common psychiatric disorders, and other normative and psychosocial issues that contribute to the need for specialized services;

(3) a rationale for the importance of multidisciplinary community psychogeriatric teams in providing services to address the needs of psychogeriatric clients;

(4) theoretical models of how psychogeriatric services should be delivered;

(5) Canadian community psychogeriatric outreach teams reported in the literature.

Psychogeriatrics

The nature and principles of psychogeriatrics has been delineated as follows, "Psychogeriatrics is comprised of a body of knowledge on the psychiatry 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."(Health and Welfare Canada, 1988b).

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

The general aims of psychogeriatric care include the reduction of stress to patient and family, the improvement and maintenance of (psychosocial/physical/cognitive) function, and mobilization of the individual's capacity for autonomous living (Health and Welfare Canada, 1988b).

Historical Development of the Field of Psychogeriatrics

Psychogeriatrics first began to emerge as a separate field in the 1950s. In Mental Health Care of the Elderly:Proceedings of a Colloquium on Issues and Service Assessment and Education (1985), Dr. Kral of London, Ontario, gave an overview of the development of geropsychiatry. He pointed out that although the term geropsychiatry is relatively new, psychiatrists have cared for aged mentally ill patients for a long time. He described two

stages in the history of geropsychiatry. The custodial stage covered the period up to World War II. During this stage, aged patients who exhibited pathological behaviour patterns with cognitive and memory impairment were committed to mental hospitals for custodial care for their own protection as well as for the protection of others. The number of admissions of such patients was relatively small. The expected lifespan was shorter than it is today, therefore the number of elderly individuals requiring psychiatric care at any time was even smaller. These patients usually remained in hospital until their death. Therapy was symptomatic, not only because there were no psychopharmacological drugs, but mainly because mental disorders of the aged, regardless of their symptomology and course, were considered expressions of cerebral aging, eventually leading to dementia and death. Consequently, mentally sick elderly patients were considered a homogenous nosological group. The attitude of psychiatry towards the aged mentally ill changed fundamentally after World War II, according to Kral, (1985). The steady increase in longevity of the population which led to a steadily increasing number of aging and aged people was one factor. This in turn brought more physicians, psychiatrists and paramedical personnel into contact with the elderly, whom they treated both within and outside of hospitals. There was thus an increasing awareness of the fact that the aged do not form a homogenous group.

In 1955 Sir Martin Roth published a paper on the natural history of mental disorders of the aged, that became a milestone in the history of geropsychiatry. Roth followed 450 patients of both sexes over 60 years of age who were admitted to mental hospitals in

England. He described 5 different diagnostic groups - senile dementia, arteriosclerotic dementia, affective disorders, late paraphrenia, and acute confusional states - which provided a basis for a geropsychiatric nosology. The impact of this new psychiatric nosology on psychiatrists and the medical profession in general was enormous. It became clear that the mentally ill aged were not a homogenous group of hopeless old people destined to become demented and die after a terminal vegetative existence; rather, this group was seen as suffering from the same kind of mental diseases as younger adults, although in a somewhat different proportion. Roth stated that dementia affected only about 30% of this population, where the other diseases which form the majority of case material were treatable, some even curable by modern psychiatric, therapeutic methods, (Roth,1955).

Today the psychogeriatric population is receiving increased attention from provincial and federal levels of government, health care institutions, community agencies, and universities, as evidenced by the growing number of interest groups, conferences, grants, publications and task forces in the field.

"The compelling importance of the field of geriatric psychiatry stems not only from the growing number and proportion of elderly, especially the very old over 80, but equally from gains in longevity and active life expectancy. This change in the life span means that old age occupies a larger proportion, currently about 20% of an average life. Consequently, the quality of life in old age, and the impact of psychiatric problems on

that quality, are growing in relevance to the whole of a person's life." (Gurland, 1991 p. 100).

GENERAL ENVIRONMENT

Hasenfield (1983, p 51) states that the general environment denotes, " those conditions in the environment - economic, demographic, cultural, political-legal, and technological- that affect all organizations and must be assumed as given." The following conditions in the general environment will be discussed in relation to the emergence of the field of psychogeriatrics:

(1) An aging population with a concurrent increase in psychiatric problems:

In 1988 the Mental Health Division of the Department of Health and Welfare Canada produced a report "Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders," which looked at population projections related to the prevalence of mental health disorders in the elderly. Their findings included:

(a) 10% of the Canadian population is aged 65 or over and that this proportion is expected to rise to 13% by the year 2000.

(b) The number of old old, i.e., those aged 85 and older is increasing most rapidly. With increasing age there is an increased risk of dementia and other disabling diseases.

(c) The most common mental disorder of later life is depression. Depression is more prevalent among the elderly than in the general population).

(d) 10% of the population aged 65 years and over is thought to suffer from mild to moderate dementia and 5% from severe dementia. In the group over 80 years of age the rate of severe dementia may be as high as 20%. Since most dementias are progressive and irreversible, their prevalence will inevitably increase with the growing proportion of elderly in the population, their increasing life span, and the longer survival of those affected. Most people with dementia are cared for at home although many in the final stages require institutional care.

(e) Other psychiatric disorders also occur among older people including neuroses (5%), personality disorders, (5%) and paraphrenia, (4%). Substance abuse and related disorders also occur.

(f) Certain disturbances of mental function, i.e. confusion or delirium may be associated with systemic infection, adverse drug reaction, trauma or surgery. These symptoms are often transient and disappear with treatment of the underlying conditions.

These findings make a strong case for addressing the growing needs of the mentally ill elderly.

(2) Care in the home is a "motherhood" value:

Keeping the elderly in the community as long as possible underpins many current programs. Wasylenki (1987) provides a rationale for providing community based care for

(a) Given the expanding elderly population and the higher prevalence of psychiatric disorder there can never be enough institutional beds to treat everyone.

(b) Elderly people prefer treatment at home in an attempt to avoid contact with institutional services.

(c) Relocation of elderly patients is widely recognized to have often deleterious effects, including anxiety, depression and even death.

(d) It has been shown that in areas that provide adequate community support a significantly higher proportion of ill people can be accommodated at home.

(3) Deinstitutionalization is seen as a positive value:

The trend to deinstitutionalize has spread from other fields, (i.e. mental health, mental retardation), to the care of the elderly. Keeping the elderly in the community as long as possible is seen as intrinsically good, as noted above. Maximum quality of life is assumed to be found "at home." However, questions that have been recently asked about whether or not deinstitutionalization has benefitted the chronically mentally, may be equally relevant to the elderly.

"Large number of such patients are unable to function in any meaningful social or occupational role; 20-30% of homeless individuals are mentally ill and in need of treatment; and significant numbers of mentally ill individuals occupy detention centres and jails". (Wasylenki, 1992, p. 200).

(4) Push to reduce costs in the health care system:

Inflation, fear of recession and policies of fiscal restraint have impacted on all human service organizations. As government funders search for ways to cut costs, there is increased pressure for fiscal accountability and demands that program efficiency be demonstrated. When this cannot be done adequately, reduction in services, program eliminations, budget freezes, staff freezes, etc. may follow. Human service organizations are asked to "trim the fat and live in the black." The health care system has certainly been affected by these trends and is searching for ways of reducing costs. Increasingly the care of the elderly has come under scrutiny. Frequently elderly people remain in acute care hospitals because there are no resources available in the community to meet their needs (Novak, 1988). In cases where disturbed behaviours exist, some long term care facilities have refused to accept transfers from acute care hospitals. (The cost of acute care hospital bed is considerably greater than the cost of a long term care bed.) There is a general belief that the cheapest way to provide care to the elderly is in the community, although as Novak (1988, p. 162) points out, this is not always true.

It is important to note that current values relating to the desirability of maintaining the elderly at home, can be used as palatable rationales for reducing their access to long term care and acute care, with the greater agenda being to reduce health care costs. If "home care" is truly to provide the "best" care for the elderly, adequate community resources to support them and their caregivers must be in place. As pointed out in "Mental Health For Canadians: Striking A Balance", there is not yet a consensus of what the essential

ingredients are for a comprehensive system of community mental health care. "The closing of hospital beds has seldom been offset by a corresponding strengthening of community resources." (Health and Welfare Canada, 1988e, p 21).

(5) Development of Psychotropic drugs to control psychiatric symptoms:

This technological innovation has made it possible to manage mentally ill people outside of institutions, and the reduction in their symptoms has facilitated their acceptance in the community, (Health and Welfare Canada, 1988b).

(6) Growing recognition that existing mental health services for the elderly are fragmented and deficient:

The Report on Future Directions for Psychogeriatric Service Delivery in Manitoba, (Mar. 1988); Wasylenki et al, (1987) in Ontario; Lehman, (1989) in Quebec; and Shulman, (1992) in Ontario, have all noted that mental health services for the elderly are fragmented, often competitive and that continuity of care is difficult to achieve, particularly between community and institution. The community sector and institutional sectors operate autonomously one from the other, and often clients are "lost" between one system and the next. This can also occur between community agencies and between hospitals and personal care homes. With no formal interface, assessments and treatment plans are often limited in their scope and may lack accuracy and/or comprehensiveness. It is generally believed that the elderly, in particular, need coordinated and integrated services (Health and Welfare Canada, 1988b).

Rodenburg, (1985) of Kingston, Ontario identifies that one of the most serious defects in the delivery of mental health services to elderly patients in Canada is the lack of comprehensive medical and psychosocial assessment aimed at the proper placement of such patients.

(7) Shift from the Medical Model to the Social Model in the delivery of health care: The medical model focuses on the treatment of diseases and injuries, with treatment generally taking place in the doctor's office, or hospital. The social model sees medical care as only one part of a complete health care system which would include personal and family counselling, home care and adult day care programs. Care, in the social model, often takes place in the client's home or other non-institutional setting (Novak 1988). A growing acceptance of the social model as the most appropriate way to deliver health care to the elderly, contributes to a belief that the psychogeriatric population can be well cared for outside institutions, and supports the development of community based programs.

(8) Recognition of barriers to the utilization of adult mental health services by the elderly:

Lebowitz, (1988) in reporting on an American study of low utilization of Community Mental Health Centres by the elderly, reported that the stigma of mental illness is especially strong in current cohorts of elderly people who tend to associate mental disorder with personal failure, spiritual deficiency or some other stereotypical view. Richman,(1985) found that elderly persons in New Brunswick showed a high rate of

hospitalization for mental disorders; however, they are more likely to be diagnosed and treated in non-specialized wards of generalized hospitals than in psychiatric units, and are least likely to have contact with mental health clinics. Zarit, (1980) showed that the elderly are under-represented in mental health clinics and in the practice of private psychiatrists.

German, et. al., (1985) in an American study of the utilization of services by elderly patients with mental morbidity, found that older individuals with mental disorders are less likely to be seen and treated for these disorders than are younger individuals.

Patterson (1976) studied the services provided to the elderly by eight American community mental health centres to determine how these centres were responding to the needs of the elderly. Patterson stated that the elderly experienced discrimination and proposed two reasons for this: negative attitudes towards the elderly held by staff, and a false belief that most psychiatric conditions in the elderly are untreatable. He suggested that the utilization rate of the elderly was much lower than the population size would indicate it should be, due to;

(1) Lack of belief in appropriateness of mental health assistance. The elderly did not like to use mental health services due to stigma. The service providers did not believe that their programs were suitable for the elderly.

(2) Transportation. This is a serious obstacle for the elderly in getting to the treatment centres.

(3) Cost of service. The ability of the elderly to meet the cost of mental health service in the United States is limited by low retirement income and the limitations of medical coverage.

Cohen (1976) discussed the problem of accessibility to mental health services by the elderly in the United States. He reported that attitudes held by psychiatrists led to reduced services for the mentally ill elderly. Stereotypes held by therapists and misinformation regarding older people interfere with the recognition of the elderly's problems and may preclude a decision to provide treatment.

Butler (1975) suggests that ageism "which is the process of systematically stereotyping and discriminating against people because they are old" allows those of us who are younger to see old people as different. We subtly cease to identify with them as human beings, which enables us to feel more comfortable about our neglect and dislike of them. Butler believes that many psychiatrists and other mental health specialists share the wider culture's negative attitude towards older people and that this is one of the reasons that the elderly do not receive their share of psychiatric care. Butler thinks that ageism is a thinly disguised attempt to avoid the personal reality of human aging and death.

Summary

It is clear from the foregoing that a growing elderly population with a concurrent increase in psychiatric problems, will require the development of more services to meet the

demand. Shifts in attitudes and values that have led to the belief that the mentally ill elderly are best treated in the community. It was pointed out that barriers exist that make it unlikely that the needs of the psychogeriatric population can be met by simply extending the services of the current adult mental health programs.

In the next section, the needs of the elderly that distinguish them from younger adults will be discussed. Common psychiatric disorders and other normative and psychosocial factors that contribute to the need for specializes services will be described.

STATEMENT OF THE NEED FOR PSYCHOGERIATRIC SERVICES

DEMOGRAPHIC CHARACTERISTICS OF THE ELDERLY POPULATION

In 1991 Health and Welfare Canada published a report, "Mental Health Problems Among Canada's Seniors: Demographic And Epidemiologic Considerations", that integrated prevalence rates for mental disorder among seniors with demographic trends. Their findings included:

According to the 1986 Canada Census figures, 10.7% of the Canadian population is over age 65. Life expectancy for males reaching age 65 in Canada is 79.9; for females, 84.2, on average. By 2006 the Canadian population as a whole will experience 21% growth over 1986 levels. Growth among the seniors population in total will increase even more, however: by 62%. The 65 - 74 age group will grow 38%, while the number of people

over 75 will double in the same period. The 75+ group is the most frail and subject to more chronic diseases than other groups.

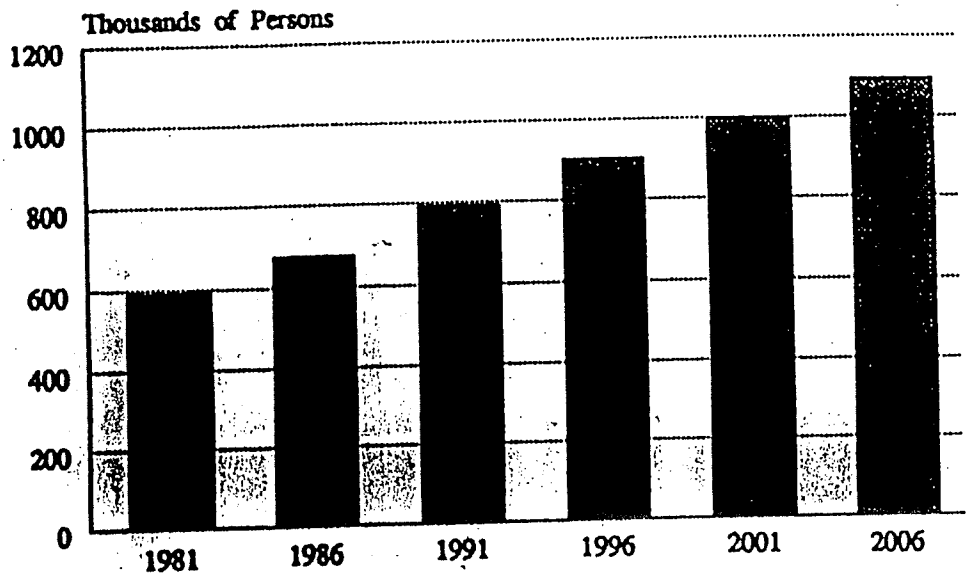
Eight per cent of Canadian elders live in institutions, with twice as many women as men in long term care facilities; at 75 and over, this ratio almost reaches 3 to 1. There is a strong linear relationship between age and institutionalization.

PREVALENCE OF MENTAL DISORDERS

The Canadian Medical Association (1987) stated that at any given moment, approximately 30% of Canadian seniors require mental health services. In the United States estimates place total prevalence of mental disorders at 17% (Kramer, German, et. al., 1985). Health and Welfare Canada (1991E) places the prevalence rate at 25% and used this figure to estimate elderly mental health cases in Canada from 1981 to 2006 (Table I). Gurland and Cross, 1982 suggest that 15 - 20% of the elderly may be in need of psychiatric services. Blazer et. al. (1982) reported that 5-10% of seniors in the community suffer from severe psychiatric impairment and another 10 - 40% suffer from mild to moderate impairment.

Table 1

Estimated Elderly Mental Health Cases, Canada



Source: Health & Welfare Canada, 1991e, p. 10.

The Organizing Committee, Canadian Consensus Conference on the Assessment of Dementia, (1991), based on a study by Evans, Funkenstein, Alberts et al, (1989), state that approximately 10% of those over 65 years of age and up to 40% of those over age 85 suffer from a type of dementia. Gurland and Cross, (1982), in an American study, found that 7.5% of all elderly suffer from progressive dementia; and about two-thirds of these reside in the community.

A North Carolina study using a stratified random sample of community elderly over age 65 found that approximately 7% of those studied had definite cognitive impairment (Blazer and Maddox, 1982).

Roberts, et. al., (1989) investigated cognitive impairment in a study of elderly Saskatchewan residents living in community and long term care facilities. They found that the prevalence of clinically significant cognitive impairment increases with age and with the dependency level in long term care facilities, and that 7.8% of the elderly population have cognitive impairment.

Rovner, et. al. (1986), of Baltimore, Maryland, using a standardized interview, found that 94% of a random sample of 180 residents at a large intermediate-care nursing home had mental disorders, according to DSM III-R criteria, with dementia the most common diagnosis. Toff and Sallet,(1986) found a prevalence of dementia in long term care institutions at about 50% Of these, 70% have a primary degenerative dementia of the Alzheimer's type.

NEED FOR SPECIALIZED SERVICES FOR THE PSYCHOGERIATRIC CLIENT

Specialized expertise and skills are necessary in diagnosing and treating the psychogeriatric client due to the complex and multiple etiology of psychogeriatric illness (Health and Welfare Canada 1988b). A basic principle of psychogeriatric assessment is that the cause of the problem does not necessarily lie in the client alone, and she/he must be seen in the context of her/his social and physical environment. The biological, psychological, social, functional and environmental factors are intimately enmeshed, and these strands must be unravelled for a complete understanding of the client's functioning. This section will describe the most common mental disorders afflicting the elderly, and then discuss some general issues that are important to consider in the assessment and treatment of the psychogeriatric client. The benefits of a multidisciplinary psychogeriatric team in addressing these issues will be highlighted.

COMMON PSYCHIATRIC DISORDERS AFFECTING THE ELDERLY

DEMENTIA

Dementia was defined by the Organizing Committee, Canadian Consensus Conference on the Assessment of Dementia, (1991) as a clinical syndrome of usually progressive, cognitive deterioration that eventually causes functional impairment developing over months and years. Deficits occur in intelligence, memory, affect, judgment, orientation and visual/spatial skills, and involve all facets of cognition. Martin, (1987), Lazerus, (1988) and Spar and LaRue,(1990) have all described the common symptoms of dementia.

The Organizing Committee, Canadian Consensus Conference on the Assessment of Dementia, (1991) stated that since dementia primarily afflicts old people, especially those of 85 years of age, the absolute number of cases will continue to increase well into the next century. In part this is due to a small baby boom that occurred between 1918 and 1930 (Humphrey 1986). This accounts for the large proportion of people ages 62 - 74 years in the current population .As these people age we can expect a higher number of cases of the mental disorders of late life, especially dementia to occur in the 1990's. Dementia is one of the most important conditions because it requires a disproportionate amount of medical care and caregiver support.

Dementia is a disorder in itself, but there are many conditions that can mimic or co-exist with dementia. Conditions that can mimic dementia area aphasia, dysarthria, psychosis, blindness, deafness and amnesia; delirium and dementia often co-exist as do dementia and depression (Organizing Committee, Canadian Consensus Conference on the Assessment of Dementia, 1991).

Dementia victims are a major challenge to care for, be it by elderly spouses, community services or long term care facilities. Affective and psychotic symptoms occur in 30 - 40 % of Alzheimer Dementia patients, (Wragg and Jeste, 1989). Teri et. al. (1988) found that 88% of the elderly with severe cognitive impairment have associated problem behaviours. Difficult behaviours such as wandering, aggression, hoarding, intractability,and restlessness at night can make these clients difficult to live with. Martin (1987) describes

changes in personality, emotions and behaviours that are difficult to adapt to. Caregivers must be diligent and anticipate behaviours that might harm the client or others. It is imperative to rule out all treatable conditions that mimic dementia, and to treat all conditions, (in the broadest sense), overlaying a diagnosis of dementia.

While dementia is progressive and irreversible, behavioral disturbances that occur can frequently be treated and this will improve the quality of life for both patients and caregivers.

As it is generally the spouse who provides care for dementia victims in the community, it is an elderly caregiver who is usually faced with the burden of dealing with this devastating illness (Zarit, 1987).

Many dementia victims have no family caregiver, and remain at home at risk, supported by community support systems and informal caregivers. Robertson and Reisner (1982), found that demented elderly persons living alone were more vulnerable to death or institutionalization than those living with family. Psychogeriatric teams are frequently consulted by other health care professionals to assess the risks of demented clients living alone. The balance between the client's right to independence/autonomy must be weighed against risk to himself and others, with no standardized method of evaluation. The perspectives, knowledge and skills of a number of disciplines are required to examine the

strengths and weaknesses of the client, in the context of both the environment and social system in which he lives, in order to determine the most appropriate care.

Most clients will ultimately require institutionalization. The behaviours of the demented individual - wandering into others' rooms, inappropriate touching, rummaging through others' belongings - may be difficult for other residents to tolerate. Outside his own home, the demented victim cannot rely on overlearned behaviours, the familiarity of his usual surroundings and thus usually functions at a lower level than previously. The increased sensory input of the institution and the demand to adapt to institutional norms of behaviour may be stressful for this client. Caregivers, both formal and informal, often have very little information or education about dementia, and frequently have difficulty providing appropriate care. This often leads to the inappropriate use of physical and chemical restraints, or unnecessary referrals to emergency rooms or psychiatric units.

It is clear that the full range of knowledge and skills represented on a psychogeriatric team are necessary to assess the complex array of biopsychosocial and environmental factors that contribute to the demented client's ability to function at an optimal level. These clients are best assessed in the familiar environment of home, and home assessments are a cornerstone of psychogeriatric service. Interventions ranging from medical, pharmaceutical, behavioral , environmental and caregiver education and support may all be necessary to support the client's living situation, be it alone, with family or in a long term care facility.

DEPRESSION

Depression is one of the most common psychiatric disorders seen in the elderly. It is often overlooked as there is a tendency by both clients and caregivers to ascribe such symptoms as sadness, social withdrawal or memory loss to normal aging or normal reactions to being old.

Health and Welfare Canada, 1991E) reports that a large American epidemiologic survey found that 8% of community dwelling seniors suffered from depression that required clinical intervention, and another 19% suffered dysphoric symptoms. In another American study advancing age was found to increase the risk of depression, with 15.5% of persons over age 80 clinically depressed. (Kay, Henderson et al, 1985).

Suicide, while seen by some as voluntary euthanasia, is most often seen as an outcome of severe depression and loneliness. During 1986, 13% of the total number of suicides in Canada were committed by people over 65 (Health and Welfare Canada, 1991E).

Weiss, (1968 p. 748) found the major factors in the high suicide rate among elderly Americans to be "isolation, along with depreciating socio-cultural attitudes, low socio-economic status with loss of psychologically and socially rewarding occupation, biological decline and clinically recognized psychiatric disorders."

Accurate detection of depression in old age can be complicated by many factors. Some features of normal aging overlap with complaints of depression and with changes associated with normal bereavement (Spar and LaRue, 1990). Some physical illnesses can cause depression (Spar and LaRue, 1990). Some medications can cause depression (Spar and LaRue, 1990, McCullough, 1991). Delusional depressions occur in which delusional thinking occurs along with other signs of depression (Wasylenki et al, 1987).

McCullough, (1991) discusses typical presentations of depression in old age. He states that depression can be masked as pseudo-dementia, somatization or anxiety/irritability, and that it may be an underlying factor in pain syndromes and alcohol abuse. He also notes that depression may be a primary or secondary symptom of a concomitant medical condition such as thyroid disease and occult neoplasm. Losses are common with the elderly, and distinguishing between normal changes associated with bereavement, and depression, may be difficult (Wasylenki et al, 1987).

Depression often presents differently in the elderly than in younger adults. Hypochondriasis is a prominent feature and agitation more commonly occurs with the elderly than with younger adults (Wasylenki et. al., 1987). Masked depressions occur whereby the client does not identify depressed mood, but rather complains of reduced energy, listlessness and increased fatigue. Both the client and the caregiver may attribute these symptoms to aging. Pain of unknown origin often masks depression, but once the

pain becomes chronic, it is increasingly difficult to distinguish its effect on the patient with signs of depression.

Meats, et. al., (1991), McCullough, (1991), Keane, et. al., (1988), and Gurland, (1991), all point out that depression in the elderly is treatable but early diagnosis is important, as after two years, it becomes difficult to distinguish depression from physical illnesses and pain management.

Accurate diagnosis is essential to the provision of appropriate treatment of depression. It is apparent that a multidisciplinary team approach is required to assess depression in the elderly. Specialized psychogeriatric expertise is needed to "tease out" underlying treatable causes of depression (i.e. grieving, social factors, physical disorders, medications etc.), and to recognize masked clinical depressions. Where a clinical depression is diagnosed, interventions reflect the skills of a number of disciplines, and may include medications, ECT, medical treatment of physical disorders, psychotherapy, emotional support and augmentation of the social support system. A psychogeriatric team assesses both the client, and the client within the social system, and is in an ideal position to assess and treat this complex disorder.

DELIRIUM

Sirois, 1988, states that delirium accounted for 13% of hospitalized patients referred for medical or surgical consultation, the majority of whom were elderly.

An estimated 30 - 50% of elderly individuals admitted to acute care facilities will develop an acute confusional state for which there are multiple biopsychosocial causes (Mattice, 1989).

Beresin, (1988), of Massachusetts, describes delirium as the most common and serious mental disorder in old age heralding death, and 25% of afflicted elderly patients die within one month of entry to hospital. Delirium is characteristically a transient disorder, which usually results in full recovery, provided it is rapidly diagnosed and treated. He cites biological variables, psychological variables and environmental variables that predispose a patient to delirium, and lists organic causes of delirium.

Lipowski (1989) of Toronto, states that, "the factors that predispose the elderly to delirium include aging processes in the brain, structural brain disease, a reduced capacity for homeostatic regulation, and hence a resistance to stress. The impairment of vision and hearing, a high prevalence of chronic diseases, reduced resistance to acute diseases and age-related changes in the pharmacokinetic and pharmacodynamics of drugs. Sleep loss, sensory deprivation, sensory overload and psychosocial stress, bereavement or relocation to an unfamiliar environment are common precipitants to delirium."

In summary, delirium is a medical emergency and requires prompt medical, (usually acute care hospital), treatment, but is often unrecognized (Beresin, 1988, Lipowski, 1989).

Early detection and prevention through sensitivity to predisposing factors can prevent hospitalization and perhaps even death. Non-medical psychogeriatric team members can be trained to recognize these factors as well as the signs and symptoms of delirium, thus providing a screen for medical team members who are often only consultants to the psychogeriatric team. The availability of a physician to the psychogeriatric team is crucial in identifying delirium and ensuring timely intervention.

PARANOID DISORDERS

Silver, (1986) of Toronto, Ontario, reported that a community survey found as many as 4% of the population over age 65 residing in the community demonstrated significant paranoid ideation. While their numbers are small their impact on others is significant.

Paranoid disorders in old age include:

- Organic syndromes with delusions
  - dementia with delusions
  - delirium with delusions
  - organic delusional disorders
- Late paraphrenia
- Major affective disorders with mood congruent disorders
- Paranoid personality disorders
- Paranoid recluse syndrome

(Silver, 1986)

The essential features of paranoid disorders are delusions

"which can't be accepted by people of the same class, education, race, and period of life as the person who expresses it, and which can't be changed by logical argument or evidence"

(Anderson and Trethowan, 1973)

Visual impairment occurs in 25%, and hearing impairment in 50% of people with late paraphrenia (Silver,1986). Social isolation is associated with paranoid symptoms, (Wasylenki, 1987).

Examples of persecutory delusions include beliefs that one is being spied upon, stolen from, cheated, talked against, drugged, or poisoned. These can be very disturbing to the client, and also to those in the social support system who often suffer from their accusation. These clients are usually brought to the attention of the medical or mental health systems by others who are upset by their behaviours, or by the police. Wasylenki identifies treatment as a combination of psychotherapy, reducing the threat from the environment, correction of sensory deficits and antipsychotic drugs. He also notes that treatment, especially in-patient, is very difficult due to the client's extreme suspiciousness.

The role of a psychogeriatric team is important in determining underlying causes and contributing factors, both physical and social. The skills of a number of disciplines are involved in assessment and treatment. A major emphasis is working with the client's

social support network to increase understanding and tolerance of the client's behaviour, and to stabilize the system to enable the client to remain in as stable an environment as possible.

IMPORTANT ISSUES TO BE AWARE OF IN WORKING WITH PSYCHOGERIATRIC CLIENT:

As noted earlier a psychogeriatric assessment includes much more than the dignosis of psychiatric disorder. It should be clear from the discussion of the common psychiatric disorders that afflict the elderly, that psychosocial factors and normative transitions can have major impacts on the elders' mental health. The following provides a discussion of important issues that those working in the field of psychogeriatrics must be knowledgable about and sensitive to in their work.

CAREGIVERS

Most elderly people live in the community (Clark, 1987, Lazerus, 1988). Care, when required, is usually provided by family, most often by an elderly spouse or a daughter. Bergman, (1978), Robertson and Reisner, (1982) and Brodey, (1981) indicate family caregivers provide a great deal of care to the cognitively impaired elderly.

Bergman, (1978) showed that the most important factor effecting a person's viability in the community was family support.

The presence of an older person requiring care is frequently a source of stress in the family, particularly on the primary caregiver. Anxiety, guilt, fatigue, physical illness, restricted social contacts and depression are often the hallmark of an adult caring for an elderly relative, according to Clark, (1987). The stress of caregiving for dementing clients, in particular, is well documented in the literature, (Zarit, 1987). The care of dementia clients is especially difficult, as the caregiver must come to terms with the loss of the personality/individuality/companionship of the spouse and develop a relationship with a constantly changing, downward spiralling victim.

Elderly caregivers are just as subject to chronic, degenerative and acute disease processes as is the person to whom they provide care. Often they become socially isolated through as a result of the care giving responsibilities and at risk for depression (Health and Welfare Canada, 1991E).

Brodaty and Hadzi-Pavlovic, as reported in Jones, (1991) found high psychological morbidity was associated with living with a demented individual, particularly a spouse with demanding problem behaviour. Poor care of physical health, social isolation, dissatisfaction with social supports, greater use of psychotropic medication and a deteriorated marital relationship, were all associated with living with a demented spouse.

Clark,(1987) states that caregivers have five primary needs: emotional support, education, support groups, information and community resources, and relief from the caregiving role

when the burden becomes onerous.

Health and Welfare Canada, (1988b), describe the needs of family caregivers for information, education, support services, emotional support and counselling.

Psychogeriatric teams are frequently asked to assess the cognitive functioning of demented individuals and to suggest ways that they can be optimally managed in the home. Caregivers often become the focus of the intervention, once the client has been assessed. For example, a client who has been assessed with severe cognitive impairment may receive no direct interventions by the psychogeriatric team. Instead, the focus may be on educating the caregiver about the limitations of the client, coaching on approaches to take in interacting with the client, and the provision of counselling to help deal with some of the frustrations and feelings commonly experienced by caregivers. (While this discussion has focused on family caregivers, caregivers in long term care facilities often require very similar education and support to provide optimal care to the demented, (Health and Welfare Canada, 1991b). Interventions with family caregivers may also focus on developing a prosthetic social network for the caregiver and\or client, that enables each to meet some of their own social and emotional needs, thus prolonging the ability to provide care for the client.

It is obvious that the skills of several disciplines , and in particular those of the physician, occupational therapist and social worker, are essential in accurately assessing the

demented client's abilities, limitations and environment in order to provide the caregiver with effective management strategies. The skills of the social worker are utilized in assessing the needs of the caregiver, the adequacy of the social supports, facilitating the resolution of difficult feelings related to caregiving and providing emotional support that enables the caregiver to balance their needs with those of the patient.

These are legitimate roles for a psychogeriatric team as they enable the caregiver to maintain the client in the community, by preventing caregiver burnout that would lead to earlier institutionalization of the client; (or in the case of facility caregivers, transfer to acute care). If elderly caregivers' needs are not addressed we are in danger of abusing them as "free" labour.

SOCIAL NETWORK AND SOCIAL SUPPORT

Changes that normally occur in the elderly person's own life and in their social network can predispose them to mental illness, particularly depression, and it necessary that those working with the elderly are sensitive to this process. (Health and Welfare, 1991E).

Because of the normal losses of aging and illness-related losses, the elderly may be considered in a process of continual grief (Harrison, 1987). Recent bereavement, social isolation, low socio-economic status and stressful life events are all risk factors that make elderly persons vulnerable to mental health problems, (Health and Welfare, 1991E). Lawton, (1983) suggests that loneliness and social isolation contribute to poor mental

health. Clark and Perry, (1987) state that people experiencing a number of major changes within a short period of time are likely to suffer from ill health as a consequence. They state that the increased rate of changes/losses with which the elderly must cope, may tax their ability to adapt and cope with each change.

The elderly experience many changes in their social network due to aging. Retirement for most occurs at age 65. It represents changes in role, changes in the structure of day to day life, a reduced income, loss of a peer group, all of which must be adapted to. Roadburg, (1985) found that income and physical health are the two most critical elements in predicting successful aging and retirement. He also found that approximately 30% of individuals encounter difficulties in adapting to retirement.

After retirement readjustment in the marital system must occur, as the couple spend much more of their time together. This may or may not be a positive experience, depending on the marital history.

Widowhood is a major life event which effects one's self concept, self esteem and the loss of a spouse may be very difficult to cope with. Some strategies, such as support groups for widows, strengthening the family and social networks, and easy access to social support systems are useful in preventing breakdown and promoting better adaptation (Lopata, 1979, Roadburg, 1985, Martin, 1987).

At a time when the elderly are most in need of peer support their circle of mentally and physically intact cohorts diminishes. A fact of aging is that the elderly person's social network of peers is undergoing similar changes to those of the self. Spouses, friends and siblings will be lost to death, debilitating diseases, physical impairments and/or cognitive dysfunction. People will make geographical moves to better climates or to be closer to children. Some will become caregivers.

An important task for those working with psychogeriatric clients is to help them navigate the losses and transitions when these jeopardize their mental health; to reconnect them to their social network or develop a prosthetic social network; and to educate caregivers about the social losses associated with aging and the impact the cumulative effects of these may have on the client's morale.

MEDICATION

Because of the chronic and acute conditions found in the elderly, they have generally been prescribed a number of medications. Polypharmacy is frequently a problem with the elderly. Martin, 1987, states that those over 65 years receive over 25% of prescription drugs, averaging 3 - 4 per person. In addition, he notes that over the counter medications are used much more frequently by elderly people than by younger adults.

Physiological changes in the elderly which effect their responses to drugs are alterations in absorption, distribution, detoxification and excretion of drugs (Martin, 1987). The

elderly have an increased vulnerability to side effects. The combination of polypharmacy and altered physiology increases the risk in the elderly person experiencing side effects or toxicity of a drug and negative interactions between drugs (Spar and LaRue, 1990). Non-compliance (defined as failure to take medications according to instructions, and includes never having purchased prescriptions, premature discontinuation, using an incorrect dosage [high or low] or dosage schedule, or taking drugs for wrong indications) in taking medications occurs with 25 - 60% of elderly patients (Martin, 1987). When the physician is unaware of the patient's non-compliance, it may be felt that the current regime is inadequate and dosage is increased or medications changed. Often, non-compliance comes to light when a caregiver takes over dispensing the medication. For the first time the client experiences the effects of all the prescribed medications, and this may be result in delirium caused by drug toxicity, or a number of side effects.

The need for those working with psychogeriatric clients to have a working knowledge of common medications used by clients and the problems associated with them, can not be under-estimated.

An important role for a psychogeriatric team is assessing the clients ' medication regime, and their compliance with the regime, and providing recommendations and education to family physicians. There is also a role for educating other professional and family caregivers about medication as well. While these roles are generally filled by medical

team members, other team members need sufficient cross training to gather appropriate data and provide basic monitoring of medication use and education to clients.

NORMAL AGING

It is important that those working with psychogeriatric clients are aware of changes associated with normal aging so that they do not confuse them with pathology, nor pathological symptoms to normal aging. A knowledge of chronic diseases associated with age, and the residual effects of acute diseases are also important to understand.

"Normal aging is the condition in which previous functional efficiency has been lost and the capacity for restitution progressively impaired" (Wasylenki et. al., 1987, p. 29). Old age is a time of loss and adaptation. The elderly are faced with changes associated with normal aging, some degree of loss of acuity in all five senses, diminishment of flexible intelligence, slowed reaction time, benign memory loss, and a decline in physical strength (Wasylenki, et. al., 1987, Spar and LaRue, 1990, and Lazerus, 1988). Inevitably, the elderly experience changes in their physical appearance: graying hair, wrinkles, sagging muscles, that in our youth-orientated society may be defined as unattractive and have a negative effect on self esteem.

Soni (1988) reports that peripheral sensory deficits are associated with the onset of delusions and perceptual errors, sometimes hallucinogenic in nature. An unrecognized or

under-estimated hearing deficit can lead those involved with the client to attribute communication problems to dementia. Hearing loss has social consequences, and a vicious circle of decreased social participation and interaction may lead to isolation and suspiciousness that can progress to paranoia (Clark & Perry, 1987). Cooper, et. al., (1976) cite the role of deafness as a predisposing influence on late life paranoid states. Gurland, (1991) reports that deafness is about three times more frequent in elderly persons with a late onset, paranoid disorder than in age matched controls.

The elderly suffer from more chronic diseases than younger adults (Statistics Canada, 1990). These may produce a variety of symptoms--discomfort, loss of stamina, vigour and mobility, to which they must adapt. These symptoms may also mask other disorders such as depression.

As aging occurs, there is an increased vulnerability to degenerative diseases such as arthritis and coronary arteriosclerosis (Wasylenki et. al., 1987). Many elderly suffer from disabilities that may limit their ability to carry out former activities of daily living. This may have an impact on their ability to socialize in the community, or on their ability to remain at home. As a result of acute disease processes, the elderly may be left with residual effects which negatively affect their lives, i.e. a stroke that leaves a speech impairment and hemiparesis will affect the client's ability to interact socially and to care for himself.

SUMMARY

It appears clear that the skills of a number of disciplines are needed to distinguish the effects of normal aging from pathological symptoms in order to intervene appropriately and effectively at the physical , environmental and social levels, thereby enabling clients to realize their full potential. An additional role is to raise the awareness of and provide education to other health care professionals and caregivers about the interplay of these complex issues and their impact on the elderly.

The literature thus far has explored some of the factors that have led to the development of community psychogeriatric outreach programs, the needs of the elderly for specialized mental health services, and the importance of multidisciplinary teams in providing these services.

The question remaining is how can psychogeriatric services best be organized to ensure that the elderly receive mental health services when required? The next section will examine theoretical models proposed for the delivery of psychogeriatric services, and descriptions of Canadian community psychogeriatric outreach programs, in the literature.

CHAPTER 2

ORGANIZATION of PSYCHOGERIATRIC SERVICES

Both the United States and the United Kingdom have considerably longer histories in the provision of community mental health services to the elderly than does Canada. Each country, in response to its own experience has developed a different approach to the organization of psychogeriatric services. Both these approaches will be described as Canada has borrowed from each in organizing services for the elderly mentally ill.

American Model for Organization of Psychogeriatric Services

In 1971 the Group for the Advancement of Psychiatry (G.A.P.) produced a report titled "The Aged and Community Mental Health: A Guide to Program Development". This report resulted from a recognition that in spite of a growing aging population and the prevalence of mental illness in late life, the elderly under-utilized mental health services.

The American model reflects a social model of providing health care to the elderly. Underlying this model is a belief that illness arises from shortages in vital supplies such as vitamins, social roles and intimate relations usually provided by family life. Although services are generally housed within a hospital, the community is the primary locus of treatment. Efforts are directed at strengthening the community's social support system in order to avoid inappropriate institutionalization of the elderly. The need for a broad range

of institutional and community services to meet the needs of the elderly is recognized. The development of consultation services is stressed, in order to help those who work with the elderly to develop positive attitudes, clinical skills and knowledge about caring for the mentally ill elderly. A range of treatments are provided, and psychiatric nurses supported by psychiatrists are seen as the ideal team to provide services. Home visits are deemed crucial to a comprehensive psychogeriatric assessment.

British Model for the Organization of Psychogeriatric Services

In 1971 the Society of Clinical Psychiatrists in Britain published a set of guidelines entitled, "The Organization of Psychogeriatrics", that addressed the need for mental health services by a growing aging population.

The British model has a more medical emphasis in the provision of health care to the elderly. There is a greater focus on the "hands on" individual assessment, diagnosis and treatment of clients, than in the American model. The Americans, while certainly recognizing the need to assess, diagnose and treat individuals, have tended to place a greater focus on the deficits in the community that contribute to individual pathology, and to direct efforts on community development/consultation to ameliorate these deficits, than have the British.In Britain, mental hospitals have traditionally housed the psychogeriatric population, whereas in the U.S., community resources,(i.e. long term care facilities) have more usually been utilized. In Britain, services tend to be organized around a Psychogeriatric assessment unit, which nowadays is usually in a general hospital. The

British model emphasizes the multiple etiology of psychogeriatric illness and the need for rapid assessment to avoid inappropriate placement. Home visits and the use of a multidisciplinary team, (comprised of a psychogeriatrician, psychiatric nurses, occupational therapists and psychologists), are central to psychogeriatric services in this model. In a 1989 review of the care of elderly people with mental illness, the Royal Colleges of Physicians and Psychiatrists identified three broad principles they believe must underlie the delivery of services to the mentally ill elderly. (1) Services, based on a defined target population within a specific geographic catchment areas, should encompass a wide range of community and institutional programs to meet the complex needs of the elderly. (2) Flexibility in all sectors of the health care system is needed to ensure the easy transfer and flow of patients based on their needs, rather than on what is available at the moment. (3) Caregivers need to be supported in order to prevent a breakdown of their ability to provide support to psychogeriatric clients.

In summary, the American and British models differ primarily in emphasis with the American model being more preventative, consultative, and community based, and the British model being more medically oriented and institutionally based. This undoubtably relates to the funding and organization of the health care system in each country, which in part may have determined the respective social and medical focus of the American and British models.

Canadian Models for the Organization Of Psychogeriatric Services

Components of both the American and British models for the organization of psychogeriatric services have been incorporated into Canadian models for providing Psychogeriatric services to the community. A description of a Canadian model is found in the Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, (Health and Welfare Canada, 1988b). Goldstein (1980), Wasylenki (1982, 1984, 1987), Rodenberg, (1985), Harris et. al. (1990) and Shulman (1991) have all attempted to articulate their visions of the important elements of psychogeriatric care. To a greater or lesser degree they have all suggested ways that psychogeriatric services should be organized, albeit they focus on different levels of organization. These models will be discussed below, in chronological order. Similarities and differences between the Canadian models, and the relationship to the American and British models will be highlighted. The limitations of each model will be noted.

Goldstein (1980) of Queensway-Carleton Hospital in Ottawa,Ontario discusses social issues in Geriatric Psychiatry and advocates that psychogeriatric specialists have a responsibility to become involved in all areas of their patient's lives, due to the frequent overlap of social, psychologic and medical problems that affect them. He describes the roles of the psychogeriatric specialist as educator, consultant, clinician and change agent. He argues that the promotion of support services in the community, and the coordination of these services, is an important role for psychogeriatric specialists. His opinions reflect the underlying philosophy of the American model. However, like the British, Goldstein

describes the cornerstone of good psychogeriatric care as a psychogeriatric inpatient treatment and assessment unit with a multi-disciplinary team. In common with both the American and British models he believes that home visits to the elderly for assessment purposes are very important, and that a broad range of community and institutional services are needed to provide a complete continuum of care. Goldstein stresses that the impact of the client's illness on the family caregiver should be a crucial part of a comprehensive psychogeriatric assessment. He also identifies a need for specialized daycare for the demented.

Wasylenki, of the Clarke Institute of Psychiatry in Toronto, Ontario, proposes a model with a strong community focus and is most closely aligned with the social model for the delivery of health care services that underlies the American model. (Wasylenki, 1982, 1984, 1987).

In common with the British model and Goldstein, however, Wasylenki visualizes a psychogeriatric assessment unit as the centre of a well coordinated network of institutional resources. In keeping with the American model a primary focus of this network would be to " stimulate, develop, support and consult to a spectrum of community services whose objectives include strengthening social supports and preserving independence in the elderly", (Wasylenki, 1982 p. 19). Like the Americans as well, Wasylenki proposes that consultation, liaison services, education, limited direct patient care and help in developing programs , should be provided to the community; (i.e. agencies, long term

care facilities, hospitals, senior's housing); in order to ensure adequate and appropriate care for the elderly. Because Wasylenki believes that the elderly mentally ill population is faced with fragmented , uncoordinated and often competitive and unresponsive services, case management is seen as a core function of any psychogeriatric service.
Wasylenki shares, with the American and British models and Goldstein, a belief in the need for home visits and for a comprehensive spectrum of resources to enable the elderly to remain in the community.

As with the other models discussed a comprehensive psychogeriatric assessment is advocated by Wasylenki. In addition, however, he notes the need for a functional or rehabilitative component as part of the assessment. This aspect of the assessment focuses on skill strengths and deficits that relate to the demands of the client's environment. He also believes that helping family caregivers deal with the stress of caring for impaired family members is an important activity for psychogeriatric professionals.

Wasylenki, as with the American model, suggests that the ideal team to provide psychogeriatric services, is nurses with the support of a psychiatrist - that is to say, usually only the nurses actually see the clients. (The American model, however, speaks of 2 year diploma psychiatric nurses while Wasylenki refers to clinical nurse specialists with training at the Master's level in Psychiatry). With the stress placed on community development and liaison, in both these models, the need for the skills and knowledge of other disciplines in these areas would seem self-evident. It is therefore surprising that the

essential core teams proposed are so limited. Wasylenki argues that nurses, who are in receipt of much of the consultative services, accept consultations more readily from other nurses, and therefore nurses are the most appropriate consultants. In spite of this argument, the training and education to nurses and others that the American model and Wasylenki deem important, would be broadened and enriched by the inclusion of other disciplines with varied, non-medical perspectives.

Rodenberg, (1985) of Kingston, Ontario, believes that the care of the mentally ill elderly requires a reorganization of the delivery of mental health services. He identified a lack of comprehensive medical and psychosocial assessment aimed at the proper placement of the mentally ill elderly, as a major deficit in the current system. This results in poor discharge planning that keeps some patients in acute care beds longer than they require, and inappropriate placement of others in long term care facilities that lack adequate facilities, staffing and expertise to manage their care. He proposes that psychogeriatric teams, headed by physicians with specialized training be housed in acute care hospitals. These teams would provide assessment, treatment, advice on social supports and assistance in decisions regarding. optimal placement of clients, to both the community and hospital He proposed that specialized psychogeriatric assessment units be established, as a resource to the team. He suggested that the role of long term care facilities in providing care to the elderly be rationalized, and that specialized facilities be developed for the care of difficult to manage mentally impaired elderly. He further noted the need for sufficient specially trained staff to provide services throughout the continuum, and urged that

geriatric and psychogeriatric training be a part of undergraduate curriculum of physicians and other health care professions. Rodenberg's model is both medically and institutionally oriented, and most closely reflects the British model.

In 1983, as a result of an initiative taken by the Mental Health Division, Health and Welfare Canada, and the Section on Geriatric Psychiatry of the Canadian Psychiatric Association, the development of guidelines outlining the essential components of comprehensive service for elderly people identified as clients or potential clients of mental health services, was undertaken. Guidelines for Comprehensive Services to Elderly Persons With Psychiatric Disorders resulted in 1988. This report recognizes that services and resources are unevenly distributed across the country, and that there are many cultural and regional differences that necessitate individualized program and service development; it is therefore not a blueprint, but a collection of guiding principles. The "Guidelines" have been widely adopted by the provincial governments in planning programs and services for the elderly with mental health problems.

The "Guidelines" discussed the principles of good psychogeriatric care; outlined the essential components, function and services of a comprehensive psychogeriatric service; defined the content of a biopsychosocial psychogeriatric assessment;and identified management and treatment options. Like the previous models the Guidelines stressed the need for home visits, a multidisciplinary team approach; (ideally made up of a psychiatrist, a nurse, a social worker, an occupational therapist and possibly a

psychologist); and care for the caregivers. In addition, the need to support facility caregivers was identified. In common with Wasylenki, the need for the coordination of services and resources, and case management, to avoid fragmentation of care were stressed in the "Guidelines". Linkages between policy and planning, resources, programs and services, and information were suggested in order to ensure coordination and collaboration at all levels of the care system. The use of catchment areas, (borrowed from the British), a single entry delivery system, case management and registries were discussed as mechanisms of coordination. In addition, the "Guidelines" reflect a social model of providing care to the mentally ill elderly, as illustrated by the assertion that a comprehensive psychogeriatric assessment must involve a systematic search for remediable physical, social and mental deficits, and go beyond medical diagnosis to look at functional abilities within the lifestyle, social and environmental contexts in which the elderly person lives.

Harris et. al., of the Joseph Brant Memorial Hospital in Burlington, Ontario (1990), in writing about the evaluation of a community Psychogeriatric outreach program, also raise some issues related to the organization of this type of service. The objectives and services provided by their program are consistent with the "Guidelines". The service is located in a general hospital, but does not have designated inpatient psychogeriatric beds. A multidisciplinary team is used, consisting of a registered nurse, a social worker/coordinator, and a part time psychiatrist, making this a broader team than suggested in the American model or by Wasylenki. Home visits are seen as an essential

component of assessment. In common with the other models too, the need for a broad continuum of resources/services for the elderly is recognized. The needs of family caregivers are acknowledged and addressed as was also the case with Goldstein, Wasylenki, and the "Guidelines". They also acknowledge the need to provide training to long term care facility staff. A medical-psycho-social approach to assessment and treatment is adhered to, as is done by all models discussed to this point.

Table 2

Patient and Non-Patient Services

Issue	Options
Direct Patient Services	- Assessment - Consultation written and verbal reports - Treatment counselling medication education behaviour management community support medico-legal advice placement assistance crisis intervention case coordination - Follow-up
Non-Patients Service	- Teaching - Research - Community Development and Consultation

Source: Harris et al. 1990, p. 215

Harris et. al. identify the typical range of patient and non-patient services commonly offered by a psychogeriatric outreach service. (See Table 2).

The authors point out that a number of different service models are possible , but that in the choice of a particular model , the needs and resources in the community must be considered , as well as the relationship with existing agencies, a point also made in the "Guidelines".

Table 3 presents the components of a psychogeriatric service as seen by Harris et. al. The authors question the ability of a team to function effectively if there is no psychiatrist, or she/he is available only on a consultative basis. This stance is different than Wasylenki's, where the psychiatrist is given a less clinical role, essentially consulting to the team, generally without actually seeing the client. Harris et. al. 's, approach suggests a primary focus of the program is the medical-psychiatric diagnosis and treatment of clients.

The authors, however, perceive the distinction between a medical model and social model of care for the elderly, and institution vs. community as false dichotomies. They believe that comprehensive models that cross boundaries rather than define boundaries are more useful in designing services.

Table 3

The Components of a Psychogeriatric Service

Continuum of Services (Community Need Assessment)	- In-Home Services assessment/treatment home care respite care - Out-Patient Services - Day Hospital/Day Care - Respite Care/Holiday Relief - Acute In-Patient Care designated beds liaison consultation - Residential Care - Chronic Care
Service Settings	- Teaching Hospital - Community Hospital - Hosted by Community Agency - Separate Community Agency - Psychiatric Hospital
Staffing	- Psychiatry - Nursing - Social Work - Psychology - Occupational Therapy - Clerical Support - Other Medical family physician geriatrician general internist/ neurologist
Funding	- Global/Core Budget - Ex-Global/Special Budget - Private - Fee for Service - Non Profit Agency

Source: Harris et al. 1990, p. 216

Shulman, of Sunnybrook Health Science Centre, in Toronto, has developed a model derived in large part from the British model, and reflects the medical model for providing health care services to the elderly. As a result of his review of the guiding principles underlying psychogeriatric care in the U.K.; and the recent trends and innovations that he observed in the U.K., Shulman (1991) has proposed a model of a regionalized network of health care delivery, for Canada. This model includes the integration of hospital-based and community-based services with well defined catchment areas, target systems and areas of responsibility. A regional network, as he conceptualizes it, would ensure appropriate links between the community and hospital, and provide a bridge between acute and chronic care facilities/systems, thereby ensuring an effective and efficient use of health resources.

Shulman presents a new concept. In his view the full range of community social services, chronic/long term care services and acute care services should come under a common administrative authority, to overcome the problems of fragmentation, competition and disassociation between the different services. He distinguishes between mental health and psychiatric services, although he does not define either term. Community based services in Shulman's model,provide mental health services rather than psychiatric services, and have a social focus rather than a medical focus. The community based services provide case management, education, health promotion, and help with the early identification of individuals who need mental health services via a multi-disciplinary team that would include primary physicians. Daycares would be provided by the community programs.

Hospital based services in this model provide psychiatric services with a medical focus. When hospital resources are necessary, Shulman believes that the hospital based team should take over case management. This includes patients who require assessment or treatment, day hospital care or coordination of medical investigations and consultations.

As with Goldstein, Wasylenki, the Guidelines and Harris et. al. the needs of family caregivers are acknowledged and addressed by Shulman. The importance of home visits; a multidisciplinary team (although he doesn't identify the core disciplines required); a bio-psycho-social approach to assessment; and the necessity of a continuum of institutional and community resources to support the elderly; are elements in Shulman's model shared with all the models thus far reviewed. It seems however, that in Shulman's model the hospital-medical system, (and therefore physicians), would oversee the complete range of institutional and community resources for the elderly, and indirectly at least, control access to and from all components of the system. The criteria by which he sees responsibility for case management being transferred to hospital from community, suggests that with this model in place there would be a higher incidence of in-patient assessment and treatment. This might lead to increased rates of institutionalization as once the elderly are taken out of their community setting their social support system can rapidly collapse (Wasylenki, et. al. 1987).

It must be noted that all the models discussed are designed for entire nations, provinces, or large urban centres, and require many resources, which are usually only found in big

cities. Only in the " Guidelines" was there reference made to the difficulties that might exist in resource poor areas. It was suggested that in these situations existing services could incorporate the principles of good psychogeriatric care (identified in the "Guidelines"), in the care of the mentally ill elderly.

Table 4 provides, in chart form, a summary of the key elements identified in each of the models.

Table 4 - Summary of Theoretical Models

MODEL	Amer. Model	Brit. Model	Goldstein	Wasylenky	Rodenburg	Guideline	Harris et Al	Shulman
SOCIAL FOCUS	X		X	X		X		
MEDICAL FOCUS		X		X		X	X	X
MULTIDISCIPINARY TEAM	X	X	X	X	X	X	X	X
TEAM COMPOSITION:					N/K			N/K
PSYCHIATRIST and RPN	X							
PSYCHIATRIST and MN				X				
PSYCHIATRIST, NURSE, SW, OT, PSYCHOLOGIST						X	X	
PSYCHIATRIST, NURSE, OT, and PSYCHOLOGIST		X						
PSYCHIATRIST and SW			X					
RANGE of SERVICES								
BIOPSYCHOSOCIAL ASSESS	X	X	X	X	X	X	X	X
ENVIRONMENTAL ASSESS				X	X	X		
SOCIAL SUPPORT SYSTEM ASSESS			X	X	X			
FUNCTIONAL ASSESS				X	X			
TREATMENT	X	X	X	X	X	X	X	X
CONSULTATION	X	-	X	X	X	X	X	-
EDUCATION	X		X	X		X	X	X
CASE MANAGEMENT				X		X		X
CASE COORDINATION			X	X	X	X	X	X
COMMUNITY DEVELOPMENT	X		X	X			X	
CAREGIVER SUPPORT		X	X	X		X	X	X
FACILITY CAREGIVER SUPPORT						X	X	
CONTINUUM of SERVICES (Comm. & Institution)	X	X	X	X	X	X	X	X
PSYCHOGER. ASSESS UNIT		X	X	X	X	X	X	X
DAY CARE						X	X	X
DAY HOSPITAL						X	X	X
RESPITE	X	X		X		X	X	X
DAYCARE FOR DEMENTED			X					
SPECIAL UNIT for BEHAVIOR PROBLEMS					X			
HOME VISITS	X	X	X	X	-	X	X	X
TARGET GROUP IDENTIFICATION	X	X				X	X	X

In summary, the theoretical models in the literature indicate a continuing evolution and refinement in the conceptualization of how the service delivery system should be organized to ensure that the elderly receive mental health services that take into account their unique needs. The models all reflect a mixture of both the social and medical models of care. All models stress the complex etiology of psychogeriatric problems, and endorse comprehensive biopsychosocial assessments, home visits, multidisciplinary teams, a range of services, and a continuum of community and institutional resources, to address these needs. There is some variation in the disciplines considered essential to deliver services, and 4 team "types" were identified. The main difference between the models are the emphasis, and the degree to which they have elaborated on different aspects/components of program/service development.

The development of an "ideal model" for a community psychogeriatric outreach program, derived from the literature, is one of the objectives of this practicum. It is intended to extract the common elements of all models, and to use the widest range of services and continuum of resources that were described in the theoretical models. The social model of care will be stressed, as it seems to best address the needs of the psychogeriatric client.

Prior to presenting the "ideal model", however, descriptions of Canadian community psychogeriatric outreach teams described in the literature, will be reviewed.

PROGRAM DESCRIPTIONS

Relatively few descriptions of Canadian community psychogeriatric outreach teams were found in the literature. Only Canadian programs will be reviewed because of the major differences in health care policy, funding and infrastruture between Canada and other countries. Each Canadian program found in the literature will be briefly described and the demographic, diagnostic and program data each program reports will be compiled in a chart at the end of this section for ease of comparison. Limitations of each program will be identified, and their strengths will be taken into account in the development of the "Ideal Model" for a community psychogeriatric team, to be proposed.

Houston, (1983) describes an outreach program in Hamilton, Ontario that was based on an in-patient unit. Inclusion criteria are that the client must be 65 or over, and certifiable under the Mental Health Act. The team consisted of a psychiatrist and a social worker who did assessments together at the request of family physicians, public health or V.O.N. nurses, home care workers, nursing homes, medical superintendents, hospitals, social workers and homes for the aged. The reasons for referral were most commonly confusion, wandering, destructive behaviour, depressed or suicidal behaviour and suspiciousness. Houston describes the value of making home visits and the importance of assessing the physical and social environment as part of a comprehensive psychogeriatric assessment. This program gave support to families and referral sources by suggesting management strategies; arranging placement in nursing home, homes for the aged, day care centres or respite. It was felt that these interventions prevented inappropriate institutionalization and

the demoralization and more rapid deterioration that would occur when the patient was removed from familiar cues.

The fact that clients had to be certifiable under the Mental Health Act suggests that this program saw a narrower range of psychogeriatric clients than is usual.

Wasylenki (1984) describes a community based psychogeriatric program, based on the recommendations of the American Group for the Advancement of Psychiatry, and designed to meet the needs of psychiatrically impaired elderly by providing a multiplicity of indirect services to community caregivers. The team is comprised of a psychiatrist and two clinical nurse specialists in psychiatry. Wasylenki discusses the choice of the mix of multi-disciplinary program staff and states that he has found a psychiatrist working with a senior nurse clinician is an ideal relationship.

The team provides consultation, education, collaboration and coordination to individuals and agencies dealing directly with the elderly client. The program is funded by the Adult Community Mental Health Program branch. The service provides all four types of mental health consultation as defined by Caplan, (1970). The majority of consultations are client-centred. The client is seen by one of the consultants in his home, always in the presence of the consultee. A comprehensive psychogeriatric assessment is carried out and recommendations for ongoing management are made. Six months after consultations were

done, data was collected on consultation outcome, and the results are discussed by the author.

Education is provided by this program. A formal course in clinical geriatric psychiatry is offered. Courses on normal aging, depression in the elderly, late life dementias, acute confusional states, reaction to chronic illness, paranoid states, medications and the elderly, assessment and management principles and family support groups, are also provided.

A collaborative relationship has been established with C.O.T.A, the Community Occupational Therapy Association and support programs for relatives of demented patients, activation programs in nursing homes and senior citizens' residence, and training sessions for community practitioners have been developed.

An important coordinating activity involves membership on inter-agency committee and counsels and active support and leadership in the creation of coordinating sub committees dealing with the needs of the elderly. This program is designed to produce a multiplier effect and as much as possible the responsibility for treatment and case management is left in the hands of the referral source.Wasylenki (1984) argues in favor of an indirect service model over the development of direct service caseloads, as a better use of resources.

As was noted in the discussion of Wasylenki's model in the foregoing chapter, this program seems limited in it's ability to do all it sets out to, by it's reliance on only nurses and psychiatrists as the core team.

Wargon et. al. (1987) describe the first three years of a community outreach service at the Sunnybrook Community Psychiatric Services for the Elderly, a general and teaching hospital,in Toronto, Ontario. Psychogeriatric assessment and treatment was provided by a multi-disciplinary team, with home visits an integral part of the assessment. A primary goal was to maintain the cognitively impaired individual in familiar surroundings for as long as was appropriate, and to avoid premature institutionalization of clients.

The team consists of one consultant and one resident geriatric psychiatrist, two social workers, one nurse and one O.T. Referrals to the program are taken from a variety of sources but the involvement of the patient's medical doctor is requested. Home assessment is done by a psychiatrist and other team member. Family and other professionals known to the patient are encouraged to be available. Assessment comprises a comprehensive review of the psychosocial factors, physical functioning, and neuro-psychiatric status of the patient. Each professional on the team offers assessment and follow-up services needed from counselling to case management to completing forms. Each is available to other team members as a consultant and resource person. Other services provided are support to patients and caregivers, information about resources, direction through the health care system and monitoring. In addition to the direct service

component basic to the program, consultation and education are provided to staff in extended care residential settings and other community agencies. In-service educational programs have been developed for several settings. Working relationships have been established with a number of residential settings in which the trust that has developed through prompt response and ongoing follow-up by the team has allowed for an acceptance of some difficult patients who might not have been admitted otherwise.

Wargon et al discuss cases where no psychiatric diagnoses were made, and indicate that in a number of these cases medical problems were found to be the underlying cause of behavior. They make a case that this demonstrates the value of having a psychiatrist make the initial assessment to identify the problem. They believe that this strategy also promotes acceptance of recommendations by primary care physicians and families. Services ranged from short-term contact to arrange admission to hospital, to long-term contact, some going on for three years or more. The average length of service provided by the program is six months. Support to patients and families is provided in virtually all cases, individually as well through support groups for relatives. Information and assistance with placement occupied the second largest share of service time to families. Referrals to other service are the next most frequent services of the team in descending order. It was felt that 15 hours of staff times was probably needed for assessment, record keeping, referrals to other agencies, discussion and review with team and sessions with patients and/or caregiver. The Sunnybrook Community Psychiatric for the Elderly has a reciprocal relationship with other departments or Sunnybrook Medical Centre. The advantage to patients, according to them, is being able to enlist the specialized services of the hospital,

having access to the full range of medical, surgical and psychiatric services available, including emergency services. This is beneficial and they say, essential for the frail elderly who often have multiple health problems.

A major disadvantage of this quite comprehensive model, is the contention that the psychiatrist should see all patients before other team members, and essentially triage the cases. This is expensive as psychiatrists are a much more costly resource than other health care professionals. On a Canada wide basis, psychiatrists with specialized expertise with the elderly are in very short supply, particulaily in smaller centres, (Health and Welfare Canada, 1988b). It would make more economic sense for other disciplines, well trained in psychogeriatrics, to do the initial assessment and consult with the psychiatrist when necessary. This program emphasizes a medical rather than a social model of care. The social model is more appropriate to the care of the psychogeriatric client, given the many non-medical determinants that contribute to their problems, as was discussed in the previous chapter.

Harris et. al. (1990) describe the psychogeriatric outreach service at Joseph Grant Memorial Hospital, a community non-teaching hospital, in Burlington, Ontario. The goals of their service are to provide a high quality, comprehensive and community orientated psychogeriatric service, to maintain the elderly within their own homes and to reduce institutionalization. This program has five objectives: the assessment of patients in consultation with the referring sources; the treatment and follow-up of selected patients;

education of patients, families, professional students in the community; community development by assisting in the coordination of existing services and developing these services; research and cooperation with other centres.

The service is structured as a community outreach in-patient service within the Department of Psychiatry. There are no designated beds. Staffing consists of a social worker, coordinator, a registered nurse and a part-time psychiatrist. This program uses DSM III-R as a diagnostic framework. The range of services is a reflection of a multidisciplinary biopsychosocial approach using as needed the social worker, the nurse and the psychiatrist. Support, counselling and education to family members is considered an essential part of the service. Harris et al noted the need for some form of legally related advice in about 25% of the cases, either determining competency or providing advice on obtaining a power of attorney. Though crisis intervention is not a stated part of the service, 3% of the patients were provided with this service.

This program provided education to patients and family and a placement for nursing students. It provided instruction in a number of professional development programs both in the hospital and community.

Team members are active on boards or committees of the Mental Health Association, the Alzheimer's Society, the District Health Council and the region's Elderly Services Advisory Committee. These provide an forum to address specific issues and to maintain a liaison with agencies. Although research has not been a major part of the service, the program cooperates with other research centres. A focus for the team has been evaluation

of the program. This team was able to compare their statistics to a number of similar services. With one exception, the ratios of organic mental disorder and affective disorder was reasonably consistent. Economic evaluation of the service was undertaken by an M.B.A. student. He concluded that the cost to the hospital alternative to the community service was 65% greater than the community program.

Harris et. al. point out a number of issues in the development and evaluation of a community psychogeriatric service that need to be considered: community needs assessment; choice of service model; choice of professional staff; choice of target population: source of referral; role of family physician: the issue of institutionalization; the issue of limited resources: crisis intervention and emergency services; and problems of evaluation. They also state that any psychogeriatric team must have adequate psychiatric support. They question the ability of the team to function adequately if the psychiatric component is only on a consultative basis or non-existent.

The isssues that Harris et. a.l raise are indeed important to consider in developing community psychogeriatric services. Research into the what kinds of professional staff and service models provide the best service to the elderly is non-existant. Evaluation of programs that measure the impact of community psychogeriatric teams on clients mental health, and their ability to delay or prevent institutionalization, are also rare in the literature. Cole, (1989),has suggested some approaches to these gaps in the body of knowledge. Community needs assessments should indeed be undertaken **before** services

are established, and this would address the issues of appropriate target group, referral sources, resources available to the elderly, and gaps in services, (Health and Welfare Canada, 1988b). It is widely accepted that the general practioner has an important and central role in providing mental health services to the elderly, (Health and Welfare Canada, 1988b). The question of whether or not a community psychogeriatric team can function adequately with a consulting psychiatrist, or with no psychiatric input, is debatable. In large part this would depend on the skills and experience of other team members; well trained mental health professionals in collaberation with physicians with an interest in psychogeriatrics, may be able to quite adequately assess and treat the psychogeriatric client. Psychiatric diagnosis is only one component of pychogeriatric care.

In the Riverview Hospital Report to the Community (1991) an elderly outreach program in Penticton, B.C. is described. This program serves people over the age of 65 and provides comprehensive assessments, treatment recommendations and follow-up care to those with organic and functional psychiatric illness. The team also provides support and education for caregivers, working both in communities and long term care facilities. The team consists of a full time nurse, social worker, clerk steno and a part-time psychiatrist. One of the objectives of the program is to prevent avoidable admissions to hospital by providing assessment, consultation and support in the community.

Grauer et. al. (1991) report on a psychogeriatric home care team at the Mortimer B. Davis Jewish General Hospital, Montreal, Quebec. This team evolved from a well

established psychogeriatric clinic which is an out-patient facility of the Department of Psychiatry at the hospital. The clinic is multi-disciplinary and provides psychiatric evaluation and treatment of patients aged 65 and older. Patients are referred to the clinic from hospital clinics, emergency rooms, crisis service, psychiatric in-patient service and hospital social agencies and community physicians. Despite the focus on community outreach by this clinic, agencies, families and physicians often referred patients who were unable to come to the clinic. It was therefore felt that the visits to their home might avoid emergency room visits and a home care team was established. Staffing consists of a full time nurse coordinator, a part-time psychiatrist, a half-time social worker, an occupational therapist and a secretary. Home visits are carried out by one or more members of the team. The team is based in the hospital. Team conferences to discuss referred cases and patient management ensure multidisciplinary input. The assignment of roles for team members is "never rigid or stereotyped" (Grauer, 1991). Interventions were divided into four categories; emergency hospitalization for psychiatric, physical or social reasons; psychiatric nursing and social intervention for patients who are in need of nursing, social intervention and psychiatric treatment on an out-patient basis; nursing and social intervention for patients with social problems which required such measures as relocation, placement in a foster home or help with disturbed family relationships. This program seems to be treatment oriented, reflects a medical model, and lacks the educational\consultative and community development components that would broaden the skills\knowledge of those caring for the elderly.

TABLE 5

SUMMARY OF PROGRAM DESCRIPTIONS

PROGRAM DESCRIPTION	Houston	Wasylenki	Wargon	Harris	Penticton	Grawer
DATA TIME PERIOD	1 YR	1 YR	3 YR	2 YR	1 YR	1 YR
CATCHMENT POPULATION	1,220,100	150,000	213,564	140,000	---	---
CATCHMENT POPULATION OVER 65	122,000	---	33,682	12,880	---	---
REFERRALS PER YEAR	116	100	154	140	253	151
REFERRALS PER 1000 65+/YR	1	---	5	11	---	---
NO. OF MEN PER YEAR	50	31	44	44	---	32
NO. OF WOMEN PER YEAR	66	69	115	95	---	119
AGE RANGE	65-91		58-97	65-95	---	---
AVERAGE AGE RANGE	79	76	78	---	---	78.2
TEAM COMPOSITION						
PSYCHIATRIST & SW	X					
PSYCHIATRIST & MN		X				
PSYCHIATRIST, NURSE, SW				X	X	
PSYCHIATRIST, NURSE, SW, OT			X			X
DIAGNOSIS (%)						
DEMENTIA	54	48	46.6	48.4	---	15.9
DEPRESSION	13.8	36	24.5	31.9	---	41.8
PARANOID/DELVSIONAL	7.2	7	5	4.7	---	21.2
OTHER/NO DIAGNOSIS	25	9	4	15.1	---	21.1
SERVICES						
ASSESSMENT	X	X	X	X	X	X
TREATMENT	X		X	X	X	X
CONSULTATION	X	X	X	X		
CAREGIVER SUPPORT	X	---	X	X	X	---
EDUCATION		X	X	X	X	
REFERRAL	X	X	X	X	---	X
COMMUNITY DEVELOPMENT		X		X		
COORDINATION		X	X	X		
DIAGNOSIS (Rates/1000 65+)						
DEMENTIA	.44	---	1.38	3.75	---	---
DEPRESSION	.11	---	.73	2.47	---	---
PARANOID/DELVSIONAL	.06	---	.15	.36	---	---
OTHER/NO DIAGNOSIS	.20	---	.12	1.17		

SUMMARY:

In summary these programs all endorse home visits, biopsychosocial assessments and multidisciplinary teams. There are 4 main team "types", and there is some variation in the range of services provided. Table 5 provides a summary of the similarities and differences between the programs described above, and presents the catchment and target population characteristics that were reported.

CHAPTER 3

MODEL FOR AN IDEAL COMMUNITY PSYCHOGERIATRIC OUTREACH TEAM

To this point the need for psychogeriatric services has been demonstrated, through a review of the literature that focused on the prevalence of mental health disorders that affect the elderly, and factors that impact on their mental health. A number of areas that are important to be aware of in working with the psychogeriatric client were discussed, as were the benefits of a team approach. Theoretical models and program descriptions in the Canadian literature were reviewed, with strengths and limitations identified.

The following discussion outlines the elements/factors, derived from the literature review, that should be part of an ideal model for a community psychogeriatric outreach program. The survey will determine how closely existing services meet this ideal.

SOCIAL MODEL OF CARE

The model for community psychogeriatric outreach teams should have a social, rather than only a medical focus. " Mental Health For Canadians: Striking A Balance", (Health and Welfare Canada, 1988E), distinguishes between a mental disorder and a mental health problem. A mental health disorder is defined as, "a recognized, medically diagnosable

illness that results in significant impairment of an individual's cognitive, affective or relational abilities," (Health and Welfare Canada, 1988E, p. 8). A mental health problem is defined as a disruption in the interactions between the individual, the group, and the environment. It may result from within the individual, (physical or mental illness, or inadequate coping skills); or from external causes, (environment, or relationship dynamics),(Health and Welfare Canada 1988E). In chapter two, many factors that can impinge on the mental health of the elderly were discussed.

A social model provides a framework for considering all the internal and external factors that contribute to mental health problems, and interventions that may be medical, psychological, social or environmental. This model provides a much broader view of mental health problems than does the medical model which focuses primarily on mental disorders: it does however encompass the medical focus. Psychogeriatrics is the social model of care in practise, as distinguished from geriatric psychiatry which reflects the medical model.

BIOPSYCHOSOCIAL ENVIRONMENTAL ASSESSMENT

Assessment is the cornerstone of appropriate psychogeriatric service, and biopsychosocial environmental assessment should be provided by community psychogeriatric outreach teams. The "Guidelines" (Health and Welfare Canada 1988b p.10), provide a description of the components of a comprehensive psychogeriatric assessment, as follows:

* Medical history and physical examination
* Psychiatric history and evaluation, with emphasis on mental state and cognitive functioning
* Review of prescription and non-prescription medication
* Assessment of capacity for self-care and activities of daily living (strengths and weaknesses)
* Assessment of domestic situation, social network and resources (strengths and weaknesses)

The medical component of a psychogeriatric assessment is like peeling an onion - "it is necessary first to clear away the physical, and the iatrogenic causes of symptoms such as medications. Next a search for acute illnesses or acute exacerbation of chronic illness is made. The potential contributing role of chronic illness which may be stable or suddenly progressive, is also looked for. Finally, the insolence of normal age-related changes which evolve to different degrees over time in many organ systems, but which together can progressively encroach an overall homeostatic integrity, are considered." (Lazerus, 1988 p. 141).

The client's pre-morbid personality and past personal and familial psychiatric history must be examined for any contribution they might make to the current problem. A mental status examination with a special focus on cognitive functioning is undertaken. A critical area of assessment is the determination or exclusion of dementia. It is important to rule

out treatable conditions that may present as dementia, and to search for treatable conditions superimposed on a dementia. (Health and Welfare Canada, 1988b).

An assessment of the social environment is an important aspect of a psychogeriatric assessment. Social environment includes the family network, the social support system (which could be friends, neighbours, ethnic associations, religious groups, etc)., socio-economic status, vulnerability to abuse, as well the nature, quality and security of the physical environment available to the individual. This aspect of the assessment also reviews the life events and experiences, coping skills, resources and roles that the elder has. Careful attention must be paid to the relationship between the elder and those who are caring for them, be it family members at home, or institutional caregivers. Difficult behaviours may result from dynamics between the elder and caregivers, or be misunderstandings based on inaccurate assessment of the elder's abilities, combined with lack of training on the caregiver's part. The caregiving environment can be either positive or negative for the elder, but must be assessed (Brody, 1985).

A functional assessment is very important because a medical diagnosis does not tell what the client is able to do. The abilities in a wide range of activities of daily living, such as self care, mobility, household tasks and social interaction must be assessed. A functional assessment must focus not only on the deficits in skills that a person has, but also on the strengths and resources that can be adapted in order to enable the person to function at optimum independence. For example a demented client might function quite well in a

familiar environment where she/he can rely on old memory and over-learned behaviours, whereas in a new environment she/he would likely function at a lower level.

An environmental assessment pays close attention to the physical environment in which the client resides, in order to assess the match between the client's abilities and the demands of the environment. An environmental assessment looks at the physical characteristics of the client's residence, especially those related to safety. This is an especially important part of the psychogeriatric assessment when dementia is present. In a document entitled " Designing Facilities for People with Dementia, (Health and Welfare Canada", 1991e), it is noted that special attention to the physical and social environment of cognitively impaired elderly can maintain and/or increase their functional capacity, self-respect, and dignity. Stotsky, (1972) describes the importance of environmental therapy in effecting the onset and course of a disorder by assisting socialization, affecting accessibility to treatment, or producing isolation, depression and alienation.

Given the complex intermeshing of factors that contribute to the problems experienced by the elderly, it is clearly beyond the realm of any one discipline to sort out these problems, thus necessitating a team approach.

INTERDISCIPLINARY TEAM APPROACH

The importance of an effective interdisciplinary team approach in geriatric services is summarized by Skelton, (1986). An interdisciplinary team approach makes the most

efficient use of a variety of disciplines, and is least invasive to the client.

There are some arguments against a team approach, (Brill,1976). However, as pointed out by Kane, (1975) arguments against teamwork tend to concentrate on the malfunctioning team, and these pitfalls may be avoided by "healthy" team. It has been observed that health care professionals generally do not receive training in the functioning of interdisciplinary teams, and that teams can only make use of the skills and experience of all members when the relationships on the team are cooperative and collaborative. (McGrath, 1988).

It is quite unrealistic to expect each discipline to see each client, on the basis of expense and time constraints. It would also be quite an overwhelming experience for the client. As well, it may be that not all disciplines are always necessary in each case.

Smith, 1990 discusses the relative merits of **interdisciplinary** team model over the **multidisciplinary** team model. The interdisciplinary team model, he states, has the advantage of each team member developing his own data, then meeting to discuss and integrate it, develop priorities, set goals and create methods to reach these goals. The relevance of data that crosses disciplinary lines is recognized. Team suggestions are developed into comprehensive treatment plans. He states that the interdisciplinary team balances care in such as way as to move it from purely medical orientation towards including psychosocial aspects to a greater degree. The interdisciplinary team is a holistic

approach that deals with problems in the biopsychosocial environmental framework, and encourages problem solving and individualized treatment planning.

Case conferences where all referrals and new cases are discussed, and the ongoing review of cases is undertaken, are imperative in ensuring interdisciplinary input into all cases. Using a team approach leads to cross-training and by necessity, the roles must overlap to some extent (Thomas 1985, Bailey 1980). However, the team should not be **transdisciplinary**, (meaning that roles overlap completely, with, for example, the social worker taking on the function of the doctor, or the occupational therapist taking on the function of the social worker). This leads to less thorough and accurate assessments. Each discipline has specific skills and expertise, and a particular perspective which it brings to the assessment process. It is necessary to maintain discipline-specific thinking; the use of a team becomes redundant if all parties are thinking alike. Cases should be assigned on the basis of expertise and skill, which is often discipline specific;(eg marital therapy is more usually provided by social workers than by occupational therapists.)

Each discipline should, however, be able to screen for other disciplines so that one person can do the initial assessment. Team members should be familiar with the skills and areas of interest of the other disciplines, and able to gather enough information for other disciplines from which they will decide whether or not they need to be involved. For example, if the social worker does the initial assessment, information about the medical and psychiatric history as well as medications, should be gathered and brought back to

the team. The geriatric psychiatrist should be able to review this information and develop some hypotheses from it and decide whether or not to see the client.

It must be borne in mind that it is simpler to screen for some disciplines (eg occupational therapy) than for others, (eg social work) where the data sought is often less obvious and its observation intimately associated with the discipline-specific assessment and treatment skills.

Ideally the social worker and another discipline appropriate to the specific case should do the initial assessment visit together. It has been argued that the geriatric psychiatrist has an overarching knowledge of the other disciplines' knowledge base, and should therefore screen elderly clients and point to areas that need further assessment and the involvement of other disciplines, (Wargon et al, 1987). This is a compelling argument when the cardinal rule of a psychogeriatric assessment is to first rule out the physiological factors contributing to the presenting problem. However geriatric psychiatrists are in very short supply in Canada, and expensive, making such a plan unrealistic. The argument for geriatric psychiatrists screening clients does not apply to other physicians.

TEAM COMPOSITION

The core team members, in order to reflect the broad range of problems and needs of the psychogeriatric client, should be a geriatric psychiatrist, a social worker, and a nurse. Consulting team members should be an occupational therapist and a neuropsychologist.

It is acknowledged that there is an overlapping of knowledge and skills of the various disciplines, and the following is intended only to highlight the unique contribution of each discipline.

Geriatric Psychiatrist

The geriatric psychiatrist brings to the team the ability to evaluate the physiological, pharmacological and biological factors that can contribute to the elderly person's symptoms, as well as knowledge of acute and chronic diseases that may occur. An important role for the geriatric psychiatrist is making recommendations to the client's family practitioner about medication regimes, laboratory tests and other physical investigations. Ideally, the geriatric psychiatrist should have access to in-patient hospital beds, when required.

If a geriatric psychiatrist cannot be recruited a geriatrician would be a very good second choice.

Social Worker

A social worker is necessary on a psychogeriatric team to provide the psychosocial assessment that is so important in understanding the elderly in the context of their earlier life events and current social system. The social worker is invaluable in identifying clients' strengths and enabling their participation in the helping process. Assessing the strength and weaknesses of the clients' social support system; advocacy; assessing the

dynamics between the caregivers and the elderly client and providing counselling to both parties in negotiating some of the transitions, (i.e. placement in a nursing home), and helping each to work through feelings associated with their caregiving/caregiver roles, are also important functions of the social worker. As well, the social worker frequently provides individual or family counselling to the caregivers in order to enable them to provide optimal care, which balances the needs of all. Social workers are also important in linking the client to appropriate community resources.

NURSES

Nurses trained at the baccalaureate level are able to assess the client's understanding of the medication regime and the impact of illnesses. They are able to provide education to clients and caregivers in understanding disease processes, normal aging and medications. When elderly are in facilities, they are able to provide nurse to nurse consultations around care planning for the client, that are relevant and non-threatening. They are able to monitor the patient's compliance to medication regimes and observe them for side effects.

OCCUPATIONAL THERAPISTS

Occupational therapists have an important role to play, although their specific skills are not necessary in all situations. Basic environmental assessments can be undertaken by other disciplines. The occupational therapist is able to assess the client's functional abilities. Assessment may be of client's mobility, spatial/perceptual skills, and activities of daily living. Through greater understanding of the strengths and deficits that the elderly

client has, more appropriate care planning is possible. The occupational therapist looks at the client within the context of his physical environment, and determines whether changes are needed in the physical environment to compensate for the deficits that may exist. For instance, a client may be socially isolated because of stairs in the home that prevent him from getting out due to mobility problems - the installation of a ramp may be most helpful to this client. Occupational therapists provide information to caregivers, including other team members, that ensure a more realistic understanding of the capabilities and limitations of the client such that appropriate treatment plans are made. The occupational therapist also looks at the safety of the client's physical environment, and may make recommendations for changes.

NEUROPSYCHOLOGIST

Basic cognitive assessment and screening can be undertaken by all disciplines on the psychogeriatric team. Neuropsychologists are only required when more precise investigations to determine diagnosis and treatment are necessary. They can provide testing that can be very helpful in pinpointing the source of an apparent cognitive impairment, the degree of the impairment, and can elaborate on the implications on day to day life and functioning of such an impairment. Neuropsychological testing can be most helpful in differentiating organically based cognitive impairment, for instance, from personality or affective disorders, in complex cases. The information that the neuropsychologist can provide to the team on cognitive functioning is important in developing appropriate care plans.

HOME VISITS

The importance of home visits in psychogeriatric assessment and treatment is well documented; (Health and Welfare Canada, 1988B; Wasylenki et al, 1984; Simon, 1984 and Jones, 1991). It is often difficult for elderly clients and/or their caregivers to come to the office of health care professionals. (Patterson, 1976). The home visit overcomes this barrier to service. As well, the home visit provides a wealth of information for the assessor. Interactions between the client and caregiver can be observed, as can be the appropriateness and safety of the environment. It can be observed how a caregiver is coping with the realities of providing care. Indicators of how well the person is able to manage are revealed, (eg. food in the cupboards or not, the accessibility of the bathroom, etc.). The assessor is also able to see the elderly person with all his possessions around him/her, if he/she is in the community. This provides another dimension entirely of the client, giving him an individuality and history that might otherwise not be apparent. (Wargon et al 1987). In facility settings, the elderly usually have so few personal belongings, this is not as true. However, in a facility setting, the context,(i.e. the type of residence, the noise level, the available activities, and the attitudes of caregivers), can all be observed.

By interviewing the client in his home environment, the assessor is likely to see the client at optimal functioning, because, firstly, he is comfortable in his own territory, and secondly, he has learned to adapt over time to this familiar environment, and in the case of cognitive impairment, might present quite differently than if in a new and unfamiliar

environment. The aim of most community psychogeriatric programs is to maintain the elderly in their own homes as long as this is beneficial for them. Without home visits, it is much more difficult to determine the feasibility of such a plan with any accuracy.

Home visits should be made by the social worker as two major functions are to acquire an understanding of the client as a unique individual, and to assess the social environment in which he lives.

INTAKE PROCESS

In some psychogeriatric outreach programs, referrals are only possible through physicians. In other models referrals are also taken from the client, family, community professionals, and facility staff. An open referral system may create the problem of inappropriate referrals due to lack of technical understanding of psychogeriatric problems. However, a referral system that is open to only physicians can be quite narrow, in terms of the type of problems referred and what is expected, e.g limited to requests for medical consultations, often with the geriatric psychiatrist only. The problems that the elderly psychogeriatric client face are multiple, and not only medical. An open referral system assures that the reasons for referral will be quite broad, and there is more likely to be identification of potential social causes for the psychogeriatric problem, such as bereavement or social isolation.

The general practitioner is, of course, a central player in providing care to the elderly person, as the team physician never takes over the primary care of the client. The team physician does not, as a rule, do physical examinations, order lab tests or provide medication. Rather, the physician serves as a consultant to the client's family doctor. It is imperative that family doctors be involved in assessments, as they have accurate information about the medical/psychiatric history of the client. Their cooperation is essential in providing further medical workups or making changes in medical treatment that might be recommended by the team. Often the family physician is the only means of entry for the client to acute care where the team physician doesn't have admission privileges.

Target Group

Many programs use DSM-IIIR (American Psychiatric Association, 1989) as a diagnostic framework for psychogeriatric problems. This a useful system in diagnosing psychiatric illness, and the standardized criteria make it a useful research tool; it also plays a significant role in the distribution of fiscal resources in the mental health field (Kutchins and Kirk, 1988). Kutchins and Kirk reported that an American survey of psychiatrists found that DSM-III "focused on signs and symptoms so much that it detracts from understanding"; that only 17% of American psychologists were satisfied with it; and that social workers rejected the medicalization of mental disorders and thought that DSM-III placed medical labels on psychosocial problems. Many from all three groups did not find Axis IV and V useful. Bassett and Beisser (1991)

in a Canadian study found that psychiatrists only used Axis IV and V 20% of the time. The diagnosis of psychiatric illness and medical illness is not, as has been discussed, the total extent of a psychogeriatric assessment. Axis IV and V have limited usefulness as they do not accurately reflect the unique stressors or complex functioning of the elderly. Therefore while DSM-III-R , Axis I, II, and III should be used, the formulation should also specifically comment on the social and environmental factors that contribute to the problem. This will ensure a superior description of the "complete" problem, and be more comprehensible to unsophisticated referral sources.

Cases should not be limited to those with Axis I or II psychiatric diagnoses only. Blazer and Naddox, (1982) argue that functional impairment in mental health is an indicator of need for community mental health service, rather than the presence of specific psychiatric illness. Their findings indicated that mentally impaired elderly require services to help them function in areas such as medical evaluation and treatment, social interaction, nursing care and physical therapy. They stated that among the elderly, mental health impairment was usually accompanied by functional impairment in other areas, social and economic resources, physical health and activities of daily living. They suggest that a geriatric mental health program should not be limited to the **treatment of mental illness**, but should be prepared to help the mentally ill elderly with other types of problems, as well.

Early Detection and Intervention as Prevention of Mental Illness

The preventative nature of early intervention has not been well documented. The

"Guidelines", (Health and Welfare Canada, 1988b), suggest that health promotion and early intervention are important functions of psychogeriatric services. Risk factors for mental health problems in seniors have been identified, such as recent bereavement, social isolation, physical disability or poor health, low socio-economic status,stressful life events, long-term hypnotic drug use, sensory deficits and genetic vulnerability, (Health and Welfare Canada, 1991E).

Research related to depression makes a strong argument for working with clients who are caregivers, socially isolated or bereaved, to prevent clinical depression. For example, Gallagher et al (1989) found that family caregivers of persons with dementia are prone to develop clinically diagnosable depression. Gurland, (1991), reviewed the literature to determine precedence for depression. He states that in depression and old age there is a strong clinical impression and some research evidence (Murphy, 1982) that negative life events, such as bereavement often precipitate the episodes of depressive symptoms. Persons without significant others with whom they can share thoughts and feelings are particularly vulnerable to depression. He cites Turner and Noh, (1988), who found in a study that included elderly with disabilities, that life events, chronic strain and social support had independent effects on depression. Earlier in this report the relationship of non-medical and non-psychiatric factors to delirium were noted.

"The promotion of mental health involves a broad range of issues, but it includes those strategies which (a) contribute towards the prevention of mental illness, and (b) promote

and maintain an individual sense of general well being. Mental health promotion appears to be a 3-stage process: (1) primary prevention - any strategy that attempts to eliminate factors which cause mental disorder; (2) secondary prevention - activities involving early detection and prompt, appropriate treatment of disorders so that they do not become more serious; (3) Tertiary prevention--the rehabilitation of an individual after an illness so that he or she will live independently and with minimal disabilities." (Wigdor, et. al., 1988).

Early detection and intervention where factors predispose the elderly to mental illness should be a focus of a community psychogeriatric outreach team. The team might provide some direct interventions, but ideally would educate other service providers (i.e. Widow's Groups, senior's Recreation Programs), and assist them in developing programs to address these factors. Early intervention can shorten treatment, particularly with depression. Teaching referral sources to identify the early symptoms of mental illness and to be sensitive to predisposing factors may ensure early interventions.

RANGE OF SERVICES

Ideally, the community psychogeriatric outreach program should provide a broad range of services, both direct and indirect. Direct services are assessment of the client and the provision of treatment. Treatments might be individual, marital or family therapy, group therapy, drug therapy, skills training, emotional support and education. There is a legitimate role for a psychogeriatric outreach program in working with family caregivers, when the primary aim of most programs is to maintain elderly clients in their home as long as beneficial. Failure to address caregiver needs will, in all likelihood,

hasten the breakdown of the caregiving situation, and the likelihood of the client's institutionalization. Additionally, as was noted earlier, caregiving is associated with higher psychological morbidity, (Brodaty and Hadzi-Pavlovic, 1991). Neglect of caregiver needs may "create" an additional client. Where community resources exist for providing non-psychiatric emotional and mental health counselling to caregivers, referrals may be made to those resources. The reality is, however, that in many communities sufficient affordable resources to meet these needs simply do not exist.

Psychogeriatric outreach programs also have a valuable role to play in providing indirect services, such as consultation to others who are involved in the care of the elderly client. Efforts can be directed to assisting care providers to develop a sophisticated understanding of the emotional needs of behaviorally disordered clients and the meaning of symptoms. As helpers better comprehend the meaning of the patient's communications, they can satisfy such needs for the patients and reduce the degree of behavioral disturbance (Stotsky, 1972).

After assessing the client, the psychogeriatric team develops a treatment plan that is often carried out, in part, by other involved professionals or informal caregivers. It is important that a consultation not be simply a written document, but that personal contact is made with the consultees to ensure their understanding of the recommendations. Their cooperation must be elicited as the recommendations must take into account the resources available and the realistic limitations of the caregiving system, (eg. understaffing in long

term care facilities), (Health and Welfare Canada, 1988B). Consultation about an individual client can assist in enabling caregivers to understand the reality of the client's situation and to adopt realistic plans and expectations.

Indirect consultations are at times useful in long term care settings. In this instance the clients are not seen, but their charts may be reviewed, problems are discussed and the consultee provided with education and understanding about the general issues and concerns related to the particular client. The indirect consultation liaison function is part of educating caregivers, and leads to generalizing what is learned to other cases.

Formal education is another indirect service that can be offered by psychogeriatric outreach programs. There are few psychogeriatric specialists in Canada and the people who tend to be looking after the psychogeriatric client are often uninformed family caregivers and long term care facility staff. These caregivers are generally non-professional and lack training and expertise in the management of psychogeriatric problems. The common problem behaviour disorders identified by Jeste and Krull, (1991), by Rovner and Rabins, (1985), Clarke, et. al, (1981) and Rovner, et. al., (1986), are ubiquitous. Rovner and Rabins, (1985), Schulman, (1991) and the Health and Welfare Canada (1988b) and Clarke, et. al., (1981) all express the need for professionals in the field of psychogeriatrics to provide advice, help, training and support for both family caregivers and staff in long term care facilities.

Psychogeriatric teams have an important role in providing caregivers with information about normal aging, about common psychogeriatric disorders, and about cognitive impairment. As well, hands-on training about the day to day management of behavioral disorders that result from mental health problems is an important function in reducing the stress on caregivers and enabling them to improve the quality of life of clients.

COMMUNITY DEVELOPMENT

Psychogeriatric outreach programs were originally conceptualized as a bridge between mental health services and geriatric services, (Health and Welfare Canada, 1988b). In this position, it is frequently possible to see gaps in services and programs that do not meet the needs of psychogeriatric clients, e.g. long term care assessments that take into account only physical need in providing home care services, thus leaving the elderly psychogeriatric client who may be physically well, but cognitively impaired, with little support. In many communities, the support to family caregivers is inadequate to meet the need and yet it is these caregivers we rely on for the bulk of care to the mentally disordered elderly. Community psychogeriatric programs have an important role in identifying these gaps through their funders and levels of government, and joining with other interested parties in the community to develop resources for psychogeriatric clients, or to adapt existing resources to better meet their needs, e.g. advocating that the local adult daycare have some time per week set aside for the provision of daycare services to cognitively impaired adults.

CONTINUUM OF SERVICES

Ideally, the community psychogeriatric program should be part of a continuum of institutional and community resources that are available to the elderly.

In-patient beds may, at times, be necessary. The psychogeriatric team does not likely require its own in-patient beds, and in fact, there is a danger if they do so, of being pressured to fill these beds, at times inappropriately. Instead, the team requires the ability to access hospital beds directly, perhaps through the geriatric psychiatrist, or through arrangements with referring physicians. Without the capacity to have elderly clients hospitalized when the need arises, the community outreach program is not able to serve the sickest of the sick. Delirium, for example, is a rapidly progressive condition, often a medical emergency, and should be managed in an acute care hospital,(on a medical, rather than on a psychiatric unit).

Frequently, the elderly require supportive environments, such as adult daycares, in which to socialize or to learn new life skills. Ideally, clients should be integrated into existing social programs for seniors where possible. However without assistance and support of another person they may lack the skills or confidence to make use of these resources. Volunteers, with special input from by the psychogeriatric team, could be helpful in this area.

Transportation can be a major obstacle to the elderly attending appointments, doing grocery shopping, attending Church or participating in social activities. Where

communities do not have an adequate transit system for the elderly, psychogeriatric programs could be instrumental in encouraging the development of an alternative service to meet this need. A prosthetic social support system may have to be devised for clients who lack sufficient support from family and friends. Volunteer visiting services and senior peers counsellors can be utilized. Special training of these volunteers, by the team, may be required as these clients are not always easy to socialize with.

Frequently, clients who are being maintained in the home need more specialized and tolerant home support services than can be provided by the continuing care system. Home support workers who are trained by the team about the common disorders of psychogeriatric clients, and in approaches that they might take with them, would also be a resource to psychogeriatric outreach programs. Respite care for caregivers is very important in supporting caregivers. Long term care facility beds that accept elderly clients with psychogeriatric problems are limited in number, and in fact, in some places psychogeriatric problems will bar a person's entry to some long term care facilities. The assurance that "back-up" can be provided by the team could alleviate this problem. Relief in the home can be also be provided by home care services.

Ideally, the team should have direct access to some of these programs for their clients, but failing that, there should be ongoing dialogue between the team and these community resources to advocate for individual clients and to ensure that clients are not excluded

because of lack of understanding or expertise in the management of their care. The psychogeriatric program can function as a resource to these other services, thus facilitating their ability to accept and manage clients with mental health problems. Additionally the team can advocate for new services that are needed for the psychogeriatric population.

SUMMARY

In summary, then, an ideal psychogeriatric outreach program would:

1 - Adhere to a social model of care.

2 - Recognize that the diagnosis of psychiatric and medical illnesses is only part of a complete assessment.

3 - Provide comprehensive biopsychosocial environmental assessments.

4 - Provide assessment and treatment in the client's home.

5 - Consist of an interdisciplinary team composed of a geriatric psychiatrist, a social worker and a nurse, a consulting occupational therapist and a consulting neuropsychologist.

6 - Recognize the needs of caregivers and provide treatment and support to them as necessary. Sometimes the caregiver becomes the client.

7 - Recognize the importance of early intervention with emotional problems. Involvement is not limited to those only with major psychiatric disorders.

8 - Recognize that treatment may be longer than is usual with younger adults, due to the special needs of the elderly (Spar and LeRue, 1991).

9 - Have a referral system open to community caregivers and physicians.

10 - Provide a range of services including direct treatment for the client, and indirect activities such as education, consultation and community development. Time should be made available to plan and undertake these activities.

11 - Recognize that the elderly's support systems are often so sparse that considerable effort may need to be expended by the team members in developing a prosthetic network of formal and informal caregivers. This is a legitimate activity, and should be recognized as such.

12 - Have directly available a range of community supports and resources which can be utilized in supporting the elderly to function at an optimal levels.

13 - Recognize that education is important to ensure knowledgable and therapeutic care of the client.

14 - Undertake research activities. It is recognized, howevr, but few staff have special training in research, (Health and Welfare Canada, 1988b). Psychogeriatric teams should be supported in acquiring these skills, or encouraged to develop collaborative links with universities.

In summary, the ideal model for a community psychogeriatric outreach program recognizes the intricate mixture of medical, social, environmental and psychological factors that impact upon the elderly, and addresses these factors both directly and indirectly, through use of an interdisciplinary team, and the involvement of community resources.

In the next section the research methods for interviewing key informants will be described, as will be the results of the key informant survey.

CHAPTER 4

REPORT ON THE KEY INFORMANT INTERVIEWS

This chapter will provide a description of the methodology used in selecting and interviewing key informants, and the development of the key informant questionnaire. The results of the interviews with key informants will be reported. The responses of the key informants in the western provinces will first be presented. This will be followed by a summary for each question and a separate report on the responses of the external key informants. A summary of the major findings will conclude this chapter.

The purpose of interviewing key informants was to:

(1) identify any issues in the field of community psychogeriatrics that had not been revealed through the literature review

(2) generate ideas that would optimize the relevance of the questionnaire to current issues in the field

(3) identify where there is/is not consensus among key informants

(4) identify community psychogeriatric outreach programs in each province

METHODOLOGY

The literature was searched to identify models for delivering psychogeriatric services, and for program descriptions of community psychogeriatric outreach programs, henceforth to

be referred to as " CPO programs". Key elements of a CPO program were identified, and incorporated into an ideal model for a community psychogeriatric outreach program. An unstructured interview format for interviewing key informants, (Appendix I), was developed.

Key informants were interviewed about issues they felt were meaningful and important in the field. This information was used to design a questionnaire with the potential of generating results relevant to current issues in the field, and that might have practical application, (Appendix II). The information was also used in developing the "ideal model" described in the previous chapter.

Three key informants were selected from each of the western provinces from the names generated, with the exception of Saskatchewan. (This problem will be discussed below.) Each key informant had a broad overview of community psychogeriatrics in their province, but from slightly different perspectives by virtue of their positions. A geriatric psychiatrist and representatives from the usual funders of psychogeriatric outreach programs, i.e. Departments of Health, and Mental Health, were interviewed.

Three people prominent in the field of psychogeriatrics were also interviewed; Drs. Martin Cole, Don Wasylenki and Ken Shulman. These individuals were chosen on the basis of their having written frequently about issues and the organization of services in the field of psychogeriatrics. It was felt that they would contribute more research and

academic points of view than the other key informants, by virtue of their study of the psychogeriatric field as a whole. The fact that these informants all resided in eastern Canada, by chance, also provided them with a slightly different perspective than the other informants.

In all, 3 persons in Alberta, 3 persons in Manitoba, 3 persons in B.C., 2 persons in Saskatchewan were interviewed, and 3 persons outside the western provinces, henceforth to be called "external key informants".

The structured interview format (Appendix I) designed for interviewing the key informants was pre-tested with a geriatric psychiatrist and the former director of a CPO program, to ensure clarity. This led to developing a preamble to questions 1 and 2.

Interviews with key informants were proceeded by a letter (see Appendix III) in which the researcher was introduced, the research described, and their participation requested. A copy of the questions to be asked was attached to give the key informants time to consider the issues. Interviews were conducted by telephone.

It was an additional challenge to arrange telephone interview appointments. Although all of the people selected were willing to answer the questions, some stated they could not be quoted because of their position in governments. Some respondents would not agree

to tape recording the interview. Where it was possible to tape record, the information gathered was considerably more detailed.

Problems in Interviewing Key Informants

The general problems in interviewing key informants has already been discussed; here only the inability to find 3 key informants, or any community psychogeriatric outreach programs to survey in Saskatchewan will be elaborated on.

In Saskatchewan it was discovered there are no community psychogeriatric outreach programs in existence, or indeed any specialized programs or services directed at the psychogeriatric population. A community psychogeriatric outreach program was operating in Saskatoon over 1 year ago, but has since closed, apparently due to inadequate funding to meet the needs the program had uncovered. Dr.L.Thorpe, who had been the Geriatric Psychiatrist on the team, was interviewed using the structured key informant interview format. Dr. Silzer, a Senior Policy/Program Analyst with Mental Health, was also interviewed, about current mental health services provided to persons 65 years of age and older. He informed me that the elderly are seen by the standard generic mental health teams. He believes it is possible that since there is no outreach to the elderly they might be under-serviced. The current situation is not an expression of declared government policy , but has evolved from a combination of the following factors: a grass roots philosophy of integrated programming for anyone with impairments, large geographic area with low population density, long distances between centres, low population, difficulty

in recruiting specialized professionals, and budgetary restraints within the whole spectrum of social and health care.

In spite of significant efforts it was not possible to find anyone in the longterm care system who was able or willing to be a key informant, or to generally discuss how the care of the Psychogeriatric clients in their facilities is being managed.

Key Informant Responses

Question 1

Various models for delivering Psychogeriatric services to the elderly residing in the community (including care facilities) have been described in the literature:

Consultation-liaison model (Wasylenki,1984)-indirect services through consultation, education, coordination, and collaboration to individuals and agencies dealing directly with the elderly.

Outpatient geriatric psychiatry assessment and treatment clinics, (Reifler, 1987) - in-clinic multidisciplinary assessment, consultation to family, treatment.

Community "outreach" services (Harris et al,1990) - in-home assessment, treatment, follow-up, consultation - provided by multidisciplinary teams.

Consultation model - in-home assessment, consultation provided by a physician and initiated by a physician: (i.e. traditional Doctor to Doctor consults).

WHAT DO YOU THINK IS THE IDEAL MODEL FOR DELIVERING PSYCHOGERIATRIC SERVICES TO THE COMMUNITY? WHY?

There was a consensus (10 of 10) that whatever model was chosen a multidisciplinary team is essential to the provision of psychogeriatric services, due to the complexity of the issues that must be assessed and the range of interventions required. All respondents spoke of the need to do holistic or biopsychosocial assessments and of the importance of home visits to the assessment process.

Five respondents stressed that all models are appropriate at times, and the choice should reflect the context in which the service is being offered, (i.e. needs and available resources). The community "outreach" service model was chosen by 3 respondents. Two respondents believed that the consultation-liaison model is the most useful model in the longterm care facilities. Another respondent reported that in her experience the consultation-liaison model is not very effective. One respondent said that none of the models can stand alone, and an inpatient unit must be part of any ideal model.

Summary:

Home visits, biopsychosocial assessments, and multidisciplinary teams were key concepts of the "ideal model", identified by all. There was wide recognition that the choice of model must meet the needs of the particular target group, and take into account available community resources. These opinions reflect the basic planning principle outlined in the "Guidelines", (Health and Welfare Canada, 1988b). It was noted earlier that these have been adopted by the provinces to guide the planning of psychogeriatric services.

External Key Informant Responses:

Dr. Shulman thinks a regionalized, comprehensive model of care is necessary -"good service can't be provided on a piecemeal basis, as you end up getting stuck somewhere". Therefore all the service models mentioned would be part of the whole.

Dr. Cole stated that it is not known which model is the best, as we so far only have opinions about their effectiveness, not evaluation.

Dr. Wasylenki believes his own model is the best, as it achieves a multiplier effect of a specialized resource. The key to delivering services, he believes, is creating linkages between mental health services and others that work with the elderly - LTC, and professional and non-professional caregivers - in order to support them in their roles. Linkages need to be created between all components of services for the elderly, at the systems, program and clinical level. Consultation and education are practical ways of

gaining access to the elderly, and breaking down barriers to mental health services for the elderly.

Question 2

Harris et. al. (1990) described the typical range of patient and non-patient services commonly offered by a Psychogeriatric service in the community;

Direct patient services	Non-patient services
assessment	teaching
consultation	research
treatment	community development
counselling	community consultation
medication	
education	
behaviour management	
community support	
medico-legal advice	
placement assistance	
crisis intervention	
case coordination	
follow-up	

A - WHICH OF THESE SERVICES DO YOU THINK ARE ESSENTIAL TO A COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAM?

There was almost unanimous agreement (9 of 10) that all the services listed are important to a community psychogeriatric outreach program.

Seven respondents stressed that they felt one of the most essential services is the provision of training to professionals, paraprofessionals and families.

Five respondents believed community development, community consultation and research are important to the field of Psychogeriatrics, but that on a community psychogeriatric outreach team these activities tended to be pushed aside due to the pressures of direct patient services and teaching. One respondent noted that it is difficult to find staff who are skilled and interested in all areas of service.

Four respondents stated they also felt inpatient assessment and treatment beds are essential to a comprehensive service.

Four respondents stated they felt the assessment of clients was the most important direct patient service provided.

Two respondents said they believed that treatment was a valuable service, but only if it was time limited so that it did not consume all team resources.

One respondent felt that a community team should not be providing crisis intervention, medico-legal advice or placement assistance, and questioned the usefulness of behaviour management and counselling.

Summary

With the exception of one, all respondents endorsed all the services listed. There was a greater stress placed on the provision of indirect services than on direct services. All key informants have input into the planning of psychogeriatric services, and may be trying to achieve the multiplier effect of scarce resources, advocated by Wasylenki, (1984).

External Key Informant Responses:

Dr. Shulman stated that all the services listed should be provided, but not necessarily by the community psychogeriatric outreach program. Their job is, he said, is to ensure everything is done, but it may, for example, be done by the hospital team.

Dr. Cole stated that Harris's description of what services a program should offer are all important, but it is not known if any of them actually benefit those they set out to serve.

Dr. Wasylenki stated that consultation, education, coordination, community consultation and community development are the essential services that should be offered. Assessment should only be undertaken in very complex cases. Treatment should be provided by those already involved in providing care to the client.

2B - WHAT STAFFING RESOURCES DO YOU THINK ARE ESSENTIAL IN PROVIDING THE SERVICES THAT YOU IDENTIFIED?

Only 9 out of 10 respondents answered this question.

There was complete consensus among the respondents that the core disciplines required on a community Psychogeriatric outreach team are a social worker and a nurse.

Seven respondents believed that a geriatric psychiatrist should be part of the core team. Of the dissenters, one believed the geriatric psychiatrist should only consult to the team, while another would prefer to use a geriatrician.

Seven respondents indicated that if a Geriatric Psychiatrist was not available that a G.P. with special training and/or interest in Psychogeriatrics would be the next choice.

Four respondents would include an O.T. as part of the core team; 4 would have them available for consultation only; one had no experience of O.T.'s.

Three respondents stated that they had not found psychologists useful on the team, but might very occasionally use them as consultants on complex behavioral programs; 4 would use them on the team; 2 respondents had no experience with psychologists in the field.

One respondent would like to see public health nurses linked to the team; another mentioned physiotherapy ; another suggested geriatricians, a third suggested a G.P. with special training.

Summary

The majority of the respondents would endorse the team composition proposed in the "ideal model".

External Key Informant Responses:

Dr. Shulman stated that as many disciplines as possible should be involved in providing care to the psychogeriatric client - social workers, O.T.s, nurses, physicians, speech-language pathologists, audiologists, etc.

Dr. Cole believes that all disciplines are important, but it is not known which discipline does what best.

Dr. Wasylenki stated that case managers who can work independently and are able to support those who provide services to the elderly are essential. A team approach is necessary in the community, he said, and while access to different areas of expertise is required, a large multidisciplinary team is not essential - consultants can be used as required.

Question 3

A large part of the work of Psychogeriatric Outreach Teams is assessing clients and providing diagnoses.

WHAT DIAGNOSTIC SYSTEM DO YOU BELIEVE SHOULD BE USED FOR THE PSYCHOGERIATRIC CLIENT? WHAT SYSTEM DO YOU USE? IS IT ADEQUATE?

Four respondents (all Psychiatrists) use DSM-III-R, but none think it is an ideal reporting system, as frequently it is not understood by the referral source. Two only find Axis I-III useful; another felt that only Axis V was not useful for the elderly. One commented that she found Axis V very helpful. All commented that there needed to be more specific criteria for organic disorders. Two find the V codes useful and use them more frequently than with younger people.

Two other respondents also stated they did not find the DSM-IIIR a good reporting system. Three respondents pointed out that DSM-III-R focuses only on diagnoses, which

is only a piece of a psychogeriatric assessment. They felt more focus should be on skills and the client's ability to function in a given setting.Two respondents felt that psychiatric labels could be barriers to receiving services,(i.e. nursing home placement), and would not recommend DSM III-R for that reason.

Summary:

DSM III-R was the only diagnostic system mentioned by respondents, but none felt it was entirely suitable for diagnosing psychogeriatric disorders.

External Key Informant Responses:

Dr. Shulman finds DSM III-R very limited, especially Axis V, with demented clients in particular. Hospital based and medical services should likely use it, he believes, but community based teams\agencies shouldn't as it is not appropriate to the people they interface with. He doesn't believe it is possible to reflect the quality of life of client or caregivers in DSM III-R.

Dr. Cole uses DSM III-R.

Dr. Wasylenki finds DSM III-R Axis I useful, but stated that the main issue is that the referral sources understand the consultation results.

Question 4

In an ideal world a continuum of services would be available to the Psychogeriatric client residing in the community:

- community outreach services
- psychogeriatric day care
- psychogeriatric day hospital
- psychogeriatric inpatient assessment and treatment unit
- respite services
- caregiver (family) support
- home support service
- psychogeriatric boarding homes/guest homes
- psychogeriatric long term/personal care beds
- psychogeriatric chronic care/mental health beds
- education to caregivers (family and staff)

A - WHAT SERVICES DO YOU THINK ARE ESSENTIAL TO PROVIDING ADEQUATE CARE TO PSYCHOGERIATRIC CLIENTS IN THE COMMUNITY?

There were 9 respondents to this question. Six respondents felt that all the listed services are essential except for Mental Health beds. They felt that the reason these beds have

been used is that longterm care facilities have been unwilling or insufficiently supported to care for psychogeriatric clients with difficult behaviours.

Three respondents believed that all the listed services, including Mental Health beds, are essential to providing adequate psychogeriatric care.

Five respondents stated that they felt an additional service, that of coordinating all the mentioned services, was imperative.

Two respondents stated that where possible all community services for the elderly should be integrated, as otherwise there was a stigma attached to the client.

Two respondents stressed the importance of caregiver (family) support in providing an adequate service to psychogeriatric clients.

One respondent suggested that an additional service should be provided, that of a non-hospital based crisis stabilization unit. Another would like to see crisis intervention services added.

Summary:

The majority of respondents felt that mental health beds were not needed for the elderly, that instead they should be integrated into mainstream services for the elderly. This

consensus reflects some of the social trends, discussed in chapter 2, that have led to the development of psychogeriatric services. Coordination of all the services for the elderly was stressed by over half the respondents.

External Key Informant Responses:

Dr. Shulman stated that all the services listed are important, but they need to be connected under a common administrative umbrella.

Dr. Cole stated that there is not enough knowledge about the impact of services/programs to know which are really essential.

Dr. Wasylenki stated that all the services listed are important, but they must be linked and care coordinated.

4B - WHAT SERVICES ARE AVAILABLE TO THE PSYCHOGERIATRIC CLIENT IN YOUR PROVINCE?

There are no specialized services available to the psychogeriatric clients in Saskatchewan.

All other respondents (9) stated that all of the listed services are available in their province, but only on a regional basis. This means that in large urban centres all services exist, but they generally have catchment area boundaries that limit access to clients within

these boundaries - sometimes covering only part of a city. In rural areas the range of available services is often quite limited.

One respondent stated that so far there has been little demand for more services in the rural areas. She speculated that where there is a lower population there is also a smaller number of difficult psychogeriatric clients, and these could therefore be managed in the general geriatric service continuum.

Summary:

The consensus is that all services are available in 3 provinces, but not to all, depending on where in the province people live. Rural areas have fewer services than urban areas.

External Key Informant Responses:

All informants stated that all the services are available in their region; Dr. Cole added that they are not equally available to all.

4C - WHAT ARE THE GREATEST OBSTACLES TO PROVIDING COMMUNITY PSYCHOGERIATRIC CARE TO THE ELDERLY IN YOUR PROVINCE?

Six respondents stated that **insufficient funding** is a major obstacle to providing psychogeriatric care to clients in the community.

Six respondents identified **lack of specialized education** and training in psychogeriatrics for professionals and paraprofessionals as an obstacle to good care. Three of these respondents mentioned the difficulty in attracting people to the field, primarily due to low status.

Four respondents thought that lack of cooperation and/or coordination between agencies that allows some clients to "fall in the cracks" is a major obstacle to adequate care.

Three respondents stated that distances between service sites in northern and rural areas is an obstacle to providing community psychogeriatric services.

Ageism combined with the stigma of mental illness was identified as a pervasive obstacle by 3 respondents.

Three respondents stated that neither the Continuing Care system nor the current care facilities were designed with the Psychogeriatric client in mind, therefore making the provision of appropriate care to them difficult.

One respondent felt that the lack of a consumer driven system, along with a general lack of awareness of options and services, are barriers to providing adequate care to clients in Alberta.

Summary:

Funding, lack of knowledgable personnel in the field of psychogeriatrics, and gaps between services were the 3 main obstacles to psychogeriatric care identified by the majority of respondents.

External Key Informant Responses:

Dr. Shulman stated that administrative issues are a greater obstacle than finances - i.e. lack of cooperation between programs, barriers that prevent people from getting services. He believes that before anyone can ask for more money, or even say that more is needed, it must be demonstrated that current funds are being used effectively. He stated that an additional obstacle to providing services is that some psychiatrists don't consider dementia a psychiatric disorder.

Dr. Cole believes that the greatest obstacle is lack of evaluative research. He noted that there is an absence of knowledge about what the different services really do and what impact they have.

Dr. Wasylenki identified that a lack of effective linkages between the various components of the continuum, and poorly coordinated care are the greatest obstacles. He advocates the creation of a system of care that is comprehensive and has a single entry point.

Question 5

Some people have suggested that there are major issues still to be addressed in providing community Psychogeriatric services, such as support for family caregivers; education for long term care/homecare staff; lack of trained health care professionals; need for evaluation of treatments, service delivery systems, and programs; implications of a growing aging population and a declining population in the middle years; and implications of the divorce rate and women in paid employment to caregiving. You may be able to identify other important issues.

WHAT DO YOU THINK ARE THE MAJOR ISSUES\CHALLENGES IN THE FIELD OF COMMUNITY PSYCHOGERIATRICS?

While there was unanimous agreement that all the challenges listed were important and worthy of investigation, there was cosiderable disagreement as to which was the most important. Three respondents stated ageism is a major challenge; they also stated that the living conditions in which the elderly are expected to live reflect society's attitude towards the old. Two respondents felt that the challenge is more fundamental than ageism, that society must decide how much care it wants to provide to al of its' members, including the elderly.

A lack of physicians trained in psychogeriatrics was an issue identified by 3 respondents.

One respondent felt that physicians require better compensation for caring for institutionalized elderly.

Needs of employed caregivers; abuse of residents in care facilities; medication abuse/misuse; lack of incentives for caregivers to look after family members; the right of society to expect families to provide care; abuse of caregiving staff by psychogeriatric clients; the right of professionals in the field to determine whether or not clients should remain in the community; and poorly developed and coordinated community resources, were all brought up by respondents as major issues still to be addressed in the field of community psychogeriatrics.

Summary:

While all respondents endorsed the importance of the challenges listed, they added many more.

External Key Informant Responses:

Dr. Shulman believes that the needs of family caregivers must be addressed, and innovative ways to improve their quality of life found for them, as well as for those they are caring for. He suggested alternatives to hospital based programs; i.e travelling daycares instead of hospital bases day cares. He also suggested that alternative forms of respite that don't remove the client from the home, such as sitter services need to be developed. He believes that community based and hospital based services within the

community should be coordinated. He believes that alternatives to long term care facilities need to be explored. He calls for evaluation that determines which are the most cost-effective services that also positively impact on quality of life.

Dr. Cole stated that effective services/service delivery models need to be identified through careful evaluation, using control groups.

Dr. Wasylenki stated that the greatest challenge is to plan a service delivery system that creates effective linkages between all service providers. Effective case coordination and the development of single entry point system of care are required, he believes.

Question 6

As you know, I will be surveying community Psychogeriatric outreach teams in western Canada in order to develop a typology of programs.

A - **WHAT ARE YOU MOST INTERESTED IN KNOWING ABOUT THESE PROGRAMS?**

Eight respondents would like to know whether or not programs have been evaluated or if any have outcome measures.

Four respondents want to know how other programs are operationalized. Three respondents asked for information on the characteristics and diagnoses of clients being seen. Two questions were asked about physicians: Does the geriatric psychiatrist see each

client? Does the family physician have to agree to a referral to the psychogeriatric outreach program? Two respondents would like to know what kind of data programs gather. Two respondents would like to know about team composition, staff numbers, and caseload size. Two respondents would like to know how psychogeriatric services are coordinated. One respondent wants to know if programs have waiting lists, and how these are managed. One respondent would like to know if any programs are consumer driven. One respondent would like to know what problems other programs have encountered and how these were solved.

Summary:

The majority of respondents would like to know if programs have been evaluated, and are interested in staffing issues and operationalization of psychogeriatric programs. These interests reflect their positions as program planners.

External Key Informant Responses:

Dr. Shulman would like to know about organizational structure,
data on utilization, standards of service, number of clients served, appropriate caseload size, disciplines on the team, how waiting lists are managed, client turnover and intake method of programs.

Dr. Cole is not interested in process or what programs say they do. He is interested in outcomes - if clients receive a service how do they benefit/not benefit?

Dr. Wasylenki is interested in whom programs serve, both targets and referral sources, and in what models of care are being utilized.

6B - HOW WOULD YOU SUGGEST I MIGHT BEST COLLECT DATA FROM COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAMS?

Most respondents suggested that I ask each program for their annual statistic, (client and program).

Two respondents suggested I approach the provincial government for demographic and diagnostic information related to the elderly.

External Key Informant Responses:

Dr. Shulman suggested data could be best collected by visiting each program and asking what they do, what sort of data they collect and how.

Dr. Cole suggested that programs be asked for outcome data - how do they know they are having an impact?

Dr. Wasylenki suggested that the survey be carried out as planned, perhaps adding telephone interviews.

Question 7

IF YOU HAD A COUPLE OF MILLION DOLLARS TO SPEND ON IMPROVING SERVICES FOR PSYCHOGERIATRIC CLIENTS IN THE COMMUNITY, WHAT WOULD YOU SPEND IT ON?

Five respondents would spend money on creating a coordinated, comprehensive single point entry system.

Five respondents would spend on educating people -professionals, paraprofessionals.

Four respondents would spend money on increasing the number of community based psychogeriatric teams.

Three respondents would spend money on researching psychogeriatric services.

Two respondents would provide more support to family caregivers.

Two respondents would expand staffing in long term care facilities.

Two respondents would increase current outreach services so that crises could be responded to quickly.

One respondent would enhance existing services.

One respondent would extend multidisciplinary psychogeriatric outreach services to small acute care hospitals.

Summary

The majority of respondents would spend money on enhancing or increasing current services; the development of a single entry point system and education were 2 ares especially focused on. These responses echo the responses given to the question asked about important services to be provided by psychogeriatric programs, and address some of the obstacles to providing services they identified earlier.

External Key Informant Responses:

Dr. Shulman stated that Ontario is bankrupt - it is necessary, he said, to evaluate all that is being done and ensure that programs are effective before more money is spent. He believes that quality of life has to be part of any evaluation as effectiveness is not just a crass money issue.

Dr. Cole would spend all the money on the evaluation of existing programs.

Dr. Wasylenki would invest in the development of community care teams that use the consultation model. He would also invest in the development of a coordinated comprehensive, single entry point system.

CONCLUSIONS:

Key Informants In Western Provinces:

There is broad consensus on many of the questions. Respondents support the proposed "ideal model", in regard to team composition, the importance of biopsychosocial assessments, home visits, the range of services that should be provided, the needs of caregivers, the continuum of services needed for psychogeriatric clients, and the limitations of DSM III-R as a diagnostic system. Respondents identified the need for integration of services for the psychogeriatric client within the mainstream of geriatric services, and commented on regional disparities in the availability of services. The major obstacles to providing psychogeriatric services were identified chiefly as funding, gaps in services and lack of personnel knowledgable about psychogeriatrics. They would address these obstacles by improving and expanding current psychogeriatric programs. They would like to see programs evaluated and are interested in the staffing and operation of programs. Finally, they identified many challenges still to be addressed in the field of psychogeriatrics.

External Key Informants:

The external key informants, especially Dr. Cole, stated that need for evaluation of existing psychogeriatric programs and services is paramount, and that until this is done many of the questions can not be answered with assurance. Most of the answers given by Drs. Shulman and Wasylenki reflected the points they made in the development of their

models for psychogeriatric services, discussed in chapter 3.

As much as possible, the responses of the key informants were used in developing the questionnaire utilized in the survey of community psychogeriatric outreach programs in western Canada, which will be reported on in the next chapter.

CHAPTER 5

ANALYSIS OF THE RESULTS OF THE SURVEY OF PROGRAMS

INTRODUCTION

This chapter will present the results of the survey of 28 community psychogeriatric outreach programs in western Canada. The questions asked in the survey were derived from the literature review and the findings of the key informant survey. The survey methodology, development of the survey questionnaire and the measures undertaken to analyze the data are described.

METHODOLOGY

Key informants were asked for the names of psychogeriatric outreach programs in their provinces, and a comprehensive list was obtained. Programs had to meet the basic criteria of being in operation 6 months or more, and providing mental health services exclusively to the elderly population. The time criterion was chosen to ensure that teams had been in operation long enough to have developed a reasonable client base from which they could draw data. The second criterion was meant to exclude programs that were only providing an extension of their usual service to the elderly, (e.g. Adult Mental Health teams, hospital out-patient departments), as opposed to services specifically designed to meet the needs of psychogeriatric clients. One potential survey site was eliminated as it did not meet the first criterion.

Following the completion of the key informant interviews, a questionnaire was designed to send out to the program directors of psychogeriatric outreach programs in western Canada (Appendix II).

The questionnaire focused on the following areas:

Program development and structure

Staffing

Referral sources

Services

Program outcomes

Catchment area characteristics.

Client characteristics

The questionnaire was pre-tested with the former director of a CPO program and a current director of a CPO program, (both programs with which the writer has a large degree of familiarity), to ensure internal validity. Thirty-one CPO programs were sent a questionnaire: 14 in British Columbia, 8 in Alberta, and 9 in Manitoba. Prior to sending out the questionnaire telephone contact was made with all but 5 potential respondents, in order to explain the research and enlist their participation. Potential respondents were promised a report of the research results, with their program's characteristics identified so they could compare their program to others. This was followed with a formal letter describing the purpose of the research in more detail. Respondents were provided with a self-addressed, stamped envelope and asked to return the questionnaire within 2 weeks.

At the end of 4 weeks 17 questionnaires had been returned. Those persons who had not completed the questionnaire were sent reminders by mail. In some cases, people had been away on holiday; in others, they just "hadn't gotten around to it". Three weeks later 3 questionnaires were outstanding, all from programs where a personal contact had not been made. In total 28 questionnaires were completed and returned; 90% of those sent out. The high rate of return is indicative of the interest CPO programs have in knowing more about how services are being provided elsewhere. Appendix IV provides the names and addresses of the CPO programs that were surveyed.

Analysis of the Data

Some of the data are qualitative, and will be reported on as such (i.e. mandate, objectives, education, research, service changes, problems in delivering psychogeriatric services, and community practice issues).

The level of measurement for some of the data is nominal and ordinal, for which non-parametric statistics will be used. In order to determine relationships between categorical variables and other categorical variables, chi square tests will be used.

The level of measurement for some of the data is interval for which parametric statistics were used. Correlations were used to determine the significance of relationships between variables. For categorical variables, the means of interval variables for different categories were compared using t-tests. Frequency tables, means, medians ,range, modes, standard

deviations and quartiles, (using Box and Whisker), were calculated on the variables identified.

Where interval variables demonstrate extreme values or outliers, statistics were determined with and with out the extreme values. Significance were reported only if it appeared both with and without the extreme values.

Only results with a significance of less than 1 in 20, ($p<0.05$) were reported.

Individual programs are not identified in this report, as the readership will be varied. It would be undesirable if this report were used as a means of criticizing particular programs, given the limitations of the results.

LIMITATIONS

It is possible that in spite of all efforts that there are programs missed that would have met the criteria for inclusion in the survey.

Quality of the data

Respondents, while providing the most accurate data they could, were often limited by the mechanisms in place within their programs for routinely gathering data. A number of respondents commented on a lack or limitation in the data they had available, and

therefore some of the data represent their "best guess" and as a result, the reliability is less than 100%.

Some of the questions asked respondents to estimate data if they had to, weakening the reliability of the data. It is not known when or how respondents estimated, or to which questions.

Some of the questions, such as how often compliance with recommendations was achieved, were answered subjectively, but these answers were treated as quantitative data. Given this, the results must be treated with caution.

The questionnaire was not pretested on a sample of programs to ensure validity. This decision was made to avoid eliminating any programs from the survey.

Questionnaire Design

The questionnaire was very long, (8 pages), and time consuming for respondents to complete. This may have been why 3 programs contacted did not participate in the survey. As well, the length of the questionnaire may have led to some respondents not providing as detailed responses as they might otherwise have done, due to the overall amount of time required. Two respondents, in fact, made this comment.

A list of operational definitions would have been helpful to respondents and increased the likelihood of all respondent interpreting the questions in the same way.

DIFFICULTIES WITH PARTICULAR QUESTIONS

Funding

The question about funding was not detailed enough to be useful. Programs should have been asked for a break down of their budgets, (i.e. staff salaries, sessional fees, and operating costs).

Time Base

Respondents were asked to report the longest period for which they had a complete client profile. It was hoped that this answer would be the same as the time period for which they provided client data, but this was not always the case and the data provided proved unusable for this purpose.

Team Philosophy

Respondents were asked if their programs adhered to a multidisciplinary team philosophy, rather than asking if they adhered to an interdisciplinary model. This was an error, as in the "Ideal Model", an interdisciplinary team model was proposed, and existing programs were to be compared to the model.

Staffing

This question was not clear enough, and led to some respondents answering with "ticks" rather than with FTEs.

Use of Time

This question was incorrectly answered by some programs and their data could not be used. It had been expected that the respondents would assume that all components together in the 2 categories should reflect their total (100%) program activity; instead some provided the information for direct and non-patient services as separate entities, each adding to 100%. The data must in any event be viewed with caution, as while the question asked for the amount of program time spent on direct and non-patient services, it failed to ask what proportion of their total work time this represents: - i.e. how much program time is spent on other activities such as administration, telephone calls, report writing, case conferences, travel, etc.? Travel time, specifically, might have had an impact on the number of cases opened, the length of time cases were kept open, average case load size, etc.

Exclusion Criteria

It would have been useful to ask respondents what exclusion criteria they used in screening for their programs.

Competency

It would have been of interest to find out if programs assess legal competency as part of their services, as where they do so this might involve considerable time, that would be taken from other areas of service.

Chronically Mentally Ill

It would have been interesting to determine if programs provide their services to the chronically mentally ill, and if so, what percentage of their case loads were comprised of this group.

Use of The Geriatric Psychiatrist

This question, derived from the interests of some key informants, was unclear, and did not provide the information sought - what reasons programs' had for their use of the geriatric psychiatrist. It was also intended to use the results to determine, indirectly, whether or not the programs were more reflective of medical or social models. A specific question should have been asked to gather this information.

Diagnoses

The list of possible diagnoses included physical disorders, which most elderly people have, and would overlap with the psychiatric diagnoses in the psychogeriatric client. The physical disorder category was excluded from the results for this reason.

The list of possible diagnoses were meant to be mutually exclusive, with all categories adding up to 100%: as some programs had totals larger than 100%, the expectation was not made clear.

Reasons For Referral

Programs were asked to give, by percentage, the most common reasons for referral, with all reasons adding up to 100%. The question was not clear enough, with some programs' totals being more than 100%.

Formal Links to Community Resources

The definition of "formal links" was not clear, and may have led to inaccurate results.

Physicians

It would have been useful to have asked respondents whether or not a physician's referral was needed to access their program. If they were required, the number of referrals received from physicians would be abnormally inflated.

Acute Care Beds in Catchment

This question was unclear, with some programs only reporting on geriatric and psychiatric beds, and others on all types of acute care beds.

PRESENTATION OF THE DATA

Essentially the presentation of the results follows the order of the survey questions, (Appendix 2). The report is thus divided into 10 main sections :

Program Context and Development
Staffing
Referral System
Services
Assessment

Catchment Area Characteristics
Client Demographics
Diagnoses
Program outcomes
Practice Issues

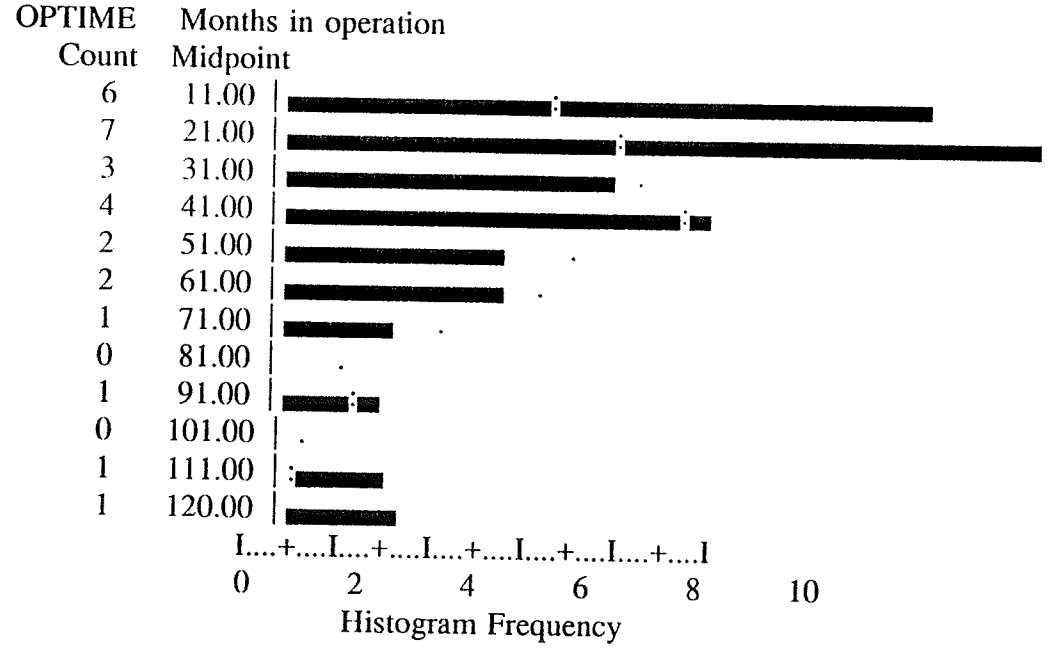
I- PROGRAM CONTEXT and DEVELOPMENT

Length of Time in Operation - (OPTIME)

Programs varied in the length of time they had been in operation, ranging from 6 months to 10 years. The average length of time in operation was 37 months; the median 27 months.

FIGURE 1

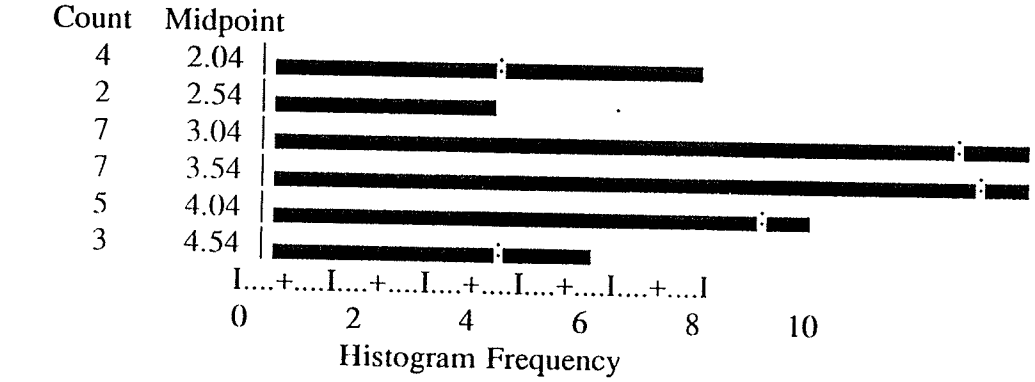
LENGTH OF TIME IN OPERATION (OPTIME)



Valid Cases 28 Missing Cases 0

As the operation time was not normally distributed, (i.e. was skewed to the left), the data were logarithmically transformed of to produce a mores normal distribution. [1]

FIGURE 2
LENGTH OF TIME LOGARITHMICALLY TRANSFORMED (OPTIMLOG)



Valid Cases 28 Missing Cases 0

A t-test confirmed that programs in Manitoba have been in operation significantly longer, (49 mo.), than programs in British Columbia, (16.5 mo), ($p<.001$).

TABLE 6

TIME IN OPERATION BY PROVINCE				
PROV.	6 - 18 MONTHS	19 - 36 MONTHS	3 YEARS +	TOTAL
B.C.	7	6	1	14
ALBERTA	1	2	2	5
MAN.	1	2	6	9
TOTAL	9	10	9	28

[1]All subsequent references to time in operation refer to logarithmically transformed data.

It should be noted that in B.C. the development of community psychogeriatric programs is relatively recent; most are in a formative stage of development and still evolving. Two thirds of the "oldest" programs are in Manitoba, but the "oldest" program is in Alberta.

TABLE 7

PROVINCE BY FUNDER				
FUNDER	MANITOBA	BRITISH COLUMBIA	ALBERTA	TOTAL
LTC[2]	3	1	3	7
HOSP.	3	4	1	8
MENTAL HEALTH	3	9	1	13
TOTAL	9	14	5	28

In Manitoba the majority of programs (6 of 9) are funded by Manitoba Health Services Commission;(3 through Long term care services, (LTC) and 3 by hospital services); the remaining 3 are funded by Mental Health. In British Columbia most (9 of 14) programs are funded by Mental Health. In Alberta, most (3 of 5) programs are funded by LTC. Inter-provincial differences in funding were significant ($p<0.01$) by chi-squared test.

Budget:

Only fifteen of the twenty-eight programs provided information about their annual budget. Budgets ranged from $7,000 - $1,010,000 with a mean of $238,160 and a median of

[2]LTC =Long Term Care division of Department of Health.

$162,222. These data are limited and cannot be readily compared, in that the budget amount is not broken down into components. In some cases the budget amount represents staff salaries only; in other cases start-up costs and/or operational costs were given. Some included salaried physicians; some included physicians costs to insurance plans, others did not.

Funding was reported to be secure for all programs, although three reported that their funding is regularly reviewed.

Catchment Area

Five of 28 programs provide their service to rural areas only, 12 to urban areas only and 11 to mixed rural/urban areas.

Programs with urban catchments have been in operation longer, (36 mo.), than programs with a mixed catchments, (16 mo.) This difference is significant by t-test, ($p<.05$).

Physical Location of Programs:

17 programs are located in community offices

6 programs are located in LTC facilities

2 programs are located in acute care hospitals

1 program is located in an extended care hospital

1 program is divided between a community office and a LTC facility

1 program is divided between a community office and an acute care hospital.

Mandate

Nineteen programs, (including all of the 14 programs in B.C.) are mandated to provide services to both long term care facilities, (LTC), and community.

Six programs are mandated to provide service only to LTC. All these programs are funded by Long Term Care and are evenly split between Manitoba and Alberta.

Three programs are mandated to provide services only to the community, not to LTC: 2 are in Manitoba and 1 in Alberta. (The Manitoba programs are funded by Mental Health and Hospital services, respectively; the program in Alberta is funded by Mental Health).

Funders

TABLE 8

FUNDER BY MANDATE				
Mandate	Hospital	Mental Health	LTC	Total
LTC Only	0	0	6	6
Community Only	1	2	0	3
LTC & Community	7	11	1	19
Total	8	13	7	28

A chi square test of relationship between funder and mandate, was found to be significant at $p<.001$.

Services To Acute Care Hospitals

TABLE 9

SERVICES TO HOSPITALS BY CATCHMENT TYPE			
CATCHMENT TYPE	YES	NO	TOTAL
URBAN	3	8	11
MIXED	5	5	10
RURAL	5	0	5
TOTAL	13	13	26

Thirteen of 26 programs that provided information about their mandate in relation to acute care hospitals reported that they provide their services to hospitals.

Only 3 of 11 urban programs are mandated to provide service to acute care hospitals. All 5 programs with rural catchment areas provide service to acute care hospitals. Half of the programs with mixed catchment areas provided services to acute care hospitals and half did not.

A chi-square test of relationship between catchment type and acute care hospital mandate was significant at $p<.001$.

Programs in rural areas all provide services to acute care hospitals; urban programs do not usually do so. This may reflect that there are usually fewer alternative resources available in rural areas than in urban, or less rigid boundaries between those that exist.

Program Objectives

One of the aims of the survey was to gather information about program objectives. All respondents provided some information, but with a wide range in the amount of detail provided. (Appendix 4).

All programs are dedicated to providing assessment, short-term follow-up and treatment, and consultation to referral sources.

All programs share an objective of providing education, (either formally or informally), to families and to professional caregivers. Five programs, four of which serve only LTC facilities, reported that they place a greater emphasis on consultation and education of caregivers than on treatment of clients. Their purpose is to create more appropriate and informed care of all psychogeriatric clients, reflecting the "multiplier approach" advocated by Wasylenki, (1987). Two programs, both sited in acute care hospitals and headed by geriatric psychiatrists, reported that one of their objectives is to provide education to medical students and other under-graduates in health care professions.

Twelve programs reported that one of their objectives is to participate in the development of enhanced or new community services for the psychogeriatric population.

Eight programs reported that one of their purposes is to coordinate services for psychogeriatric clients, which they do through liasoning and networking with other

agencies/professionals involved in the care of their clients. Seven programs reported that one of their objectives is to reduce inappropriate or premature admissions to acute care hospitals. Seven programs described one of their purposes as supporting the caregivers of clients, through education or counselling. Six programs reported that one of their objectives is to engage in research. Four programs that have a provincial mental institution in their area stated that they are involved in the admission and discharge of their clients to these facilities.

The following table summarizes program objectives.

TABLE 10

PROGRAM OBJECTIVES	
PROGRAM OBJECTIVES	NUMBER
ASSESSMENT	28
TREATMENT	28
FOLLOW-UP	28
EDUCATION	28
CONSULTATION	28
COMMUNITY SERVICES	12
COORDINATE SERVICES for PSYCHOGERIATRIC CLIENTS	7
REDUCE ADMISSIONS	7
CAREGIVER SUPPORT	7
RESEARCH	6
ADMIT/DISCHARGE to MENTAL HOSPITAL	4

In the chapter, "Model for an Ideal Community Psychogeriatric Outreach Team", it was proposed that programs should provide a wide range of services that included assessment and treatment of clients, support to caregivers, consultation, education, and community development. With the exceptions of caregiver support and community development, all programs have an objective of providing this range of services. It could be argued that all programs do in fact provide caregiver support indirectly through consultation and education. As noted above, 12 programs are involved in community development. As would be expected, none of these programs provides their services only to LTC facilities.

There appears to be no relationship between objectives and funder, province, catchment type, type of team or size of team. Whether or not programs are achieving their objectives will be explored under "Program Activity" later in this chapter.

Team Philosophy

All 28 respondents report that they subscribe to a multidisciplinary team philosophy. In 25 programs this occurs primarily through the use of case conferences where all cases are routinely discussed, and the diagnoses made with the input of all disciplines. In 6 of these programs it was reported that initial assessments are usually conducted by 2 disciplines.

In 3 programs the team discusses only problem cases in case conferences. This reflects a unidisciplinary approach to service, where the clinician assigned to a case only consults with other disciplines as needed.

II- STAFFING

Team Coordinator

Twenty-five of 28 teams reported having a team coordinator. The discipline of the team coordinator was as follows;

14 - nurse (Of these 14 nurses, 1 is an R.N., 2 are M.N's, 3 are B.N's, and 8 are R.P.N.'s.)

5 - psychologist

3 - geriatric psychiatrist as team coordinator

3 - social worker

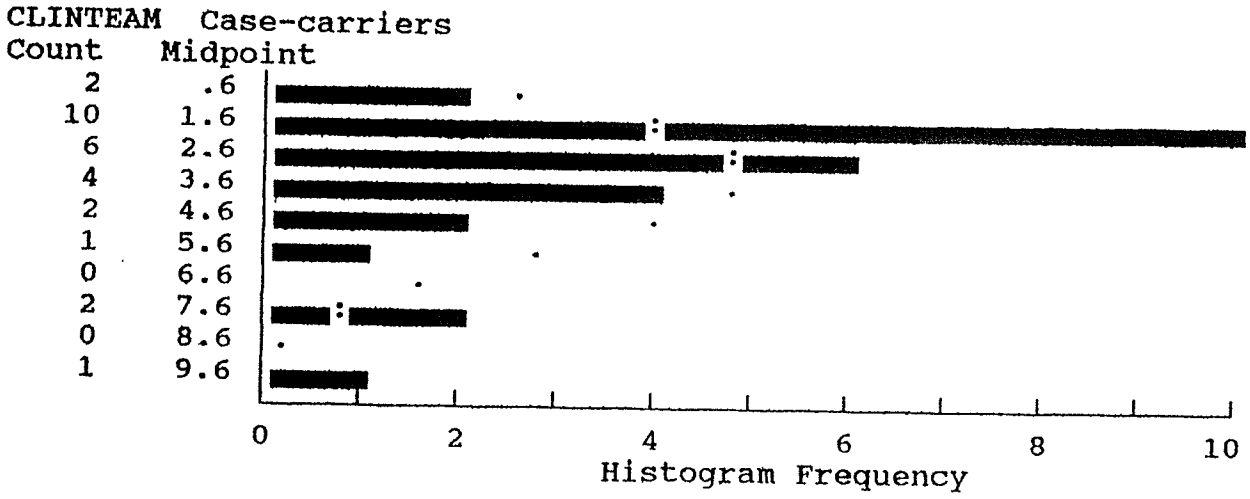
Eighteen of the 25 teams indicated that the team coordinator carried a clinical caseload. The percentage of their time spent on clinical work ranged from 5% to 100% with a mean of 58%, and a median of 65%.

Current Clinical Team Composition:

Clinical team was defined to include only staff who carried cases, and therefore excluded the time team coordinators spent on administration, and consultants.

FIGURE 3

DISTRIBUTION OF CLINICAL TEAM SIZE



Valid Cases 28 Missing Cases 0

Clinical/core teams ranged in size from .1 -- 10.0 FTE, with a mean of 3.2 FTE and a median of 2.3 FTE. If two extremely large teams are removed, the mean is 2.8, and the median 2.2.

Clinical teams composed of physicians, nurses, social workers and 1 or more other discipline are almost twice as large, (mean 3.3), as those composed of only physicians, nurses, and social workers, (mean 1.8). This difference is significant by t-test, ($p<.05$). Clinical teams in urban catchments are 2.25 times larger, (mean 3.6), than those in rural catchments, (mean 1.6). This difference is significant by t-test, $p<.05$).

All programs reported on the disciplines represented on their core teams, by FTE, as follows:

TABLE 11

DISCIPLINES ON CLINICAL TEAM (N = 28)		
DISCIPLINE	NUMBER of PROGRAMS	RANGE (FTE)
NURSE	ALL	
R.N.	9	.2 - 4
R.P.N.	12	1 - 3
B.N.	10	1 - 2.5
M.N.	5	.6 - 1
SOCIAL WORKER	19	1. - 3
PSYCHOLOGISTS	10	.2 - 2
OCCUPATIONAL THERAPISTS	9	.5 - 1
GERIATRIC PSYCHIATRISTS	8	.2 - 2
GENERAL PRACTITIONERS	5	.2 - 2.5
OTHER *	4	---
GERIATRICIANS	2	.1 - 1
ACTIVITY WORKER	1	1

* 2 clinical counsellors, 1 dance therapist, 1 physiotherapist

Consultants to the Team

Twenty-one programs reported having consultants. Consultants attended case conferences, and saw clients only at the request of the team, for specific needs.

Eighteen programs had physicians as consultants. Of these, 11 were geriatric psychiatrists; 6 were general psychiatrists; 4 were geriatricians; and 4 were general practitioners. Six programs had more than 1 medical discipline as consultants. Four programs reported psychologists as consultants; 2 programs reported O.T.'s as consultants; 2 programs reported other disciplines as consultants(1 BN, 1 Behaviour Specialist).[3]

Total Team

In 2 cases respondents had "ticked off" consultants rather than giving the actual FTE. The ticks were arbitrarily assigned a value of .2 FTE, and included in calculating the team total.

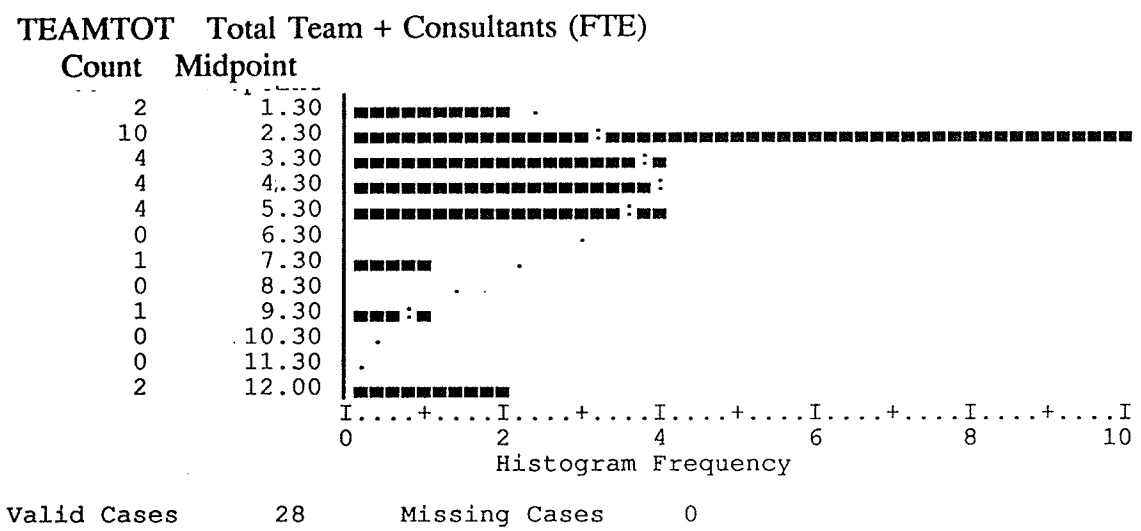
The total team, (including, clinical staff, consultants and the team coordinator's administration time) ranged in size from .8 - 12 FTE, with a mean of 4.27, and a median of 3.25. When 2 extremely large teams are removed, the mean is 3.7, and the median 2.9.

---

[3]The above list is not mutually exclusive - some programs have more than one consultant.

FIGURE 4

DISTRIBUTION OF TOTAL TEAM SIZE



Use of the Geriatric Psychiatrist

Nine programs have no access to a geriatric psychiatrist - 6 of these have access to a general psychiatrist. The remaining 3 have no input from psychiatrists on either the core team or as consultants. These have access to other physicians.

The 25 programs with access to psychiatrists reported on how they use psychiatric input. In most (17) programs the psychiatrist only sees clients at the request of the team; in 4 programs the psychiatrist generally sees all clients first, and in the remaining 4 programs

the psychiatrist generally sees all the clients, after the other team members have begun the assessment. Four respondents volunteered that as the team developed more skills in assessment and diagnosis, and the psychiatrist developed confidence in their competence, there was a tendency to involve the geriatric psychiatrist less in "hands on " assessments of cases, instead relying on indirect consultations.

Respondents were asked how the use of the psychiatrist was determined; 23 programs answered this question; 10 stated their use of the psychiatrist was related to the availability of the resource; 8 programs stated their use of the psychiatrist was related to a philosophical orientation. The remaining 5 programs reported other reasons for how they choose to use the Geriatric psychiatrist;

> "they are only used when other disciplines can not manage the problem"
>
> "occasionally at the specific request of the referring agent"(2)
>
> "they are used as consultants when the case is particularly difficult to manage or where medications need to be reviewed" (2)

COMPOSITION of TEAMS

Four types of teams were derived from the literature review, and programs were categorized by these team types in order to determine how team composition relates to funder, mandate, catchment area , services, recommendations and other variables. Consultants were not included in the team types, except in the case of physicians. This

decision was made because while few programs have physicians on the core team, all programs have them as consultants. This is not true for other disciplines.

Team Type

10 - (A) Physician(s), Nurse(s), Social Worker(s), and OT(s) and\or Psychologist(s)

9 - (B) Physician(s), Nurse(s), Social Worker(s)

5 - (C) Physician(s), Nurse(s)

4 - (D) Physician(s), Nurse(s),OT(s) or Psychologist(s)

The first category represents the "ideal team" as discussed in the literature review.

Four of the five Alberta programs do not have a social worker. Two of these programs are in large urban centres where it might be expected social workers would be available, so the lack of a social worker appears to be a choice.

Three of the five physician/nurse teams provide service solely to LTC facilities. It may be as Wasylenki(1987) discussed, that nurses are seen as being most able to gain the trust of LTC staff, which is primarily nursing. This hypothesis is supported by the finding that the two other physician/nurse teams are located in hospitals and led by geriatric psychiatrists.

Two of the three teams that provide services solely to the community lack a social worker; both of these are in urban areas, so again it would appear that the absence of a social worker is a choice.

A chi square test of relationship between team composition and mandate was found to be significant, ($p<.05$).This may indicate that team composition is determined by mandate.

Ideal Team

The program respondents were asked what disciplines would be represented on their ideal team.

Twenty-five of 28 programs would like to enlarge their teams. (The remainder would only change composition).

All programs wanted a nurse on their team; and most would like more degree nurses than they currently have.

The ideal team differs in composition from the current clinical team, and would be larger. The mean of the ideal team would be 6.1 FTE, and the median 5.5 FTE, compared to the mean (4.2) and median (3.2) of the current total team.

TABLE 12

DISCIPLINES ON IDEAL TEAM		
DISCIPLINE	NUMBER of PROGRAMS	RANGE (FTE)
NURSE		
R.N.	10	1 - 3
R.P.N.	15	1 - 3
B.N.	11	1 - 3
M.N.	7	1 - 2
SOCIAL WORKER	27	.5 - 3
OCCUPATIONAL THERAPISTS	24	.5 - 2
GERIATRIC PSYCHIATRISTS	23	.2 - 2
PSYCHOLOGISTS	20	.5 - 1
GERIATRICIANS	14	.5 - 1
GENERAL PRACTITIONER	6	.4 - 4
ACTIVITY WORKER	5	1
GENERAL PSYCHIATRIST	2	.5
DIETICIAN	2	---
BEHAVIOUR SPECIALIST	1	---
CASE AIDS	1	---
RECREATIONAL THERAPIST	1	---

If teams were able to achieve their ideal, all but one would conform to the "ideal team" as discussed in the literature review. This exception is a program that provides its

services to LTC facilities only, and currently has a social worker on the team who they would replace with a behavioral specialist. This program reported they receive 75% of their referrals for behaviour problems, and that behaviour management is the most frequent type of recommendation they make. They see an RPN, psychologist and behavioral specialist as the most appropriate disciplines to serve their target group.

III- REFERRAL SYSTEM

Referral Sources

Respondents were asked for the percentage of their clients referred by various sources;

Averaging all 28 programs together, the most common sources of referral, in declining order, are listed below;

32% - Long Term Care (Range 0-100%)

23% - Family Doctor (Range 0-100%)

23% - Other Community Professionals (Range 0-87%)

9% - Acute Care Facility (Range 0-30%)

4% - Family (Range 0-18%)

4% - Community Agencies (Range 0-23%)

2% - Other (Range 0-13%)

2% - Client (Range 0-11%)

The data were collapsed to create 4 categories as follows.

1 - LTC = 50% or more Long Term Care Referrals

2 - Medical = 50% or more Family Doctor or Acute Care Facilities Referrals

3 - Community = (50% or more Community Referrals) = Other Community Professionals or Family or Community Agencies or Client or Other Referrals

4 - Mixed = none of the above

TABLE 13

REFERRAL SOURCE BY FUNDER

FUNDER	Mixed	LTC	Medical	Community	Total
Hospital	2	1	2	3	8
Mental Health	1	0	4	8	13
LTC	1	6	0	0	7
TOTAL	4	7	6	11	28

Eleven programs receive referrals primarily from community sources. Eight of these programs are funded by Mental Health and 3 by hospitals.

Seven programs receive referrals primarily from LTC facilities. With one exception these programs are mandated to provide service to LTC facilities only and are funded by Long Term Care. The exception is mandated to serve a designated number of LTC facilities within its catchment area, as well as the community.

Six programs receive referrals primarily from medical sources; 4 of these are funded by Mental Health and 2 by hospitals. Five of these have a geriatric psychiatrist or geriatrician as part of their core team.

Four programs, (all in BC), 2 funded by Hospital, one by Mental Health and one by a LTC - Mental Health partnership), receive the majority of their referrals from a fairly even distribution of all categories of referral sources, (mixed).

Programs funded by LTC receive the majority of referrals from LTC facilities, and programs funded by Mental Health receive the majority of their referrals from informal community sources.

A chi- square test of the relationship between funder and major referral source was significant at $p<.01$.

TABLE 14

REFERRAL SOURCE BY MANDATE					
MANDATE	Mixed	LTC	Medical	Community	Total
Ltc Only	0	6	0	0	6
Community Only	0	0	1	2	3
LTC & Community	4	1	5	9	19
TOTAL	4	7	6	11	28

A chi-squared test of the relationship between mandate and primary referal source, was found to be significant at $p<.001$.

TABLE 15

REFERRAL SOURCE BY PROVINCE					
MANDATE	Mixed	LTC	Medical	Community	Total
Alberta	0	3	1	1	5
British Columbia	4	0	2	8	14
Manitoba	0	4	3	2	9
TOTAL	4	7	6	11	28

In B.C. the primary sources of referrals are the community and "mixed", while Manitoba and Alberta's referrals come primarily from LTC and medical sources.

A chi-square test of the relationship between primary referral source and province was found to be significant at $p<.05$. This is not surprising as it has already been reported that significant relationships exist between province and mandate, and funder and mandate.

In summary there are relationships between primary referral source and funder, mandate and province. Programs receive the majority of their referrals from the sector that they are mandated to serve; the funder determines the mandate and this is reflected by the primary source of referral for their programs; the primary source of referrals is associated with province, just as are funders and mandate.

Reasons for Referral

Respondents were asked to report on the reasons for which clients were referred to their program, by percentage of cases. Twenty-six programs answered this question. Some programs' reasons for referral totalled more than 100%; the data for these programs was recalculated to add up to 100%. In descending order the most common reasons for referral, for all programs, are listed as follows:

Behaviour
Cognitive Impairment
Possible Depression\Suicidal Ideation
Other
Caregiver Burnout
Marital/Family Problem

Conflict with caregivers/others
Grief
Social Withdrawal
Communication Difficulties

Data were collapsed to create 3 groups, and programs were put into the group where they received the majority of referrals.

1 - Cognitive Impairment\Behaviour = Behaviour + Cognitive Impairment

2 - Depression = Possible Depression\Suicidal Ideation + Grief + Social Withdrawal

3 - Other = Other + Caregiver Burnout + Marital/Family Problem + Conflict with Caregivers/Others + Communication Difficulties

Of the 26 programs that provided data, the majority (19) gave the most common reasons for referral as "cognitive impairment/behaviour".

Four programs reported the most common reasons for referral as a mixture of "cognitive impairment/behaviour" and "depression".

Three programs reported the most common reasons for referral as "depression". All of these are funded by Hospital, and two of them are led by geriatric psychiatrists.

Six programs funded by LTC and mandated to provide services only to LTC facilities fell into the "cognitive impairment/behaviour" category. LTC facilities are where it would be expected that the highest proportion of cognitively impaired elderly would reside. The

remaining programs (13) all provide service to both LTC facilities and community.

A chi-square test of the relationship between reason for referral and funder was found to be significant, $p<.05$. A significant relationship between funder and mandate was already reported; programs appear to receive the majority of referrals from those they are mandated by funders to serve.

TABLE 16

FUNDER BY REASON FOR REFERRAL				
REASON for REFERRAL	Hospital	Mental Health	LTC	Total
Cognitive Impairment/Behaviour	3	9	7	19
Depression	3	0	0	3
Mixed	1	3	0	4
TOTAL	7	12	7	26

IV- SERVICES

Program Activity

Respondents were asked to estimate the percentage of program time spent on direct and indirect services, by specific categories as listed below. Only 21 responses could be used as some programs had misunderstood the question, as was discussed in "Limitations".

DIRECT CLIENT SERVICES: (DCST)

Assessment (ATIME)

Treatment (TTIME)

Consultation to caregivers (CTIME)

Direct service to family (e.g. counselling) (DTIME)

NON-PATIENT SERVICES (NPST)

Education (ETIME)

Research (RTIME)

Community Development (CDTIME)

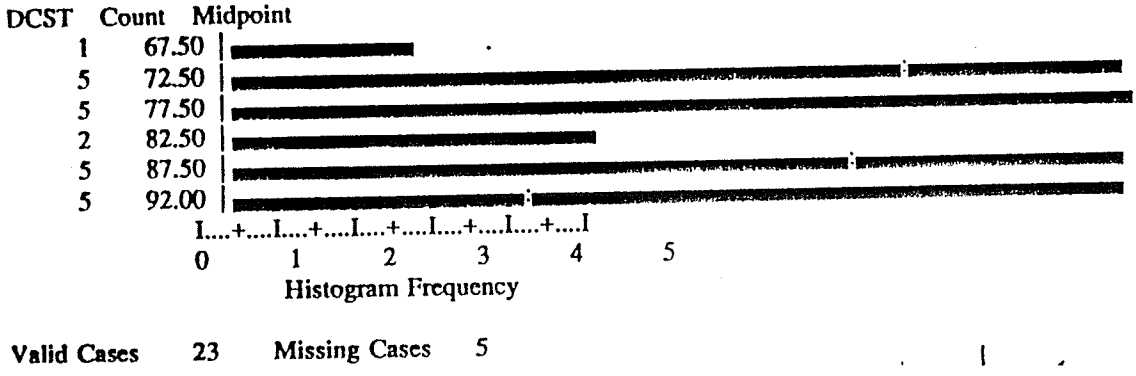
Community Consultation (CCTIME)

Direct Client Services (DCST)

Time spent on direct client services by the 23 programs reporting data in this area ranged from 65% - 92%, with a mean and median of 80%.

FIGURE 5

DISTRIBUTION OF TIME SPENT ON DIRECT CLIENT SERVICES (DCST)



The range and mean for each of the categories that comprise direct services to clients, (N=23) are as follows:

TABLE 17

PROPORTION OF TIME SPENT IN DIRECT SERVICE CATAGORIES		
SERVICE	Mean(%)	Range(%)
Assessment	32.7	16-60
Treatment	22.7	5-55
Consultation to Caregivers	14.4	0-40
Direct Services to Family	8.4	0-30

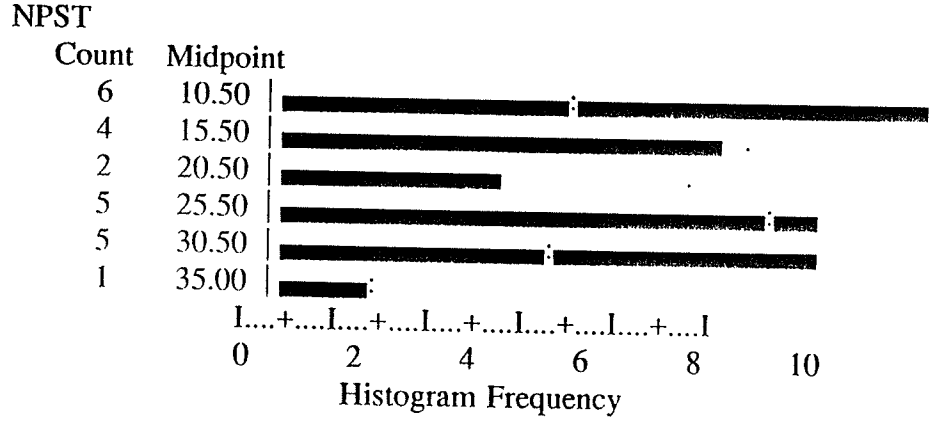
Within this category, eleven programs spend the greatest single portion of their time providing assessment services - (mean 33.6%, range 30 - 60%, N=11). Three programs spend the greatest single portion of their direct service time in providing treatment - (mean 50%, range 45 - 55%, N=3). One program that serves only LTC facilities, does not provide treatment. There was no commonality among the way the remaining six programs spend their time.

Non-patient services (NPST)

Twenty-three programs provided information on the percentage of time they spent on non-patient services. The range was 8 - 35%, with a mean of 20%, and a median of 21%.

FIGURE 6

DISTRIBUTION OF TIME SPENT ON NON-PATIENT SERVICES (NPST)



Valid Cases 23 Missing Cases 5

The range and means for the specific categories, (N=23), that comprise indirect services to clients are as follows (see Table 18, next page):

TABLE 18

PROPORTION OF TIME SPENT IN INDIRECT SERVICE CATEGORIES		
SERVICES	Mean(%)	Range(%)
Education	8.8	1-25
Research	1	0-5
Community Development	3.3	0-10
Community Consultation	6.1	0-16

Within the non-patient service category, five programs spent most of their non-patient time providing education, with a mean of 30%, and a range of 10 - 25%, (N=5). There was no commonality in how the remaining programs spent their non-patient service time.

Programs spent the least time in research, with 8 programs of 21 reporting from 1 - 5%, (N=8), of non-patient service time in this area, the remainder no time.

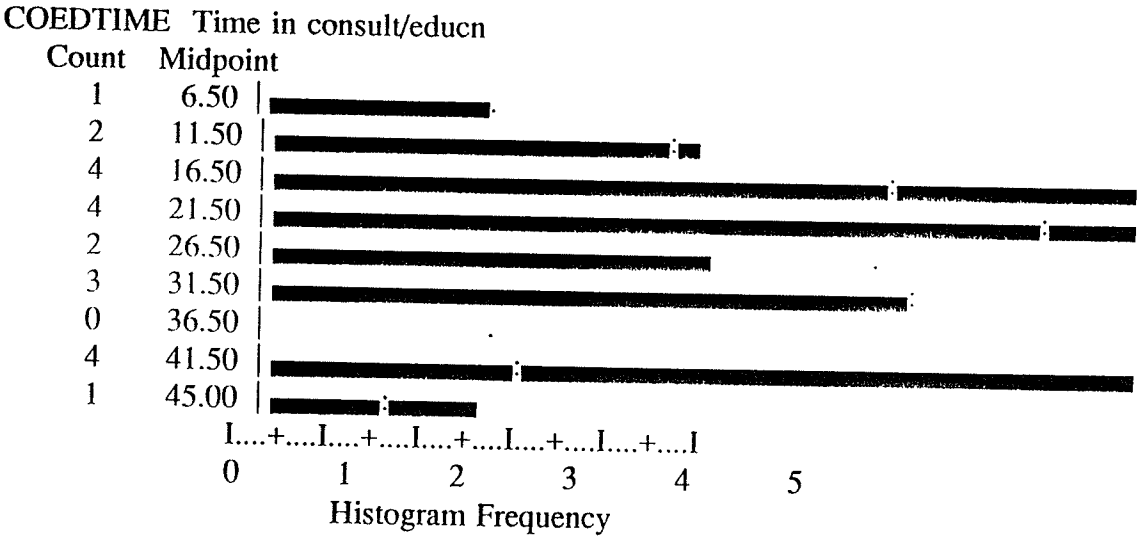
Consultation to Caregivers and Education Time

Consultation and education are two important services that should be provided by the "ideal" community psychogeriatric team, as discussed in "Ideal Model". They are time consuming services that may not or may not be linked to specific cases, but will affect time spent on other program activities.

Consultation and education were combined for 21 programs to determine if there was a relationship between time spent in these areas and the presence of a waiting list, the length of time programs have been in operation, average case load size, the length of time cases are kept open, mandate, teamtype, or clinical/core team size.

FIGURE 7

DISTRIBUTION OF TIME SPENT ON CONSULTATION\EDUCATION (COEDTIME)



Valid Cases 21 Missing Cases 7

The range was 4 - 45% of program time, with a mean of 24% and a median of 20%.

There was a significant, ($p<.05$), positive correlation, ($r = .4833$, between the percent of referrals received from LTC and medical sources and the amount of time spent in consultation and education. Programs that receive their referrals primarily from community sources, spend the lowest proportion of their time on consultation/education. It may be that it is more feasible to provide consultation\education to LTC facilities, where there is a staff onsite and able to carry out recomendations.

Education

All programs state that as part of their mandate they provide education to family and/or professional caregivers. Education is provided by programs only to the community if they only provide service to community; to LTC only if they only provide service to LTC. Education is provided to community and LTC if they are mandated to provide service to both areas.

Twenty-five programs provided lists of educational topics they cover. The range of topics is broad but the major areas are specific mental health disorders of the elderly, management of difficult behaviours, assessment skills, and normal aging and transitions. Caregiver needs, stress and coping skills are also offered by a number of programs. A complete listing of the educational topics reported by programs may be found in Appendix 5.

Four programs provide formalized training programs that are repeated, but the majority

develop " new " education/training for each target group. Two programs have written pamphlets about psychiatric conditions for lay populations.

Research

Nine programs report that they have engaged in research. Four programs have mandates which specifically state that research is an objective; only 2 of these reported doing research. The remaining 6 programs that are pursuing research are doing so as a result of staff interest. Areas of research cited are listed in Appendix 6.

Satisfaction With The Way Time Is Distributed

Of the 28 respondents to this question, 10 are satisfied with the way their time is spent, while 18 respondents would like to change the way their time is used. Of these, 18 respondents, 17 stated how they would change their distribution of services. Of these 17, 4 would increase direct services, and 13 would increase indirect services; specifically:

8 - would increase time spent in research

8 - would increase time spent in education

3 - would increase time spent in community development

3 - would increase time spent in caregiver support

1 - would increase time spent in indirect services generally

1 - would increase time in community consultation

1 - would increase time spent in prevention

* Some programs reported more than 1 category in which they would like to increase their services.

In describing how they would redistribute the time spent on various service activities, programs are echoing the opinions of key informants who stressed the importance of indirect services.

Obstacles To Altering The Way Time Is Distributed

Respondents were asked what obstacles prevented them from changing their distribution of services as they wished. While 20 programs identified obstacles, some mentioned more than one. The following obstacles, all of which relate to lack of resources, were named:

10 - lack of staff
7 - direct service demands utilized all available time
6 - lack of funds
2 - lack of staff interest in changing
1 - excessive travel time
1 - lack of agency support

Service Changes

Respondents were asked to comment on the way their programs had changed, or planned to change. Seventeen programs answered this question, and detailed responses are listed in Appendix 7.

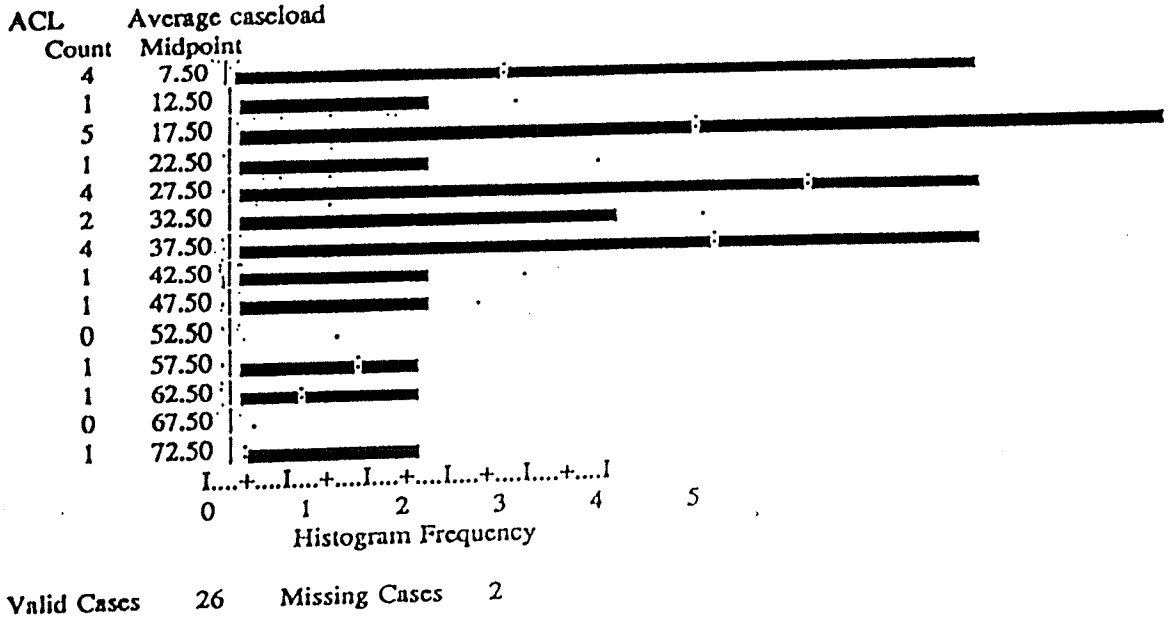
Seven programs stated that the amount of service provided and their focus has changed as a result of changes in directives from their funders, or changes in their funding.

Seven programs stated that they intend to increase their staffing so that they could more completely achieve their mandate, particularly in the areas of treatment and education.

Average Caseloads

Two programs stated that they do not have caseloads as they provide a consultation service only. The remaining 26 programs reported that caseload sizes ranged from 8 to 75 cases per FTE; with a mean of 28, and a median of 30. If one program with an extremely high caseload was removed, the mean is 26, and the median 27.5.

FIGURE 8
DISTRIBUTION OF AVERAGE CASE LOADS (ACL)



Data were collapsed to determine if relationships existed between average case load and core/clinical team size, the amount of time spent on consultation and education, referral source or reasons for referrals. Programs with an average case load of 29 or less, (N=15), were put into "small" category, and those with 30 cases or more, (N=11), into the "large" category.

With 2 exceptions, of the 8 programs with 3 or more FTE on the clinical team, all had small case loads. Teams with fewer than 3 FTE on their clinical team were just as likely to have large caseloads as small ones. The relationship between the size of the clinical team and the average case load size was found to be significant, ($p<.05$) by a chi square test. The largest teams may spend more time on internal case consultation and collaboration than small teams, and thus carry fewer cases per FTE.

TABLE 19

AVERAGE CASE LOAD BY CLINICAL TEAM			
CLINICAL TEAM SIZE			
	Less than 3 FTE	More than 3 FTE	Total
Average Case Load Size			
29 or Less	8	6	14
30 or More	7	2	9
Total	15	8	23

The average case loads of teams composed of physicians, nurses and an O.T or Psychologist are 3.5 times larger,(mean 36.5), than average case loads of teams composed of only physicians and nurses, (mean 10.5). This difference is significant, ($p<.01$), by t-test.

The average case load of teams composed of physicians, nurses, social workers and an O.T. or psychologist are 2.7 times larger, (mean 27.4), than those of teams composed of only physicians and nurses, (mean 10.5). This difference is significant by t-test, ($p<.01$). The average case loads of programs with urban catchments are 2.5 times larger, (mean 30.9), than the average case loads of teams with rural catchments, (mean 12.5). This difference is significant, ($p<.05$), by t-test.

The average case load size of programs funded by Mental Health are 1.7 times larger, (mean 33.5), than those funded by hospitals, (mean 19.8). This difference is significant by t-test, ($p<.05$).

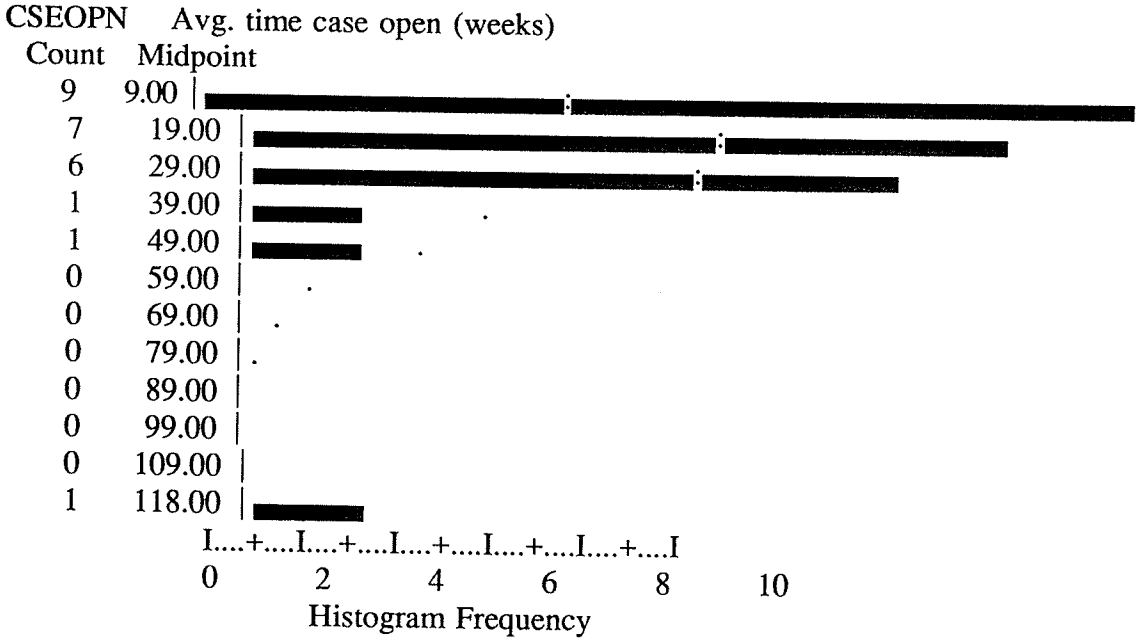
Average Length of Time Cases are Opened

Twenty-three programs responded to this question. Two programs stated that they do not carry caseloads. It was possible to determine the length of time cases were opened for 2 programs that did not provide this information by calculating it from their average case load size: (Length of time cases opened = Average case load size x Clinical team size x 52 weeks, divided by Number of cases opened per year). The range was 4 - 118 weeks,

with a mean of 22.5 weeks, and a median of 18 weeks. Half of the programs keep cases open between 12 and 23 weeks. If one program with an extremely long period of keeping cases open is removed the mean is 18.5, and the median 17.

FIGURE 9

DISTRIBUTION OF LENGTH OF TIME CASES OPEN (CSEOPN)



Valid Cases 25 Missing Cases 3

Data were collapsed into two categories. Programs that keep cases open less than 18 weeks were categorized as "short", (N=12), while those that kept cases open 18 weeks or longer were categorized as "long", (N=13). With the exception of 4 programs, 2 of which provide their service only to community, all programs that fell into the long category had large average case load sizes, and all but 2 that fell into the short category had small cases loads. A chi-square test of the relationship between average case load size and the

length of time cases are open was found to be significant, ($p = <.05$). Perhaps when case loads are large, service is less time intensive; that is to say there may have to be longer time periods between contact with individual clients, it may take longer to complete assessment documentation, etc.

TABLE 20

LENGTH OF TIME CASES OPEN BY AVERAGE CASE LOAD

	LENGTH OF TIME CASES OPEN (WEEKS)		
Average Case Load	Less than 18 Wk.	More than 18 Wk.	Total
29 or Less	10	4	14
30 or More	2	10	8
Total	12	12	24

The length of time cases are kept open is 3.3 times longer in British Columbia, (mean 20 weeks), than in Alberta, (mean 6 weeks). This difference is significant by t-test, ($p<.001$). It was reported earlier that B.C. programs receive the majority of referrals from the community sources, while Alberta programs receive theirs primarily from LTC sources. It may be possible to close cases more quickly in LTC facilities where there is a staff in place to carry out recomendations.

Waiting List

Only 10 programs of 28 reported having a waiting list, with a range of 1 - 4 weeks wait, the median 3 weeks, and the average 2.6 weeks. There was no relationship betweenhaving a waiting list and the mandate, catchment area, size of the core/clinical team, the length of time cases were kept open, the average case load size, or the amount of time spent on consultation and education.

Prioritization of Cases

Eighteen programs reported on how cases are prioritized:

11 - by apparent urgency

6 - by date of referral and apparent urgency

1 - by date of referral

Problems in Delivering Psychogeriatric Services

The program respondents were asked to identify problems that they have encountered in providing psychogeriatric services, and how they have overcome them. Twenty programs responded to this question, but only 9 programs provided any information on their efforts to overcome problems. Responses are listed in Appendix 8.

Eleven programs reported that they have had difficulties in developing effective linkages with other components of the continuum of care, (both community and institutional), for clients. They cited lack of coordination, mistrust of others and fragmentation of services as reasons for these difficulties.

Seven programs said that lack of adequate funding to provide a comprehensive service to clients was a problem in delivering services. Five of these were funded by hospitals. Six programs reported that the lack of specialized community and institutional resources for their clients was a problem. Four programs stated that funders and referral sources had unrealistic expectations of the services they could provide. Four programs reported that they had difficulty in recruiting qualified and experienced staff, two of these were rural. Given that psychogeriatrics is a relatively new field it is to be expected that there is a scarcity of well-trained and experienced people in all the disciplines. It was reported in the key informant results, that one factor in recruitment to the field is that it is seen as having a low status.

TABLE 21

PROBLEMS IN DELIVERING PSYCHOGERIATRIC SERVICES

PROBLEM	NO.
Forming Links with Other Programs	11
Lack of Funding; Providing Comprehensive Services	7
Lack of Specialized Resources	6
Difficulty Recruiting Qualified/experienced Staff	4

V - ASSESSMENT

Assessment Components

All programs reported that their initial assessment included the following areas:

medical status/history

psychiatric history

social history

functional status

environmental factors

medications

mental status

current social system

All programs (N = 27) are providing comprehensive biopsychosocial environmental assessment to their clientele.

Eight programs stated other areas that they assessed: physical assessment, behaviour (2), old medical records, community services involved (2), competency, and neurological assessment.

Two programs stated that they assessed risk factors in the initial assessment.

Home visits are made by all programs. Twenty-seven of 28 programs reported that

clients are routinely assessed in their home setting. The exception, an acute care hospital based program, reported that they usually, but not always, assess clients in their residence.

Diagnostic System

Respondents were asked what diagnostic system they used in assessments. Three reported they use no diagnostic system. Twenty-two stated they use DSMIII-R. Two programs use a combination of DSM-III-R and a holistic biopsychosocial model for assessment; one did not respond to the question.

Respondents were asked to state whether or not they found the system they used adequate. Of 27 respondents, 12 found their system adequate, 6 did not answer, and 9 (all users of DSM-III-R) did not find their system adequate, primarily expressing dissatisfaction with Axis IV and V. (A detailed list of inadequacies is provided in Appendix 9).

Testing Instruments

Respondents were asked to identify instruments they use as part of client assessment. All programs answered this question:

TABLE 22

TESTING INSTRUMENTS			
INSTRUMENT	NEVER USED	ONLY if REQUIRED	ALWAYS USED
FOLSTEIN MINI MENTAL STATE	---	8	20
GERIATRIC DEPRESSION SCALE	6	19	3
BECK DEPRESSION INVENTORY	15	13	---
HAMILTON DEPRESSION SCALE	17	10	1
NOSIE SCALE	26	2	---
CAREBURDEN INDEX	25	3	---
DOARS	26	2	---
OTHERS	10	18	---

Eighteen programs identified other testing/screening instruments used as required. These are listed in Appendix 10.

Recommendations

Programs were asked to rank order, by frequency of use, a list of 13 typical recommendations made to referral sources.

Overall, programs ranked recommendations as follows, from most to least frequently made.

1 - Investigations of Physical Symptoms

2 - Pharmacological

3 - Education

4 - Behaviour Management

5 - Social Support System Augmentation

6 - Counselling to Client\Individual Psychotherapy

7 - Environmental Changes

8 - Counselling to Families\Family Therapy

9 - Referral to Other Agencies\Specialists

10 - Inpatient Assessment and\or Treatment

11 - Group Therapy

12 - ECT

13 - Other

Compliance with Recommendations

Programs were asked to estimate, by percentage, how often their recommendations were followed by specific groups. Twenty-seven of 28 programs answered this question.

For all respondents combined, compliance for each group was estimated to be:

Community professionals	73.4%
Family caregivers	68.7%
Facility caregivers	66.3%
Family doctors	65.3%
Clients	64.8%

There is a negative correlation, ($r = -.4657$, $p = .017$), between the number of physicians on the team and the perceived compliance of family caregivers. This may indicate that physicians have less confidence in family caregivers than do other disciplines.

VII- CATCHMENT AREA CHARACTERISTICS

Level of Community Services Available To Clients In Catchment

Respondents were asked to rate, on a 3 point scale, the level of 12 specific services available to psychogeriatric clients in their community:

0 = none; 1 = some but insufficient; 2 = sufficient

The maximum sum possible for a given service (i.e. if rated 2 by all programs) is 56. Totals ranged from 6 - 41. Results are shown on the next page.

facility respite care	28
in-home respite care	25
psychogeriatric day-hospital	18
psychogeriatric day-care	24
psychogeriatric in-patient assess. and tx.	21
long term care facility beds	41
psychogeriatric group homes	6
geriatric assessment beds	24
general psychiatric beds	36
E.C.T.	38
mental hospital beds (long term)	23
extended care beds	34

Level of Resource Available to Individual Programs

An index of how well-resourced each program is was obtained by adding the ratings given for each resource by each program.

The maximum a program could "score" services was 24 (i.e. if all services were sufficient), the minimum 0. The range was 6 - 20, the median 14, and the mean 11.

There is a positive correlation, ($r = .4889$, $p = .008$), between the availability of resources and the length of time programs have been in operation.

There is a positive correlation, ($r = .4099$, $p < .05$), between the number of physicians on the team and the availability of resources. There are generally more resources available in urban centres, and more physicians practising in urban ares as well.

Community Services Formally Linked To Programs

Twenty- three programs identified those services from the above list to which they are formally linked; e.g. that they have direct access to. The maximum "score " a program could have was 12; the range was 0 - 9.; the median 2.2 and the mean 2.

Data were collapsed into 4 groups; none = 0; low = 1 - 4; medium 5 - 7 ; high 8 -12. Ten programs reported that they had no formal links/direct access to any of the services. Ten programs had no formal links, 9 had low number of formal links, 2 a medium and 2 a high number of formal links to community services.

Looking at the rating for each service by all the programs totalled, the maximum "score" possible for each service was 23. The range was 1 - 7; services "scoring" 1 - 4 are services that few programs are linked to, and services scoring 5 - 7 have some programs linked to them.

FEW FORMAL LINKS	SOME FORMAL LINKS
In-Home Respite	Facility Respite
Psychogeriatric Assess/tx beds	LTC beds
Psychogeriatric Day-Care	Geriatric Assess/tx beds
Psychogeriatric Group Homes	General Psych beds
Mental Hospital Beds	Psychogeriatric Day Hospital
Extended Care Beds	E.C.T.

Catchment Area Size

Only 9 of 28 programs were able to provide information on the size of their catchment area. Catchment area sizes varied from 20 square miles to 260,000 square miles. (One program provides its service to an entire province).

Catchment Population

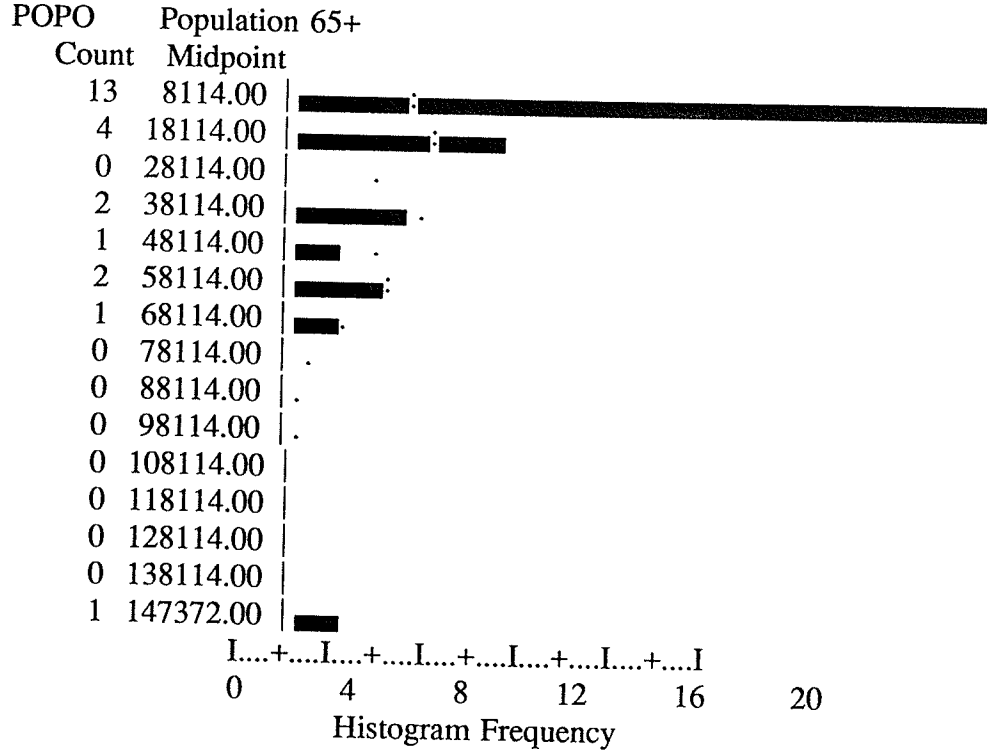
Twenty-four of 28 programs provided data on the population of their catchment area.

Total population ranged from 23,215 to 1,066,000, with a mean of 218,504, and a median of 105,499 people.

The population of people over 65 in each catchment area ranged from 3,114 to 147,3762, with a mean of 26,763, and a median of 11,340 people.

FIGURE 10

DISTRIBUTION OF POPULATION OVER AGE 65 (POPO)



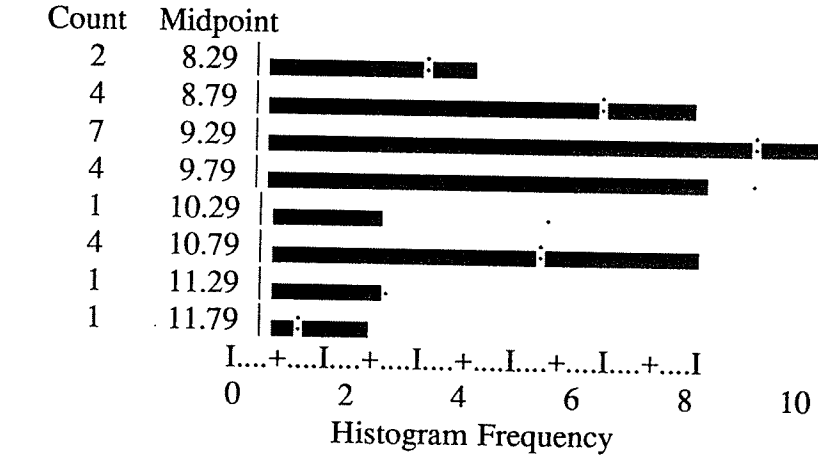
Valid Cases 24 Missing Cases 4

As the population over age 65 was not evenly distributed, but skewed, logarithmic transformation of the data was made to create a more normal distribution.[4]

[4]All subsequent references to population refer to logarithmically transformed data, except in the case of rates.

FIGURE 11

DISTRIBUTION OF LOGARITHMICALLY TRANSFORMED POPULATION OVER AGE 65+



Valid Cases 24 Missing Cases 4

There is a positive correlation, (r = .5706, p <.01), between the logarithm of the population over age 65 and the number of physicians on the team. That is, the greater the population over age 65, the greater the number of physicians.

There are positive correlations, between both the total team size, (r = .558, p <.01), and the size of the clinical team, (r = .5965, p <.01), with the logarithm of the population over the age of 65. The larger the population over age 65, the bigger the total team, and therefore the larger the clinical team, and the more physicians on the team.

There is a positive correlation, (r = .565, p <.01), between the availability of resources and the logarithm of the population over age 65. Urban catchments have larger

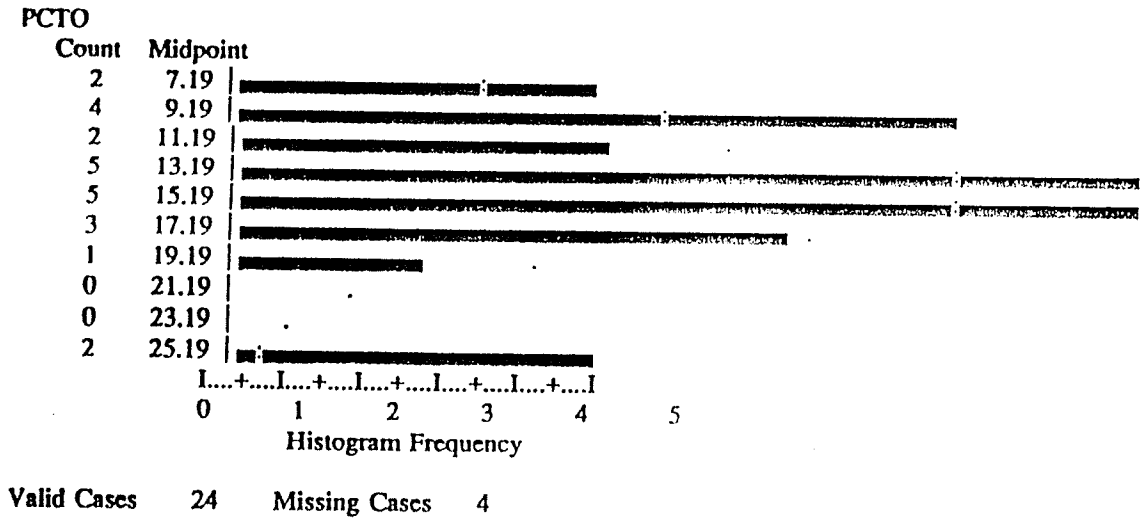
populations over age 65, (mean 22,000), than do rural catchments, (mean 7,000). This difference is significant, ($p<.01$), by t-test.

Percent of Population over age 65 per Catchment Area for Each Program

In order to make comparisons between programs, the percentage of the population over the age of 65 in each catchment area was calculated by dividing the catchment area general population into the catchment area population over age 65. The range for 24 programs was 6.2% to 25.3% with a median and mean of 14%.

FIGURE 12

DISTRIBUTION OF POPULATION 65+ IN EACH CATCHMENT (PCTO)

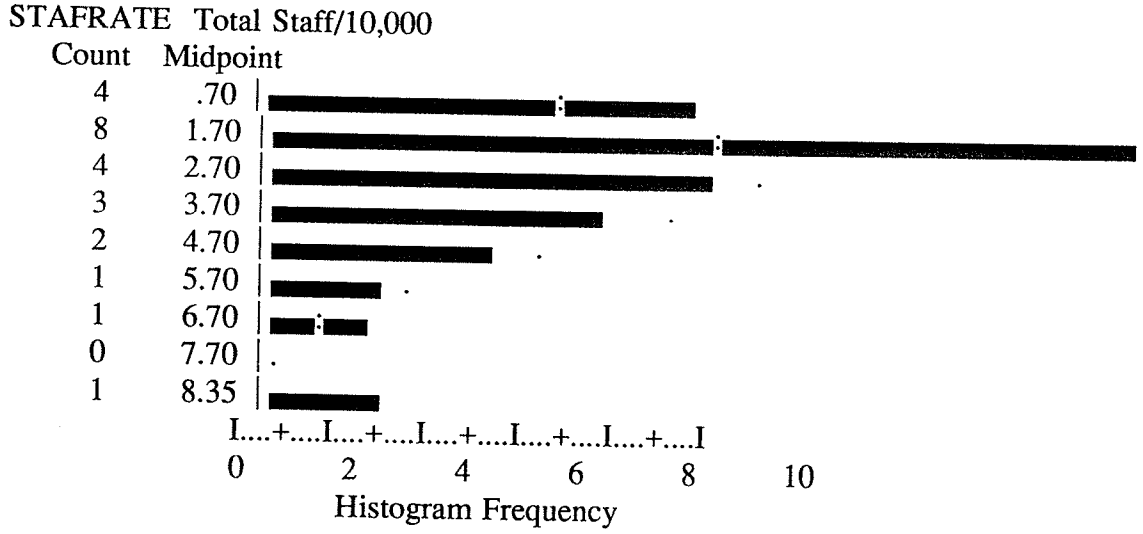


Staff Rate

The staff rate per 10,000 people over age 65 in the catchment area was determined for 24 programs by dividing the total team size (clinical team + consultants + team coordinator's administration time) by the catchment population over the age of 65. The range was .20 - 8.35 staff, with a mean of 2.8 and a median of 2.1.

FIGURE 13

DISTRIBUTION OF STAFF RATES PER 10,000 PEOPLE 65+ (STAFRATE)



Valid Cases 24 Missing Cases 4

Programs in British Columbia have a staff rate almost twice as high, (mean 2.8), than those in Alberta, (mean 1.5). This difference is significant by t-test, ($p<.05$).

There is a negative correlation, ($r = -.4385$, $p < .05$), between the staff rate and the availability of resources. That is, areas with fewer other resources have higher staff rates.

There is a negative correlation, ($r = -.6918$, $p < .001$), with the size of population over age 65. Larger populations are associated with lower staff rates.

Teams with physicians, nurses, social workers and OTs or psychologists have a mean staff rate 4 times higher, (mean 4), than programs with teams composed of physicians and nurses only, (mean .96). This difference is significant by t-test, ($p<.01$).

Teams composed of physicians, nurses and social workers have staff rates 2 and one half times larger, (mean 2.5), than those composed of only physicians and nurses, (mean .96). This is significant by t-test, ($p<.05$).

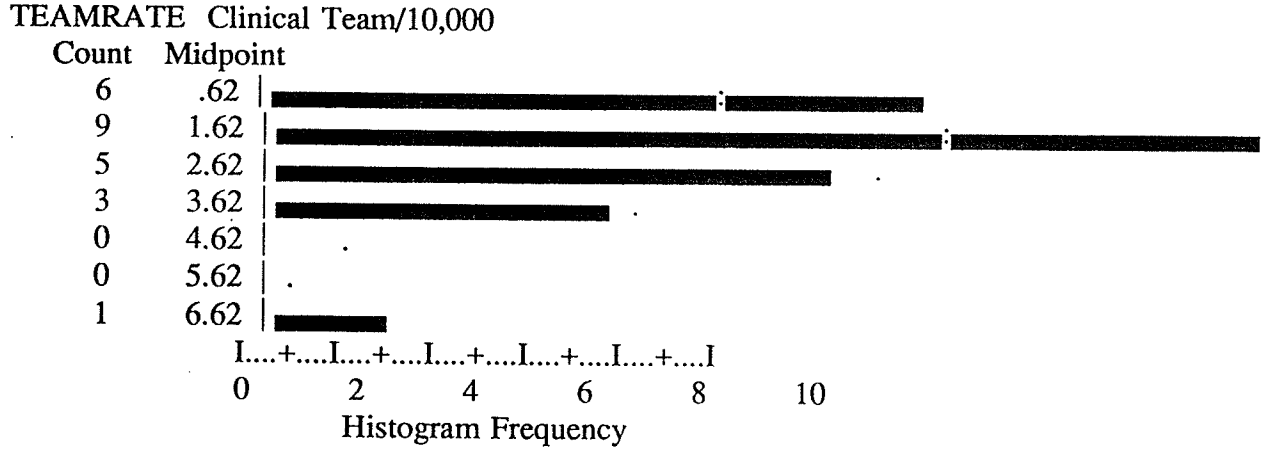
TEAM RATE

The team rate per 10,000 elderly people was calculated for 24 programs by dividing the clinical team size[5] by the catchment area population over age 65. The range was .12 - 7, with a mean of 2, and a median of 1.7 clinical team members per 10,000 elderly. If one program with an extremely high team rate is removed, that mean is 1.8, and the median 1.7 FTE.

[5]Clinical team is defined as staff who carry cases, and therefore excludes time team coordinators spend on administration, and consultants.

FIGURE 14

DISTRIBUTION OF TEAM RATE



Valid Cases 24 Missing Cases 4

There is a positive correlation, ($r = .8766$, $p<.001$), between staff rates and team rates, as would be expected.

There is a negative correlation, ($r = -.5756$, $p <.01$), between team rate and the logarithm of the population over age 65.

A negative correlation,($r = -.4181$, $p <.05$), also exists between team rate and the availability of resources.

The team rate for programs with teams composed of physicians, nurses, social workers, and OTs or psychologists is almost 4 times higher, (mean 2.6), than for programs with teams composed of only physicians and nurses, (mean .7). This difference is significant by t-test, ($p<.01$).

Programs that are mandated to serve both community and LTC facilities have a team rate 3.6 times higher, (mean 2), than do programs mandated only to serve LTC facilities, (mean .55). This difference is significant by t-test, ($p<.01$).

IDEAL TEAM RATE

The ideal team rate per 10,000 elderly was calculated by dividing the average ideal team total by the catchment area population over age 65. The range is .6 to 25.7 FTE per 10,000 elderly. The mean is 5 FTE and the median 4 FTE. This is approximately double the actual staff rate.

Long Term Care Beds In Catchment

Twenty of 28 programs were able to provide data on the number of LTC beds in their catchment area. The number of LTC beds ranged from 85 - 4,056 beds with the mean 1378 beds, and the median 804 beds.

The number of LTC beds per 1,000 people over age 65 in the catchment ranged from .91 - 157, with a mean of 60, and a median of 60 beds.

Acute Care Beds In Catchment

Ten programs provided information on the number of acute care hospital beds in their catchment area. The number of acute care beds ranged from 49 to 4,739, with the mean being 796 beds, and the median being 309 beds.

The number of acute care beds per 1,000 people over age 65 in the catchment ranged from .1 - 8, with a mean and median of 4.

VIII- CLIENT CHARACTERISTICS

The period of time for which programs provided data ranged from 1 to 51 months, with a mean of 14.1 months and a median of 12.0 months. These data were all annualized to one year for comparison purposes.

Respondents reported on whether or not they felt the period of data they reported was representative of their program's operation. Answers were as follows (N = 28).

13 - yes
7 - no
7 - don't know
1 - no answer

CLIENT DEMOGRAPHICS

Number Of Clients Referred/Cases Opened

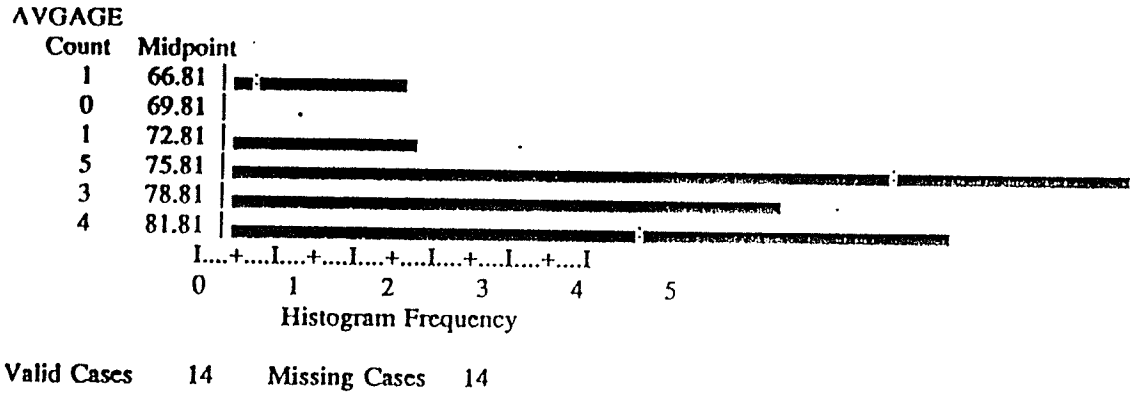
Programs were asked to report the number of clients referred and cases opened for the period (time base) which they could provide data. The number of clients referred was provided by 18 programs and ranged from 8 to 684 clients per year. The number of cases opened per year was provided by 27 programs, and ranged from 8 to 684. There was very little difference between the number of clients referred and cases opened for most programs, indicating that very few referrals were screened out at intake.

Age Of Clients

Only 14 programs could provide information on the average age of their clients. The range was 65 - 82 years, the mean was 77 years.

FIGURE 15

DISTRIBUTION OF AVERAGE AGE (AVGAGE)



There is a positive correlation between the average age of clients and the proportion of time teams spend on consultation to caregivers and education, ($r = .7379$, $p < .01$). It was noted earlier that there is a strong linear relationship between age and institutionalization, (Health and Welfare Canada, 1991e). It would therefore be expected that older clients might be more likely to be in LTC facilities, where interventions are often indirect, in the form of consultations. Additionally, there is typically a high rate of organic mental disorders in LTC facility residents, and interventions in these cases are most often aimed at modifying their environment and working with caregivers, a form of

consultation\education. This might explain the correlation between average age of clients and proportion of time spent on consultation and education.

Sex Of Clients

25 programs provided this information. More women were seen than men by 21 programs, and more men than women by 4 programs.Two of these programs have rural catchment areas.[6]

Marital Status

Only 3 programs were able to provide data about their clients marital status.

Referral Rates

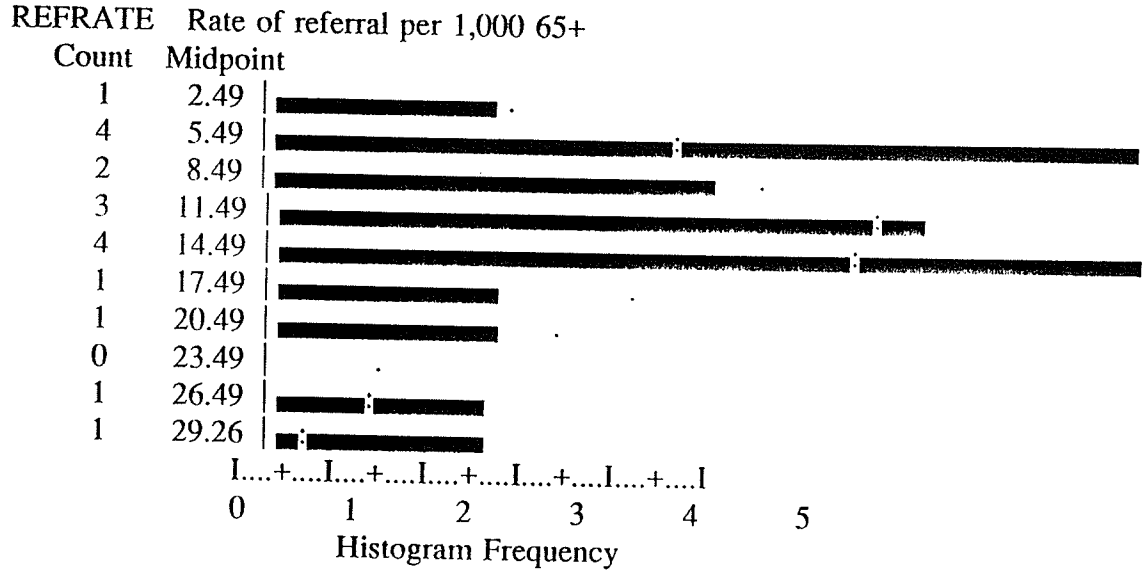
The number of referrals received per year, per 1000 people over age 65 was determined for 18 programs. The referral rate was calculated by standardizing each program's data for one year and dividing it by catchment population over age 65. Referral rates ranged from a low of 1 to a high of 29 referrals per 1,000 persons 65+ in the catchment area. The mean was 12 per 1,000, and the median 11 per 1,000.

---

[6]Two programs serve only LTC facilities, which generally have larger female populations than male; perhaps men are more likely to present with aggressive or other threatening behaviours, and are thus over-represented in referrals.

FIGURE 16

DISTRIBUTION OF REFERRAL RATES (REFRATE)



Valid Cases 18 Missing Cases 10

There is a negative correlation between referral rates and the size of the catchment population, (r = -.5152, p <.05). The larger the elderly population the lower the referral rate. Urban areas have the largest elderly populations. In urban areas there are usually a greater variety and number of alternative services to which the elderly can be referred to. Perhaps this leads to greater specialization by urban programs, and hence lower referral rates.

There is a positive correlation between referral rates and team rates, (r = .4856, p <.05), suggesting either that teams grow to meet the number of referrals, or that a higher staff:population ratio attracts more referrals.

Referral rates were collapsed into 2 groups; (low = less than 11, n = 8; high = 11 or over, n = 10). Four of the 5 rural programs that a referral rate could be calculated for, had low referral rates.

A chi-square test of the relationship between catchment type and referral rates was found to be significant, $p<.05$.

TABLE 23

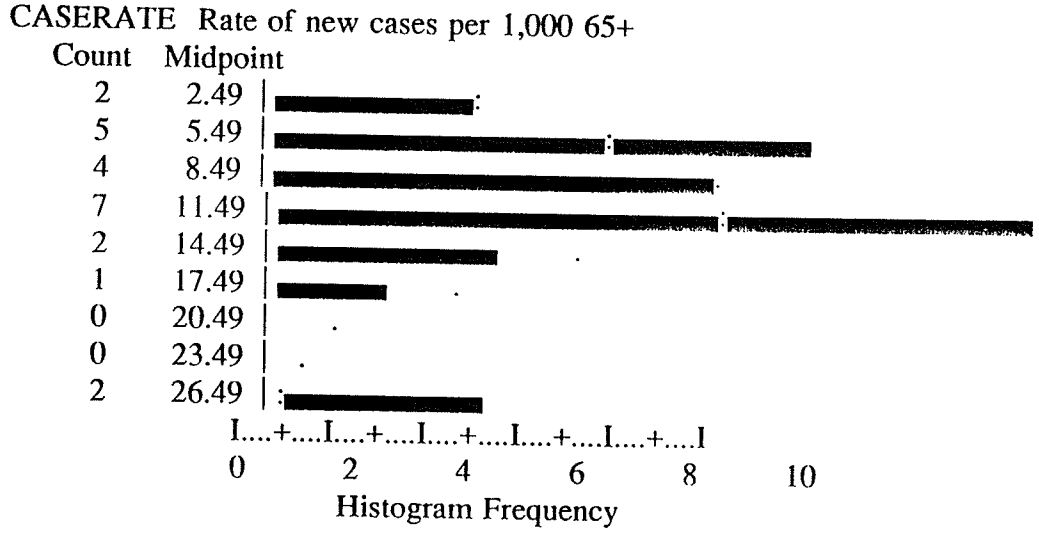
REFERRAL RATES BY CATCHMENT TYPE			
CATCHMENT	REFERRAL RATES		
	Less than 11	11 and Over	Total
Rural	4	0	4
Urban	2	3	5
Mixed	2	7	9
TOTAL	8	10	18

Case rate

The number of cases opened per year was provided by 23 programs. The case rate was calculated by annualizing all program data and standardizing the number of new cases per year, per 1,000 elderly in the catchment area population. Case rates ranged from 1 - 27, with a mean of 10.6 cases, and a median of 10 cases per 1,000 persons over age 65.

FIGURE 17

DISTRIBUTION OF CASE RATES



Valid Cases 23 Missing Cases 5

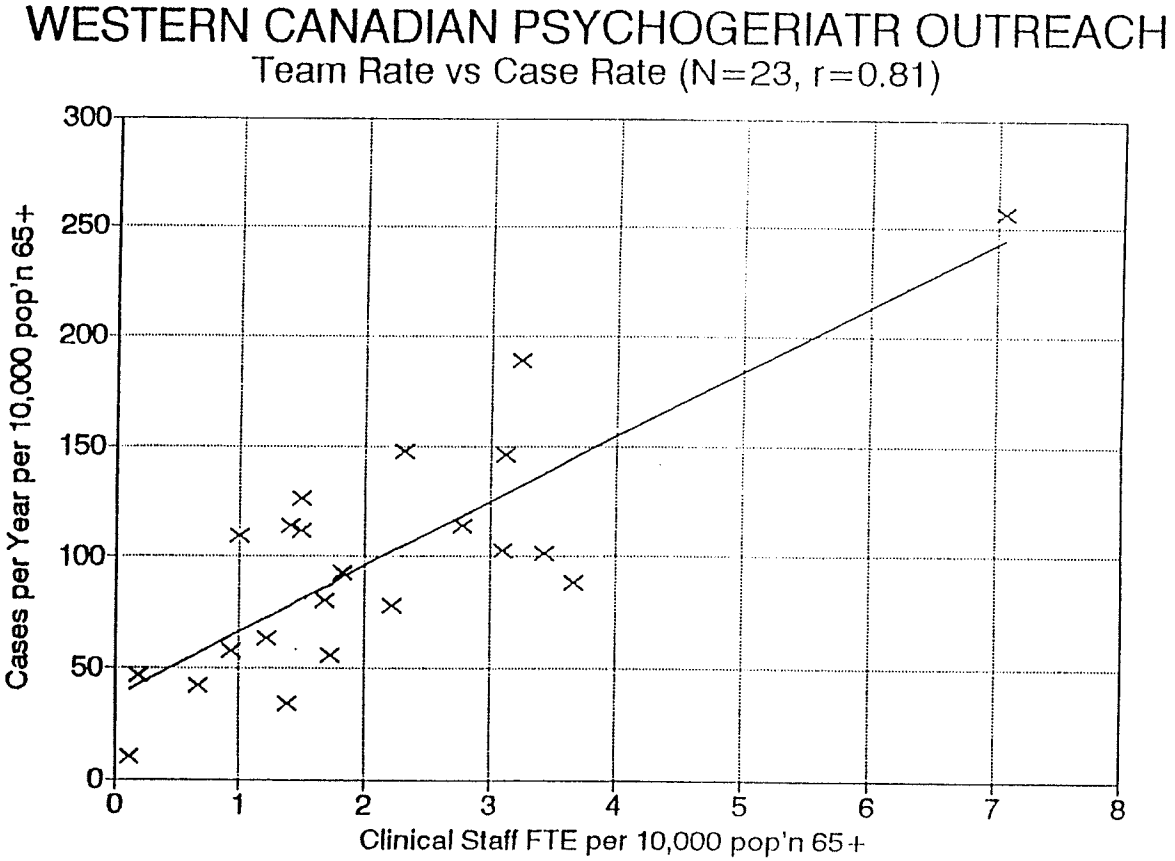
Programs funded by hospitals have a case rate 3 times higher, (mean 13), than programs funded by LTC, (mean 4.3). This difference is significant by t-test, ($p<.05$).

Programs mandated to serve both community and LTC have a case rate 4.5 times higher, (mean 11.6), than those mandated to serve only LTC, (mean 2.6). This difference is significant by t-test, ($p<.05$). As would be expected, programs with a broader mandate are seeing a greater proportion of the elderly population, and thus open more cases per 1,000 elderly, than do programs mandated to serve LTC facilities only.

As would be expected there is a positive correlation between referral rates and case rates, ($r = .9705$, $p < .001$).

There is a positive correlation, ($r = .4726$, $p < .05$), between case rates and team rates. This implies that the larger the clinical team, the greater the number of cases that are opened per 1,000 elderly. It would be expected that as the number of staff is increased there would eventually be a "levelling off" of the number of cases opened. As the following scattergram illustrates none of the programs surveyed have yet reached this point. It would appear that programs are not yet sufficiently staffed to provide all the service required by potential psychogeriatric clients.

FIGURE 18



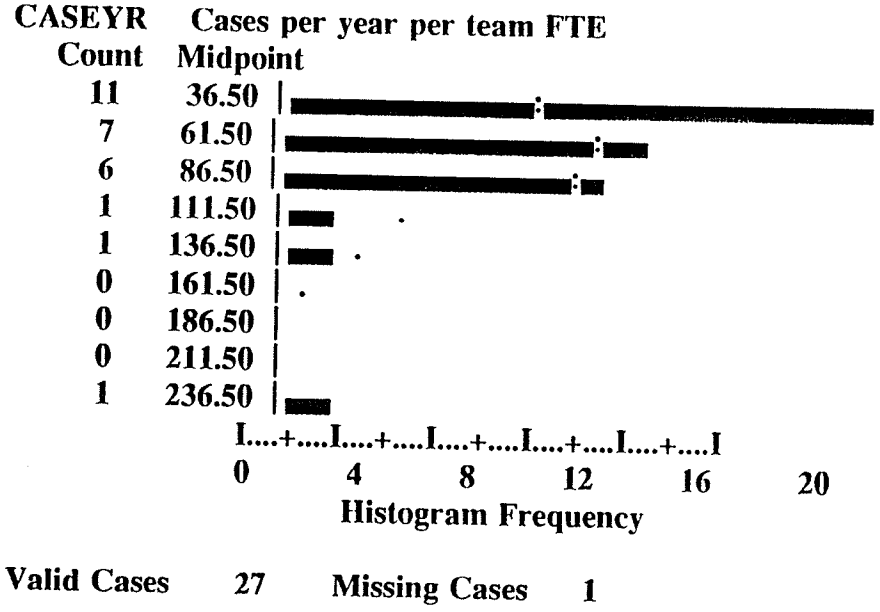
There is a negative correlation, ($r = -.4528$, $p < .05$), between the case rate and the size of the population over age 65, (i.e. the larger the population the lower the case rate.)

Cases opened per year per FTE

The number of cases opened per year per clinical staff FTE was determined for 25 programs, by dividing the case rate by the team total. The range was 24.0 - 244.29 cases per year per FTE, with a mean of 66, and a median of 58 cases per year per FTE. If two programs with extremely large numbers of cases opened per year per FTE are removed, the mean is 56, and the median 55.

FIGURE 19

DISTRIBUTION OF CASES OPENED PER YEAR PER FTE (CASEYR)



Programs with teams composed of only physicians and nurses open almost twice as many cases per year per FTE, (mean 77.25), as do programs with teams composed of physicians, nurses, social workers, and OTs or psychologists, (mean 42.8). This difference is significant, ($p<.05$), by t-test.

Physician-nurse-social worker teams open one and a half times more cases per year per FTE, (mean 67.6), than do teams composed of physicians, nurses, social workers and 1 other discipline, (mean 42.8). This difference is significant, ($p<.05$), by t-test.

There were negative correlations between the number of cases opened per year per FTE, and both the staff rate, ($r = -.558$, $p < .05$), and the team rate, ($r = -.5042$, $p < .05$).

These findings may indicate the "price" of the interdisciplinary team approach; the more disciplines, (and staff), on the team, the greater the proportion of time spent on internal case consultation, perhaps leaving less time to see clients; alternatively, more time is spent on direct service, and less on consultation.

Cases Opened Per Year Per FTE Per 1,000 Population 65+

The number of cases opened per year per FTE per 1,000 65+ was determined for 23 programs, by dividing the case rate by the clinical team. The range was .8 -13.5, with a mean of 4.8 cases opened per year per FTE, per 1,000 population over age 65.

Programs in mixed catchments open more than twice as many cases per year per FTE per

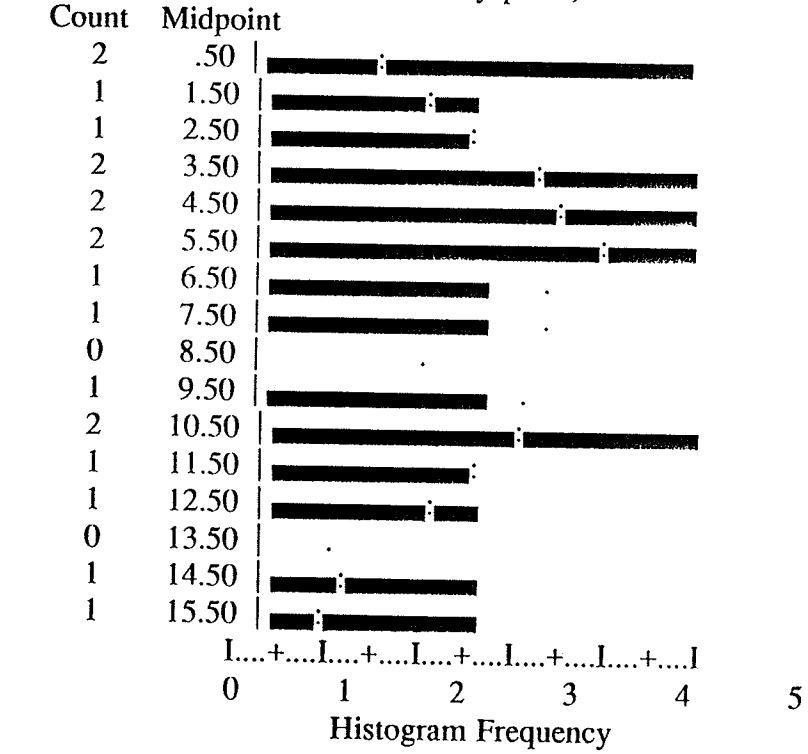
1,000 people over age 65, (mean 6.28), than do programs in urban catchments, (mean 2.7). This is significant by t-test, ($p<.05$).

Community Referral Rate

FIGURE 20

DISTRIBUTION OF COMMUNITY REFERRAL RATES (COMMRATE)

COMMRATE Ref from community per 1,000 65+



Valid Cases 19 Missing Cases 9

The rate of referrals from the community was determined for 19 programs. (Six programs that provide services only to LTC facilities were not included). The community referral rate was calculated by annualizing the number of community referrals and dividing by the number of elderly in the community. Community referral rates, (per 1000 65+), ranged from 1.19 to 15.5, with a mean of 6.8 referrals, and a median of 5.7 referrals.

Programs with mixed catchments had a community referral rate 2.3 times higher, (mean 8.6), than those with rural catchments, (mean 3.7). This difference is significant by t-test, ($p<.05$).

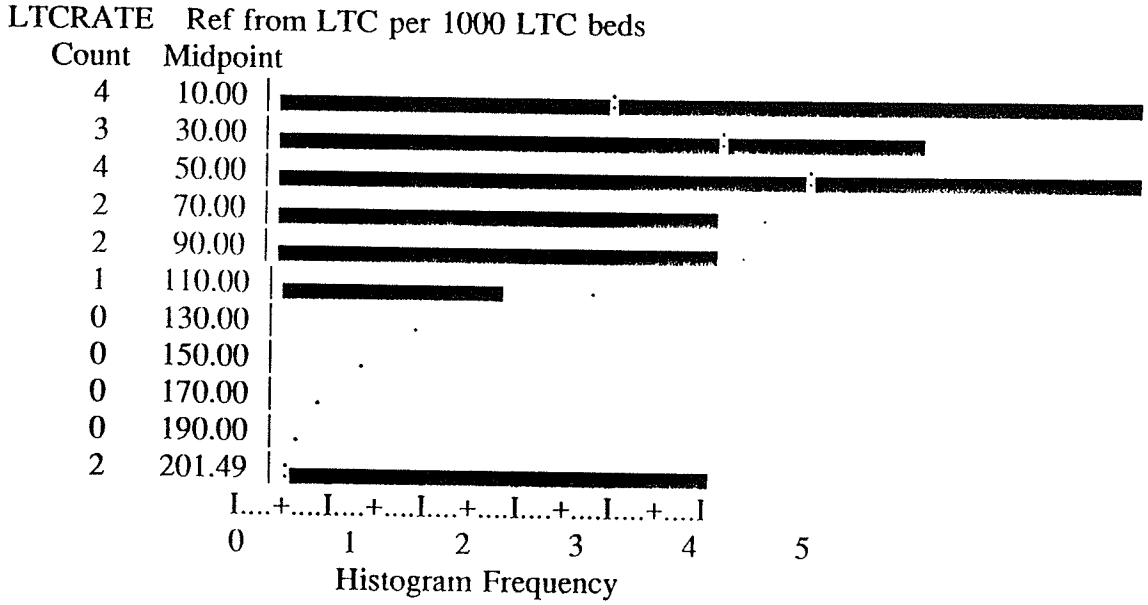
There is a positive correlation between community referral rates and team rates, ($r = .4614$, $p = .054$), suggesting that larger teams receive more community referrals than do smaller teams. Larger teams generally have a broader range of disciplines than do smaller teams, and perhaps referral sources perceive them as having more to offer than smaller, often narrower teams.

Long Term Care Referral Rate

The number of LTC referrals per 1000 LTC beds in each catchment area was determined for 18 programs. (Programs that provide service only to the community were not included). The LTC referral rate was calculated by annualizing the number of LTC referrals, and standardizing it per 1,000 LTC beds in the catchment area of each program. LTC referral rates ranged from 0 to 201, with a mean of 65 referrals and a median of 48 referrals per 1,000 beds. If two programs with extremely high LTC rates are removed, the mean is 40, and the median is 43.5.

FIGURE 21

DISTRIBUTION OF LTC RATES



Valid Cases 18 Missing Cases 10

It is noteworthy that programs mandated to provide services only to LTC facilities did not have the highest LTC referral rates; many programs that provided service to both LTC and community had higher LTC referral rates.

The number of clients seen in institutions other than LTC was reported by only 3 programs.

Diagnoses

Programs were asked to report on the diagnoses they made, by percentage of caseload. Twenty-four of 28 programs responded to this question. There was overlapping of some

diagnoses by some programs such that their total diagnoses totalled over 100%. These data were recalculated to show each diagnostic category as a percentage of all the diagnoses reported by the program.

Averaging all programs data, (N = 24), the percentage for each diagnosis is as follows:

TABLE 24

DIAGNOSES REPORTED		
DIAGNOSES	MEAN(%)	RANGE(%)
Organic Mental Disorders	36	10-60
Mood Disorders	25	0-61
Psychotic & Delusional Disorders	9	0-32
Adjustment Problems	5	0-15
Anxiety Disorders	5	0-26
Delerium	5	0-20
Marital/Family Disfunction	4	0-22
Personality Disorders	4	0-11
Other/No Diagnoses	3	0-40
Alcohol/Drug Dependency	3	0-10

Data were collapsed into 4 categories derived from the literature review: Organic, Mood, Delusional and Other - (combination of all other diagnoses), and programs were placed into the group where they reported the highest percentage of diagnoses. Twelve programs were placed in the "organic" category, 5 in the "mood" category, none in the "delusional" category, and 6 in the "other" category. One program had an even mixture of diagnoses in organic, mood and other.

Diagnostic Rates

Rates for each diagnostic category were calculated per 1000 people over age 65, so that programs could be compared to each other.

TABLE 25

DIAGNOSTIC RATES		
DIAGNOSES	MEAN(%)	RANGE(%)
Organic Mental Disorders	3.48	.84-10.76
Mood Disorders	2.59	0-11.35
Psychotic & Delusional Disorders	0.79	0-2.96
Anxiety Disorders	0.61	0-3.68
Adjustment Problems	0.59	0-3.03
Marital/Family Dysfunction	0.50	0-5.13
Delerium	0.44	0-2.69
Alcohol/Drug Dependency	0.35	0-2.02
Other/No Diagnoses	0.28	0-5.06
Personality Disorders	0.28	0-1.02

The following histograms illustrate the distribution of selected rates of disorders per 1,000 65+.

FIGURE 22

DISTRIBUTION OF ORGANIC DISORDER RATE PER 1000 65+

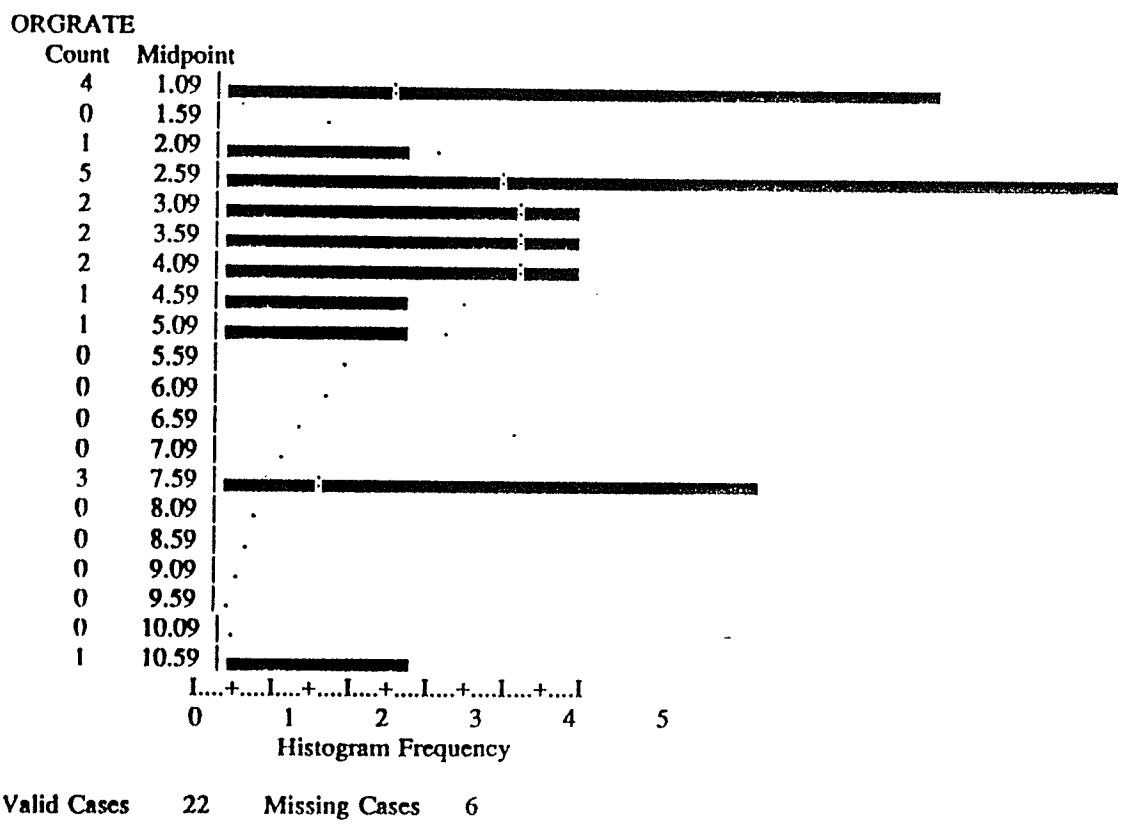


FIGURE 23

DISTRIBUTION OF DELIRIUM RATE PER 1,000 65+

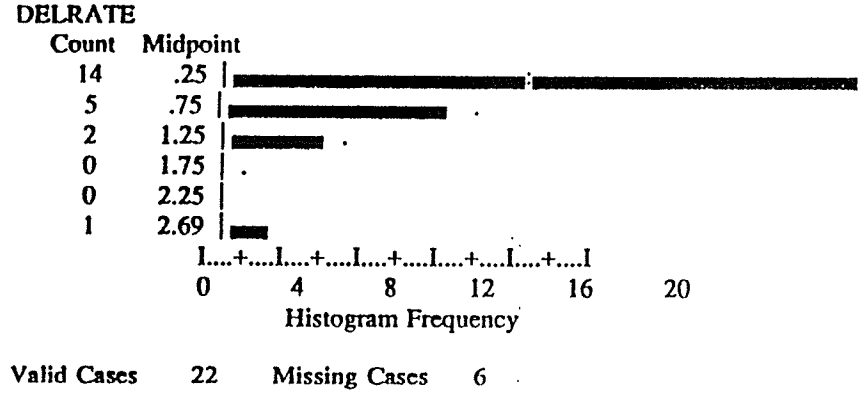
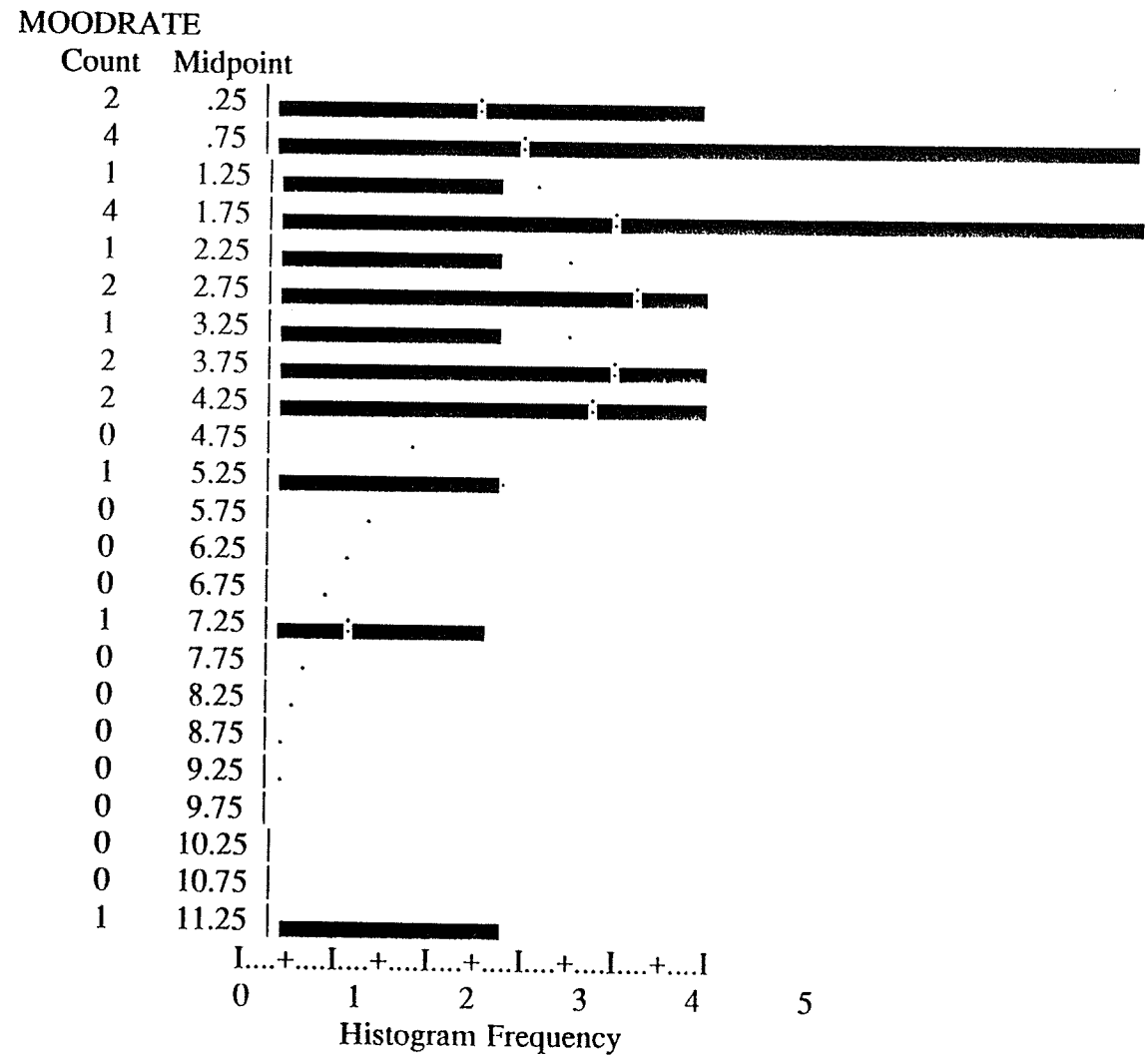


FIGURE 24

DISTRIBUTION OF MOOD DISORDER RATE PER 1,000 65+



Valid Cases 22 Missing Cases 6

FIGURE 25

DISTRIBUTION OF DELUSIONAL DISORDER RATE PER 1,000 65+

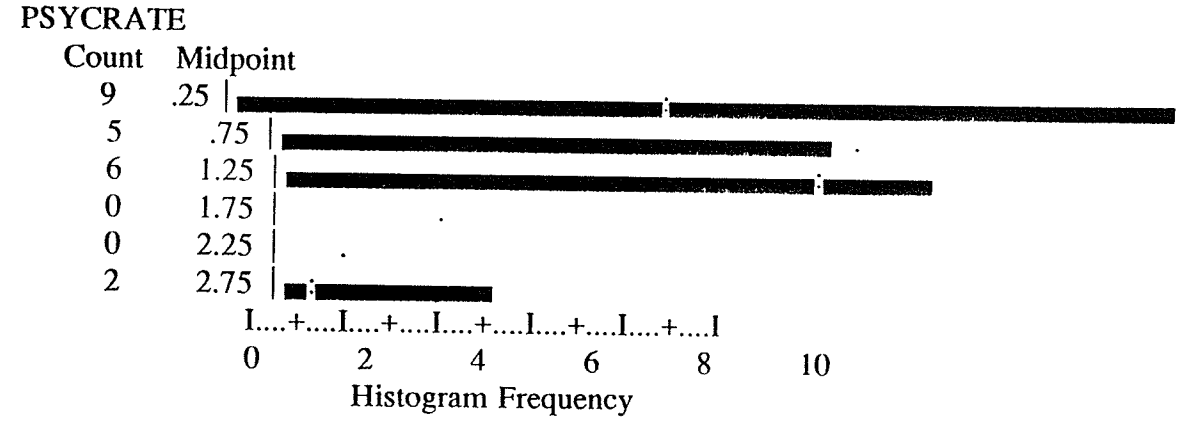
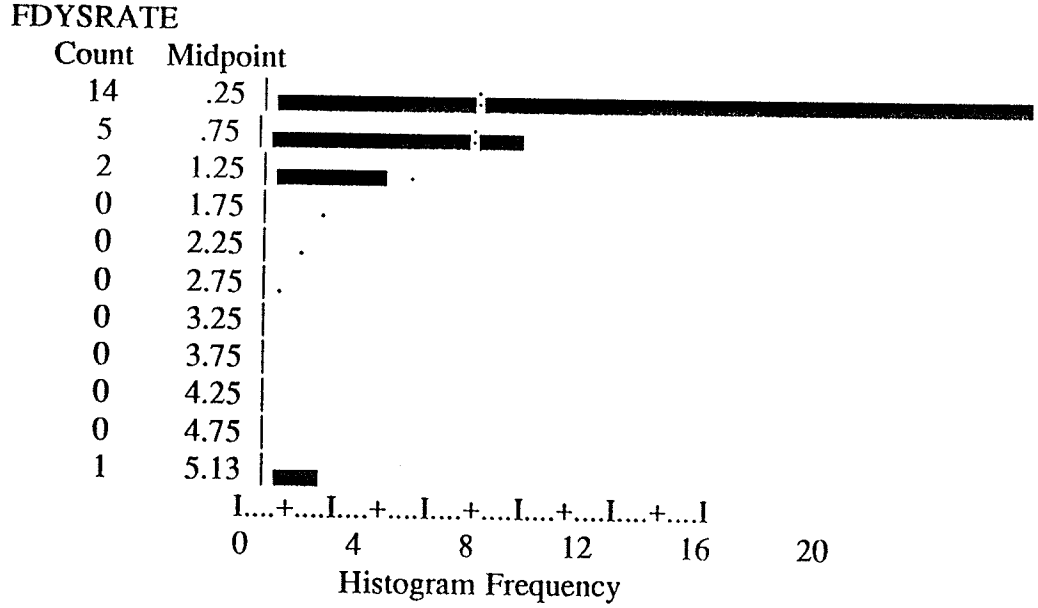


FIGURE 26

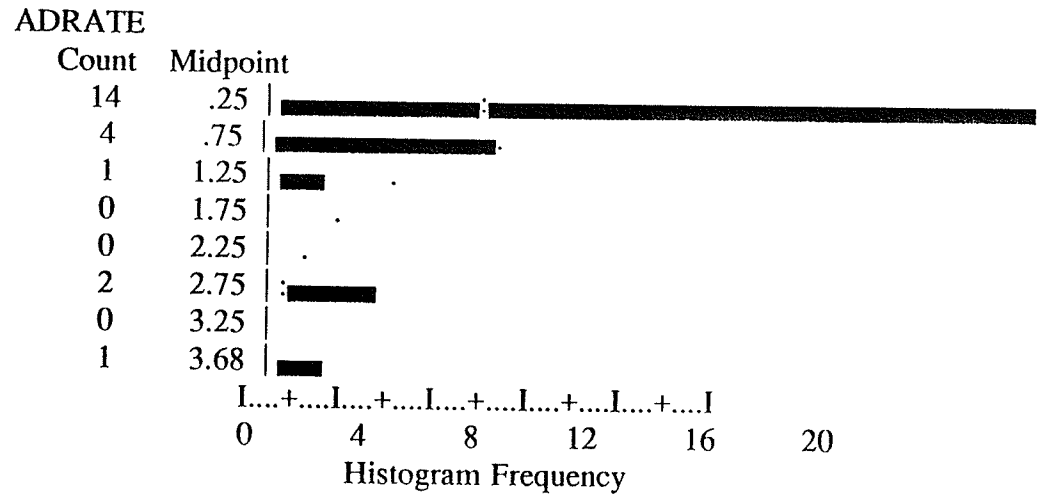
DISTRIBUTION OF MARITAL\FAMILY DYSFUNCTION RATE PER 1,000 65+



Valid Cases 22 Missing Cases 6

FIGURE 27

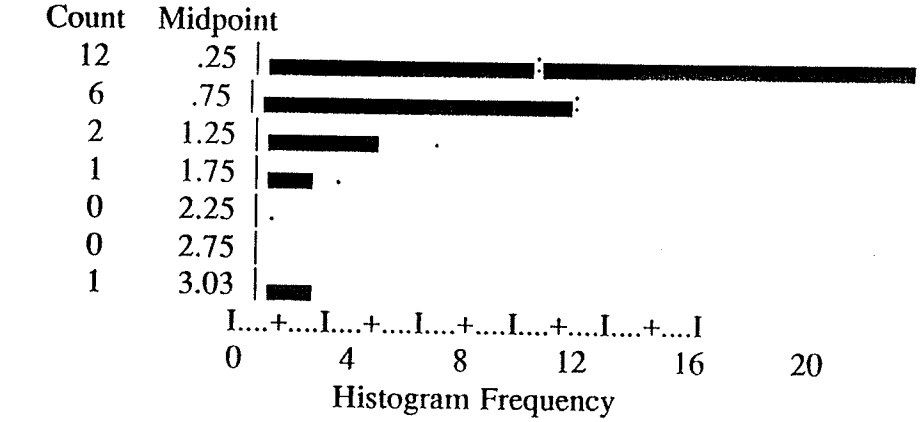
DISTRIBUTION OF ANXIETY DISORDER RATE PER 1,000 65+



Valid Cases 22 Missing Cases 6

FIGURE 28

DISTRIBUTION OF ADJUSTMENT PROBLEM RATE PER 1,000 65+



Valid Cases 22 Missing Cases 6

Following is a table of correlations between diagnostic rates:

TABLE 26

Correlations:	ORGRATE	DELRATE	MOODRATE	PSYCRATE	FDYSRATE	ADRATE	PERRATE	ALRATE	APRATE	NYDRATE
ORGRATE	1.0000	.4937	.2059	-.0491	.3297	.3995	.2544	.3959	.4030	-.1569
	(0)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)
	P= .	P= .020	P= .358	P= .828	P= .134	P= .066	P= .253	P= .068	P= .063	P= .486
DELRATE	.4937	1.0000	.2035	-.0577	.0258	.2061	.4986	.2452	.3941	-.1046
	(22)	(0)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)
	P= .020	P= .	P= .364	P= .799	P= .909	P= .357	P= .018	P= .271	P= .070	P= .643
MOODRATE	.2059	.2035	1.0000	.5250	.2001	-.0086	-.0005	-.0126	.1232	-.1632
	(22)	(22)	(0)	(22)	(22)	(22)	(22)	(22)	(22)	(22)
	P= .358	P= .364	P= .	P= .012	P= .372	P= .970	P= .998	P= .955	P= .567	P= .452
PSYCRATE	-.0491	-.0577	.5250	1.0000	-.2460	-.0019	-.1148	-.1398	.0518	.0386
	(22)	(22)	(22)	(0)	(22)	(22)	(22)	(22)	(22)	(22)
	P= .828	P= .799	P= .012	P= .	P= .270	P= .993	P= .611	P= .535	P= .819	P= .865
FDYSRATE	.3297	.0258	.2001	-.2460	1.0000	.5126	.2941	.5157	.1268	-.1007
	(22)	(22)	(22)	(22)	(0)	(22)	(22)	(22)	(22)	(22)
	P= .134	P= .909	P= .372	P= .270	P= .	P= .015	P= .184	P= .014	P= .574	P= .656
ADRATE	.3995	.2061	-.0086	-.0019	.5126	1.0000	.4751	.7140	.4400	.1609
	(22)	(22)	(22)	(22)	(22)	(0)	(22)	(22)	(22)	(22)
	P= .066	P= .357	P= .970	P= .993	P= .015	P= .	P= .025	P= .000	P= .040	P= .474
PERRATE	.2544	.4986	-.0005	-.1148	.2941	.4751	1.0000	.3244	.2600	-.0673
	(22)	(22)	(22)	(22)	(22)	(22)	(0)	(22)	(22)	(22)
	P= .253	P= .018	P= .998	P= .611	P= .184	P= .025	P= .	P= .141	P= .243	P= .766
ALRATE	.3959	.2452	-.0126	-.1398	.5157	.7140	.3244	1.0000	.5764	.1777
	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(0)	(22)	(22)
	P= .068	P= .271	P= .955	P= .535	P= .014	P= .000	P= .141	P= .	P= .005	P= .429
APRATE	.4030	.3941	.1292	.0518	.1268	.4400	.2600	.5764	1.0000	.1973
	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(0)	(22)
	P= .063	P= .070	P= .567	P= .819	P= .574	P= .040	P= .243	P= .005	P= .	P= .379
NYDRATE	-.1569	-.1046	-.1692	.0386	-.1007	.1609	-.0673	.1777	.1973	1.0000
	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(0)
	P= .486	P= .643	P= .452	P= .865	P= .656	P= .474	P= .766	P= .429	P= .379	P= .

ORGRATE = Organic Mental Disorder Rate per 1,000 65+
DELRATE = Delirium Rate per 1,000 65+.
MOODRATE = Mood Disorders per 1,000 65+.
PSYCRATE = Delusional Disorders per 1,000 65+.
FDYSRATE = Marital/Family Dysfunction per 1,000 65+.
ADRATE = Anxiety Disorders per 1,000 65+.
PERRATE = Personality Disorders per 1,000 65+.
ALRATE = Alcohol/Drug Dependency per 1,000 65+.
APRATE = Adjustment Problems per 1,000 65+.
NYDRATE = No Diagnosis as yet per 1,000 65+.

Following is a table of correlations between diagnostic rates and other variables.

TABLE 27

Correlations:	REFRATE	CASERATE	COMMRATE	TEAMTOT	COEDTIME	AVGAGE	CSEOPN	STAFRATE
ORGRATE	.7634	.6808	.3494	-.3663	.2422	.1967	.3538	.3710
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .000	P= .000	P= .155	P= .112	P= .349	P= .540	P= .130	P= .089
DELRATE	.3405	.4303	-.0114	-.3303	.5428	.7469	-.0945	-.1777
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .181	P= .046	P= .964	P= .155	P= .024	P= .005	P= .700	P= .429
MOODRATE	.6576	.6731	.6683	-.0997	.2258	.0831	.4562	.1078
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .004	P= .001	P= .002	P= .676	P= .383	P= .797	P= .050	P= .633
PSYCRATE	.1664	.2111	.2421	.2345	-.0939	-.0942	.4767	-.0726
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .523	P= .346	P= .333	P= .320	P= .720	P= .771	P= .039	P= .748
FDYSRATE	.6522	.6077	.4976	-.0814	.0652	-.2732	-.3180	.6358
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .005	P= .003	P= .036	P= .733	P= .804	P= .390	P= .185	P= .001
ADRATE	.4465	.4084	.4398	-.1390	.1796	-.1439	-.0427	.3500
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .072	P= .059	P= .068	P= .559	P= .490	P= .655	P= .862	P= .110
PERRATE	.2788	.3706	.0041	-.2169	.4150	.4356	-.5465	.2827
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .279	P= .089	P= .987	P= .358	P= .098	P= .157	P= .015	P= .202
ALRATE	.6085	.2683	.3217	-.0519	.1324	-.1632	-.0051	.4031
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .010	P= .227	P= .193	P= .828	P= .612	P= .612	P= .984	P= .063
APRATE	.4265	.2727	.3869	.1770	.2493	-.0330	-.0494	.2081
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .088	P= .220	P= .113	P= .455	P= .335	P= .919	P= .841	P= .353
HYDRATE	-.2362	-.1713	-.0258	.5928	.1040	-.4480	-.0016	-.0273
	(17)	(22)	(18)	(20)	(17)	(12)	(19)	(22)
	P= .361	P= .446	P= .919	P= .006	P= .691	P= .144	P= .995	P= .904

For diagnostic rate codes (vertical axis), refer to Table 26, previous page.

REFRATE = Referrals per 1,000 65+
CASERATE = Number of cases opened per year per 1,000 65+
COMMRATE = Community Referral Rate per 1,000 65+
TEAMTOT = Total Team (Consultants, Clinical Staff and Administration)
COEDTIME = Consultation and Education Time
AVGAGE = Average Age
CSEOPN = Length of Time Cases Opened
STAFRATE = Number of Cases Opened per 10,000 65+ per FTE (Team Total)

Following is a table of correlations between diagnostic rates and other variables.

TABLE 28

Correlations:	OPTIMLOG	PCTO	DENSITY	POPOLOG	RESOURCE
ORGRATE	-.5053	-.1528	.3797	-.5125	-.4111
	(22)	(22)	(8)	(22)	(22)
	P= .016	P= .497	P= .354	P= .015	P= .057
DELRATE	-.2546	-.2217	.1173	-.0144	.0716
	(22)	(22)	(8)	(22)	(22)
	P= .253	P= .321	P= .782	P= .949	P= .751
MOODRATE	-.0601	.1046	-.0824	-.2348	.0305
	(22)	(22)	(8)	(22)	(22)
	P= .790	P= .643	P= .846	P= .293	P= .865
PSYCRATE	-.0046	.3497	.5558	.0036	-.0247
	(22)	(22)	(8)	(22)	(22)
	P= .984	P= .111	P= .153	P= .987	P= .913
FDYSRATE	.0372	-.0539	.2019	-.4049	-.2499
	(22)	(22)	(8)	(22)	(22)
	P= .667	P= .812	P= .632	P= .062	P= .262
ADRATE	-.0691	-.0315	.9495	-.2960	-.4442
	(22)	(22)	(8)	(22)	(22)
	P= .760	P= .889	P= .000	P= .180	P= .038
PERRATE	.2726	-.1479	-.0889	-.2019	-.0832
	(22)	(22)	(8)	(22)	(22)
	P= .220	P= .511	P= .834	P= .368	P= .713
ALRATE	-.1716	-.0966	.9126	-.2438	-.3168
	(22)	(22)	(8)	(22)	(22)
	P= .445	P= .669	P= .002	P= .274	P= .151
APRATE	-.2625	-.2127	.8376	-.1407	-.1325
	(22)	(22)	(8)	(22)	(22)
	P= .238	P= .342	P= .009	P= .509	P= .331
HYDRATE	.2682	-.1811	.1413	.2382	.0021
	(22)	(22)	(8)	(22)	(22)
	P= .228	P= .420	P= .739	P= .286	P= .993

For diagnostic rates (vertical axis) refer to Table 26.

OPTIMLOG = Length of Time Programs in Operation (Logarithmic)
PCTO = Percent of Population of 65 years in catchment area
DENSITY = Population Related to Geographic Area
POPOLOG = Size of Catchment Area, Population 65+ (Logarithmic)
RESOURCE = Community Services Available to Clients in Catchment

There are intercorrelations between rates for marital/family dysfunction and adjustment problems, which are somewhat related to community referral rate and team rates. Perhaps teams with higher team:population ratios get more clients with these diagnoses, reflecting broader mandates with less restrictive "admission" criteria.

DIAGNOSTIC RATES COMPARED TO THE LITERATURE

The diagnostic rates were regrouped into the four categories derived from the literature review, so valid comparisons between programs' rates and rates in the literature, could be made.

TABLE 29

DIGNOSTIC RATES FOR SURVEYED PROGRAMS				
	Organic	Mood	Delusional	Other
Mean:	3.48	2.59	0.79	0.30
Range:	0.84-10.76	0-11.35	0-2.69	0-5.13

The following are the rates for each diagnostic group, from 3 of the programs that were discussed in the literature review.

TABLE 30

DIGNOSTIC RATES FROM THE LITERATURE				
	Organic	Mood	Delusional	Other
Houston, 1983	0.44	0.11	0.06	0.20
Wargon, 1987	1.38	0.73	0.15	0.12
Harris, 1990	3.75	2.47	0.36	1.17

While the programs in this survey have a greater variation in each diagnostic group than those reported in the programs described in the literature; the means of all but the DELUSIONAL category are quite close to the range of those in the literature. The mean for the DELUSIONAL category is considerably higher for the surveyed programs than for those reported in the literature.

PROGRAM OUTCOMES

Program Impact

Of 28 programs, 6 reported that no measures are currently used to measure program impact. The remaining programs stated that the following measures were being undertaken (the list is not mutually exclusive):

13 - Referral source satisfaction

10 - Team rates outcome

10 - Client satisfaction

7 - Global Assessment of Functioning compared at intake and discharge

Thirteen out of 28 programs reported that their program has never been evaluated. In the cases (15) where the program had been evaluated, this was done.

11 - by funders
9 - internally
1 - by others
1 - unknown

Fourteen programs reported that there are no plans to evaluate them. Nine programs did not answer this question. The remaining 5 stated the evaluation would be undertaken by:

3 - (2) internal evaluation
1 - (3) funders
2 - (4) other - unspecified
1 - (5) 2 + 3

The list is not mutually exclusive as some programs expect to have an evaluation undertaken by more than one party.

Information System

Programs were asked if their information system could produce:

	Yes	No
report of client characteristics	18	10
service delivery statistics	16	12
periodic statistical reports	24	4

Computerization

Programs reported that their information system was

not computerized	10
on a personal computer	9
on a mainframe	8
not answered	1

Seventeen of 22 programs that used measures to evaluate their program's impact had an information system that was computerized.

Of the 12 programs that have never been evaluated, 6 did not have an information system that was computerized, and 4 used a main frame computer, perhaps making data less likely to be gathered or less easy to retrieve for the evaluation process.

Practice Issues

Respondents were asked to identify community practice issues that they would like to discuss at a conference with others in the field of psychogeriatrics. There were 13 responses to this question and they are listed in detail in Appendix 11.

Five programs would like to discuss the issue of establishing effective linkages with others in the continuum of care for the elderly.

Four programs stated that they would like to see ethical issues addressed.

Four programs would like to collaborate on the development of educational strategies, particularly for LTC facility staff. Four programs would like to explore assessment and treatment issues.

The major findings will be discussed further in the following chapter.

CHAPTER 6

DISCUSSION OF MAJOR RESEARCH FINDINGS

The purpose of this practicum was to survey community psychogeriatric outreach programs in Western Canada, to compare them to each other, and to an "ideal model" derived from a literature review and key informant interviews. The data analysis has provided statistically significant information on relationships between programs, and therefore only unexpected or provocative results will be further commented on here. The current state of the practise as compared to the "ideal model" will be discussed. Policy implications of the results and suggestions for future research will presented. An evaluation of the writer's learning objectives will also be reported on.

I - PROGRAM SURVEY FINDINGS AND THE "IDEAL MODEL"

A model for an ideal community psychogeriatric outreach program, was proposed earlier in this report. The key elements, to be discussed, are; assessment, home visits, team model, team composition, intake process, range of services, target group, and continuum of services available to psychogeriatric clients.

1 - Comprehensive Psychogeriatric Assessment

It was proposed, in the "ideal model" that teams should provide a comprehensive biopsychosocial-environmental-functional assessment. All of the programs report that they provide such an assessment. It is not known precisely how teams perform their assessments, or if there is consistency in assessment between programs.

Four different types of team composition were identified in the literature review and in the programs surveyed. It is difficult to imagine that teams composed of only physicians and nurses can provide the same depth and quality of assessment in all areas as do multidisciplinary teams.

The development of standardized protocols for assessihg the various facets that comprise a comprehensive psychogeriatric assessment would be especially useful to teams that lack a broad range of disciplines. This would help to ensure that their assessments are as comprehensive as those of multidisciplinary teams.

Programs use a wide variety of testing instruments with their clients. Only the Folstein Mini-Mental State Examination,however, is used routinely by all programs. Overall there is no consensus on which testing instruments are most useful. Evaluation of which instruments are most useful, (and valid), in screening and diagnosing different problems would be a useful area for research. Selected instruments could become part of a standardized assessment protocol, and go part of the way toward ensuring that all clients receive a similar quality of assessment.

2 - Home Visits

In the ideal model it was suggested that home visits are an integral part of both assessment and treatment of clients. Home visits also break down the traditional barrier of inadequate transportation as an obstacle to receiving mental health service. (Patterson,

1976). All of the surveyed programs provide some services in the client's home. The cost of providing this service, in terms of staff time, is not known, but it can be assumed that programs with very large catchment areas, (i.e. most likely those with rural and mixed catchments), need to take this cost into consideration when determining the number of staff they require. Unfortunately, one of the limitations of the survey was a failure to ask how much time teams spent in travelling. In addition, only ten programs were able to provide information on their catchment size. Findings reported indicated that programs with rural catchments have smaller average case loads than do programs in urban catchments; it is possible that this in part reflects time involved in travel in rural areas.

3 - Team Model

The ideal team proposed was interdisciplinary in nature. A limitation of the questionnaire was that it asked whether teams were committed to a multidisciplinary team philosophy, rather than asking whether they functioned as interdisciplinary teams. It was possible to determine, however, through the questions asking how case conferences were used, and how multidisciplinary input was ensured, that 25 of the programs function as interdisciplinary teams. These teams discuss all cases in conferences, and diagnoses are made with the input of all disciplines. This kind of conference is time- consuming, and the amount of time involved would be expected to increase with the range and number of disciplines involved. This might in part explain some of the findings reported. Teams with 3 or more disciplines are larger, have higher staff rates and team rates, have larger case loads, keep cases open longer, and open fewer cases per year per FTE, than do teams

composed of only physicians and nurses. To date however, no evidence exists to show that either team composition produces better health outcomes.

The ideal team proposed consisted of a geriatric psychiatrist, a social worker, a nurse, and a consulting occupational therapist and neuropsychologist. Only 2 teams met this criterion.

However, with the exception of one program, the ideal team identified by respondents meet the criteria of the ideal team proposed. It can be assumed, then, that team composition is a reflection of the availability of funding and qualified staff, rather than a reflection of what disciplines are seen as required on the team. Multidisciplinary teams see a wider range of disorders than do physician-nurse teams; this may reflect the broader range of specialized disciplines required to detect and assess non-medical problems. These findings may also support the hypothesis that less discipline-rich teams can not provide as comprehensive an assessment as teams with a wide range of disciplines. If funders wish to increase the range of disorders seen by psychogeriatric programs they will need to staff their teams with at least 3 disciplines.

The implications of less discipline-rich teams for assessment were discussed, above. As well, it could be postulated that the range and depth of interventions is more limited when the team is comprised of only physicians and nurses. To some extent this hypothesis is supported by the research findings. There were positive correlations reported between population density, and the rates of anxiety disorders, alcohol\drug dependency and adjustment problems; and between the rate of marital\family dysfunction and staff rates.

Large clinical teams are usually comprised of 3 or more disciplines, and are found more frequently in urban areas, which have large populations over age 65, and high population density.

4 - Referral Process

Where referrals come from is to some extent determined by mandate. As reported, programs mandated to provide their services only to LTC facilities, generally receive all their referrals from that source. Of programs with wider mandates, none limit themselves to taking referrals only from physicians, although several reported that they asked for physician agreement. This indicates that programs with broader mandates take referrals from a wide variety of sources, as was proposed in the "ideal model".

The reasons given for referral were also varied, as were the diagnoses made, supporting the importance of an open referral system in procuring referrals that reflect the range of medical and non-medical factors that can impact on the functioning of the elderly.

It should also be noted that programs that provide their services only to LTC do not have higher LTC referral rates than do programs that provide service to both LTC and community. This implies that the provision of a specialized team to LTC does not ensure that a greater proportion of potential clients are seen.

6 - Range of Services

As was reported, programs provide a wide range of services; only 5 of the 21 programs

that responded, however, provide service in every category of the prescribed list used in the survey. All but 2 of the respondents provided service in all categories of direct services to clients. Direct service to families is provided by all but 2 of the program respondents. Research, community development and community consultation were the areas where programs spent the least amount of time, if any.

Seventeen programs reported that they would like to increase the amount of time that they spent on non-patient services. The reasons given for not doing so essentially related to the pressures of direct service work, and insufficient staffing\funding to increase any services. It appears that programs perceive that high direct service time is correlated with low indirect service time. The findings, paradoxically, indicate that those programs that do some indirect service, have higher case turnovers, (i.e. see more clients per FTE).

A - Education

Education was proposed as an important service that should be offered by psychogeriatric programs, and is provided by all programs. Wasylenki (1987) has pointed out the importance of psychogeriatric specialists providing educational services to a broad range of targets, to achieve a multiplier effect for a scarce resource. Education can have two purposes. One approach is to provide education about approaches and treatment to professional care providers. This focus would enable care providers to support and treat clients more therapeutically and appropriately. This approach might ultimately lead to fewer referrals to psychogeriatric programs, as care providers develop more expertise in

the management of their clients\patients. A second approach is the education of referral sources, the general public and consumers, to sensitize them to what a psychogeriatric problem is, (as opposed to normal aging), the treatability of these problems, and when to refer. This approach might result in an increase in referrals to programs, and thereby the rate of elderly people seen with mental disorders.

Programs surveyed spend an average of 9% of their time on education. No matter which approach programs take, in order to increase educational services time would have to be built into programs to prepare educational material, as well as to teach it. This would likely mean more staff would have to be hired, (in particular staff with the ability to teach). This may be problematic, in part due to economic constraints of funders, and in part because there is a scarcity of specialized psychogeriatric clinicians in all disciplines; this is likely even more true if they must also be skilled in teaching. It may be possible to compensate for these limitations by facilitating the development of standardized educational materials that could be shared within the field. This would increase efficiency and help to standardize the quality of education being provided, which may vary from program to program. Currently some of the programs have developed or use standard educational programs and videos that might be able to be made more widely available to other programs. In order to accomplish this, it would be necessary to increase communication between psychogeriatric programs, across provincial, mandate and funding boundaries. It is hoped that by sharing a report of the results of this practicum with all participants, a start will be made in this process. Any educational programs being currently used should be subject to evaluation.

B - Community Development

Only 13 of 21 respondents reported spending any time in this activity. As was discussed in the "ideal model" this is an important role for community psychogeriatric programs. Shulman and Wasylenki, as reported in the results of the key informant survey, both stated that linkages must be created at all levels, (clinical, program, and policy), between all components of the service spectrum to the elderly, to ensure coordination of services, accessibility, and efficient use of resources. When programs were asked about the availability of a particular set of resources to psychogeriatric clients, they reported that the level of service was low, except for facility respite care, LTC beds, ECT, general psychiatry beds, and extended care beds. If programs spent more time in community development, (e.g. on boards,in interest groups), they might be able to help devise a better continuum of care for their clients.

Bridging the gap between geriatric and mental health services, psychogeriatric programs are often in a position to identify deficiencies in services available to the elderly. For example, several survey respondents and key informants stated that LTC facilities are inadequately staffed, (in numbers and skill level), to provide appropriate care to psychogeriatric clients with difficult behaviours. Several also stated that the level of community home support services are inadequate, and sometimes difficult to access for clients. Programs could make their concerns known to the funders and community at large. They could join with others in advocating on behalf of their clients for increased funding for home support staff and LTC facilities, or for the establishment of specialized

care facilities.

7 - Continuum of Services

Key informants reported that almost the entire continuum of services they were asked about, was available in their provinces. It was noted by key informants, however, that many resources were found only in larger areas, and had catchment boundaries that excluded some clients. This information was borne out by the survey results, where it was found that more resources are available in urban areas, than in rural areas. Overall, programs had virtually no direct access\formal links to other resources. Several key informants and survey respondents stated that some resources refused to provide their service to clients with difficult behaviours. More support to these services through education to staff, and provision of consultation services to assist with the management of difficult clients, could be provided by community psychogeriatric programs to ameliorate this problem.

Penetration of Services

Mental Health Disorders in General

The Canadian Medical Association (1987) has stated that approximately 30% of elderly Canadians require mental health services, at any point in time. Kramer et al (1985) report the total prevalence of mental disorders in the elderly is 17%. Health and Welfare Canada (1991E) used a figure of 25% in reporting the rate of prevalence of mental disorders

among seniors. Gurland and Cross (1982) suggested that 15 - 20% of the elderly may need psychiatric services. These rates are not necessarily directly applicable to western Canada as it is not known that the definitions of mental disorders\need for psychiatric services are the same. The term mental health services would be expected to encompass a broader range of services than usually provided by a psychogeriatric outreach program. Additionally we don't know how prevalence was determined; eg. by survey of symptoms, clinician interviews, or review of established diagnoses. For the purpose of this discussion the most conservative figure will be used, 15% In the survey results the number of cases opened per year per 1,000 people over age 65, was calculated for 23 programs. The median was 10 cases per year per 1,0000 seniors. This is a considerably lower rate than the 150 cases per 1,000 elderly that would be expected from the most conservative estimate of prevalence in the literature. Currently programs are only seeing 1 in 15 of the potential cases.

This is not to say that the elderly receive no treatment for mental health problems. The mentally ill elderly **are** treated, but this tends to be occur in outpatient clinics, general hospitals, long term care facilities and in the offices of family physicians, (Canadian Mental Health Association, 1988).

Nevertheless, the low penetration rates of the surveyed programs supports Zarit's (1980), and German et al's (1985) studies that found the elderly under-utilize mental health and psychiatric services. Some of the possible reasons for this discrepancy were discussed in

the literature review. Lebowitz (1988),stated that the stigma of mental illness is especially strong in the current cohort of elderly people; perhaps this leads them to avoid psychogeriatric services. Patterson (1976) suggested that the elderly experienced discrimination by health care professionals, and as a result were less likely to be referred to community mental health services. Cohen (1976) suggested that negative stereotypes and misinformation held by psychiatrists might preclude a decision to provide treatment. Butler (1975) believed that ageism is one of the reasons that elderly people do not receive their share of psychiatric services.

Psychogeriatric programs have been put in place to overcome some of these barriers, but those in a position to refer to these programs may continue to carry the attitudes aforementioned. More public education is required, particularly directed at health care professionals and the elderly, to overcome these obstacles and to increase awareness of the prevalence of mental health disorders in the elderly and their treatability. This is an important role that can be undertaken by psychogeriatric professionals, and the funders of psychogeriatric programs. As we have seen, programs currently spend an average 9 % of their time on education. If they are to provide more education, time would have to be allocated for this purpose, and more staff would likely be required. If, as a result referrals increase, a further increase in staff would be required.

All psychogeriatric programs that were surveyed in British Columbia, and 3 in Manitoba, (N=15) do not accept people who are chronically mentally ill or substance abusers,

unless there are concomitant problems associated with aging, or new psychiatric symptoms separate from the chronic illness\substance abuse. People with dementia are not accepted by these programs unless other psychiatric symptoms or behaviour problems are associated with the dementia. The exclusion criterion of other programs is unknown. Where these exclusion criterion are in place, it would seem likely that psychogeriatric programs would have diagnostic rates substantially lower than the prevalence of mental disorders reported in the literature, but just how much lower these rates could be reasonably expected to be, is unknown.

Several respondents stated that for administrative reasons they were not able to open "cases" on caregivers, even though they were providing services to them. This would usually occur in situations where the spouse had a dementia: the case would be opened under "organic mental disorder", even though it was with the caregiver that they intervened. This practice, which seemed to relate to demands of funders, may have inflated some diagnostic categories, and left unreported others. Both key informants and survey respondents have strongly stated that there is a need to provide services to caregivers. If funders are interested in programs supporting caregivers, and seeing a wide variety of mental health problems, and would like this accurately reflected in programs' statistics, they will need to legitimize opening "cases" on caregivers.

An additional factor that might affect penetration rates is supported by the research findings. There is a correlation between high staff:population ratios and higher referral

and case rates; that is to say, programs with higher numbers of staff per population over age 65 in their catchment tend to have more referrals and cases per elderly in the catchment, than do programs with lower staff:population ratios. It seems obvious from this, that if higher penetration of the target group is desired, higher staff:population ratios are required. Given the current economic situation, it may not be realistic to increase staffing enough to provide specialized psychogeriatric services to everybody in need of them. An alternative, (or complementary), approach would be to focus more effort on the education of non-specialized care providers, through formal education and the use of the consultation model. If this route were chosen, psychogeriatric specialists would then only provide assessment and treatment to the most complex cases.

Organic Mental Disorders

In the literature review various prevalence rates were given for dementia. Health and Welfare Canada (1988B) reported that 10% of the elderly suffer from mild to moderate dementia, and 5% from severe dementia. Evans, Funkenstein Alberts et al (1989) stated that approximately 10% of the elderly suffer from a dementia. Gurland and Cross (1982) found that 7.5% of elderly Americans are demented. As mentioned above, psychogeriatric programs surveyed only see people with dementia if there are associated behavioral problems or other psychiatric symptoms. It was reported by Teri et al (1988), that 88 % of people with severe cognitive impairment have associated problem behaviours. Wragg and Jeste (1989), reported that affective and psychotic symptoms occur in 30 - 40% of patients with Alzheimer's Dementia. The most conservative estimate of need can be

obtained by taking 5% as serverely demented, of whom 30-40% can be assumed to have affective or psychotic symtoms, for a result of 1.5%. The mean rate of organic mental disorders diagnosed by the surveyed programs was 3.5 cases per 1,000 elderly, as compared to the prevalence of 15 cases per 1,000 calculated from the literature. Currently then, programs are seeing approximately 1 in 4 potential cases of organic mental disorders. This is a high proportion, compared with the overall proportion of 1 in 15 potential cases. In part this relatively high proportion may reflect the finding that the elderly were most frequently referred to psychogeriatric programs because of cognitive impairment\behaviour problems. These kind of problems are likely frequently referred because of the difficulties they cause caregivers. Education of potential referral sources might be a role undertaken by programs, to increase the penetration of psychogeriatric services to those with mild or moderate dementias.

The program that has the highest rate for organic mental disorder, (10.8 cases per 1,000 elderly),is seeing 1 in 1.4 potential cases per 1,000 elderly; this program may be seeing a greater number of less severe cases than programs overall.

Mood Disorders

Health and Welfare Canada (1991e), reported that Blazer, Hughes and George (1987), in a large American epidemiologic survey found that 8% of the community-dwelling elderly had depressive symptoms that required clinical intervention, and an additional 19% had dysphoric symptoms. Kay, Henderson et al (1985) found that 15.5% of those over age 80

met DSM III-R criteria for a major depressive disorder. Blazer (1989), estimated that there would be a 9.7% prevalence rate of depression in Canadian seniors in 1991. The rate of mean mood disorders diagnosed by the programs surveyed was 2.6 cases per 1,000 people over age 65. When compared to the prevalence rate suggested by Blazer et al, 80 per 1,000 elderly, the programs are only seeing 1 case in 31 potential cases. The program with the highest rate of mood disorders (11.3 cases per 1,000 elderly), is seeing only 1 case in 7 potential cases.

There may be a lower number of depressed clients referred to psychogeriatric programs for all the reasons previously discussed. Many are being treated by family physicians. Some cases may not be referred as they are long-standing disorders, and would not meet program "admission" criteria. As well, people may be " quietly" depressed, causing no problems to care givers, and thus less likely to be referred for assessment and treatment than those with organic mental disorders. The elderly and their care givers may accept depressed feelings as a normal result of losses associated with aging. This is unfortunate as depression responds well to treatment. There needs to be a greater emphasis on providing education to health care professionals and consumers about signs and symptoms of depression, and its treatability.

Psychotic and Delusional Disorders

Silver (1986) found that 4% of the community-dwelling elderly demonstrated significant paranoid ideation. Christian and Blazer (1984) also found generalized persecutory ideation

in 4% of community-dwelling elderly. The programs surveyed diagnosed a mean rate of 0.8 cases per 1,000 elderly. Compared to the most conservative rates in the literature , programs are seeing 1 case in 50 potential cases. Even the program that has the highest rate of psychotic disorders, (3 cases per 1,000 elderly), is seeing only 1 case per 13 potential cases. It may be many of the potential cases are chronically mentally ill, and would not meet the programs' "admission" criteria. Nonetheless, this low rate is somewhat surprising, as often people with psychosis and delusional disorders are disturbing to those they come into contact with, and therefore a greater number of cases would be expected to come to the attention of psychogeriatric programs.

Delirium

In the literature it is reported that 30 -50% of elderly individuals admitted to acute care facilities will develop delirium, (Mattice,1989). There are no prevalence rates for delirium in community-dwelling elderly to be found in the literature. Beresin,(1988) and Lipowski, (1989), state that delirium is often unrecognized. The mean rate of delirium diagnosed by the programs surveyed was 0.44 cases per 1,000 people over age 65 with a range of 0-2.69 cases per 1,000 elderly. Perhaps delirium is unrecognized by referral sources, or conversely , it is identified and people are sent directly to acute care facilities. As delirium is a potentially lethal medical emergency, (Beresin, 1988), educating potential referral sources about delirium is an important preventative service that psychogeriatric programs should provide.

A positive correlation between the rate of delirium and the average age of clients was reported; this finding tends to support the validity of the research results, as it is well documented in the literature that vulnerability to delirium increases in the old-old. (Leresin,1988; Lipowski 1989).

Anxiety Disorders

Bland et al (1988) found a prevalence rate of 3.5% among community-dwelling elderly in Edmonton, for anxiety/somatoform disorders.The programs surveyed diagnosed 0.6 cases per 1,000 people over age 65. Compared to Bland et als' rate, programs are seeing only 1 in 58 potential cases. Even the program with the highest rate of anxiety disorders, (3.7 cases per 1,000 elderly), is seeing only 1 in 9 potential cases per 1,000 elderly. These low rates may reflect the ageism discussed earlier, as well as a lack of recognition of anxiety symptoms on the part of referral sources. Once more, education of referral sources and consumers is an important role psychogeriatric programs can provide, in order to facilitate more people with anxiety disorders being treated.

Personality Disorders

According to the Health and Welfare Canada, 1988b) personality disorders occur in 5% of the elderly population. Programs surveyed diagnosed 0.3 cases per 1,000 people over age 65. Programs are seeing 1 in 166 potential cases. The program that sees the highest rate of personality disorders, (1.02 cases per 1,000 elderly), is seeing only 1 case in 49 potential cases. In part these very low rates may reflect the exclusion criteria of many

programs, whereby the elderly with chronic mental illness are not "admitted". It seems unlikely that people develop personality disorders for the first time after age 65, and they would therefore not be seen if there were not also concomitant problems associated with aging presented.

Alcohol\Drug Dependency

Perry (1987), reported that 5.7% of the elderly are alcoholics. Programs surveyed diagnosed a mean rate of 0.35 case per 1,000 people over age 65. Programs see 1 in 163 potential cases. The program that has the highest rate of alcohol\substance abuse, (2 cases per 1,000 elderly), is seeing 1 in 28 potential cases. As discussed earlier however, many psychogeriatric programs do not "admit" alcohol\substance abusers unless there are concomitant psychiatric symptoms or problems associated with aging, thus reducing the rate of alcoholics that would be expected to be referred to them.

Marital\Family Dysfunction and Adjustment Problems

Prevalence rates for marital\family dysfunction and adjustment problems could not be found in the literature. This could be an area for future research. Wide differences in rates of these disorders between programs surveyed, (range 0-22%, and 0-15%, respectively), may reflect differences in "admission" criteria,(as discussed above), or in team composition. Multidisciplinary teams may see more of these cases, in part because they have the resources to assess and manage them, but also because referral sources may perceive them as more able to provide this service than are physician-nurse teams. This

is borne out by the findings that team rates for multidisciplinary teams are higher than physician-nurse teams, and a positive correlation exists between team rates and case rates.

Summary

Overall psychogeriatric programs have low penetration rates for mental disorders in general, (1 in 15), and for almost all specific disorders: (1 in 31 mood disorders, 1 in 50 psychotic and delusional disorders, 1 in 57 anxiety disorders, 1 in 178 personality disorders, and 1 in 163 alcoholics.) The exception is organic mental disorders, (1 in 4), which might be explained by the problem behaviours associated with dementia that lead to referrals. Aside from this same exception, penetration rates calculated for the programs that reported the highest rate for each disorder, indicated programs see fewer cases expected from prevalence studies. The barriers, (e.g. ageism and stigma), to the provision of mental health services; the exclusion criteria of many programs; and that some cases are being treated by others, were suggested as reasons for the low penetration rates for other disorders. The survey results showed that the rate of cases seen by programs is proportional to the number of staff per 1,000 elderly people in their catchments, and therefore staff numbers, were demonstrated to be a significant factor in the low penetration rates. Education was suggested as a potential strategy for improving penetration rates and increasing referrals. Goldberg and Huxley, (1980), suggest that identification of mental disorders is less of an issue with General Practioners than is the decision to refer to specialized services. Education of non-specialized care providers was also discussed as potential means of reducing referrals, through enabling care providers to manage psychogeriatric disorders more effectively. The latter approach is most

effective, leaving the psychogeriatric program to assess only the most difficult cases.

II- PROGRAM PLANNING\POLICY ISSUES

1 - Staffing

Although the survey results permitted calculation of staff rates per 10,000 elderly, and case rates per 1,000 elderly, there is nothing in the literature that reveals whether these rates are appropriate, high or low. British Columbia, proposes a staff rate of 5 FTE per 10,000 elderly[7]. If this somewhat arbitrary rate were accepted as the benchmark, only 4 programs have achieved it, 2 in Manitoba and 2 in British Columbia. It is interesting to note that the average ideal team rate (5 per 10,000 elderly) met the proposed benchmark, i.e. almost half of the programs would meet the benchmark if they were provided with the staffing for their ideal team. The fact, however, that programs are only seeing 1 in 15 potential mental health cases per 1,000 elderly, suggests that current staffing is insufficient. This was supported by the research; as team rates rise, case rates also continue to rise, with no "levelling off".

Nowhere in the literature is it suggested what the appropriate case load size or case turnover should be for a psychogeriatric program, so it is impossible to evaluate the appropriateness of programs' case loads sizes or the length of time they keep cases open.

---

[7]Personal communication with Program Consultant in B.C. Mental Health, 1992.

These deficiencies in the body of knowledge make it impossible for program planners to develop realistic staffing targets for programs. It also makes it very difficult for programs to develop rational arguments for requesting more personnel. Research is badly needed into why penetration rates are so much lower than expected, and what appropriate staff:population ratios should be.

There have been no studies to indicate which types of teams, which disciplines, and which model of service has the best health outcomes. This is an area for future research, and strategies have been suggested by Cole, (1989).

2 - Target Group

An argument was made in the chapter on the "ideal model" for not limiting the target group served by community psychogeriatric teams to those who can be given a DSM-III-R psychiatric diagnosis. As was pointed out by Health and Welfare Canada, (1988b), a psychiatric diagnosis is only part of a psychogeriatric assessment. Functional impairment in mental health is an indicator of need for community mental health services, rather than the presence of a specific psychiatric illness, (Blazer and Naddox,1982).Throughout the literature the complex array of medical and non-medical factors that can impair the mental health of the elderly were highlighted. The field of psychogeriatrics developed from a recognition of the complex etiology of psychogeriatric issues\problems, and the underlying philosophy of the field is holistic, reflecting the social model. When psychiatric diagnosis is seen as the primary reason\justification for "treatment" by a psychogeriatric program,

it can be argued that geriatric psychiatry is being practised, rather than psychogeriatrics, and the medical model becomes paramount.

Currently programs in western Canada are diagnosing a psychiatric illness in 87% of the cases they see. In that they were provided with a list of diagnoses to choose from, and only 21 programs use DSM-III-R, it is difficult to know whether the results indicate the true target group. It is possible that some programs "translated" their "diagnoses" to fit the question. Earlier it was suggested that the practise of some programs that open cases on dementia clients, while actually intervening with caregivers, may also distort accurate reporting of the range of mental health problems being seen.

Funders need to examine whether the promotion of community care, health and prevention is best served by geriatric psychiatry, or psychogeriatric programs that incorporate geriatric psychiatry.

The needs of caregivers would be more likely to be directly met through the practise of psychogeriatrics, as discussed in the "ideal model".

3 - Education of Professionals in Health Care

It has been found that there is little formal training, particularily at the graduate level for health care professional, other than psychiatry, about the mental health problems of the elderly, (Canadian Mental health Association, 1988).

All disciplines that practice in the health care field, need to be trained at the undergraduate level in gerontology, in recognition of the increasing number of elderly who will require services. Key informants and survey respondents both cited lack of well-qualified staff as a problem faced in recruitment. Team functioning skills are also needed for effective practice on teams as was discussed in the "ideal model"; presently each discipline is prepared to work as an independent professional, (McGrath, 1988).

Given the interdisciplinary team approach favoured by psychogeriatric programs, some degree of cross-training needs to be undertaken. Presently this is done "on the job" by osmosis and through individual effort. This process needs to be formalized, through, perhaps, certificate programs in psychogeriatrics.

Schools of social work, in particular, need to provide social workers with a basic understanding of physical disorders, normal aging, medications, cognitive impairment\psychiatric disorders in order for the profession to maintain a credible role\presence in health care. Few Canadian schools of social work offer instruction in these areas.

4 - Caregivers

The needs of caregivers, particularly family caregivers, must be addressed by program planners and policy makers. This necessity was discussed in the literature review, and it was reported as a concern of both key informants and survey respondents. Trends

discussed in the literature, that supported the development of community psychogeriatric teams , are deinstitutionalization, desirability of providing care in the home, and the push to reduce health care costs. It is important that the "attractiveness" of the first 2 trends is not used to justify lack of service or unreasonable cuts to health and social services to the elderly. These current trends place the burden of care for the elderly on the shoulders of family members, often old and frail themselves.(Bergman, 1978; Robertson and Reisner, 1982; Brody 1981). The stresses of caring for an elder, particularly when dementing, has been well documented, (Health and Welfare Canada,1991e; Clark 1987; and Zarit 1987), as has the potential for the caregiver to experience mental health problems,(Brodaty and Hadzi-Pavlovic, 1991, Health and Welfare Canada,1991e).

The survey results revealed that all but 2 of 21 programs that responded, provide some direct services to clients' families. With the exception of one program, all provide consultation to caregivers. As discussed earlier, some respondents mentioned that they could not "open" cases on caregivers unless they could give them a DSM III-R diagnosis. This causes some problems in case recording, and may "bury" the number of caregivers without psychiatric diagnoses who are being seen by programs.

The role of providing services directly to caregivers should be legitimized by funders, both as part of the objective of keeping psychogeriatric clients at home as long as possible, and as a preventative service for caregivers. The vulnerability of caregivers to

mental health problems has been well documented, but it has not yet been clearly demonstrated that any preventative interventions actually reduce the incidence of mental disorders. This is an area for future research.

5 - Program Evaluation and Outcomes

As discussed in the key informant survey results, Dr. Cole believes that it is imperative that programs be evaluated in order to determine whether or not they are seeing appropriate target groups, and which if any program models\ interventions are effective. When asked what they wanted to know about community psychogeriatric programs, other key informants were keenly interested in finding out which programs had been evaluated, who they were seeing, workload measures and how the programs had been operationalized. In these times of cut-backs in health and human services, rigorous program evaluations are necessary to justify the existence\activity of almost any service.

It was reported in the data analysis that 15 programs have been evaluated, but it is not known what exactly was evaluated or how rigorously, as these evaluations have not been published. Outcome measures are reported to be used by 22 programs, using referral source satisfaction measures, team ratings of client outcomes, client satisfaction measures, and\or comparisons of Global Assessment of Functioning at intake and discharge. Again it is not known how valid or rigorous these efforts have been. It would be very useful if psychogeriatric programs with the same mandates, along with their funders, could each collaborate with their peers in developing standardized (and therefore comparable)

designs for evaluating their programs, client outcomes, and interventions. Limitations in undertaking this successfully are lack of communication between programs, lack of time and lack of skills. It is likely that very few programs have staff with expertise in research methods or evaluation design, and this was in fact reported by 2 programs.

Alberta Mental Health, in Edmonton, is attempting to overcome this by providing their nurses with these skills as part of a Nursing Job Enhancement Project. Other funders might follow this lead, or perhaps a professional researcher could be contracted by funders to provide leadership and expertise to existing staff.

An additional barrier to evaluation is the ability of programs to gather, store and analyze data about demographic and diagnostic characteristics of clients, and their program activity. Only 14 programs could provide information on the age of clients they see, and 3 on clients' marital status, both basic items of demographic information. Seven programs could not be certain that the data they reported related to clients was representative of their programs' operation. This may relate to the finding that only 17 programs have a computerized information system, and 8 of these are part of a main frame (presumed to belong to the funder), from which they may not be able to retrieve appropriate information for evaluation, as they would be limited in what data they could input. A standardized information system and data base would be very important in collaborative research between programs, and for developing methods for comparing programs. Communication and collaboration in this area by psychogeriatric programs could be of

great benefit to future research.

As discussed above, under "Assessment", the development of a standardized protocol for assessing psychogeriatric clients, and the investigation of suitable testing instruments, are both areas for future research that could benefit programs and their clients.

Summary

Overall surveyed programs were found to conform to many aspects of the "ideal mode", albeit to greater or lesser degrees. Penetration rates were found to be generally low compared to prevalence studies found in the literature.

It is as yet unknown what the appropriate staff:population ratio that is required to serve the psychogeriatric population; nor is it known what discipline mix or program model has the best outcome with these clients. Mandates need to be clarified and services rationalized to ensure a broad range of mental health disorders are being detected and treated. This would encompass direct care to caregivers. Psychogeriatrics, as opposed to geriatric psychiatry, needs to be practised if the social model of care is to be provided. More education at the undergraduate level in all health care professions needs to be undertaken to ensure a sufficient number of people with specialized skills in psychogeriatrics. Program evaluations need to occur, as do investigations into what interventions and models are most effective.

III- RECOMMENDATIONS AND AREAS FOR FUTURE RESEARCH

Many areas for research were derived from the foregoing discussion, and were highlighted. The following provides a brief summary of the areas that were discussed.

1 - The development of a standardized protocol for assessing psychogeriatric clients, and the investigation of suitable testing instruments, are both areas suggested for future research, that could benefit programs and their clients.

2 - The development of standardized education materials, with evaluations built in, was discussed as an area for future research.

3 - Research needs to be undertaken to determine which discipline mix, and which program model, (ie psychogeriatric or geriatric psychiatry; consultation or direct service), are most beneficial and cost-effective.

4 - Research needs to be undertaken to determine whether clients treated by psychogeriatric programs have better outcomes than clients that are treated by non-specialists.

5 - Research needs to be undertaken to determine the appropriate staff:population ratio for psychogeriatric programs.

6 - Research needs to be undertaken to determine if direct service to caregivers reduces their vulnerability to mental health problems. An additional question would be to determine which interventions, if any, are most effective in reducing this vunerability.

7 - In the discussion on penetration of services it was pointed out that there is a lack of research in the area of the prevalence of delirium, marital\family dysfunction and adjustment problems that occur with the elderly. Research into these areas would be useful in planning for service needs. Research is also needed into which interventions, if any, are most effective in treating the latter two problems.

8 - Program evaluation was discussed as an essential area for immediate research. It is important that program staff are involved in these evaluations.

9 - Programs need to develop standardized methods for gathering data, so they can be compared to each other.

10 - This study should be replicated, taking into account the limitations reported, in order to compare programs in western Canada with those in eastern Canada.

11 - Many programs reported dissatisfaction with DSM III-R as a diagnostic system for psychogeriatric clients. It was found in the literature, (Kutchins and Kirk,1988; Bassett and Beiser,1991), and through the key informant survey, that Axis IV and V are seen as

particularly limited in applicability to the elderly. The development of new scales to rate stressors, and global assessment of functioning, specific to the elderly, would be a very useful area for research.

12 - One of the objectives of many programs surveyed is to delay or forestall inappropriate or premature institutionalization. An area for future research would be to determine how programs' define "inappropriate\premature institutionalization", and how it can be proved that they achieve this objective. The potential risks to the client and costs to caregivers must be taken into account in meeting this objective. A second research question might be to ask how these risks are measured.

13 - Many community psychogeriatric programs are asked to consult about the ability of cognitively impaired clients to continue living alone in their homes. This is an area that was brought up by a number of key informants and programs as a practise issue they would like to discuss at the ethical and practical levels. There is no standardized way of making these assessments, which by their very nature are extremely complex. They can also have a major impact on the client's life. Research that explores the ethical dimensions of these assessments, and research into the development of a standardized risk assessment protocol would be beneficial to clients and health care professionals.

CHAPTER 7

CONCLUSIONS

The research has revealed that psychogeriatric programs in western Canada are not homogeneous. There is variety in catchment area characteristics, funders, mandates, team composition, staff:population ratios, primary referral sources, referral rates, staff rates, case rates, the size of caseloads, length of time cases are kept open, size of populations being served, range of services provided, range of mental health problems seen, and availability of community resources. It is difficult to determine which factors "cause " what. Funders and catchment area (ie rural or urban) may be the most important differentiating factors, from which other differences arise.

Programs funded by Mental Health are generally mandated to serve both community and LTC; are mostly in B.C.; all but one have team compositions like that proposed in the "Ideal Model", and teams are usually large; they get their referrals from a wide range of sources, see people with a broad range of reasons for referral, and diagnose a broad range of mental health problems. These programs spend the smallest proportion of their time on consultation\education; have high referral rates, case rates, staff rates and team rates. They have larger caseloads which they "turn over" more slowly than programs funded by LTC or hospitals, and open fewer cases per year per FTE. They do not provide their services to acute care hospitals.

Programs funded by LTC provide their services to LTC only in all but one case; they are mostly found in Manitoba and Alberta; 33% of the teams conform to the team composition proposed in the "Ideal Model", and 50% are composed of physicians and nurses only. Teams are generally smaller than those funded by Mental Health or hospital. These programs get their referrals almost exclusively from LTC facilities, and have the narrowest range of reasons for referral, and the least variety in diagnoses made, perhaps indicating that they see a more homogeneous population than programs with broader mandates. They only provide their services to acute care hospitals when they have rural catchments. Programs funded by LTC have lower referral rates, staff rates, team rates and case rates than those funded by other sources. Programs funded by LTC have small case loads which they turn over more quickly than programs funded by Mental Health or hospitals. They also spend a greater proportion of their time on consultation\education, and open more cases per FTE per year, than do other programs; perhaps these characteristics indicate that they tend to use a consultation model to provide their services.

Programs funded by hospitals fall between those funded by LTC and Mental Health. They are mostly found in Manitoba and B.C.; 62% of the teams conform to the team composition proposed in the "Ideal Model", and 25% are composed of physicians and nurses only. They get their referrals from a broader range of sources, and see a wider range of reasons for referral, than programs funded by LTC or Mental Health. They have larger average caseloads, which they keep open longer, as compared to programs funded by LTC, but their average caseloads are smaller and turn over faster than those of

programs funded by Mental Health. They provide less consultation \education than LTC funded programs, but more than Mental Health funded programs. Their referral rate, case rate, staff rate, and team rate are higher than programs funded by LTC. They usually provide their services to acute care hospitals.

Similarities between programs funded by hospitals and those funded by LTC may result from similarity in team composition,(i.e. use of physician\nurse teams), that lead to their greater use of the consultation model than by programs funded by Mental Health.

Teams in urban areas, as opposed to those in rural areas, tend to be funded by Mental Health; to serve both community and LTC facilities; to serve large, dense populations; to have larger, multidisciplinary teams, but lower staff:population ratios; to have more physicians; to have higher referral rates; to receive referrals from a wider range of sources; to have larger case loads which they keep open for longer periods of time; to see a broader range of mental health problems; and to have a greater range of community resources available to them.

Rural programs all extend their services to acute care hospitals. Rural programs may be less specialized than urban teams, and have a greater need to "multiply" their services through more indirect service, in response to the smaller number of other resources available to their clients, and to travel time.

It is unclear if these models have been deliberately designed in response to the defined needs of the communities they serve, or if they have simply evolved differently by chance. Common sense would suggest that funder would be the most important independent variable, which would shape mandate, which might lead to the selection of disciplines for the team; this choice might lead to the choice of service model, and\or lead to the range of clients seen. Much more research is needed to determine whether any model is the "best" response to the different characteristics of the rural and urban catchments. In planning new services or expanding existing programs, community needs assessments which take into account demographics, existing resources and gaps in services, are needed.

One thing that is clear from the research results is that no program is sufficiently staffed to come close to providing services to all potential mental health clients. If funders wish to improve penetration rates, to expand the range of mental health problems seen, and to provide more direct services to caregivers, not only will teams have to be larger, they will also have to be multidisciplinary.

Alternatively, if it is desired that most of those in need receive appropriate treatment from non-specialists, then a great deal more time needs to be spent in providing education and consultation to these non-specialists.

In the previous chapter, implications of the research for program planning and policy, and suggestions for future research were discussed. The most important of these is that

programs must be evaluated to determine which service model, discipline mix, and interventions are the most effective in meeting the complex needs of the psychogeriatric client. This necessitates not just evaluating individual programs, but comparing them to each other. In order to undertake this, programs will have to gather comparable data.

CHAPTER 8

EVALUATION OF LEARNING

This has been a rich learning experience.

Through completing this practicum, I expected to acquire a broad and in-depth knowledge of how community psychogeriatric outreach programs are providing services in western Canada. As well, I expected to develop expertise in the development, design, and implementation of survey techniques, and in data analysis.

The specific skills I expected to learn were as follows:

Ability to develop, design and implement a survey.

Ability to develop and design a survey instrument.

Ability to analyze data using appropriate statistics.

Ability to relate the results of the analysis to existing studies/literature.

Ability to relate research results to social policy, program planning, areas of future research.

The literature review provided me with the opportunity to expand my knowledge of the multiple etiology of psychogeriatric problems, and forced me to consider and analyze different models for delivering psychogeriatric care. This served to reinforce my conviction that the needs of the psychogeriatric client are best met by the use of

multidisciplinary teams using a social model of care. As a result of this research I have come to believe that the practice of psychogeriatrics is different from the practice of geriatric psychiatry, and that the mental health problems of the elderly are much broader than simply mental disorders. Community psychogeriatric programs need to practice psychogeriatrics, to intervene with the mental health problems of the elderly effectively, and again this calls for multidisciplinary teams within a social model of care.

The interviews with key informants were interesting and informative, and provided me with a variety of perspectives on issues in providing psychogeriatric services. It was most encouraging to find such a large amount of consensus among key informants, and congruence with my own ideas. In looking back I wish I had asked for more in-depth answers to the questions, that would have explained more about their rationales for answering questions about team composition, and target groups.

The development of the research instruments was a rich learning experience. I learned most from the errors of commission and omission, outlined in the section on limitations. In future research efforts I would spend much more time on developing and attempting to validate my instruments prior to sending them out. It was only when I attempted to interpret the results that the deficiencies in the designs came to light.

Data analysis was a true challenge; numbers were a foreign language. I had no background in statistics, beyond a course taken many years ago, and quickly forgotten.

Discovering the mysteries of non-parametric and parametric statistics was a major part of my learning, the accomplishment of which was revealed in the data analysis. I intend to use this learning again as quickly as possible, before it fades. This research also forced me to become computer literate, which was not a learning experience I had anticipated.

The development of the ability to critically analyze the literature and to relate it to the research results was hard won; I discovered I had tendency to want to accept whatever was "in black and white", as truth. The criticisms of my committee helped me to overcome this.

One of the greatest learning experiences was that I could analyze and synthesize material from a wide variety of sources, and relate it to the research results in a meaningful way. This enabled me to develop suggestions for program planning, policy development and future research that are well supported, and therefore credible.

In closing, I learned a great deal from undertaking this practicum; I was able to meet all my learning objectives, I discovered some things about my own learning style, and I gained confidence in my ability to successfully challenge myself academically.

BIBLIOGRAPHY

Abrahams, R. B., & Patterson, R. D. (1978). Psychological distress among the community elderly: prevalence, characteristics and implications for services. International Journal of Aging and Human Development, 9, 1-18.

Abramson, M. (1984). Collective responsibility in interdisciplinary collaboration: an ethical perspective for social workers. Social Work in Health Care, 10(1), 35-43.

Agbayewa, M. O. (1992). Anxiety in the elderly. Geriatrics, January\February, 16-18.

Ancill, R., & Holliday, S. (1988). The assessment and management of dysfunctional behaviour in the cognitively impaired elderly. Psychiatry, April, 20-24.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders, Third Edition, Washington DC: American Psychiatric Press, Inc.

Bachrach, L. (1981). Continuity of care for chronic mental patients: a conceptual analysis. American Journal of Psychiatry, 138(11), 1449-1456.

Bailey, D., Thiele, J., Ware, W., Helsel-Dewert, M. (1985). Participation of professionals, paraprofessionals and direct-care staff members in the interdisciplinary team meeting. American Journal of Mental Deficiency, 89(4), 437-440.

Baribeau-Braun, J., Goldstein, S., Braun, C. (1979). A multivariate analysis of psychogeriatric readmissions. Journal of Gerontology, 34, 351-357.

Barry, P., & Moskowitz, M. (1988). The diagnosis of reversible dementia in the elderly. Arch Intern Med, 148(September), 1914-1918.

Bassett, B., & Beiser, M. (1991). DSM-III: use of the multiaxial diagnostic system in clinical practise. Canadian Journal of Psychiatry, 36(4), 270-274.

Beresin, E. (1988). Delerium in the elderly. Journal of Geriatric Psychiatry and Neurology, 1(3), 127-143.

Bergman, S. (1973). Facilitating living conditions for the aged in the community. The Gerontologist, 13(2), 184-188.

Berkman, B. (1977). Community mental health services for the elderly. Community Mental Health Review, 2(3), 1-9.

Bienenfeld, D., & Wheeler, B. (1989). Psychiatric services to nursing home: a liaison model. Hospital and Community Psychiatry, 40(8), 793-794.

Bland, R. C., Newman, S. C., Orn, H. (1988). Prevalence of psychiatric disorders in the elderly in Edmonton. Acta Psychiatric Scand, 77(suppl 338), 57-63.

Blazer, D., & Maddox, G. (1982). Using epidemiologic survey data to plan geriatric mental health services. Hospital and Community Psychiatry, 33(1), 42-45.

Blazer, D., Hughes, D., George, L. (1987). The epidemiology of depression in an elderly community population. Journal of the American Geriatric Society, 27, 281-287.

Bloom, M., & Blenkner, M. (1970). Assessing functioning of older persons living in the community. The Gerontologist, 10, 31-37.

Borson, S., Liptizin, B., Nininger, J., Rabins, P. (1987). Psychiatry and the nursing home. American Journal of Psychiatry, 144(11), 1412-1418.

Boyd, W. D., Woodside, M., Zealley, A. K. (1979). Psychogeriatric consultation: a review of 100 home and hospital visits in Edinburough. Health Bulletin, 37, 202-220.

Brill, N. (1976). Teamwork: working together in the human services. Philadelphia: J.B. Lippincott Co.

British Columbia Mental Health Society. (1991). Riverview hospital: report to the community, June. 2-5.

Brody, E. M. (1981). Women in the middle and family help to older people. The Gerontologist, 21(5), 431-480.

Brothwood, J. (1971). The organization and development of services for the aged with special reference to the mentally ill. British Journal of Psychiatry Special Publication, 6.

Butler, R. N. (1975). Psychiatry and the elderly: an overview. American Journal of Psychiatry, 132 (9), 893-900.

Canadian Medical Association. (1987). Health care for the elderly: today's challenges: tomorrow's options. Ottawa, Ont: Canadian Medical Association.

Caplan, G. (1970). Theory and practise of mental health consultation, New York. Basic Books.

Christenson, R., & Blazer, D. (1984). Epidemiology of persecutory, ideation in an elderly population in the community. American Journal of Psychiatry, 141, 1088-1091.

Clark, D. (1987). In Wasylenki et al. Psychogeriatrics: a practical handbook, Toronto: Gage Educational Publishing Co.

Clark, D., & Perry, L. (1987). In Wasylenki et al. Psychogeriatrics:a practical handbook, Toronto: Gage Educational Publishing Co.

Clarke, M., Williams, A. & Jones, P. (1981). A psychogeriatric survey of old people's homes. British Medical Journal, 283(14, November), 1307-1310.

Cohen, G. D. (1976). Mental health services and the elderly; needs and options. American Journal of Psychiatry, 133, 65-68.

Cohen, G. D. (1980). Community mental health programs for the elderly. International Journal of Mental Health, 8, 50-0.

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

Cole, M. (1989). Development of geriatric psychiatry: the next stage. Annais RCPSC, 22(7), 497-498.

Cole, M. (1988). Evaluation of psychogeriatric services. Canadian Journal of Psychiatry, 33(1), 57-58.

Conwell, Y., Nelson, J., Kim, K., Mazure, M. (1989). Elderly patients admitted to the psychiatric unit of a general hospital. Journal of the American Geriatrics Society, 37, 35-41.

Copeland, J., & Folstein, M. (1991). Geriatric psychiatry. Current Opinion in Psychiatry, 4, 563-564.

Cooper, A. F., Garside, R. F., Kay, D. (1976). A comparison of deaf and non-deaf patients with paranoid and affective psychoses. British Journal of Psychiatry, 129:532.

Craig, T. G. (1982). An epidemiological study of psychiatric liaison service. General Hospital Psychiatry, 4(2), 131-137.

Currie, C. T., Moor, J. T., Friedman, S. W., Warsaw, G. A. (1981). Assessment of elderly patients at home; a report of 50 cases. Journal of the American Geriatric Society, 29, 398-401.

Curson, D., Patel, M., Liddle, P., Barnes, T. (1988, October). Psychiatric morbidity of a long stay hospital population with a chronic schizophrenia and implications for future community care. British Medical Journal, 297, 819-822.

Daggett, D. T., Jones, M. E., Feider, L., Clarke, R. (1974). Consultation improves care of the aged in community facilities. Hospital and Community Psychiatry, 25, 170-172.

Dagen, E. M. (1982). Planning and development issues in implementing community-based mental health services for the elderly. Hospital and Community Psychiatry, 33(2), 137-141.

Daniel, R. A. (1972). A five-year study of 693 psychogeriatric admissions in Queensland. Geriatrics, 27, 132-140.

Davidson, H. (1985). Mental health consultation to nursing homes. Unpublished manuscript.

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

Dunlop, B. D. (1980). Expanded home-based care for the impaired elderly: solution or pipe-dream? American Journal of Public Health, 70(5), 514-519.

Eisdorfer, C. (1977). Evaluation of the quality psychiatric care for the aged. American Journal of Psychiatry, 134(3), 315-317.

Engel, G. (1980). The clinical application of the biopsychosocial model. The American Journal of Psychiatry, 137(5), 535-544.

Erickson, B.H., & Nosanchuk, T.A. (1977). Understanding Data. McGraw-Hill Ryerson Limited.

Fenton, F., Tessier, L., Conandriopoulos, A., Nguyen, H., Struening, E. (1988). A comparative trial of home and hospital psychiatric treatment: financial costs. Canadian Journal of Psychiatry, 27(3), 177-187.

Finkel, S., (1980). Psychiatric consultation in a community agency serving the elderly. Hospital and Community Psychiatry, 31(8), 551-554.

Folstein, M., Anthony, J. C., Parhad, I., Duffy, B., Gruenberg, E. M. (1985). The meaning of cognitive impairment in the elderly. Journal of the American Geriatrics Society, 33, 228-235.

Frank, P. J., Klein, S., Jacobs, J. (1982). Cost-benefit analysis of a behavioral program for geriatric inpatients. Hospital and Community Psychiatry, 33, 374-377.

Friedman, R. (1985, September). Resistance to alternatives to hospitalization. Psychiatric clinics of North America, 8(3), 471-482.

Gallagher, D., Rose, J., Rivera, P., et al (1989). Prevalence of depression in family caregivers. Gerontologist, 29(4), 449-456.

Garetz, F. K. (1975). The Psychiatrist's involvement with aged patients. American Journal of Psychiatry, 132(1), 63-65.

Gauthier, S., McDowell, I. & Hill, G. (1990). Canadian study of health and aging (CaSHA). Psychiatric Journal of the University of Ottawa, 15(4), 227-229.

German, P., Shapiro, B. & Skinner, E. ( ). Mental health of the elderly: use of health and mental health services. Journal of the American Geriatrics Society, 33(4), 246-252.

Glasscotte, R., Gudeman, J., Miles, D. (1977). Creative mental health services for the elderly. Washington, D.C.: Joint Information Service of the American Psychiatric Association and the Mental Health Association.

Goering, P., Wasylenki, D., MacNaughton, E. (1992). Planning mental health services: II current Canadian initiatives. Canadian Journal of Psychiatry, 37(4), 259-263.

Goering, P., Wasylenki, D., Farakas, M., Lancee, W., Ballantyne, R. (1988). What difference does case management make? Hospital and Community Psychiatry, 39(3), 172-276.

Goldberg, D., Huxley, P. (1980). Mental illness in the community: the pathway to psychiatric care. London: Tavistock Publications.

Goldstein, S. (1980). Social issues in geriatric psychiatry. Journal of the American Geriatrics Society, 28(9), 415-418.

Gomez, G., Gomez, E. (1987). Delirium. Geriatric Nursing, 8(6), 330-332.

Gorden, R., Eisler, R., Gutman, E., Gorden, K. (1991). Predicting prognosis by means of the DSM-III Multiaxial diagnoses. Canadian Journal of Psychiatry, 36(3), 218-221.

Grau, L. (1989). The changing context of mental health care for the elderly. Gerontology and Geriatrics Education, 9(3), 7-15.

Group for the Advancement of Psychiatry, Committee on Aging. (1971). The aged and community mental health, 8(81).

Gurian, B. S., Scherl, D. J. ( ). Community focused model of mental health services for the elderly. International Journal of Ag., Human Development, , 77-86.

Gurland, B. (1991). Epidemiology of psychiatric disorders. In Sadavoy, J. et al (Ed.), Comprehensive Review of Geriatric Psychiatry, (pp. 24-40). Washington DC: American Psychiatric Press, Inc.

Gurland, B. J., & Cross, P. S. (1982). Epidemiology of psychopathology in old age: some implications of clinical services. Psychiatric Clinics of North America, 5(1), 11-26.

Harris, A. G., Marriott M. B., Robertson, J. (1990). Issues in the evaluation of a community psychogeriatric service. Canadian Journal of Psychiatry, 35, 2152-2222.

Harrison, M., (1987). Loss, grief and adaptation. In D. Wasylenki et al. (Eds.), Psychogeriatrics: a practical handbook, Toronto: Gage.

Health and Welfare Canada. (1991E). Mental health problems among canada's seniors: demographic and epidemiologic considerations. Ottawa Ont: Supply and Services.

Health & Welfare Canada (1990). Services to elderly residents with mental health problems in long term care facilities: guidelines. Ottawa Ont: Supply and Services Canada.

Health and Welfare Canada. (1988B). Guidelines for comprehensive services to elderly persons with psychiatric disorders. Ottawa Ont: Supply and Services Canada.

Health and Welfare Canada. (1988E). Mental health and aging in Canada. Ottawa Ont: Supply and Services Canada.

Humphrey, BC (1986). The projected prevalence of major mental disorder in Canada: 1986-2006. Presented to The Canadian Academy of Psychiatric Epidemiolgy. Annual Meeting, Vancouver, September.

Houston, F. (1983). Two year follow-up study of an outreach program in geriatric psychiatry. Canadian Journal of Psychiatry, 28(5), 367-370.

Jarvik, L. F. (1982). Dementia in old age: reflections on nomenclature. Psychiatric Clinic of North America, 5(1), 105-106.

Jeans, E., Helmes, E., Meresky, D., Robertson, J., Rand, K. (1987). Some calculations on the prevalence of dementia in Canada. Canadian Journal of Psychiatry, 32(2), 81-85.

Jeste, D., & Krull, A. (1991). Behavioral problems associated with Dementia: Diagnosis and treatment. Geriatrics, 46(11), 28 -34.

Jolley, D., Arie, T. (1978). Organization of psychogeriatric services. British Journal of Psychiatry, 132, 1-11.

Jones, R. (1991). Community services in old age psychiatry. Current Opinion in Psychiatry, 4, 603-607.

Kaplan, R. M., & Bush, J. W. (1982). Health-related quality of life measurement for evaluation research and policy analysis. Health Psychology, 1, 61-80.

Kane, R. (1975). Interprofessional teamwork. Manpower Monograph Number Eight, Syracuse University School of Social Work.

Kay, D., Henderson, A., et al. (1988). Dementia and depression among the elderly living in the Hobart community: the effect of diagnostic criteria on prevalence rates. Psychological Medicine, 15, 771-788.

Keane, S., Sells, S. (1988). Recognizing depression in the elderly. Journal of Gerontological Nursing, 16(1), 21-25.

Kirby, H., & Harper, R. (1987). Team assessments of geriatric mental patient: The care of functional dementia produced by hysterical behaviour. The Gerontologist, 27(5), 573-576.

Knight, B., & Carter, P. (1990). Reduction of psychiatric inpatient stay for older adults by intensive case management. 30(4), 510-515.

Knight, B. (1986). Management variables as predictors of service utilization by the elderly in mental health. International Journal of Aging and Human Development, 23(2), 141-147.

Kovess, V., & Lafleche, M. (1988). How do teams practise community psychiatry? Canada's Mental Health, June\September, 9-16.

Krakowski, A. J. (1979). Psychiatric consultation for the geriatric populations in the general hospital. Bible Psych, 159, 163-185.

Kral, V. (1979). Twenty years of progress in geriatric psychiatry. Psychiatric Journal of the University of Ottawa, 4, 81-84.

Kral, V. (1984). Present status of geriatric psychiatry. Psychiatric Journal of the University of Ottawa, 9, 53-55.

Kral, V. (1985). in Proceedings of a Colloquium on Issues in Service , Assessment and Education, Ottawa: Minister of National Health & Welfare, Ottawa, 5-13.

Kramer, M., German, P., et al (1985). Patterns of mental disorder among the elderly residents of eastern Baltimore. Journal of the American Geriatrics Society, 33, 236-245.

Kutchins, H., & Kirk, S. (1988). The business of diagnosis: DSM-III and clinical social work. Social Work, May-June, 215-220.

Kyle, D., Drummond, M., White, D. (1987). The Hereford district department of mental health of the elderly; a preliminary evaluation. Community Medicine, Oxford, 9(1), 35-46.

Lamb, H., & Peterson, C. (1983) The new community consultation. Hospital and community Psychiatry, 34(1), 59-64.

Lawton, M. P. (1983). Environmental and other determinants of well-being in older people. The Gerontologist, 23, 349-357.

Lazarus, L. (Ed.) (1988). Essentials of geriatric psychiatry. New York: Springer Publishing company.

Lebowitz, B. D. (1988). Correlates of success in community mental health programs for the elderly. Hospital and Community Society, 39(7), 721-722.

Lehman, A. (1989). Strategies for improving services for the chronic mentally ill. Hospital and Community Psychiatry, 40(9), 916- 920.

Levitan, & Kornfeld, D. (1981). Clinical and cost benefits of liaison psychiatry. American Journal of Psychiatry, 138, 790-793.

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

Linn, M., et al (1985). Nursing home care as an alternative to psychiatric hospitalization. Arch General Psychiatry, 42, 544-551.

Lipowski, Z.J. (1989). Delerium in the elderly patient. New England Journal of Medicine, 320(9), 378-381.

Lipowski, Z.J. (1986). Consultation-liaison psychiatry: the first half century. General Hospital Psychiatry, 8, 305-315.

Lipowski, Z. J. (1983). The need to integrate liaison psychiatry and geropsychiatry. American Journal of Psychiatry, 140, 1003-1005.

Lipowski, Z. J. (1983). Current trends in consultation/liaison psychiatry. Canadian Journal of Psychiatry, 28(53), 328-329.

Lopata, H. (1979). Women as widows: support systems. New York: Elsevier.

Lucas, M., Steele, C., Bognanni, A. (1986). Recognition of psychiatric symptoms in dementia. Journal of Gerontological Nursing, 12(1), 11-15.

Lyness, J., Conwell, Y., Nelson, J. (1992). Suicide attempts in elderly psychiatric inpatients. Journal of the American Geriatrics Society, 40, 320-324.

Mainprize, E., & Rodin, G. (1987). Geriatric referrals to psychiatric consultation - liaison service. Canadian Journal of Psychiatry, 32(1), 5-9.

Magni, G., Pallazzolo, O., Bianchin, G. (1988). The course of depression in elderly outpatients. Canadian Journal of Psychiatry, 33(1), 21-24.

Mannis, F. V., & Shore (1979). Evaluation of consultation; problems and prospects. New Directions for Mental Health, 3, 99-113.

Markson, E., Kwoh, A., Cumming, J., et al (1971). Alternatives to hospitalization for the psychiatrically ill geriatric patients. American Journal of Psychiatry, 127, 1055-1062.

Martin, B. (1987). In Wasylenki et al. Psychogeriatrics: a practical handbook, Toronto: Gage Educational Publishing Co.

Mattice, M. (1989). Intrahospital room transfers: A potential link to delirium in the elderly. Perspectives, 13(2), 10-12.

McCullough, P. (1991). Geriatric depression: a typical presentations, hidden meanings. Geriatrics, 46(10), 72-76.

McIntosh, J., & Eisner, H. (1984, October). Community mental health and the elderly: service and training approaches. Journal of Community Psychology, 12, 359-368.

McKegney, F. P., McMahon, T., King, J. (1983). The use of DMS-111 in general hospital consultation liaison service. General Hospital Psychiatry, 5, 115-121.

Meier, H., Besir, M., Sylph, J. (1992). Psychological hospitalization: terminable or interminable? Canadian Journal of Psychiatry, 37(3), 157-162.

Mei-Tal, V., & Meyers, B. S. (1985). Emoirical study on an inpatient psychogeriatric unit: diagnostic complexities. International Journal of Psychiatric Medicine, 15, 91-109.

Morgan, K., Dallosso, H., Arie, T., Byrne, E., Jones, R., Waite, J. (1987). Mental health and well-being among the old and very old living at home. British Journal of Psychiatry, 150, 801-807.

Munro, A. (1992). Delusional disorders in the elderly. Geriatrics, August\September, 41-45.

Murphy, E. (1982). Social origins of depression in old age. British Journal of Psychiatry, 141, 135-142.

Novak, M. (1988). Aging And Society. Nelson, Canada.

O'Connor, M. (1987). Disturbed behaviour in dementia-psychiatric or medical problem? The Medical Journal of Australia, 147, November 16, 481-485.

Organizing Committee: Canadian Consensus on the Assessment of Dementia (1991). Assessing dementia: the Canadian consensus. Canadian Medical Journal, 144(7), 851-853.

Pankratz, W. (1991). Geropsychiatry - a challenge for the '90s. Canadian Journal of Psychiatry, 36(9), 623-629.

Paterson, R. D. (1976). Services for the aged in community mental health centres. American Journal of Psychiatry, 133(3), 271-273.

Perry, L. (1987). Substance Abuse. In D.Wasylenki et al, (Eds.), Psychogeriatrics: A Practical Handbook, Toronto: Gage.

Popovin, M. K. (1984). Psychiatric consultation to the geriatric medically ill patients in a university hospital. Arch General Psychiatry, 41(7), 703-707.

Potvin, J. (1988). Psychogeriatric consultation in "reception centres": a descriptive account. Canada's Mental Health, 36(2-3), 2-4.

Psychogeriatric Planning Committee (1988). Report on the future directions for psychogeriatric service delivery in Manitoba, Winnipeg: Manitoba Health.

Raskind, M. A., Alvarez, C., Pietrzyk, M., et al (1976). Helping the elderly psychiatric patient in crisis. Geriatrics, 31, 51-56.

Rathbone-McCuane, E. (1976). Geriatric day care: a family perspective. The Gerontologist, 16, 517-521.

Reifler, B. V., Cox, G. B., Hanley, R. S. (1981). Problems of mentally ill elderly as perceived by patients, families, and clinicians. Gerontologist, 21, 167-0.

Reifler, B. V., Kethley, A., O'Neill, P., Hanley, R., Lewis, S., (1982). Five year experience of a community outreach program for the elderly. American Journal of Psychiatry, 139, 220-223.

Reifler, B. V., Raskind, M., Kethly, A. (1982). Psychiatric diagnosis among geriatric patients seen in an outreach program. Journal of the American Geriatric Society, 30, 530-533.

Reifler, B. V., Larson, E. B., Teri, L. (1987). An outpatient geriatric psychiatry assessment and treatment service. Clinics in Geriatric Medicine, 3(1), 203-209.

Resnik, H. L., & Cantor, J. M. (1970). Suicide and aging. Journal Of the American Geriatrics Society, 18, 152-158.

Richman, A. (1985). Use of Psychiatric Services by elderly in Canada. Canadian Journal of Psychiatry, 30(2), 89-97.

Roadburg, A. (1985). Aging: Retirement, Leisure and Work in Canada. Toronto: Methuen.

Robertson, D., Rockwood, K., Stolee, P. (1989). The prevalence of cognitive impairment in an elderly Canadian population. Acta Psychiatric Scand, 80, 303-309.

Robertson, D., & Reisner, D. (1982). Management of Dementia in the elderly at home: Stress & the supporter. Canada's Mental Health, 30(3), 36-38.

Roca, R., Storer, D., Robbins, B., Tlasek, M., Rabins, P. (1990). Psychogeriatric assessment treatment in urban public housing. Hospital and Community Psychiatry, 41(8), 916-920.

Rockwood, K., Stolee, P., Brahim, A. (1991, May). Outcomes of admission to a psychogeriatric service. Canadian Journal of Psychiatry, 36, 275-279.

Rockwood, K., Stolee, P., Robertson, D. (1989). The prevalence of problem behaviours in elderly residents of long term care institutions. Canadian Journal of Public Health, 80, 302-303.

Rodenburg, M. (1985). Psychiatric and non-psychiatric facilities in the care of psychogeriatric patients. Canadian Medical Association Journal, 132, 244-247.

Rooner, B. W., & Robins, P. V. (1985). Mental illness among nursing home patients. Hospital and Community Psychiatry, 36, 119-128.

Roth, M. (1955). The natural history of mental disorders in old age. Journal of Mental Science, 101, 281-302.

Roth, M., & Mountjoy, C. O. (1980). Mental health services for the elderly living in the community. A U. K. perspective. Journal of Mental Health, 8, 101-116.

Rovner, B., Kafonek, S., Filipp, L., Lucas, M., Folstein, M. (1986). Prevalence of mental illness in a community nursing home. American Journal of Psychiatry, 143(11), 1446-1449.

Rovner, B., & Rabins, P. (1985). Mental illness among nursing home patients. Hospital and Community Psychiatry, 36(2), 119-128.

Royal College of Physicians of London and Royal College of Psychiatrists (1989). Care of elderly people with mental illness: specialist services and medical training. London: Royal College of Physicians of London and Royal College of Psychiatrists.

Ruch, M. (1984). The multidisciplinary approach: when too many is too much. Journal of Psychosocial Nursing, 22(9), 18-23.

Ruffin, J., & Urquart, P. A. (1980). A comprehensive geriatric mental health service in San Francisco. International Journal of Mental Health, 8, 101-116.

Ruskin, P. E. (1985). Geropsychiatric consultation in a university hospital: a report on 67 referrals. American Journal of Psychiatry, 142(3), 333-335.

Sadavoy, J. (1981). Psychogeriatric care in the general hospital. Canadian Journal of Psychiatry, 25(5), 334-336.

Sadavoy, J., Lazarus, L., Jarvik, L., eds (1991). Comprehensive Review of Geriatric Psychiatry. Washington DC: American Psychiatric Press, Inc.

Santore, A. F., & Diamond, H. (1974). The role of a community mental health centre in developing services to the aging: older adult. The Gerontologist, 14(3), 201-201.

Sherr, V. T., Eskridge, O. C., Lewis, S. (1976). A mobile mental-hospital-based team for geropsychiatric service in the community. Journal of American Geriatrics Society, 24, 362-0.

Shulman, K. (1991). Regionalization of psychiatric services for the elderly. Canadian Journal of Psychiatry, 36, 3-8.

Shulman, K., Arie, T. (1991) UK survey of psychiatric services for the elderly: direction for developing services. Canadian Journal of Psychiatry, 36, 169-175.

Shulman, K., Silver, I., Hershberg, R., Fisher, R. (1986). Geriatric psychiatry in the general hospital: the integration of services and training. General Hospital Psychiatry, 8, 223-228.

Silver, I. (1986, April). Paranoid disorders in old age. Geriatric Medicine, 2, 81-84.

Simon, A. (1984). Some observations of a geropsychiatrist on the value of house calls. The Gerontologist, 24(5), 458-464.

Sirois, F. (1988). Delirium: 100 cases. Canadian Journal of Psychiatry, 33, 375-378.

Skelton, D. (1986). The future of geriatric medicine in Canada. Gerontion, (Nov-Dec), 19-23.

Skulmoski, A. (1988). Assessment and treatment of mental health problems in the elderly. B.C. Medical Journal, 30(4), 241-246.

Smith, D. (1990). The interdisciplinary team approach to long-term care of the demented patient. The Journal of Long-Term Care Administration, , 8-11.

Smith, S., & Marshall, W. (1989). Alternative programs in a psychogeriatric hospital. Dimensions, March, 17-33.

Soni, S. (1988). The relationship between peripheral sensory disturbance and the onset of symptoms in elderly paraphrenics. International Journal of Geriatric Psychiatry.

Spar, J., & LaRue, A. (1990). Concise guide to geriatric psychiatry. Washington: American Psychiatric Press, Inc.

Stansfeld, S., Leek, C., Travers, W. & Turner, T. (1992). Attitudes to community psychiatry among urban and rural general practitioners. British Journal of General Practise, August, 322-325.

Statistics Canada (1990). The health and activity limitation survey: highlights- disabled persons. (Catalogue 83-603). Ottawa: Supply and Services.

Stotsky, B. A. (1972). Social and clinical issues in geriatric psychiatry. American Journal of Psychiatry, 129(2), 117-126.

Swan, J. (1987). The substitution of nursing home for inpatient psychiatric care. Community Mental Health Journal, , 3-18.

Teri, L., Larson, E., Reifler, B. (1988). Behavioral disturbance in dementia of the Alzheimer's type. Journal of the American Geriatrics Society, 34, 711-721.

Thomae, H. (1980). Personality and adjustment to aging. In J.E. Birren and R.B. Sloane (Eds) Handbook of mental health and aging. New Jersey: Prentice-Hall, Inc.

Thompson, R., Rhyne, R., Stratton, M., Franklin, R. (1988). Using an interdisciplinary team for geriatric education in a nursing home. Journal of Medical Education, 63, October, 796-798.

Toff, M. A., & Sallet, J. D. (1986). Report on issues of policy: The mentally ill in nursing homes. National Institute of Mental Health, June, - .

Tourigny-Rivard, M., & Drury, M. (1987). The effects of monthly psychiatric consultation in a nursing home. The Gerontologist, 27(3), 363-366.

Tripodi, T. (1983). Evaluative research for social workers. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Turner, R., & Noh, S. (1988). Physical disability and depression. Journal of health and Social behaviour, 29, 23-27.

United States Department of Health, Education, and Welfare ( ). Mental health and the elderly: recommendations for action.

Wargon, M., & Shulman, K. (1987). Community psychiatric services for the elderly: the Sunnybrook experience. Canada's Mental Health, March, 2-6.

Wasson, W., Ripechkyi, A., Lazarus, L. W., Kupferer, S., Barry, S. (1984). Home evaluation of psychiatrically impaired elderly: process and outcome. The Gerontologist, 24, 238-242.

Wasylenki, D. (1982). The psychogeriatric problem. Canada's Mental Health, 30(3), 16-19.

Wasylenki, D., Goering, P. & MacNaughton, E. (1992). Planning mental health services: I background and key issues. Canadian Journal of Psychiatry, 37(3), 199-205.

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

Wasylenki, D., Martin, B., Lennox, E., Perry, L., Harrison, M. (1987). Psychogeriatrics: a practical handbook, Toronto: Gage Educational Publishing Co.

Weiler, P. G., Kim, J., Pickard, L. S. (1976). Health care for elderly Americans: evaluation of an adult day health care model. Medical Care, 14(8), 700-708.

Weissert, W. G. (1976). Adult day care programs in the U.S.: Current research projects and a survey of 10 centres. Public Health Reports, 92, 49-56.

Weissert, W. G. (1976). Two models of geriatric day care: findings from a comparative study. The Gerontologist, 16, 420-427.

Wigdor, B., Gerstein, R., Goldenberg, K., Shulman, K., Tindale, J. (1988). Mental health and aging in Canada. Canadian Mental Health Association.

Wilcox, F. M. (1986). Issues in the development of training for mental health service to the elderly. Gerontology & Geriatrics Education, 6(2), 49-63.

Wilson, K. (1991). Epidemiology, risk factors and clinical features. Current Opinion in Psychiatry, 4, 587-590.

Winn, S., & Kessler, S. (1973). Community health care centres and the nursing home patient. The Gerontologist, 14(4), 345-348.

Winn, S., & Kessler, S. (1984). Community health care centres and the nursing home patient. The Gerontologist, 36, 345-348.

Wragg, R., & Jeste, D. (1989). Overview of depression and psychosis in Alzheimer's disease. American Journal of Psychiatry, 146, 577-587.

Zarit, S. H. (1980). Aging and mental disorders: psychological approaches to assessment and treatment. New York Free Press.

APPENDIX I

KEY INFORMANT INTERVIEW QUESTIONS

1 - Various models for delivering Psychogeriatric services to the elderly residing in the community (including care facilities) have been described in the literature:

Consultation-liaison model (Wasylenki,1984)-indirect services through consultation, education, coordination, and collaboration to individuals and agencies dealing directly with the elderly.

Outpatient geriatric psychiatry assessment and treatment clinics, (Reifler, 1987) - in-clinic multidisciplinary assessment, consultation to family, treatment.

Community "outreach" services (Harris,1990) -in-home assessment, treatment, follow-up, consultation-provided by inter\multidisciplinary teams.

Consultation model -in-home assessment, consultation provided by a Physician and initiated by a Physician:(i.e traditional Doctor to Doctor consults).

WHAT DO YOU THINK IS THE IDEAL MODEL FOR DELIVERING PSYCHOGERIATRIC SERVICES TO THE COMMUNITY? WHY?

2 - Harris(1990) described the typical range of patient and non-patient services commonly offered by a Psychogeriatric service in the community;

Direct patient services	Non-patient services
assessment	teaching
consultation	research

treatment

counselling

community development

community consultation

medication

education

behaviour management

community support

medico-legal advice

placement assistance

crisis intervention

case coordination

follow-up

A- WHICH OF THESE SERVICES DO YOU THINK ARE ESSENTIAL TO A COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAM?

B- WHAT STAFFING RESOURCES DO YOU THINK ARE ESSENTIAL IN PROVIDING THE SERVICES THAT YOU IDENTIFIED?

3 - A large part of the work of Psychogeriatric Outreach Teams is assessing clients and providing diagnoses.

WHAT DIAGNOSTIC SYSTEM DO YOU BELIEVE SHOULD BE USED FOR THE PSYCHOGERIATRIC CLIENT? WHAT SYSTEM DO YOU USE? IS IT ADEQUATE?

4 - In an ideal world a continuum of services would be available to the Psychogeriatric client residing in the community:

community outreach services

psychogeriatric day care

psychogeriatric day hospital

psychogeriatric inpatient assessment and treatment unit

respite services

caregiver (family) support

home support service

psychogeriatric boarding homes\guest homes

psychogeriatric long term\personal care beds

psychogeriatric chronic care\mental health

beds

education to caregivers (family and staff)

A - WHAT SERVICES DO YOU THINK ARE ESSENTIAL TO PROVIDING ADEQUATE CARE TO PSYCHOGERIATRIC CLIENTS IN THE COMMUNITY?

B - WHAT SERVICES ARE AVAILABLE TO THE PSYCHOGERIATRIC CLIENT IN YOUR PROVINCE?

C - WHAT ARE THE GREATEST OBSTACLES TO PROVIDING COMMUNITY PSYCHOGERIATRIC CARE TO THE ELDERLY IN YOUR PROVINCE?

5 - Some people have suggested that there are major issues still to be addressed in providing community Psychogeriatric services, such as support for family caregivers; education for long term care\homecare staff; lack of trained health care professionals; need for evaluation of treatments, service delivery systems, and programs; implications of a growing aging population and a declining population in the middle years; and implications of the divorce rate and women in paid employment to caregiving. You may be able to identify other important issues.

WHAT DO YOU THINK ARE THE MAJOR ISSUES\CHALLENGES IN THE FIELD OF COMMUNITY PSYCHOGERIATRICS?

6 - As you know, I will be surveying community Psychogeriatric outreach teams in western Canada in order to develop a typology of programs.

A - WHAT ARE YOU MOST INTERESTED IN KNOWING ABOUT THESE PROGRAMS?

B - HOW WOULD YOU SUGGEST I MIGHT BEST COLLECT DATA FROM COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAMS?

7 - IF YOU HAD A COUPLE OF MILLION DOLLARS TO SPEND ON IMPROVING SERVICES FOR PSYCHOGERIATRIC CLIENTS IN THE COMMUNITY, WHAT WOULD YOU SPEND IT ON?

APPENDIX 2

SURVEY OF COMMUNITY PSYCHOGERIATRIC OUTREACH PROGRAMS

NAME OF PROGRAM: _____

NAME OF RESPONDENT: _____ PHONE NUMBER _____

PROGRAM DEVELOPMENT AND STRUCTURE:

1. Does your program meet the **following criteria**?
   in operation six months or more: Yes ☐ No ☐
   provide mental health services, exclusively to the elderly and/or their care-givers: Yes ☐ No ☐

2. How many months has your program been **in operation**? _____

3. **Who funds** your program ? _____

4. What is your **annual budget**? _____ Is this funding secure? Yes ☐ No ☐
   If not, how often is funding reviewed? (Please use back for more room.)

5. What other program(s) in Canada were **most influential** in the design/development of your program, and in what way? (Please use back for more space.)

6. What is the **Mandate** of your program? (i.e. to provide what to whom?)

7. More specifically, what are the **Objectives** of your program?

8. What is the **context** within which your program is situated? (Physically and organizationally).

   acute care hospital ☐
   non-acute care hospital ☐
   long term care facility ☐
   community agency ☐
   other _____

II STAFFING:

1. How many full-time or part-time staff make up the **core** Psychogeriatric Outreach **Team?** (e.g. It is assumed that core team members are those who carry cases, along with other duties; therefore do not include consultants to the team. Use boxes at **left** of disciplines.)

2. In the boxes at the **right,** please mark the disciplines that work **only as consultants** to the rest of the team.

CORE TEAM	CONSULTANTS	CORE TEAM	CONSULTANTS
☐ Social Worker	☐	☐ Geriatric Psychiatrist	☐
☐ R.N.	☐	☐ General Psychiatrist	☐
☐ R.P.N.	☐	☐ Geriatrician	☐
☐ B.N.	☐	☐ General Practitioner	☐
☐ M.N./M.Sc.Nursing	☐		
☐ O.T.	☐	☐ Activity Worker	☐
☐ Psychologist	☐	☐ Other (specify)_____	☐

3. Please put a star (*) next to the discipline of the **Team's Coordinator** (above).

4. What is the **average caseload** of a full-time equivalent team member? (i.e. How many active cases are carried at one time per full-time team member?)

5. What would you consider to be your **ideal team**? (Please mark the number of full-time members of each discipline in the box next to the discipline.)

☐ Social Worker	☐ Geriatric Psychiatrist
☐ R.N.	☐ General Psychiatrist
☐ R.P.N.	☐ Geriatrician
☐ B.N.	☐ General Practitioner
☐ M.N./M.Sc.Nursing	
☐ O.T.	☐ Activity Worker
☐ Psychologist	☐ Other(specify) _____

6. Does the Team Coordinator carry a clinical **caseload**? N/A ☐ Yes ☐ No ☐
If yes, what percentage of his/her time? _____

7. Does your program subscribe to a **multidisciplinary team philosophy**? Yes ☐ No ☐

8. How do you ensure **multidisciplinary input** into cases? (Please use back for more space.)

9. How are **case conferences** used? (Check all that apply.)

☐ no cases are conferenced	☐ team discusses only problem cases
☐ team discusses all clients	☐ other: _____

10. Does the Geriatric Psychiatrist (or other team Physician) routinely **see all clients?**

- ☐ No, only at the request/discretion of the team
- ☐ Yes, generally sees the client first
- ☐ Yes, generally as part of the team, after other team members have begun the assessment

11. **How** was the use of a geriatric psychiatrist, as indicated above, **determined?**

- ☐ not applicable
- ☐ availability of the resource
- ☐ philosophical orientation
- ☐ other:

III REFERRAL SYSTEM:

1. What **percent** of your clients do each of the following agencies **refer** ?

____ Long Term Care Facility Staff
____ Family Doctor
____ Other Community Professionals (i.e. Long Term Care Assessors, Home Care)
____ Acute Care Facility Staff
____ Community Agency
____ Family
____ Client
____ Other (please specify) _____

Total= 100%

2. Please estimate the **percent** of cases referred for each of the following **reasons:**

____ Behaviour
____ cognitive impairment
____ possible depression/suicidal ideation
____ communication difficulties
____ social withdrawal
____ grief
____ marital/family problem
____ caregiver burnout
____ conflict with care-givers/others
____ all other (if more than 10% specify most common problems)

3. Have your **services changed** since the beginning of your program, or are there plans to change your services? Please explain: (use back for more space)

IV SERVICES:

1. Please estimate the percentage of **program time** spent on each service component:

Direct Client Services:
___ Assessment
___ Treatment
___ Consultation to caregiver
___ Direct service to family (e.g. counselling)

Non-patient Services
___ Education
___ Research
___ Community Development
___ Community Consultation

2. Would you like to see a **different** distribution of services than you have indicated above?
Yes ☐ No ☐

3. If yes, **what distribution** of services would you like to see? (Use back for more space)

4. What are the **obstacles preventing** you from achieving this?

5. Do you have a **waiting list**? Yes ☐ No ☐ If yes, how long a wait?_____

If yes, please describe how cases are **prioritized.**
___ by date of referral
___ by apparent urgency
___ other, please elaborate (on reverse)

6. A few cases are probably open for quite some time, and a few cases are probably closed quite quickly. Discounting these, what is the **average length of time** that typical cases are open, calculated from the date of referral to the date of last contact?

7. If your program provides **training or education** to family and/or professional caregivers, could you please provide a list of topics covered in the last year, and who was targeted? (Use back)

8. If your program has engaged in **research**, could you please briefly describe it? (Use back)

V ASSESSMENT:

1. Is a visit to the **client's home** an integral part of the assessment process?
Yes ☐ No ☐

2. Check the areas assessed by your program in an **initial assessment:**

____ medical status/history	____ medications
____ psychiatric history	____ mental status
____ social history	____ current social system
____ functional status	____ risk factors
____ environmental factors	____ other: _____

3. What **diagnostic system** is used in assessment?

- ☐ None
- ☐ DSM-III-R
- ☐ ICD-10
- ☐ Other (please specify) _____

Do you find this system adequate? yes ☐ no ☐

If not, please elaborate on back

4. What **instruments** are used routinely by the team as part of client assessment?

(Check the appropriate box)	NEVER USED	ONLY IF REQUIRED	ALWAYS USED
Folstein Mini Mental State	☐	☐	☐
Geriatric Depression Scale	☐	☐	☐
Hamilton Depression Scale	☐	☐	☐
Beck Depression Inventory	☐	☐	☐
NOSIE Scale	☐	☐	☐
Careburden Index	☐	☐	☐
DOARS	☐	☐	☐
Others (specify) _____	☐	☐	☐

5. Rank order, from 1 to 11, the categories of **recommendations** most frequently made to referral sources, by your Program: **(You may rank more than one category the same.)**

N\A= not used **1= used most frequently** **11= least frequently used**

___ Investigations of physical symptoms (e.g. lab tests)
___ Pharmacological
___ E.C.T.
___ Behavioural management
___ Counselling to client/individual psychotherapy
___ Counselling to family/family therapy
___ Environmental changes
___ Referral to other agencies/specialists
___ Education to caregivers/staff
___ Social support system augmentation
___ Inpatient assessment and/or treatment
___ Group therapy
___ Other: Please specify _____

6. In your judgement, what **percent** of your recommendations are **complied with** by others?

by clients _____
by family Doctors _____
by facility staff _____
by community professionals _____
by family caregivers _____

VI PROGRAM OUTCOMES:

1. What measures are used to **evaluate Program impact**? **(Please check all that apply.)**

- ☐ none
- ☐ team rates client outcome (please describe on back)
- ☐ Global Assessment of Functioning is compared at intake and discharge
- ☐ client satisfaction is measured
- ☐ referral source satisfaction is measured
- ☐ other (please elaborate)_____

2. Has your Psychogeriatric Outreach Program been **evaluated**? Yes ☐ No ☐

- ☐ internal evaluation
- ☐ by funders
- ☐ by other (please name) _____

If not are there plans to evaluate? Yes ☐ No ☐
By whom: _____

3. Does your Program have an **information system** which can produce:

a report of client characteristics (referral sources, ages, etc.) Yes ☐ No ☐
statistics on service delivery (types of service, amount, etc.) Yes ☐ No ☐
periodic statistical reports (e.g. monthly, quarterly, etc.) Yes ☐ No ☐

4. Is your information system **computerized?** No ☐ personal computer ☐ mainframe ☐

VII CLIENT CHARACTERISTICS:

1. What is the **longest period** for which you have a complete client profile?
one month ☐ three months ☐ six months ☐ one year ☐ more than one year ☐

2. Do you feel this period of data is **representative** of your program's operation?
Don't Know ☐ Yes ☐ No ☐

3. Using the information for the above period, please answer the following OR give estimates:

	NUMBER	Don't Know
How many clients were **referred**?	_____	☐
How many cases were **opened**?	_____	☐
How many **men** were seen?	_____	☐
How many **women** were seen?	_____	☐
How many clients lived **outside of institutions**?	_____	☐
How many clients lived **in long term care facilities**?	_____	☐
How many clients lived **in other institutions**?	_____	☐
What was the **average age of men** seen?	_____	☐
What was the **average age of the women** seen?	_____	☐
How many clients were **under 65**?	_____	☐
How many clients were **married**?	_____	☐

How many **women** were: 65-69____ 70-74____ 75-79____ 80-84 ____ 85+ ____

How many **men** were: 65-69____ 70-74____ 75-79____ 80-84 ____ 85+ ____

4. Please state the **percentage of** the Program's caseload in which each of the following **diagnoses** were made? Please report only primary diagnosis (i.e.."Axis 1" or the condition you were treating). If you do not have actual data, please estimate from your experience, based on the same time period you used above.

	PERCENT OF CASELOAD	PERCENT IN INSTITUTIONS	PERCENT NOT IN INSTITUTIONS
Organic Mental Disorders	_____	_____	_____
Delirium	_____	_____	_____
Mood Disorders	_____	_____	_____
Psychotic and Delusional Disorders	_____	_____	_____
Marital/Family Dysfunction	_____	_____	_____
Anxiety Disorders	_____	_____	_____
Personality Disorder	_____	_____	_____
Physical Disorder	_____	_____	_____
Alcohol/Drug Dependency	_____	_____	_____
Adjustment Problem	_____	_____	_____
Diagnosis Deferred/No Diagnosis	_____	_____	_____
Other _____	_____	_____	_____

(ONLY USE "OTHER" FOR GROUPS OVER 10% OF TOTAL CASELOAD

5. For each diagnostic group, please go back and give the percent which occurred **in institutions** , versus the percent which were **not in institutions.** (e.g. 20% of your cases may have been diagnosed with mood disorders, and 40% of these may have occurred in institutions and 60% outside of institutions.) If your program goes into both hospitals and nursing homes, please treat both of these as institutions.

VIII CATCHMENT AREA CHARACTERISTICS:

1. Is your catchment area: rural ☐ urban ☐ mixed ☐
2. What is the geographic size of your catchment area? _____(sq. miles/km)
3. What is the total population of your catchment area? _____
4. What is the population of people over 65 in your catchment area? _____
5. What is the number of long term care facility beds in your catchment area? _____
6. What is the number of acute care beds in your catchment area? _____

   Are you mandated to serve them? Yes ☐ No ☐

7. Please give **your judgement** of the **level of service** available to psychogeriatric clients in your community:

	NONE	SOME BUT INSUFFICIENT	SUFFICIENT
facility respite care	☐	☐	☐
in-home respite care	☐	☐	☐
psychogeriatric day-hospital	☐	☐	☐
psychogeriatric day-care	☐	☐	☐
psychogeriatric in-pt. assessment beds	☐	☐	☐
long term care facility beds	☐	☐	☐
psychogeriatric group homes	☐	☐	☐
geriatric assessment beds	☐	☐	☐
general psychiatric beds	☐	☐	☐
E.C.T.	☐	☐	☐
mental hospital beds (long term)	☐	☐	☐
extended care beds	☐	☐	☐

8. Please star (*) the services above that are **formally linked to** your program, to which you have direct access.

9. What **problems** have you encountered in providing Psychogeriatric services to the community, and how have you overcome them? (please use back)

10. If you could attend a working conference with people in the field of psychogeriatrics, what **community practice issues** would you like to see addressed?

THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS QUESTIONNAIRE! I'M SURE THE RESULTS WILL BE INTERESTING, AND I'LL SHARE THEM WITH YOU AS SOON AS THEY BECOME AVAILABLE.

Please enclose any written documents on your program that you can share (e.g. brochures, proposals, client/program statistics, annual/quarterly reports, organizational charts, etc.).

APPENDIX 3

Letter to Key Informants

PENNY MacCOURT
2940 KILLARNEY PLACE
NANAIMO, B.C., V9T 1A6
Phone: (604) 755-1322 Fax:(604) 754-2967

Dear

I am a graduate student in the faculty of Social Work at the University of Manitoba, and a Social Worker on a community Psychogeriatric Outreach team in Nanaimo, B.C.

I am researching community Psychogeriatric Programs in western Canada. With the growing elderly population, the increased prevalence of age related mental health disorders, and concerns about health care costs, there has been a proliferation of community Psychogeriatric services. Very little is documented about existing community Psychogeriatric Programs. My work is intended to fill in some of this gap in the knowledge base and to lay the groundwork for future research. There is a need to identify what community Psychogeriatric Programs do; the diagnostic and demographic characteristics of clients utilizing community Psychogeriatric Outreach Programs; which services and staff are considered essential to these programs; and how programs compare to each other.

I will develop a typology of Psychogeriatric Outreach Programs in western Canada, by describing systematically all Programs that meet the following inclusion criteria:

- in operation 9 months or more
- identify themselves as offering mental health services exclusively to the elderly, outside their institution\agency
- in Manitoba, Saskatchewan, Alberta, or British Columbia

I will survey each program in order to gather information about the clients, catchment area, and program structure and activity. The results of the survey will enable me to describe the current program models being used in the delivery of community Psychogeriatric services; to compare and contrast programs; and to develop hypotheses for future research about significant differences in programs and client groups.

I want my research to generate results that are relevant to current issues in the field and have the potential for practical application. In order to ensure this, I am interviewing several key informants in each of the western provinces, who have a broad overview of the field of community Psychogeriatric in their province.

I would like you to be a key informant. I hope you will be willing to give me 20 minutes of your time to answer the attached questions. I will call you in the near future to arrange a telephone appointment for this purpose. I will, naturally, send you a report summarizing the significant results of the survey.

I look forward to talking with you, and thank you for your assistance in this matter.

APPENDIX 4

MANDATES\OBJECTIVES OF PROGRAMS SURVEYED

The following is a list of the program mandates\objectives provided by respondents. N=28

British Columbia

Program 1

Mandate

- Using an interdisciplinary team, provides biopsychosocial assessments, recomendations and in some cses short- term treatment to elderly people living in the community. The team also provides consultation and education to primary caregivers, physicians continuing care facility staff, and others.
- don't provide service to those requiring long-term treatment or monitoring of medication; where alcohol or substance abuse are the primary problem; those receiving treatment in an acute care hosp.; those who are acutely suicidal or homicidal; those experiencing an acute exacerbation of a previously diagnosed chronic mental illness.

Program 2

Mandate

A specialized geriatric service providing assessment, treatment, follow-up, consultation and education to multi-problem elderly and their caregivers.

Objectives

- to provide locally available and accessible treatment, assessment, and follow-up services
- to provide support to primary caregivers of elderly with mental health problems including Continuing Care staff and facilities, family members and other service providers.
- to provide education to service providers and primary caregivers
- to provide a triaging function by exploring and facilitating access to alternative options
- to reduce hospitalizations and re-hospitalizations into acute hospitals and Riverview by providing; (1) effective early intervention and assessment services (2) effective follow-up services following discharge

Program 3

Mandate

Consultation and assessment of persons 70; over 60 with AD
(Do not carry caseloads)

Program 4

Mandate

- To provide locally available and accessible mental health treatment, assessment and follow-up services, through use of a mutidisciplinary team, to elderly persons with dementing conditions, or who have psychiatric problems and\or a decline or change in behavioral functional abilities, or who are chronically mentally ill and have developed complicating disorders arising fr. age related decline in physical and mental health.; those under 65 with a pre-senile dementing disorder with associated psychiatric and \or behavior management prob.;those with recent onset situation related depressions and\or delusional disorders.

Services

- assessment, treatment and follow-up of elderly living in the community or other residential facilities
- triaging and care planning
- Riverview discharge planning and follow-up
- liaison with acute care hosp. and follow-up of mentally ill persons discharged from acute care hospital
- on-going communication and liasion with primary care physicians consultation to continuing care case managers and service providers , primary care physicians and other primary caretakers and service providers
- education to continuing care resources, other relevant service providers and family care takers
- participation in community planning and develpoment initiatives as they relate to services to the elderly

Program 5

Mandate

- Provide assessment, support, consultation and counselling services to elderly persons in facilities (including acute care) and at home.

Program 6

Mandate

- Specialized service for persons 65+, or persons with dementing conditions with psychiatric problems and or a decline or change in behavioral and or functional ability , who live in their own homes, in supportive housing, in continuing care facilities, or persons requiring admission to, or discharge from Riverveiw.

Objectives

To provide treatment, assessment and follow-up services.
Support to primary caregivers.
Education to service providers and primary caregivers
Consultation to service providers and primary caregivers
Triaging, exploring options.
To reduce hospitalizations to acute hospitals and Riverview

Program 7

Mandate

- Specialized psychogeriatric assessment and treatment to individuals 65+ with functional and\or organic illness.

Objectives

assessment,treatment and follow-up
consultation
caregiver support
education (formal and informal)

Program 8

Mandate

- To provide multidisciplinary service to clients over 65 yrs. with major age-related psychiatric disorders or situational clinical depressions.

Objectives

To reduce admissions to Valleyveiw and acute care hosp. of elderly psychiatric clients, and maintain independence in the community as long as possible.

To support Continuing Care case managers and LTC facility staff via consultation and education.

Program 9

Mandate

- To provide a specialized community mental health program to the elderly pop. living in the South Okagnogan, and experiencing psychiatric symtoms such as depression, confusion, behavioral or management problems.

Objectives

Specialized assessment service, consultation and followup
prevent avoidable admissions to hosp.
increase capacity of continuuing care services to manage the elderly
to provide caregiver education and support.

Program 10

Mandate

- To provide assistance to seniors with mental, emotional or behavioral difficulties, to support and optimize their level of functioning and to promote their level of functioning and to promote their quality of life in a cost efective manner.

Objectives

- provide professional, mutidisciplinary outreach services to seniors 65+, living in catchment area, who are experiencing mental health problems.
- improve the quality of life of seniors and to enable them to be as autonomous as possible, within a safe environment, through direct service, consultation, advocacy, community development and education
- provide liaison and support to those involved with the care of seniors
- forestall unnecessary hospitalization or facility admission, and to facilitate such admission when required
- provide consultation and education to existing agencies serving the elderly

Program 11

Objectives

- to provide enhanced service to the elderly in order to see an increased no. of patients for psychiatric assessment and treatment, including longterm follow-up as required.
- to provide shared educational and research opportunities for hospital and GVMHS staff with respect to Geriatric Psychiatry
- to develop cooperation between hospital and the GVMHS to prevent duplication of services and to assist in the coordination of mental health services to patients as required.
- to provide education for community agencies and professionals.

Program 12

Mandate

- Still being discussed - but draft mission statement states geriatric psychiatric services are integral part of services offerred by GVMHSS; that they are committed to providing a specialized service to clients 65+ who have a serious psychiatric disorder and\or an organic mental disorder.
- Draft mandate says they are a specialized service primarily for clients 65+ who have serious mental disorders where treatment is complicated by co-existing complex medical health problems. These individuals are perceived to be at risk due to a combination of psychiatric, complex medical and social factors or significant caregiver stress. They live in their own residences , in supportive housing or in LTC facilities. They may require admission to and discharge fr. STST units, acute care hospital and Riverview and\or other crisis intervention units as part of the continuum of treatment.

- Will see clients who first develop a serious mental illness in old age; 65+ with no prior psychiatric history who have a dementia with associated psychitric\behavior management problems, or significant caregiver stress; 65+ with longstanding serious mental illness and complex medical problems; clients under 65 with pre-senile dementing disorder with associated psychiatric and\or behavior management problems.

- Exclusions; longterm chronically mentally-ill elderly without complicating disorders; and clients with neurological disordered associated with trauma

Objectives

- BiopsychosocialAssessment by multidisciplinary.
- Treatment by team or by others as recommended by team
- Follow-up by team or consultation to physician and care staff
- Consultation; client or program centered
- Education; to primary caregivers, family and formal
- Research; program evaluation

Program 13

Mandate

- to provide a specilized mental health service,(assessment, treatment and follow-up) to 65+, residing in the community including longterm and extended care beds; experiencing psychiatric symptoms, and\or present with "dysfunctional" behavior due to a psychiatric disorder.

Objectives

- assessment treatment and follow-up
- consultation\liasion with professionals and all community agencies providing services to the elderly
- to provide education to caregivers and public and health professionals on mental health issues and the elderly
- community development around mental health issues and the elderly

Program 14

Mandate

- To provide a community based mental health treatment service to the elderly residents of the West End of Vancouver incorporating both home based, outpatient clinic and inpatient elements.
- Provide formalized service to LTC facilities - case conferencing, case finding, consultation, education and staff support

ALBERTA

Program 15
Mandate

- To provide an multidisciplinary outreach consulting service to psychogeriatric patients and residents in LTC instituions in the Northeast region of Alberta.

Objectives

- To provide on-site psychogeriatric assessment and consultation of and for residents with psychogeriatric problems (i.e. dementia, depression, behavioral problems), using a consultation model.)
- to act as an educational resource to staff in LTC facilities and the community at large

Program 16
Mandate

- Assessment and consultation, (education to staff), and all residents of LTC who are experiencing mental health\behavior problems.

Objectives

- maintain where possible in "home" facility

Program 17
Mandate

- Joint program involving the Alta. Mental Health Division, and the Medicine Hat Regional Hospital; committed to providing specialized care to the psychogeriatric population of Medicine Hat and the surrounding catchment area. The community assessment team is responsible for the initial psychiatric and functional assessment of patients in their residence. Each member of the team will be trained to provide a standard form of assessment. Where it is deemed possible for patients to remain in their home, treatment and followup assessments will be provided by members of the community psychogeriatric team.

Objectives

- Provide a specialized multidisciplinary approach to the care of the mentally dysfunctional elderly patients
- Provide an individualized assessment and treatment plan\program that ensures the optimal level of independence and self-management for each patient
- Ensure appropriate follow-up treatment, discharge or placement of each client following assessment.
- Involve and support family members and\or significant others at all levels of intervention
- Provide educational resources for caregivers, the community and health care

professionals within available resources.
- Promote cooperative working relationships with all community resources.
- Promote the services and the importance of early referral to professionals, caregivers and community agencies.

Program 18

Mandate
- To provide psychogeriatric services to LTC facilities in the city of Calgary.

Objectives
- Case consultation
- Education
- Program Development

Program 19

Mandate
- Dedicated to promoting the emotional, physical, and social well-being of older individuals, and to enhancing their quality of life.

Objectives
- To provide assessment and treatment for 65+ who are experiencing mental , emotional or behavioral problems
- To refer concerned seniors, their families or other caregivers to existing community resources, as needed.
- To promote a positive and knowledgeable attitude among the senior population towards mental health services, through educational services.
- To serve in an active consultant role for other community services involved in the care of elderly clients.

MANITOBA

Program 20

Mandate
- To provide educatioal, consultative services to 11 LTCs re. geriatric clients with behavioral problems

Objectives
- to assist LTCs to better manage difficult clients

Program 21

Mandate

- Designed to treat mental disorders in clts 65+. The primary emphasis is to treat clients with mental disorders whose epidemiology, origin, prevention, development and treatment of such disorders are those associated with aging, therefore it is anticipated physical problems related to aging may also be evident.
- Services delivered using an interdisciplinary team, to provide a biopsychosocial-environmental assessment to determine treatment needs.
- Treatment is aimed at encouraging a level of independence and a quality of life consistant with available resources and the capacities of the client and his family.
- Education of clients, caregivers and community to promote skill development, adaptive behaviors and integration into society.
- There is a continuing emphasis on staff development and research to enhance the quality of psychogeriatric care.

Program 22

Mandate

- To provide consultative service to 10 LTCs. Consultation includes direct clinical intervention to both staff and residents , and the provision of educational inservices to the facilities.

Objectives

- To help staff better deal with and to better understand both their residents and the field of psychogeriatrics.

Program 23

Mandate

- To assist the elderly and their families who are experiencing stress or age related difficulties to remain in the community of their choice, through use of an interdisciplinary team

Objectives

- assessment
- short term treatment
- education re. issues related to aging, for professionals and general public

Program 24

Mandate

- To provide outpatient consultation to caregivers and health care facilities who deal with elderly clients with disruptive behaviors.

Program 25

Mandate

- We service a target population of clients who experience the first onset of mental illness at 65+, or are under 65 but have a cognitive impairment related to a disease associated with aging, or 65+ who have experienced mental illness throughout their lifetime and, due to the interaction of the course of their disease together with maturation, require the specialized services of a multidisciplinary Psychogeriatric team.

Objectives

- To provide a continuum of psychogeriatric services for psychogeriatric clients in the catchment area.
- To provide a pre-admission screening service for the psychogeriatric inpatient unit
- To utilize a multidisciplinary approach to service delivery
- To coordinate resources to expediate discharge plans from the psychogeriatric unit
- To acheive adequate human and physical resources to meet the needs of the program
- To demonstrate the efficacy of the program in meeting its' objectives
- To promote\provide educational opportunities for staff professional development
- To encourage study into the aspects of psychogeriatric care

Program 26

Mandate

- To meet the educational needs of the University
- To provide clinical services to elderly with psychogeriatric problems
- To provide a comprehensive psychogeriatric service

Program 27

Mandate

- To provide assessment and short term treatment to individuals 60+ who are experiencing mental disorders or stress thst is interfering with day-to-day functioning or recent behavioral changes
- To provide education and consultation to caregivers.
- To participate in research.

Objectives

- To provide assessment and consultative services to clts, families and caregivers in the community and to LTCs.
- To increase current knowledge about psychogeriatric problems

- To develop knowledge about effective early detection, intervention strategies and policy direction

Program 28

Mandate

- To be a resource to primary caregivers of the elderly , including GPs, LTC staff, families and service agencies.
- To provide primary care, treatment and case coordination as needed to make up for scarce resources in this rural area

APPENDIX 5

EDUCATION PROVIDED BY PROGRAMS SURVEYED

The following is a list of education being provided by the programs surveyed. While all programs reported they provide some education, only 25 provided detailed information.

British Columbia

Program 1

Provide a 10 session course on issues of geriatric psychiatry,primarily intended for home support workers and facility care aides. Certificate provided.
Ethical dilemmas and aging
Losing memory, losing self
Medications and their side effects in the elderly
Happiness-don't worry, be happy.
Depression
Elder abuse and neglect
Management of challenging behaviors
Care for the caregivers
Psychosis
Use and abuse of humour in working with the elderly

Program 2

Behavior management of the dementing individual, and dementia vs depression.

Program 3

Communication , stress, and drugs, directed at caregivers

Program 4

LTC facility staff, community home support workers were provided with education re Alzheimer's.
Senior's housing managers were provided with education about working with the elderly.

Program 5

Dementia
Aging process
Sandwich generation
Elder Abuse

Program 6

Dementia - (Alzheimer's and Multi Infarct)
Depression
Mental health hygeine
Delusions
Delerium
Normal aging

RN's have been targeted.

Program 7

Aggression
Depression
Dementia
Sexuality
Suicide assessment

Directed at nursing home staff, home care staff, college students and physicians
They write pamphlets for lay people on various illnesses; eg depression

Program 8

- Directed to community agencies and facility staff undergraduates in all disciplines, and residents.
- Developed Video program, "Assessing Difficult Behavior in the Elderly"'
- Reminiscence group for moderately demented women.
- Understanding Chinese cultural values

Alzheimer dementia - how it affects caregivers and families caregiving
What competency in th elderly "looks" like
Alcohol and drugs - caregiver stress
The socialization of women as caregivers
Behavior management - a social approach
Who are the elderly
Effect of chronic illness on family
Coping with Depression
Grief and elderly as reflected through literature and poetry
Caregiving issues

Political implications of caregiving
Abuse of the elderly
Role of the social worker in the psychogeriatric outreach team
Psychodynamically oriented group work and the elderly
Group cognitive approach to the treatmrnt of the elderly
Critical incident debriefing
Normal aging
Intro to dementia
Families caring for elderly with mental illness
Competency - issues
Affective disorders
Psychotherapy
Dealing with difficult behavior
Behavioral symptoms in the elderly
Bipolar Disorder
Assessing behavioral symptoms
Dementia and drug therapy
Depression and anxiety
Frontal lobe syndromes
Neuropsychology of aging
Neuropsychological testing in the elderly
Understanding DSM III-R Axis IV and V
Epilepsy and the elderly
Sleep disorders and drug use in the elderly
Geriatric mental health issues
Drugs and alcohol

Program 9

How to do the Mini Mental State Exam - General Hospital
Sundowning syndrome
MS and Personality Disorder - Case reveiw - General Hospital
Delerium, depression ,dementia, delusions -- LTC
Minimum standards for a Geriatric Psychiatry assessment - Mental Health
Psychiatric aspects of dementia - Mental Health
Putting a loved one in LTC- Greiving process - family support group

Program 10

Approaches to problem behaviors in the elderly
Assessment of confusion in the elderly and nursing interventions
Dementia
Depression
Elder abuse
Normal changes in aging

Physical changes in aging
Prevention and management of aggressive behavior in the elderly
Psychosocial changes of aging
Psychotropic side effects
Quality of life for the elderly
Stress management for caregivers
Supporting family caregivers of the elderly
Therapeutic communication

Program 11

Management of disruptive behavior-for LTC facilities
Management of aggressive behavior-directed at LTC facilities
Depression
Uniqueness - our clients and ourselves
Care of the behaviorally disturbed elderly- directed at community groups

Alberta
Program 12

Aggression
Behavior management r\t brain injury
A.D. - overview
Reality reinforcement

Program 13

Prevention of aggression; all levels of LTC staff
Management of behaviors

Program 14

Dementia
Depression
Medication
Suicide Prevention in the Elderly
Violence in the workplace
Psychiatric Medication
Drug and alcohol abuse
Restraints
Program Activities for dementia
Grief

* The above is offerred as a series similtaneously to a number of facilities(PCH, Extended care facility, in-patient psychiatry)

Program 15

Numerous training sessions; Deal with dementia and delerium.

Program 16

Aging well from a mental health perspective
Taking action on lonliness
I'm not stressed, I'm just---

Above are directed at seniors

Normal aging and mental fitness
Mental health refrral and assessment
Ethnicity and mental health
Emotional responses to chronic illness
Coping with stress
Implications of medications.
Alcohol and drug abuse
Family support
Elder abuse
Lonliness
Sexuality and aging
Depression
Acute confusional state
Dementias of a chronic nature
Paranoid illnesses
Managing aggressive behavior
Behavioral management of disruptive behaviors

Manitoba

Program 17

Aggression management
Stress
Sexuality
Behavior management
AD
Calling out
Conflict
Communication breakdown
Korsakoff's
Bipolar disorder
Obsessive compulsive disorders

All directed at LTC staff

Program 18

- Main area of family education relates to management of the client with a dementing illness.
- To professionals topics include health promotion in the elderly, program information, depression, assessment of dementia vs pseudodementia.

Program 19

All directed at LTC - does not say what topics are, but they say they do lots.

Program 20

Depression and Dementia - continuing care staff
Cognitive impairment - LTCs
Aggressive behavior - LTCs
Psychogeriatric disorders - Mental health professionals
Elder abuse - seniors, Women's shelter
Wellness promotion
AD family support group

Program 21

Staff at referring facilities are included in educational case conferencing. Topics include:

Noisy behavior
Wandering
Aggression

Program 22

professional caregivers and facility staff have been provided with workshops on:
Managing aggressive behavior
Managing behavior problems

Program 23

- Provide to Nurses, residents, Geriatricians, Medical students, Physios and other health care professionals
Delirium
Depression
Mental status
Dementia
Psychosis
Emergency Psychogeriatric treatment
Medications
Behavior Therapy
Psychotherapy

Program 24
To the Community

Elder abuse
Building relationships with the elderly
Communication skills
Dementia\depression\delerium
Interacting with the cognitively impaired

Difficult behavior problems
Mental status exam
Team building
Needs of LTC facilities
Current issues in Psychogeriatrics

To LTC Facilities
Aggression
Depression
Wandering
Stress on the job\care for the caregiver
Management of disruptive\difficult behaviors
Dementia
Grief and grief counselling
Physical and psychological changes associated with aging
Normal Aging
Approaches with characterologically difficult residents
Falls in the elderly
Reality Orientation and validation approaches to patient management
Psychogeriatric assessment
Special care units
Substance abuse\chemical dependency
Use of Folstein Mini-Mental State Exam.

Program 25
Caring for the caregiver
Losses, Grief
Transition and change
Coping with chronic illness
Family dynamics
Values, Ethics, and LTC
Basic Psychogeriatrics
AD
Delerium
Treatment approaches in AD
Arthritis
Pain management
Elder abuse
Skin care
Sucessful aging
Developing a rural therapy team
Sexuality and aging
Developing nursing care plans
Behavioral problems

APPENDIX 6

RESEARCH

The following is a list of research that programs have undertaken by 9 of the programs that were surveyed.

British Columbia

Program 1

Will start in June- will participate in RNABC challenge proprosal to decrease aggressive behavior through caregiver education on dementing process and approach.

Program 2

Quality assurance measures - utilization, outcomes (subjective)

Program 3

Correlation between the Folstein, the Geriatric Depression Scale, and the Zung Depression Scale.

Program 4

Development of a measurement of client progress while in treatment, and outcome. Likart scale is used to measure changes in formal support; informal support; caregiver burden; use of medications; and physical, cognitive, social and psychological functioning.

Alberta

Program 5

Study of outcome of elderly clients who had been in a support group using Life Satisfaction Scales..

Outcome study of clients with Paraphrenia looking at any type of treatment or length of treatment that had a particular influence.

Incidence\impact of post traumatic stress on older clients

LTC facilities resposes to suggested behavioral interventions by our team, to see why they didn't always act on our suggestions

***We are implementing a nursing research training program with our program and the adult service this year as part of a nursing job enhancement project and hope to increase our skills in doing research. We are interested in research but have lacked skills and time and have had no computers. We expect things to have improved in the next two years.

Program 6

Stress in formal caregivers

Manitoba

Program 7

Drug company sponsered trials (post-stroke depression., dementia)

Program 8

Male caregivers of spouses with dementia

Program 9

Health care delivery research

2 drug trials

APPENDIX 7

SERVICE CHANGES

The following is a list of responses to the question of how service have changed or will be changed, provided by 17 programs.

British Columbia

Program 1

withdrew from evening and weekend emergency backup to the hospital as, 1) not much call for it, 2) patients referred were often not medically stable and needed hospitalization, 3)funding

Program 2

Will have 5.5 FTE and .7 sessional psychiatry and 1.7 administrative in near future. We will then be more able to fulfill our manfdate and provide treatment and education.

Program 3

Still evolving - started as 1 year pilot. Emphasis is on helping caregivers work better with clients - therefore work with them as much or more than clients themselves. With more staff we plan to offer more follow up and more education to the community and other professionals.

Program 4

Services and mandate expand as the team gets better known.

Program 5

Constantly in a state of flux - staff changes, regional changes. Basic philosophy remains the same, but greater emphasis
on clinical assessment and greater influence of the medical model now.

Program 6

increase in educational focus planned
increase in caregiver support, counselling planned

Program 7

Funding will now be under Mental Health Services, rather than continue as a contracted position.

Program 8

Mandate still being clarified

Program 9

We have had a geriatric psychiatrist and nurse come on board and a social worker will be coming
Planning hospital liasion.

Program 10

Will be moving under Mental Health

Alberta

Program 11

When we started criteria for referral was limited to 65+ residing in LTC; we have now removed age restrictions and we also see those who are in acute care awaiting placement in LTC. We also do community insevices with differant community agencies.

Program 12

We have incorporated an education component into our program , at present offering 3 inservices per month, (at 2 LTC facilities and 1 auxillary hospital), on the same topics. Started this Feb. 92. We also hope to start a caregivers support group, in the future.

Program 13

Until 1980 we did psychogeriatric assessments in City Hospitals as well as LTC and community in our role as pre-screening for Altberta Hospital Edmonton admissions. We got out of that job by 1980, and continued the pre-screening role until 1991 when AHE Geriatric Psychiatry Service changed its focus with the arrival of Dr. Bonnyman. We consulted in LTC facilities for treatment and AHE admissions until 1991, and provided management rounds in those facilities. We have gradually increased our educational\inservice focus in the community with a slight change, in that since 1989 we are doing more health promomotion and teaching with seniors themselves rather than just the agencies that deal with them. We have more rounded psychotherapy skills and broader range of treatment skills since 1988, with formal family\marital therapist hired; 1990 psychodynamic group psychotherapy ; more staff proficient in cognitive therapy, and psychodynamic psychotherapy. We will be adding a Home Care Consultant by September who will do more immediate psychiatric triage type work with Home Care to decrease wait time for one of our staff to assess, based on geographic area.

Manitoba

Program 14

Originally program was designed as an assessment team with a focus on comprehensive assessment andconsultation. We have now evolved into an assessment and treatment team, provide short-term treatment services to clients and their families.

Program 15

Plans to change services are under review as the government's Reforms for Mental Health are being discussed and instituted.

Program 16

Initially the program was comprehensive, then was decreased to a consultation service only. Now with increased resources there has been a return to comprehensiveness;(ie inpatient\outpatient\follow-up\consultation only)

Program 17

Initially focus of requests seemed to be individual consultation with some provision of education. Requests for inservices\staff development gradually increased , and in the past year there has been a move towards increased requests for consultation re program development.

APPENDIX 8

PROBLEMS IN DELIVERING SERVICES

The following is a list of problems that 20 programs identified in the delivary of their services. Some programs reported on how they are attempting to resolve these problems.

British Columbia
Program 1
Problems

expectation that program will "cure" clients of incurable processes ie dementia
recommendations for treatment not being followed
pressures from within the Ministry to break the program into smaller catchment area\ units
expectation that program act as a "quick fix" into hospital
lack of special care units for clients with dementias

Program 2
Problems

lack of specialized geriatric psychiatry beds
lack of special, separate psychogeriatric beds in ECU
lack of a geriatric psychiatrist
Less than optimal relations with LTC case managers;

* improved dramatically as a result of the calling of a special meeting to discuss the problem, monthly meetings between us and LTC, and a regular telephone contact re clients

Insufficient respite beds; being addressed by community groups, with involvement of ourselves and LTC

Program 3
Problems

funding

Program 4
Problems

not enough psychogeriatric beds - clients must be admitted to general psychiatry beds

Program 5
Problems

too many clients for present level of funding
Ministries and agencies fighting over territory

Program 6
Problems

Regional directives fluctuating
Hospital\community service development
Team building

Program 7
Problems

community physician resistance - good provision of service seems to be helping with this.

Program 8
Problems

Initial relutance\fear of GP's that they would be excluded * dealt with this by initially spending a lot of time talking about the program and involving the GP's from the beginning.

Large catchment area to cover * still a problem but have assigned certain communities to certain staff to avoid doubling-up.

Program 9
Problems

Development of information system

Program 10
Problems

Lack of money * lobbying for more coordination

Program 11
Problems

Travel time
Lack of medical histories in LTC charts
"Casual" staff, high staff turnover in LTC facilities
Probs with GP's - who does what, or locums who change medications without letting us know
Lack of knowledge in psychogeriatrics in all disciplines
Facilities too crowded with high noise levels
Differant charting procedures used in differant LTC facilities
Polypharmacy
Difficulty locating family members , supports
Access to past psychiatric, medical records, lab results

LTC facility demands - focus on custodial care, due to short staffing, and the lack of training that aides have in approaches to demented clients put them at risk for injury by violent patients

Program 12
Problems

Lack of trained ,experienced staff
Too few trained staff in the community facilities re. behavior management

Program 13
Problems

Gaining cooperation and respect of community physicians
Recruitment of social worker

Alberta

Program 14
Problems

Lack of awareness of our services by many key people, especially physicians so clients don't get referred soon enough. * We are trying to increase awareness by sending out program brochures and by maintaining our profile through representation on integrating groups, increased publications in seniors papers etc.

The Mental Health Act is making it more difficult to get psychiatric treatment for vulnerable elderly as it has gotten much stricter in terms of establishing beyond a doubt that the person constitutes a danger to himself or others. Patients have to get really sick , and families\agencies perceive us at times as ineffectual if we can't intervene with someone who is at times obviously sick but refusing help.

Manitoba

Program 15
Problems

Lack of available community resources to meet identified community based client needs. * We have made the appropriate resources aware of our concerns, but have not overcome the problem.

Program 16
Problems

Problems exist with Psychogeriatric service delivery system-fragmentation of services;
lack of services
lack of access to adult daycare

LTC is funnelled through Continuing Care Services
Lack of "continuity of care"

* We have attempted to address these issues through advocacy on behalf of clients for needed services through playing a co-ordinator role to ensure services are put into place and filling in the gaps where needed.

Program 17
Problems

- making other community programs aware of service
- clients are not getting as extensive a service as needed as while referrals have risen staffing levels have not
- Continuing care is not linked to Mental Health - they are the only ones who can assess for placement and panel, and placement for MH clts get backlogged in the system
- Currently we are restricted to the city of Brandon, although there are needs in rural areas. The adult mental health teams lack the specialized expertise and manpower to provide our service, so clients are admitted to the inpatient unit which removes them from their support system. As the provincial mental health facility will be closed in 5 years, these communities will need to develop services
- There is a major stigma attatched to the term "mental health services" in this area, and public education does not seem to have an impact.

Program 18
Problems

Lack of funding

Program 19
Problems

Primary care physicians often lack sufficient knowledge re psychogeriatric issues, diagnoses, medications etc, *we plan to offer information packages and education sessions to GPs.

Follow-up is a problem due to increasing demands on our program * don't know what to do.

Insufficient affordable options in the community for long-term psychotherapy\family therapy, even if we identify the need * we provide some of this and are planning to propose a Psychogeriatric Day Hospital.

Program 20
Problems

The concurrence of psychiatric and physical illnesses.* Our model has addressed this by working in acute care, having admitting privlages in ECU, an acute psychiatric hospital, and a special care unit for the behaviorally disturbed. We sit on the admission commmittees for the aforementioned and a PCH. This has enabled us to transfer patients quickly from one facility to a more appropriate one at short notice and we think provides a more comprehensive srevice. However it stretches our staff.

Resource deficiencies in our region, our program and in other programs. * We have become involved in the development of appropriate community resources (ie. a proposal for a day hospital program; AD support groups, senior's centres, transportation services)
Lack of staff to do all the things we think are important

APPENDIX 9

LIMITATIONS OF DSM III-R

The following is a list of reasons given 7 by programs as to why they are not satisfied with DSM III-R as a diagnostic system for their clients.

"doesn't address the medical or social problems of the elderly adequately"

"not suited to the elderly, particularly Axis IV and Axis V".

"difficulty in fitting the elderly into some of the diagnostic categories"

"inadequate for diagnosing the elderly--lacks terms like cognitive affective disorder"

"inadequate - depression and dementia diagnoses need expansion for the elderly"

"inadequate - greater precision needed in organic psychosis category"

"DSM III-R alone doesn't allow for comprehensive assessment and identification of problems"

Appendix 10

OTHER TESTING INSTRUMENTS

The following is a list of tests that respondents use as necessary, that were not on the list provided to them in the questionnaire.

The number in parentheses signifys the frequency with which a test was named.

Camdex (Camcor) (2)
Mattis Demential Rating Scale
F.A.S.T.
Blessed
MOSES
Neuropsychological tests
Zung Depression Scale
Kingston Dementia Rating Scale
C.A.P.E.
O.S.O.T.
Nursing Home Behaviour Rating Scale
Clifton Behavioral Rating Scale
Set Test (4)
Saskatoon
Savage Britton
Weschler Memory test
WAIS
Lubber Social Network Scale
Katz
Clock drawing

APPENDIX 11

PRACTICE ISSUES

Respondents were asked to list the community practice issues they would like to see addressed in a working conference with other people in the field of psychogeriatrics.

British Columbia

Program 1
- Linkages

Program 2
- Coordination of services

Program 3
- Team development
- Team functins, roles.

Program 4
- Ethical areas
- Assessment tools
- Education resources available

Program 5
- Ethical Issues.

Program 6
- Community Practice Issues
- Revise DSM-III-R re elderly
- Strategies for sustaining the elderly at home with adequate support
- The ethics of supporting the mentally incompetent who pose a risk to others (eg where is the cut-off?)

Program 7
- Closer working with GP's - case conferencing with GPs in LTC facilities
- Systematic way of following up patients

Program 8
- developing good working relationships with GP's

Program 9
- Mental health in facilities
- Education\training staff (facility and community)

Manitoba

Program 10

Ethical issues re long term care planning for patients with dementia.

Program 11

Family - centered treatment of dysfunctional families and abuse situations
Assessment and treatment of depression in the elderly clt.
Training of LTC staff to cope with behavior problems

Program 12

Transition from hospital to community based nursing
environmental influences
activity programs
family support system

Program 13

Linkage of inpatient and outpatient services