SOCIAL WORK WITH OLDER ADULTS

by

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Abstract

This practicum report represents an account of my experience with the Elderly Services Program under Mental Health and Addiction Services, Northern Health Authority, Prince George British Columbia. Though this experience I was able to achieve my learning goals in areas of clinical assessment, case management, adult protection investigations, interprofessional practice and working with older adults who experience various mental health issues. Included are the observations of the organizational shift in services to older adult clients. Research literature in the various topic areas compliments this practical learning experience. This report also highlights components of ethical geriatric social work practice with the application of life course and ecological perspectives as guiding theoretical models influencing practice.
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Dedication

This report is dedicated to the memory of my mother, Jane Sofonoff.
Chapter One: Introduction

This report represents the integration of knowledge and experience gained through my practicum placement with Elderly Services and master level studies at the University of Northern British Columbia. In order to achieve my desired learning goals, the team at Elderly Services went out of their way to include me in cases where they thought a practicum student would benefit. I had the advantage of working with my supervisor and other team members for seven months, four years prior to this placement, and as a result I was able to "jump right in" and take my learning to the next level. This was a tremendous benefit and I was able to easily set goals, knowing exactly what areas I wanted to expand with a more in depth practical experience for further clinical knowledge acquisition.

Integral to my learning experience with the team at Elderly Services in Prince George were the many opportunities to understand the perspective of an older adult living in the community experiencing a mental health illness or substance misuse issue. By spending quality time, encouraging open dialogue with a genuine curiosity, I was able to connect and listen to rich accounts of several life course histories, vital to the assessment of a vulnerable older adult needing mental health services. Pearce, Forsyth, Boyd and Jackson (2011) describe a "values history" as what is important to the individual now, what matters to the individual and why the individual has made the choices he has. This privilege enriched my professional practice by reinforcing the need to constantly advocate the unique interests and perspective of older adults, crucial to ethical geriatric social work practice.

In this chapter I describe the practicum setting, highlight the history of community geriatric services in Prince George and the current structure of the Elderly Services team. Subsequently there is a list of my learning goals and objectives.
Elderly Services Program of Northern Health

Practicum Setting

Northern Health covers two-thirds of British Columbia and is home to approximately 300,000 Northern, rural living people (Northern Health, 2016). The Northern Health region is sparsely populated, covering a large geographic area with a population aging faster than other areas of the province (Northern Health, 2016). The vision of Northern Health is to promote health and provide access to integrated health services built on a foundation of primary care (Northern Health, 2015). Programs and services for older adults are developed and guided by the Elder Care program of Northern Health (2016) with support from a guidance council of interdisciplinary experts with links to researchers including committee member, Dawn Hemingway from the University of Northern British Columbia (D. Hemingway, personal communication, June 5, 2014). The aim of the Elder Care Program in Prince George is to enhance the quality of service by strengthening at-home service preventing admission to hospital or early discharge from hospital, respite for unpaid caregivers, assisted living services to clients who are still independent but require a higher level of care, residential care services and advanced care planning (Northern Health, 2016). Elderly Services is a Mental Health and Addiction Specialized Service of Northern Health. A team approach provides assessment services to adults 65 and over in the Prince George area and telephone consultative services to other rural and remote areas within Northern Health. The Elderly Services program also provides mandated Adult Protection Services for vulnerable adults. The program area boundaries are based on case specific needs and availability of other community support services.
History of Elderly Services in Prince George

I heard anecdotal stories about the Elderly Services team starting in 1993 with a physician and social worker. Karla Staff (1997), in her thesis report, documented the resources at the Mental Health Psychogeriatric Assessment Clinic in Prince George. At that time, there was one social worker and one contracted physician working in the clinic for seven hours per week. Staff (1997) commented "treatments and follow-ups of any nature are limited to the quantity of salaried sessional time" (p. 72). She recorded that a geriatric psychiatrist from Riverview Hospital made visits to Prince George four times a year and a team of geriatric clinical nurses from St. Vincent's Hospital provided outreach services in the form of a two day program at a facility in Burn's Lake, a lecture at UNBC and programs in Prince George.

Current Services

Under the umbrella of Mental Health and Addiction Community Services of Northern Health (2016), Elderly Services "provides services to people over 65 (or age related) with a new onset of mental health problems or whose mental health problems are complicated by aging" (para. 1). People eligible for service are adults experiencing symptoms of dementia, substance abuse/misuse, sudden change in mental status or physical deterioration of an unexplained source, and multiple health or mental health problems that require critical investigation. Typically, the older adult has behaviours or needs that exceed the capabilities of primary caregivers or care facility (Northern Health, 2016).

The purpose of my placement with Elderly Services, Mental Health and Addiction Community Services was to learn the role of a clinician on that team. Clinical case managers who work for Elderly Services provide case management, substance abuse counselling, adult protection services and assessments for Certifications of Incapability. Clinicians are part of
an interprofessional team. At the time of the practicum the Elderly Services team was comprised of one team lead, one geriatric psychiatrist, three sessional physicians, one nurse, one adult protection consultant (social worker), one community social worker, one life skill worker and various resident doctors on rotation as part of their learning requirements. This program provided consultation services, along with case management and treatment planning, to outlying areas through outreach and in-office support.

**Practicum Learning Goals**

My learning goals encompassed the following seven categories:

1) Gain insight and understanding of the policies and procedures of Northern Health relevant to the Elderly Services Program.
   - review current policies and procedures
   - review report released by Northern Health (2014) entitled *Healthy Aging and Senior Wellness*
   - observe and reflect on the shift within Elderly Services

2) Build an awareness of and working knowledge of programs available through Northern Health specific to clients of Elderly Services.
   - review the range in services offered by Elderly Services and other pertinent programs like Geriatric Assessment and Treatment Unit and chronic disease support programs

3) Gain an understanding of the social work case management role on an interprofessional team.
   - shadow each team member and understand their role and contribution
   - understand how the Elderly Services team practice interprofessional collaboration
   - review organizational charts and protocols
• learn the role of a case manager
• learn how to triage clients
• fulfill the role with a small short term caseload

4) Gain an understanding of the older adult's perspective living in the community with a mental health illness.

• spend time listening and understanding individual stories
• develop an understanding of the bio/psycho/social and spiritual needs of culturally diverse older adult clients
• learn about the community, governmental and home support resources promoting independence
• facilitate connections and make referrals to appropriate services

5) To identify various mental health diagnoses and common health issues in older adults

• identify and use a variety of assessment tools to produce a diagnostic impression
• learn the intake process used by Elderly Services
• understand the assessment process used by other health professionals
• research current "best practice" treatment strategies for older adults living in the community with mental health and addiction concerns
• connect with existing mental health and addiction services to educate them about working with older adults
• understand the impact of life course on health in particular client situations

6) Develop professional clinical geriatric social work practice

• demonstrate ethical social work practice
• identify ethical dilemmas that might be encountered when working with older adults
• understand the pertinent legislation regarding specific client situations
• inform clients about appropriate use of legal and health planning tools

7) Become aware of how my own experiences, values and beliefs affect my practice.
• recognize the triggers that might affect my interaction with older-aged clients
• ensure each client exercises their right to self-determination and are treated with dignity
• continue to develop a self-care regime

In this chapter I highlighted the practicum setting and identified 7 learning goals. I discuss in chapter 2 a life course perspective and an ecological approach to establish a theoretical orientation. This combined approach encompasses a holistic view of an older adult. The purpose of chapter 3 is to critically analyze academic literature pertinent to the practicum setting experience. Learning experiences from the practicum placement are recorded in chapter 4 by referencing general experiences and the practical knowledge gained without compromising confidentiality. Finally, chapter 5 illustrates how this experience impacts my future geriatric social work practice.
Chapter 2: Theoretical Orientation

In this chapter I discuss my theoretical orientation that incorporates both a life course and ecological perspective. For the purpose of this report concepts of life course like life cycle, life history and life span will be used interchangeably. Alwin (2011) identifies "life course" as a combination of the following: time and age, life stages and human development, events, transitions and trajectories of life course, and early influences on later adult outcomes. Researchers now recognize the influence of social/economic resources on health related choices and the accumulative effect over a lifetime and for generations (Braveman, Egerter & Williams, 2011). As a geriatric social worker, the underpinnings of a life course perspective impacts the determinants of mental health at the macro (society) and micro (community and individual) level of care (MacCourt, Wilson & Tourigny, 2011). Working from an ecological lens people are viewed not as single units but contributors to their environment and society in reciprocal relationships that change and influence each other time (Germain & Bloom, 1999). Ungar (2002) takes this understanding further and points out that deeper ecological social work intrinsically values each individual within their role and association with community by recognizing the influence of power and privilege of the dominant culture determining appropriate, relevant social interventions. Germain and Bloom (1999) also suggest that looking at various systems within these transactions provides useful information and understanding of human behaviour. By combining these two concepts and philosophies social work with older adults takes into consideration the history and life experience of a person with a focus on current functioning within their environment. Alex Gitterman (2009) suggests that for social work practice to remain relevant the cause and function of a problem must be approached in an integrated manner. Geriatric social work in a community health care setting requires well developed problem solving skills, broad
knowledge of health services and community supports, and the desire to work together to maintain the health and well-being of clients.

**Life Course Perspective**

Life course is the developmental experience between human beings and their environment from birth to end of life (Gitterman & Germain, 2008). Using a life course perspective the unique developmental pathways of older adults become their individualized, personal and collective life story (Gitterman & Germain, 2008). The concept of the life course is based on a person-in-environment perspective that recognizes the undetermined pathways of life and the influence on the biopsychosocial development within diverse cultures (Germain & Gitterman, 2008). This perspective fits with the notion that an older adult's life story is an accumulation of unique experiences that shapes their perception and understanding of the world. Human development and aging are lifelong processes and outcomes can be very different for people simply because they come to that common place in different ways (Crosnoe & Elder, 2002).

According to the life course model, historical time and the context of social change have formative effects on a particular birth cohort (Gitterman & Germain, 2008). For example some of the current cohort of older-aged adults grew up during a depression era of severe food rations. Many people with this experience are now elderly and impacted by early nutritional deficiencies and other effects of extreme poverty. It is through this shared experience we are able to understand the effects on current health status.

According to life course theory, the nature of people is to self-direct and move forward towards growth and health (Gitterman & Germain, 2008). Jack (2012) suggests the direct involvement of people and their views, perceptions and understanding of the connections between various aspects of their problems is a starting point for assessment.
This approach supports patient involvement with the assumption it will bring about healthy changes.

The concept of life course also recognizes the developmental stages in a person's life and levels of stress are thought to be reactions to life events that are ongoing and can occur at any point (Gitterman & Germain, 2008). An editorial in a recent publication of the American Journal of Psychiatry (Kaplow & Layne, 2014) looks at a study of bereavement over a lifespan and the "potency of accumulated losses in predicting psychiatric disorders across a life course" (p. 807). The study apparently supports assessment for accumulative loss risk factors in an older adult population to help understand the compound effect on mental health. Through life there are events that occur that are enjoyable from which we benefit in positive ways and then there are times when we struggle with life choices that are beyond control and life changing. Sanders, Fitsgerald and Bratteli (2008) state that assessment of mental health issues in older adults is complicated by the influence of other disease processes. This is one reason assessment of older adults should always include a detailed life health history and that the information must reflect all areas of life lived.

Alwin (2012) highlights five life course principles:

(a) **principles of life-span development**, that is human development and aging are lifelong processes; (b) **the principle of agency**-individuals construct their own lives through the choices and actions they take within social structures (i.e., the opportunities and constraints of social arrangements) and historical circumstances; (c) **the principle of time and place**-lives of people are embedded and shaped by the historical times they experienced over time; (d) **the principle of timing**-the developmental consequences of events and transitions are conditional on their timing in people's lives; and (e) **the principle of linked lives**-people's lives are lived
interdependently and sociohistorical influences are expressed through networks of shared relationships. (p. 212)

These principles form a basis for a life course perspective when understanding human behaviour.

**Ecological Social Work**

The ecological model of social work practice fits well with my philosophy and general principles of working with people. Ecological thinking focuses on the person in the environment and the influence of a reciprocal relationship which changes over time (Gitterman & Germain, 2008). According to Schmidt (2007) the advantage of the ecological perspective is that it is context-sensitive and context-focused which fits well with the diversity of northern social work practice. People have interdependent relationships within various aspects of their lived lives (Jack, 2012) and social work practice with older adults views a person not as an island unto themselves but as a person with a mix and interplay of relationships and influences. A social work strategy is to recognize the vulnerabilities of people and their environments and strive to work with their strengths to temper the challenges. A good example is to recognize a person's mobility issues and work with the strengths of the individual and their family support at home to adapt the environment. In adapting the home environment the person may be able to remain longer in their comfort zone with their family and enjoy a better quality of life. As Jack (2012) states, small changes in key areas can have significant influence on a problem over time.

Dating as far back as 1902, Mary Richmond presented a model of casework that viewed the environment as being multidimensional having not only personal dimensions, but also family, neighbourhood, civic organizations, private charitable organizations and public relief organizations (Hutchinson, 2011). This historic contribution to relating human
behaviour and the environment identified five dimensions: culture and society, communities, organizations, groups and families that impact people's lives (Hutchinson, 2011). The ecological perspective considers the micro, meso, and macro systems that influence daily life (Hutchinson, 2011). Each system represents aspects of the human condition, from the personal perspective to the influence of large societal/economic systems.

According to Gitterman and Germain (2008), through a refining process the "life-modeled" practice was developed, offering a guide for several "ecological concepts like; person/environment exchanges, person/environment fit, habit and niche, abuse or misuse of power, life course, life stressors and resiliency and protective factors" (p. 51). From a social work perspective, this could be a strategy to map relationships and identify problem areas for reflection and possibly intervention. When working with older adults it is important to recognize the unique developmental pathways of life and levels of stress; these are matters of life that are ongoing and occur at various points across the life course (Gitterman & Germain, 2008). Adjusting to change is a common occurrence in the lives of many older adults. Some people have more difficulty accepting those changes than others and need assistance. Gitterman (2009) states if the environmental resources are unresponsive then people feel negatively about their own capacities to adapt. Informal supports can help people maintain independent living situations and planning ahead eases the uncertainty of what's to come. Jack (2012) suggests that the ecological perspective places an emphasis on the individual's idea about their own circumstances. An older adult's perspective is key to assessment, and forms the basis for working together to develop course of action, intervention or treatment.

In practice an ecological perspective offers a holistic view of individuals and the relationships that give meaning to their lives. The person and their environment are not to be considered separate entities but interdependent living organisms. Germain and Bloom (1999)
further explain the notion that transactions, from an ecological perspective, provide useful information from the individual to the collective and their environments. Rural social work benefits from integrative thinking and by appreciating the various elements including the cultural, social, physical, political, economic and spiritual contexts through which we can begin to understand the uniqueness of the human condition (Cheers, Darracott & Lonne 2005). The ecological approach is particularly relevant to consider when developing programs and other interventions in rural communities because each system is unique and interdependent upon the other in a way that is usually relevant to survival.

According to Brown and Hannis (2008) the human ecological perspective describes goodness of fit as "people actively creating or gravitating to environments where they fit" (p. 59). This model supports people to be involved in constructing their own reality by adapting to the environment. Germain and Bloom (1999) describe adapting as constant adjustments and the changes people make for survival with a desire to attain a level of fit between themselves and their environment.

The rural context presents unique challenges for providing services to the elderly. According to Gitterman and Germain (2008) the environment influences life course and the diverse experience within the pathways of human development. There is a higher proportion of elderly people living in rural settings who have complex medical and social needs (Sanders et al. 2008). Providing mental health services to adults aging in rural settings is difficult as these adults are often found to be isolated and home-bound (Kaufman, Scogin, Burgio, Morthland, & Ford, 2006). They are faced with challenges in finding appropriate services, the resources to buy them, and the lack of in home assistance requires a move to a facility for care (Sanders et al. 2008). An explorative study by McGee, Tuokko, MacCourt and Donnelly (2004) found that rural communities have few options and share a lack of
services for elderly people. A Northern BC focused report also identified similar themes like inequities of psycho-geriatric resources in surrounding rural communities (Morrow, Hemingway, Grant, & Jamer, 2012).
Chapter Three: Literature Review

The purpose of this review is to critically analyze the literature as it pertains to my focus area of social work with older adults in a community health care setting. The chapter opens with a world health view which situates older adults from a population based perspective. Various topic areas are then explored that relate to older adults and my practicum placement with Elderly Services. Specifically these include health services, recommendations and changes to capacity assessment guidelines from the Office of the Ombudsperson report (2013), primary care, mental health concerns, substance misuse, barriers to accessing programs, adult protection concerns, ethical issues, advocacy, social work practice, Aboriginal influence on aging, advocacy, case management and future trends in addiction services.

Context of Older Adults

Though not legally binding, the United Nations protects the human rights of older adults with authoritative interpretations of international declarations represented by a consensus of international opinion (Pan American Health Organization, 2008). In 1999, the United Nations issued Principles For Older Adults and stated, "Older persons should remain integrated in society, participate actively, in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations" (Pan American Health Organization, 2009, p. 5). A report to the United Nations (2011) emphasized the world's population is aging faster than ever before and subsequently identifies challenges such as discrimination, poverty, violence and abuse, and the lack services for the growing demand. It is estimated that 20 % of those older adults are faced with some form of mental or neurological disorder and the most common are dementia and
depression (World Health Organization - WHO, 2016). Guidelines by the WHO (2016) suggests the following when caring for older adults with a mental disorder:

- early diagnosis to promote early and optimal management
- optimizing physical and psychological health, including identifying and treating; accompanying physical illness, increasing physical and cognitive activity and optimizing well-being
- detecting and managing challenging behavioural and psychological symptoms by providing information and support to caregivers

Health Services

Ultimately the responsibility for mental health services for older adults in Canada falls under the jurisdiction of the Ministry of Health in each Province, guided by provisions of the Mental Health Act (Government of Canada, 2016). According to Statistics Canada (2011) there are 4.4 million people in BC and 688,900 are over the age of 65 years. That number is projected to double by 2030 (British Columbia Stats, 2014). There are approximately 74,133 people in Prince George and 9,482 of these individuals (11%) are over the age of 65 (Statistics Canada, 2011). The British Columbia Ministry of Health (2012) announced plans to improve the home and community care system for older adults by creating an action plan based on a report release by the Ombudsperson's office. This comprehensive review of home support, assisted living and residential care services identifies changes that need to be made (Office of the Ombudsperson, 2012).

Further to their first report, the Office of the Ombudsperson (2013) released a review of the "fairness of process that results in the Public Guardian and Trustee being appointed to manage the financial affairs of adults for whom a certificate of incapability is issued by a
health authority because they are incapable of making their own financial decisions" (p. 3).

The report made several recommendations accepted by the BC Ministry of Health and Ministry of Justice including:

- Ministry of Justice to provide the Public Guardian and Trustee with a court process to apply to act as a temporary guardian property

- Ministry of Justice development of regulatory standards for conducting functional assessments with a legally binding definition of financial capability

- Ministry of Health development of an ongoing training program that must be taken by health authority staff before completing a functional assessment

- Ministry of Justice to require certificates of incapability to be based on a current in-person medical assessment conducted by a physician and a functional assessment by a trained clinician

- Provincial government to cover costs of assessments.

- At the beginning of an investigation written notice by the Public Guardian given to all adults

- Health Authorities are to ensure that adults are given timely notice of and adequate information about functional and medical assessments of an adult's incapability.

- Ministry of Justice to require regulation that Health Authorities offer adults copies of their functional assessments.

If there is reason to believe serious mental or physical harm to self or property may occur as a result of advising an adult, a qualified health care professional could waive the requirement. (Public Guardian and Trustee, 2016).
Primary Care for Older Adults

For older adults the general practitioner (GP) is the most utilized health care provider and evidence suggests Mental Health and Substance Misuse (MHSU) services are more effective when integrated into primary care (BC Ministry of Health, 2012). According to this report a highly acclaimed program, (Improving Mood-Promoting Access to Collaborative Treatment) (IMPACT), is a collaborative approach to care with elderly populations that includes mental health components such as pharmacology, psychotherapy (e.g., cognitive behavioural therapy, solution-focused therapy) with telephone and face to face follow-up. One study found that overall primary care physicians managed 80% of their patients with psychological issues and it appears the most effective way to provide service to older adults is to reduce barriers, increase access and address patient need all within a primary care setting (Rybarczyk, Garroway, Auerbach, Rodriguez, Lord, & Sadock, 2013).

Dementia is also a growing concern within primary care and GPs have an average of 40-50 patients with dementia (Dalziel, 2009). An estimated 76 % of those with dementia or probable dementia were not being diagnosed by their primary care provider until they were in the moderate to severe stage of the disease process (Lin, O'Connor, Rossom, Perdue, & Eckstrom, 2013). Early identification by primary care providers could lead to a more encouraging prognosis with health, psychological and social benefits including access to specialist services (Lin et al., 2013).

Older Adult Mental Health Concerns

Depression is the most prevalent mental health problem in old age and it is important to recognize the diagnostic criteria (Ray, Bernard & Phillips, 2009). The Geriatric Depression Scale (GDS) is a tool commonly used to screen for depression (Rosen & Reuban, 2011). Steinman et al., (2007) state up to 20% of older adult living in the community have
some sort of depressive symptoms impacting their quality of life. Depression in older adults is characterized by physical ailments such as weight loss, insomnia, fatigue as well as cognitive disturbances, memory loss, and difficulty concentrating (Corcoran, Brown, Davis, Pineda & Kadowh, 2013). From a meta-analysis Corcoran, et al., (2013) found that bereavement, relationship stressors and communication challenges with family members were risk factors for depression. The cumulative effects of certain types of trauma (e.g., loss of loved ones) are associated with depressive symptoms (Ogle, Rubin & Siegler, 2014) and the aging process, itself, can exacerbate symptoms and behaviours related to post-traumatic stress (Graziano, 2008). Walton and Cairney (2000) found there were twice as many women with depression than men and this number increased with age. Furthermore, other research suggests that depression is also common for institutionalized adults, with 25% affected (Beyer, 2007). Left untreated this debilitating, chronic disease can raise the likelihood of further physical and mental decline and history of a depressive disorder is a risk factor for developing dementia in later life (Ray et al., 2009; Thorpe, 2009).

Assessing for and knowing the difference between normal bereavement, complicated grief, and a psychiatric illness is useful when working with older adults. For example, an estimated 10-20% of people who are bereaved develop a syndrome called complicated grief (Shear, 2010). Symptoms include feelings of intense yearning for the person who died, preoccupation with memories interfering with everyday activities, reoccurring painful emotions related to the death, avoidance of situations and difficulty restoring the capacity for meaningful, positive emotions (Shear, 2010). It is now recognized in the DSM V (American Psychiatric Association, 2013) that people who experience normal grief may go on to develop a depressive disorder.
According to Dow, Lin, Tinney, Harambous and Ames (2013) research evidence of effective treatments for depression include antidepressants, electroconvulsive therapy (ECT), cognitive-behavioural therapy, reminiscence therapy, problem-solving treatment, bibliotherapy, and exercise. Despite the evidence and efficacy of ECT in older adults, this form of treatment remains controversial (Dow et al., 2013).

Recently, hoarding has become recognized as a major mental health concern of older adults and it is vital to understand when collecting turns into a pathological disorder. Nordsletten and Mataix-Cols (2012) described collecting as an "egosyntonic leisure activity" that provides psychological benefits but becomes extreme when it hinders individual, interpersonal and occupational functioning (p. 166). The DSM V (American Psychological Association, 2013) describes hoarding as the persistent need to save items, distress associated with discarding them, and the accumulation of items that congest and clutter areas compromising their intended use. Hoarding causes clinically significant distress in maintaining a safe environment and cannot be explained by another disorder (American Psychological Association, 2013). Older adults who experience this disorder appear to be more isolated, live within hazardous home environments and become at an increased risk for falls, cognitive impairment, poor nutrition, and health/medication mismanagement (Ayers, Saxena, Espejo, Twamley, Granholm & Wetherell, 2014; Diefenbach, Di Maura, Frost, Steketee & Tolin, 2013). Ayers et al., (2014) explain that deficits in executive functioning (e.g., planning, categorization, decision making, memory, cognitive flexibility) are characteristics of a hoarding disorder across the lifespan.

An additional ongoing concern is the mental health and well being of an older adult who spends a lengthy time in hospital waiting for placement in a long term care facility. People are waiting up to 6 months in a hospital bed for a complex care bed (Costa, Poss,
Peirce & Hirdes, 2012). Patients who occupy non-medical acute care beds while waiting for nursing home admission are commonly in need of capacity planning and co-ordination of services within the health system (Costa et al., 2012). Fifty-four per cent of older adults who waited in acute care and subsequently discharged to a residential care facility have dementia with challenging behaviours and complex needs are without a strong support system at home (Canadian Institute of Health Information, 2012). However, research suggests that many of these older adults could be cared for in their own homes (Canadian Institute of Health Information, 2012).

**Substance Misuse and Older Adults**

An aspect of health care that receives little attention is substance misuse by older adults. The BC Ministry of Health (2010) supports expanding abuse prevention programs for seniors however omits any reference to addictions in older adults. Although the report identifies seniors as vulnerable, it appears the focus is on developing programs for children, youth and their families in direct addiction work. An estimated 1 to 3% of older adults have alcohol-use disorders with a lifetime risk for men at 20%; 15% for alcohol abuse and 10% for alcohol dependence (Caputo et al., 2012). Another study found 11% of older women misuse and abuse prescription drugs prescribed for pain, insomnia and anxiety (Culberson & Ziska, 2008). Richards (2009) posits this neglected area of care for older adults is fueled by ageist attitudes that older-aged substance abusers do not respond well to treatment and go unnoticed until they require hospitalization. Memmott (2008) identifies three main constructs in elderly substance abuse literature: the early-onset user, late-onset user and episodic patterns of substance use. A systematic review of treatment for older people found older people respond slightly better to treatment than younger people and are more likely to complete their course of therapy (Moy, Crome, Crome & Fisher, 2011). In another study of age specific treatment
outcomes older adults experienced improved function of cognitive processes like memory, concentration and understanding of information (Outlaw et al., 2012).

**Barriers to accessing programs.** Jensen, Lukow and Heck (2012) identified barriers to care are sometimes related to the lack of understanding of physical and psychological changes in older adults' metabolism and, as we age, the impact of alcohol and other substances. Caputo et al., (2012) listed a variety of physical conditions and indicators that warrant screening older adults for alcohol abuse such as:

- worsening of a chronic disease
- reduced or increased pharmacological effect of chronic therapies
- onset of gastrointestinal disorders
- incontinence
- accidental hypothermia
- orthostatic hypotension
- frequent falls, fainting
- heart failure
- aspiration pneumonia,
- dehydration and malnutrition
- onset or deterioration of cognitive or psychiatric disorders

Older adults often visit their primary care providers on a regular basis which is an opportunity for physicians to intervene and identify those who drink too much and recommend a treatment plan (Caputo et al., 2012). Christenson, Low and Anstey (2006) found a brief intervention (e.g., psychoeducation) provided in primary care effective and significantly reduced drinking by older adults. One 15 minute visit with a healthcare
professional can potentially reduce nondependent problem drinking by 20% (Sorocco & Ferrell, 2006). Early screening for alcohol substance abuse prevents the detrimental "physical, psychological and social effects" prevalent in older adults (Boyle & Davis, 2006, p. 95). When used together, screening tools to diagnose alcohol abuse and dependence such as the four-item questionnaire on Cutting down, Annoyance at criticism, Guilty feelings and use of Eye-openers (CAGE) and the Short Michigan Alcoholism Screening Test - Geriatric Version (SMART-G) are particularly effective (Caputo et al., 2012). Included in the assessment of an older adult is a cognitive exam for an alcohol-related dementia and, despite the current controversy whether someone can have a dementia as a direct result from ethanol neurotoxicity, it remains a valid concern (Ridley, Draper & Withall, 2013).

**Adult Protection Concerns**

An important role for any health professional is to screen older adults for abuse and neglect. According to the Adult Guardianship Act (1996) abuse is the "deliberate mistreatment of an adult that causes the adult physical, emotional or mental harm, or damage or loss in respect of the adult's financial affairs" (p. 2). Elder abuse can also be a lack of appropriate action which causes harm to an older person (Killick, Taylor, Begley, Anand & O'Brien, 2015). Abuse of older adults is a result of a combination of risk factors related to gender, age, health profile and living arrangement (Ray et al., 2009). The incidence of abuse is much higher than reported and these types of relationships are complex and multifaceted with elders often unwilling to report maltreatment in the form of withholding of financial support, physical and sexual assault, psychological persuasion, and neglect (Ray et al., 2009). Rather than focus on the abusive acts and prosecution, older adults prefer family preservation support or harm reduction strategies (Killick et al., 2015). Psychological abuse is most common with a prevalence from 29% to 62% (Dong, Chen & Simon, 2014). The Elder
Abuse Suspicion Index (EASI) is a useful screening tool used to prompt a more in-depth exploration of a more culturally sensitive inquiry with a possible victim (Yaffe & Tazkarji, 2012).

Varying degrees of self-neglect is also one of the most concerning issues impacting social work practice with older adults. Crucial to understanding this phenomenon is the complex spectrum of behaviours that are characterized by an inattention to health and hygiene and an inability or unwillingness to accept remedying measures (Pavlou & Lachs, 2006). A key ethical and clinical distinction in identifying adults at risk for self-neglect is their ability to make and implement decisions regarding personal needs, health and safety (Dong et al., 2014; Naik, Lai, Kunik, & Dyer, 2008). A review of the literature finds self-neglect as a multi-factorial syndrome where deficits in executive functioning is the overriding factor alongside inappropriate decision making and problem solving (Hildebrand, Taylor & Bradway, 2014). This area of impairment has also influenced the older adult's ability to cope with physical disabilities resulting in loss of function (Hildebrand, Taylor & Bradway, 2014).

Additionally there are more reports in the media of abuse and neglect by healthcare providers. According to Ray et al., (2009) some common features of poor care and mistreatment by healthcare providers include service environments with rigid routines, task-oriented care, a lack of engagement and stimulation, and poor staffing levels. Raising awareness of a facility's care culture encourages the reflection on quality and where to improve and set new standards (Rytterstrom, Arman & Unosson, 2012). Social workers are ultimately responsible to ensure the needs of their clients are met and assist in supporting the client to hold the service industry accountable for timely and appropriate services (Fuchs, 2001).
Ethical Issues

When caring for older adults the British Medical Association (2009) suggests specific ethical guidelines that promotes care; specifically care that is person-centered, mindful of dignity, safeguard privacy, promoting independence, considers quality of life, facilitates the ability to exercise control, respect for different cultural values, consider issues of justice without discrimination of age and the societal factors that affect behaviour and attitudes towards older adults.

Daly and Fahey-McCarthy (2014) identify an ethical decision-making framework suitable for use in health and social-care contexts. There are different philosophical perspectives to consider when analyzing an ethical dilemma and it is useful to identify and critically assess from all dimensions (Reamer, 2009). For example, by encouraging informal caregivers to provide a complex level care in an attempt to meet the 'unmet need' is abusive of this vulnerable group and ethically challenging for health care workers to promote (Rangel, 2009). Ethics are ways of living and looking at life that set a standard for behaviour (McAuliffe, 2012). Social workers are guided by "ethical obligations and responsibilities" to do no harm regardless of practice area and are at times weighed down by making ethical decisions in difficult situations (Jones 1999, p. 306). Human and social service ethical practices are based on core values that uphold "differences and diversity, privacy, quality of service, humanity, positive change, choice and the environment" (McAuliffe, 2012, p. 316).

Social Work with Older Adults

It is important to view people who have lived long lives as individuals with rich, unique histories and, according to Wilson (2013), by adopting this perspective we can enhance the involvement of people in making decisions about their future. Older-aged clients have the right to sensitive and ethical practice and the right to participate in decisions
affecting their lives (Kropf & Hutchinson, 2000). Richardson (2009) suggests older adults are complicated human beings with problems that are interrelated with biological/health, psychological, social and cultural dimensions. Some key factors affecting older adults and their families are grieving and adapting to loss, restructuring after loss and "bereavement affecting mental health and disruption of lifestyle" (Bradley, Whiting, Hendricks, & Wheat, 2010, p. 217). Gerontological social workers are able to integrate the inherent complexities of an older person by using a generalist practice framework that acknowledges the macro and micro influences, psychological and social events, community diversity, and the policies and inequities that influence their life (Richardson, 2009). Towns and Schwartz (2012) found social workers are ideally suited to work in health care because of their training in macro and micro levels, including advocacy in mental health reform, and community-based practice. Social work is well positioned to be the aging competent professional whose interventions positively affect health care costs and the use of health care services as well as the quality of life of older people (Rizzo & Rowe, 2006).

From a critical social work perspective the oppressiveness of outdated, traditional theories of aging is a challenge for social workers (Ray et al., 2009). Ageism impacts attitudes and decisions about the value and use of limited resources for treatment of an elderly person. An important skill is the ability to genuinely engage and support older people and their carers to take control of their lives and provide the information for decision making to occur (Ray et al., 2009). A strengths perspective with frail older adults promotes the resources of people and their environment (Chapin & Cox, 2001). Research into the clients' experience with social workers identified the value of advice and advocacy, counseling support, practical guidance, negotiating with other agencies and accessing financial support (Ray et al., 2009).
Aboriginal Influence on Aging

According to Statistics Canada (2014) Aboriginal people living off reserve have poorer health compared to non-Aboriginal people partly due to the chronic health conditions. It is reported that 56% of Aboriginal people have more than one chronic health condition compared to 48% of non-Aboriginals (Statistics Canada, 2014). Mortality rates of Aboriginal Canadians of all ages are 4 to 5 times higher than in the non-Aboriginal population (Hamptom, Baydala, Bourassa, McKenna, Saul, et al., 2011). Wilson, Rosenberg and Abonyi (2011) however, indicate that there are only a handful of articles that pertain to the health of older-aged Aboriginal people. Similar to the general population, there is a rise in chronic diseases in older-aged Aboriginal people with one in three over the age of 55 diagnosed with diabetes (Habjan, Prince & Kelly, 2012). Apparently the health and quality of life is poor for Aboriginal people regardless of whether they went to residential school or not (Barton, Thommasen, Tallio, Zang & Michalos, 2005). Yet, residential school survivors who make up the current cohort have their own unique health pattern (Wilson, 2011). A lifetime of stress alongside social, emotional, economic, and cultural deprivation can biologically affect health later in life (Braveman, Egerter, & Williams, 2011).

Finlay, Hardy, Morris, and Nagy (2010) support a framework for older adults utilizing the social determinants of health such as housing, income, health services, and employment. For Aboriginal people, the framework needs to also include "colonization, globalization, migration, cultural continuity, poverty, self-determination and disempowerment" (p.249). Wilson et al. (2011) point out that it is important to also consider age as a determinant of health status and health care.
Advocacy and Older Adults

Older adults living in BC now have the support of an appointed Seniors Advocate who has travelled to various communities to hear from older adults and pledges to:

- monitor services to seniors
- provide information and referral
- analyze systemic issues that relate to health and well-being
- provide recommendations to governments and service providers on improvements to care (Office of the Senior's Advocate, 2014)

Creating communities that are inclusive by promoting aging in place is one strategy to ensure older adults have continued support and care. Scharlach (2009) highlights initiatives to promote change and enhance age-friendly communities for older adults by improving access to a variety of local tangible, social support and enhancing the ability of local agencies to provide much needed programs. Burack, Reinhardt and Weiner (2012) reported that autonomy and choice are important to everyday life for elders and self-determination is exercised by choosing to participate in activities that give meaning to the individual. Dewar and Nolan (2013) recognize that there are two competing interests when it comes to care for older adults; one that is focused on efficiency and effectiveness and the other based on relationships and responding to people as individuals. Health Authorities are generally challenged to provide cost efficient care yet meet the needs of older adults in a dignified manner. Some of the concerns voiced by those in care include the loss of remaining skills, emotional distress, isolation and loneliness, loss of social support networks, abuse, and inappropriate care (Ray et al. 2009).
Case Management Role

The goal of a case management approach is to respond to the complex needs of each client by connecting them directly to service providers (Fuchs, 2001). According to Fuchs (2001) the role of case managers is to conduct a needs assessment, plan for service or treatment, link or refer the client to services, monitor the situation, and advocate. Richardson (2009) identifies the value of the biopsychosocial perspective, knowledge of community services and a willingness to participate on interdisciplinary teams as a unique skill set necessary for working with older adults. Richardson (2009) is adamant that for social workers to be effective they must know how to assess the older adult and be able to treat a complex array of problems by applying an "integrative gerontological practice framework" (p. 943). This approach includes a functional assessment to determine ability to perform tasks and a social evaluation to understand what is important to the older adult. Evaluation also considers the presence of any comorbidities including medical diseases, psychological, social, cognitive, and functional issues that affect health in an older adult (Rosen & Reuben, 2011). A geriatric assessment uses a variety of tools to determine a person's status across various systems which also includes economic, environmental and spiritual influences (Rosen & Reuban, 2011). Additionally a systemic review of case management programs for patients with dementia found a clinical impact with patients following through with recommendations from their physicians and patients and their caregivers having an enhanced quality of life (Somme, Trouve, Dram, Gagnon, Couturier & Saint-Jean, 2012). Case management was often related to quality of life and when there is compliance with treatment there is an expected accumulative effect (Somme, et al., 2012).
**Future Trends in Addiction Work with Older Adults**

An evidence based practice framework ensures that knowledge for effective intervention is derived from research (Ray et al., 2009). Current research identifies the age and gender relatedness of substance misusers and acknowledges that programs are destined to fail if the needs of older adults are not considered (Ciero, Surratt, Kurtz, Ellis & Inciadi, 2012). Future trends will require specific treatment programs and a shift in the way services are delivered to address the special needs of an older population (Gfroerer, Penne, Pemberton & Folsom, 2003). A little researched problem is a small sub population of elderly people who have illicit substance misuse issues (Taylor & Grossberg, 2012). Higher levels of illicit drug use potentially have adverse and residual physical and psychological health effects (e.g., social and occupational impairments) that also affect inherent personality traits such as impulsivity, hyperactivity, or antisocial personality traits (O'Connell & Lawlor, 2013).

A life course perspective of older adults and their substance misuse habits is helpful. Such an approach would reflect on that time in history when baby boomers were born, between 1946 and 1964. Jensen, Lukow and Heck (2012) identified this cohort of "baby boomers" as physically healthier, having different quality of life expectations given their high level of education, possessing expanded world views because of technological advances, and having not experienced the challenges of previous generations (e.g., Great Depression, World War II). They also suggest that "Boomers" will use mental health and addiction services more because of their own unique life-stressors such as the economic down turn, a need to work later in life, and the effects of increased divorce rates, blended families and childrearing responsibilities (Jensen, et al., 2012).

The focus and treatment of substance misuse in this growing population of older people living in the community should include outreach services. This may mean
psychologically reaching out to people in their home, neighbourhood, or where the person is otherwise most comfortable (Baron & Carver, 2004). Outreach means addressing the most important problems of concern to the client, not having unrealistic expectations that they will fit into a rigid program, and adjusting the efforts to help (Baron & Carver, 2004). An effective strategy used by geriatric social workers is to ask direct questions and relate medical problems with substance abuse (Memmott, 2008).

There is also need to understand people who might be at risk of dependency and an intentional screening for addictions in the older adult population. There are several models to draw upon when developing programs. Of particular interest is the evaluation of the "Florida BRITE Project", a state funded pilot program of screening for "hidden cases" and brief intervention for the older adult substance misusers (Schonfield, King-Kallimanis, Duchene, Etheridge, Herrera, et al., 2010). They found prescription medication misuse was most prevalent, followed by alcohol then over the counter medications. Often depression accompanied misuse. Brief interventions were found to effectively improve alcohol and medication misuse as well as an improvement on depression measures (Schonfield, et al., 2010). In a systemic review, Moy et al., (2011) also found support for brief interventions; support may not be more intensive with older adults but brief advice providing motivational enhancement maybe enough to bring about change.
Chapter Four: Activities, Tasks, Learning

My practicum placement with Elderly Services proved to be a fast-paced, rich learning environment filled with opportunities to practice diverse skills and develop new understandings of older adult specialized mental health care. I was challenged numerous times by ethical dilemmas that required me to think critically, below the surface, about the complexity and the attention to detail necessary when working with older adults and their families. It was numerous debriefing sessions with staff members, my guiding social work principles, appropriate legislation, NHA policies and relevant literature that helped me to make sound ethical decisions and clinical judgements while working with the team. This chapter will describe the activities and tasks that fulfilled the goals identified in Chapter One.

Practicum Activities and Learning

Northern Health Policies and Procedures

I spent a considerable amount of time reviewing policies and pertinent legislation specific to mental health care with older adults. It was important for me to understand the procedures and guidelines for making decisions that potentially could have a tremendous impact on people who came for help. Many policies supported my understanding and guided me with knowledge and steps to problem solve in particularly tenuous situations. Northern Health has a policy and a framework for ethical decision making. This clearly identifies a step by step approach to a process in sound decision-making. Another decision support tool, "Best practice for Complaint Management", gives specific guidelines for clinicians to use when handling clients who are unhappy with the way they have been treated (Northern Health Authority, 2013). Another important policy is in relation to "Client Advocates" as many older adults have family or friends who act in this capacity. This Northern Health
Authority (2013) policy states "the advocate is a welcomed member of the care team and can provide significant assistance to the healthcare team" (para. 1). I encountered many clients with a supportive family who contributed to the planning and care of their aging family member. There is appropriate legislation in place, such as the Adult Guardianship Act to protect the rights of clients who need support to make decisions about their care. Policies also guide how and where client complaints can be addressed and the appeal process with regards to healthcare decisions. This also includes any complaints regarding staff of a Northern Health facility. The Patient Care Quality Office is where grievances can be expressed and formally registered. This is important information to relay to patients and their families because it is their legislated right to know about the appeal process of a health care decision. For Northern Health care workers an informal problem solving approach is suggested and, if this is not successful, then there is a formal appeal process. There are numerous policies and, for the purpose of this report, I have highlighted only a few of the ones that seem most important in the context of my practicum. Overall it appears there is a policy and related procedures for most anticipated situations to provide a uniform standard of care.

I learned that policies are under constant review and as legislation is altered or added to, so must the policies must be altered to support those changes. For example the Adult Guardianship Act was amended in June 20, 2014 and these amendments became effective December 1, 2014. Under this legislation, Northern Health, like all other Health Authorities, as a Designated Agency, has a lawful, statutory mandate to act and is required to adjust their practices and policies to adhere to the amendments. I reviewed the changes and highlights of the new guidelines. I comment further about the impact of those amendments in other areas of this report (see page 40).
Amongst other readings, two reports are of particular note. First, the 'Let's talk about Healthy Aging and Seniors' Wellness' report (Northern Health, 2014) was a result of a community consultation process initiated by Northern Health in 2013 and was meant to provide guidance to Northern Health for planning and decision making purposes. It was also an opportunity for citizens to express what it means to be well and how to stay healthy as one ages. Obvious, from this report, is the need for all health stakeholders to be involved in setting the direction of older adult care by identifying areas of greatest concern and working together to organize a more seamless service. It is important to acknowledge and record the perspective of older adults in future planning for the results to be effective and meaningful. It appears that this initial gathering of information was the beginning of a systemic shift in service delivery.

I also reviewed "The Best of Care: Getting it right for Seniors in British Columbia (Part 2)" (Office of the Ombudsperson, 2012). Some of the highlights pointed to what was already being done in terms of senior care and gave recommendations to the Northern Health Authority. One of the important recommendations encourages tracking of "older adults and their experiences in the following areas: wait times for a facility bed while in acute care, wait times for a facility bed after assessment, wait time for placement in a facility, and wait time for placement in a facility of choice" (Office of the Ombudsperson, 2014, p. 1). Answers to these questions in particular would give valuable, concrete information based on facts and spur the development of programs and services to meet the needs of people and enhance quality of life. There appears to be a lack of system support for interventions that are community based (e.g., family support initiatives). Health support services alone cannot fill the gaps. Caseloads are over capacity, long waitlists exist, and there is competition between
programs for valuable resources. Many older adults are waiting up to 6 months in an acute care bed as they wait for placement in a facility.

**Additional Training Opportunities**

During my practicum, there were many opportunities to increase my knowledge of working in mental health and addictions. I participated in new staff training and learned about criteria for different programs and how to make referrals. Northern Health has adopted a psychosocial rehabilitation philosophy of care for people with mental health and addiction concerns. Cognitive behavioural therapy is a promoted treatment for some mental health issues and is easily taught in a group format. This form is not effective with adults who have a dementia or otherwise have an inability to reason. There were opportunities to talk about addiction services for older adults and after many discussions there appears to be little to no counselling specifically for older adults and especially for those with dementia.

Over the course of the practicum there were opportunities to participate in knowledge translation/exchange webinars including: evidence-informed practice offered by Northern Health and 'Successfully Managing BPSD: How to Use the BC BPSD Algorithm'. The Northern Health Library Services, in the hospital library offered opportunities to peruse the latest health publications. Other training opportunities included a presentation on delirium by the Elderly Services geriatric psychiatrist to family practice residents and an "academic half day" with resident physicians to learn about abuse, neglect, self neglect and the question of incapacity from the adult protection consultant. It was interesting to note what questions were asked and reflect on the comments made by the physicians in training to better understand their perspective.

To effectively work in the field of older adult mental health I needed a broad understanding of many different psychiatric conditions and disease processes and their
trajectories. Knowledge of medications and various treatment options also contribute to care plans and are important to working with older adults with addictive behaviours.

Use of tools like the DSM V and a pharmaceutical dictionary guided my understanding of the medical jargon. Some of the best resources are in the hospital library where various textbooks are available and other current medical journal publications. I also found the latest clinical information for most topics was available on the 'Uptodate' medical database.

**Reorganization of Integrated Primary Care Teams**

One of my practicum goals was to understand the re-organization and shift to integrated health services and what it means for the older-aged patient. By gathering the appropriate documentation (e.g., previous agendas, meeting minutes, and emails) I traced and better understood the process. One of the first tasks in this process was a Patient Journey Mapping exercise conducted by Northern Health with five patients and their caregivers to better understand the experience of transitioning from hospital to community. By illustrating their experience the hope was to identify gaps in services. The aim of the next meeting was to bring together the existing Integrated Health Team for Seniors (IHTS) and Elderly Services to discuss with each team opportunities for integration. Subsequent meetings included managers and staff from the Geriatric Assessment Unit. All three program groups were brought together to understand and confirm what the primary care functions were, the function of specialized services, and determine next steps to achieve the Integrated Health Services. From my understanding, the integration of services will be re-organized into two streams: Primary Care and Specialized Services. The transition will take a phased approach. Specialized Services will provide: services to individuals, specialized knowledge to primary
care teams regarding individuals with special needs and specialized knowledge to the primary care team regarding populations with specific needs.

One Integrated Health Team for Seniors existed and a second team was in the development stage by the end of my practicum. My understanding is that interdisciplinary teams will support the Primary Care Home (Physician Practices) and the team will include a social worker, mental health clinician, physiotherapist, occupational therapist, Home Care nurse, and a life skills worker. The coordinated team approach was established to benefit frail elderly and older adults with more than one chronic condition. It was recognized during this process that not every older adult fits into the typical Primary Care Home scenario. Some are more effectively served by the Central Interior Native Health Society or The Blue Pine Clinic, the first transitional Primary Care Home for unattached patients. For example, an older adult without a physician from a rural neighboring community might be better served by either clinic as they work with unattached patients. Clients who have been assessed by Elderly Services are then followed by their physician and appropriate members of the Integrated Health Team. At this time, it appears the monitoring of complex cases will remain with the Elderly Services team.

A large aim of several Specialized Geriatric Service meetings was also to identify and compare the key functions of existing services. This included information about what programs are doing in terms of assessment and follow-up, hospital liaison, facility liaison, outreach and who is using a consultative format. Discussions then focused on work processes like triage, intake and scheduling. A "parking lot" list was also established for all the extraneous but important questions, comments, observations and discoveries that would eventually need to be addressed. I noticed that the list grew as this exercise stimulated more
questions and comments. During this process I learned more about each program and what services they offer and who they serve.

At the time of my practicum placement, a meeting occurred with staff from all Geriatric Services expressing frustration with the process and uncertainty of how system change would affect their jobs. There were general comments about a lack of consultation with individual programs. Soon thereafter communication was enhanced, more detailed meeting notes circulated, and there were additional invitations for stakeholders to join the process.

**Guiding Legislation**

An important aspect of working in health care is understanding the appropriate legislation that guides decisions and processes. Working with the adult protection consultant enhanced my understanding of the Adult Guardianship Act, the Patients Property Act, Health Care Consent and Care Facility Admission Act, the Representation Agreement Act, and the Mental Health Act. The provision of healthcare can require the knowledge, understanding and guidance offered in several parts of different legislation. I learned to differentiate between each type of legislation and when to apply relevant guidelines. For example, a representation agreement is a helpful reference for a health care worker when a client loses the capacity to make decisions. A Representation Agreement Act provides a way for people to appoint someone in advance to make decisions about their health care, personal care and routine financial management.

Gerrit Clements, lawyer and writer of the Mental Health Act and Specialty Law Consultant for Ministry of Health was available to give advice regarding particularly complex situations with issues needing interpretation in specific case scenarios. An example of such a situation is the need to select a Temporary Substitute Decision Maker (TSDM)
when a client is deemed incapable of making a health care decision and there is no Committee of person or Representative (person named in a Representation Agreement) known for this client. Under the Health Care Consent and Care Facility Admission Act a TSDM is determined by a hierarchy of near relatives. The TSDM is only valid for three weeks and should the health care not be provided in that length of time the process of assessing for incapability and determination of a TSDM starts all over again. I also reviewed a Ministry of Health (2011) document called 'Health Care Providers' Guide to Consent to Health Care' to help me understand this process and pertinent information provided by the Nidus Personal Planning Resource Centre.

Gerrit Clements also facilitated afternoon sessions for mental health care clinicians about the Mental Health Act and how it relates to those who receive involuntary treatment and the practical application of Mental Health Certification. A number of older adults put their lives at risk because of self-neglect. By not adhering to treatment for their severe mental health conditions or where families were providing inadequate support, some were eventually certified under the Mental Health Act and admitted to a designated facility. The Mental Health Act was created to safeguard individual rights by providing provisions for care and contains protections to ensure care is appropriate and lawful. Common language among clinicians meant that when someone was 'Pinked', a Form 4 was used for the first certificate, indicating a recent detention which was one month less a day (BC Ministry of Health, 2005).

Mental health certification is considered a last effort to keep older adults safe and provide opportunities for psychiatric treatment. Some situations were straight forward and did not require such drastic measures. A delirium causes an older adult to lose capacity and is a medical emergency requiring a physician evaluation. Elderly Services staff make arrangements for the appropriate physician to advise on the situation from a medical
standpoint and decide whether to enforce treatment if necessary under the Mental Health Act. After treatment, some individuals return to their previous level of function and resume life at home. Others who may have had a pre-existing mental health concern like dementia and presenting in a crisis situation might not be discharged back into the community because of the severity of their on-going symptoms. Depending on the course of the disease and supports at home not everybody was able to return to their former lifestyle. The subsequent work of clinicians was to strategize with hospital social workers how to best support the client in their home upon discharge. In many cases a connection was needed to Home and Community Care where they offered medication support, personal care and some respite for caregivers. In more complex cases when an individual's needs were difficult to meet at home the person remained in hospital, at times under certification, until a bed became available in a full care facility. Certification was also used for individuals who lacked capacity and were a flight risk.

**Public Guardian and Trustee of BC and Certificates of Incapability**

Certificates of Incapability are issued by Health Authorities under the Adult Guardianship Act when adults are found to be incapable of managing their financial and legal affairs (Adult Guardianship Act, 2014). This frequently happened to individuals who had dementia and lost their capacity to make clear, logical decisions about their financial affairs. Certificates of Incapability and Court Orders are usually only issued as a last resort when less intrusive options have been considered or tried (Public Guardian and Trustee of BC, 2011). An important strategy that we used at Elderly Services was to be supportive and work together with the individual and family to find a solution to problems. For example, there were many times when a trusted family member would assist more readily when provided with clear information about the disease and strategies for dealing with problem behaviours.
Another common issue encountered was the complicated family dynamics that influenced many situations. Due to the limited scope of the Elderly Services program, counselling was apparently not available for families to resolve differences despite the obvious need.

I reviewed documents, guidelines for capacity assessments and an executive summary entitled, "No Longer Your Decision" (Office of the Ombusperson, 2013) to better understand the process of appointing the Public Guardian and Trustee to manage the financial affairs of incapable adults. During my practicum placement Northern Health was moving towards implementing a new legal framework in answer to the legislative changes to the new Certificate of Incapability process. As of December 1st, 2014 the Public Guardian and Trustee became the adult's 'statutory property guardian' when a Certificate of incapability was issued. Northern Health provides training to qualified health care providers including registered social workers who are then authorized to conduct assessments for the Certificate of Incapability process. Another important change acknowledges and supports the inherent autonomy of the adult and their right to information about the assessment that determines their financial capability. It is important to respect the adult's refusal to participate, allowing a support person present, providing a copy of the assessment and being open to questions regarding the results. Also, before a Certificate is issued, the adult and their spouse or relative need to be given a written explanation by the Health Authority Designate of the intention to issue Certificate of Incapability and notice must be provided within specific timeframes. An adult may request a reassessment after 12 months and if a subsequent assessment declares an adult capable there is a reversal process.

During the practicum it was useful to shadow the adult protection consultant as she worked on high risk situations involving abuse, neglect or self-neglect. A large component of my learning was in working with individuals and their families regarding the formal and
informal options available when there is a risk of harm to assets or when an adult is not capable of managing their financial affairs. For example learning about a person and what other legal authorities might assist the adult is least intrusive. Trustees, representatives or attorneys can manage an adult's financial affairs and must follow a set accountability protocol. Pension trusteeship is another mechanism to ensure vulnerable adults who are incapable have someone credible to manage their financial affairs (Service Canada, 2016). This would allow pension income to be distributed to the adult in a more manageable way. The office of the Public Guardian (2011) could exercise 'protective measures' in situations where there is immediate risk and freeze bank accounts preventing property from being transferred. This can happen quickly when absolutely necessary by diligent staff guiding the investigation and process of protection. On occasion, under supervision, I filled out referral forms for the PGT, gathered collateral information, and sat in on family meetings. There were situations where individuals needed extra support and encouragement to reflect on who they might appoint as Power of Attorney and/or help with health care decision making. This seems to be an area where older adults need help and many express the desire to 'tie up loose ends'. Nidus (2016) a personal planning resource and registry, provides guidance for individuals who were appointing a Representative to make health care decisions as well as financial planning. The Ministry of Health also provides an advanced care planning guide.

Another important role of the adult protection consultant is to organize the referrals for physician capacity assessment by ensuring all the collateral information has been gathered. In situations where the physician found the adult capable but in need of support it was then up to me to organize those supports by referrals to other Northern Health programs like Home and Community Care (H&CC) or other community resources. I shadowed clinicians as they reviewed hospital records regarding particular clients where there was little
collateral information or they did not have a regular physician to contact for a mental health history. I used a checklist to guide my understanding before and after a certificate of incapability was signed.

**Other Adult Protection Responsibilities**

Shadowing the adult protection consultant for Northern Health included many different types of adult protection concerns and participation in various aspects of adult protection investigations. There were times when I responded to messages left on the Adult Protection hotline and followed-up on several telephone calls from people expressing concern for a friend, neighbour, community member, or family member who they thought were at risk of self harm or harm from others. There was an opportunity for reflection on how people were coping in smaller communities. Some of those calls required referrals to other programs, further investigation by meeting with the individual of concern and assessing their living situation, and or the gathering corroborating information from other health professionals, neighbors, friends and family. I observed, listened and participated in many consults via conference calls with various health professionals from different communities within the Northern Health Region. Most of these situations were regarding older adults and issues of safety and capacity to make decisions.

All Health Authorities in BC have the statutory responsibility under the Adult Guardianship Act to investigate reports of abuse, neglect and self-neglect, and provide support and assistance to vulnerable adults 19 and older who are not covered under Community Living BC services. An adult may be vulnerable because of physical restraint or physical handicap (i.e., lack of mobility, difficulty communicating) or an illness, disease or condition that affects the individual's ability to make decisions about abuse or neglect. As an employee of Northern Health it is each person's responsibility to recognize and respond to
reports of abuse, neglect, and self-neglect of vulnerable adults that typically arise in Acute Care, Home and Community Care, and Mental Health and Addictions. While staff may refer a situation to the adult protection consultant, it is a shared statutory responsibility to respond regardless of what program clients belong to. I was able to watch a number of presentations by the adult protection consultant whose role included education about adult protection guidelines for staff, physicians in training, and students.

During my practicum many adult protection concerns came from people in the community who had 'good intentions'. I spoke to several concerned community services and family members, who struggle with understanding why the health system does not help older adults live safely by rescuing them because they may be seen as old and helpless. There were many conversations with people about the right to live at risk. It was challenging for people to understand that having mental capacity is the determining factor in the ability to choose a particular lifestyle and the associated risks. Ageism may be a factor in many cases as an underlying paternalistic attitude and the 'good intentions' of people usually reinforces the expectation that the health system will protect old people who live riskier lifestyles.

**Case Management and an Interprofessional Team**

As part of the practicum I reviewed the job descriptions of each social worker on the team and was able to identify their unique contribution. It was evident that social work principles guided their work and that their expertise and scope of practice was valued by other team members. Commonly social work values were infused in the day to day interactions with clients and co-workers. For example, promoting the rights and dignity of individuals as valued contributors to their care plan was standard practice. At times, it was a balancing act managing risks with the right to live at risk. I spent countless hours debriefing with other team members to understand their role on the team as it pertained to specific client
situations. Job shadowing and working with a partner were strategies to help me understand how the team worked. Partnering with a team member is common practice when visiting new clients or investigating allegations of abuse. A formal risk assessment for each unpredictable situation was also completed and placed on file for future reference. Many older adults seemed to be living in highly volatile family situations where it was important to partner with a co-worker and have a backup plan.

Three case managers on the team all worked with several interesting and complicated client situations. They were involved at various levels and intensities depending on each person's needs. For example, a client may have a geriatric psychiatrist appointment which the case manager is required to attend to assist in developing the treatment plan and sometimes carry out related duties. This was particularly important when the individual had no family or close friends. The support and monitoring duties increased for unconnected older adults with challenging behaviours living in the community with few if any social connections and follow-up was crucial. There were also times when case managers met with families to strategize on how to best support the client who refused treatment. When there are questions and issues around competency, a case manager made arrangements for an assessment. Assessment of competency should be for a specific purpose and is not for random information gathering.

Case load

I developed a small short term case load to enrich my practice experience by coordinating and advocating for services so people could remain independent and live in their home. I made referrals to other Northern Health programs, provided substance misuse counseling and participated in case conferences. It was during those interactions with other
program workers where I realized there were few supportive housing resources for older adults with mental health and substance misuse issues.

My goal was to develop relationships with clients to better understand their perspective of living with the challenges of mental health issues. It was vital to encourage people to tell their life story, appreciate their history and recognize the influence of their life course on current health status. I encountered several adults who lived in the surrounding rural communities who struggled with accessing health services because they lived beyond service boundaries. At times these people relied heavily on their neighbours.

Elderly Services meetings were held on Monday mornings and the team would discuss specific client files and new, urgent referrals. Team members would also ask for suggestions and brainstorm together if they were struggling with a particular situation. This was the opportunity to reflect about some of the people on my caseload and contribute when appropriate to the conversation about other referrals.

I also shadowed a rotating team member for 'hospital rounds' each week. These rounds involved an interdisciplinary team made up of a charge nurse, dietician, physiotherapist, speech and language therapist, occupational therapist and a hospital social worker. The team came together to share information about treatment plans for difficult client situations and plan together for discharge.

**Managing Referrals**

Referrals to the wider geriatric services group were handled at regular Wednesday morning meetings to determined what program best met the referral issues. At these meetings, referrals were reviewed and triaged by team leaders from Home and Community Care, Geriatric Assessment and Treatment Unit (including Geriatric Day Hospital and Memory Clinic), the Elderly Services team, and contracted physicians. An Elderly Services
team member facilitated the meetings alongside the designated person who had gathered collateral information. This information included a problem list, medication profile, and lab results. Some cases were very complex and clarification was needed from their physician or from other program staff before the team could move forward. Some of the common presenting problems included:

- cognitive disorders (possible dementia)
- mood disorders / psychosis
- physical frailty, declining mobility, falls
- rehabilitation needs in the Day Hospital setting
- medication reviews
- substance abuse / misuse issue
- self / neglect / abuse issue
- caregiver burden
- review of competency for decision making (i.e., personal care, driving, finances)

There were many opportunities for discussions with staff and to learn about criteria from other geriatric programs including: adult day programs, supportive housing, Geriatric Assessment Unit, Geriatric Day Hospital and Memory Clinic. The geographical boundaries of Home and Community Care service area apparently prevented many rural living older adults from accessing in home services. In those situations, outreach staff from Elderly Services found the necessary supports for people and in many situations community members or neighbours offered to help.
Community Resources and Education

In order to make appropriate connections to resources, some of my time was spent becoming familiar with community programs designed to support people in their homes. A good example is meeting with the Better at Home program coordinator to discuss the details of accessing their support services and housing coordinator for the Canadian Mental Health Association (CMHA). There appears to be very little appropriate housing for seniors especially if they have mobility issues and mental health challenges. At that time CMHA was looking into accommodations for some of the homeless older adults who want to live near their downtown community. There are few supportive housing accommodations in Prince George and some places would allow only a few older adults at one time because of their extreme support needs. One service in particular struggled to support the few independent living older adults who lived in their building because of mobility issues and cognitive decline. The local BC Housing office provided a review of what was currently available in subsidized housing including the newly renovated Victoria Towers.

People needed assistance to find housing for many reasons including: long-term homelessness, current residence no longer suitable because of mobility issues, relocation to access services, and affordability of current residence. It was important to compile a list of housing options including the criteria for each program, the process to apply and the application forms. To further my knowledge about older adult issues I attended a Seniors' Fair in Prince George where local resources were on display, such as the BC Association of Community Response Networks which focuses on raising awareness about elder abuse. That day I also learned about post polio syndrome, the symptoms, nature of disease and treatment from a man who experiences the disease and runs a local support group.
Assessments and Documentation

A geriatric assessment is completed by a physician including the psychological, social, cognitive and functional aspects of health. A geriatric social worker would also be constantly assessing those areas. At times, it was a prescribed functional assessment or a non-intrusive first time general mental health assessment. As a clinician it was important to look for symptoms of distress that might indicate a person was a suicide risk especially in men who were particularly vulnerable. An assessment is not a static document and the process is on-going. There were many opportunities to sit in on interviews with new patients and the geriatric psychiatrist as well as attend appointments between clients and the Elderly Services physician to begin the assessment process. I was able to watch physicians, nurses and social workers conduct mental health status exams and functional / physical evaluations. The Folstein Mini-Mental State Exam (MMSE) is widely used to test cognition and a Montreal Cognitive Assessment (MOCA) also provided information regarding aspects of decision making capability. A 'Functional History' was explored with each patient using the Physical Self Maintenance Scale and Instrumental Activities of Daily Living Scale.

I listened carefully to people describing their symptoms and looked for clues about their general ability to cope with the day to day challenges. Depression and loneliness were common complaints that overshadowed many peoples' health history. The geriatric psychiatrist stressed numerous times the importance of treating depression aggressively because of the risk for irreversible dementia to develop. The Geriatric Depression Scale (GDS) screening tool is widely used to flag people but does not provide a diagnosis per se. I also observed the results of electroconvulsive therapy (ECT) used to treat depression and learned the importance of follow up care.
It was also apparently common practice for a physician's assessment to start with a series of blood tests to determine if the symptoms are related to an infection, vitamin/mineral deficiency or one of many other complex and chronic conditions. A urinary tract infection in an older adult is a medical condition that can produce psychotic symptoms or dementia-like behaviour. When treated, patients returned to their baseline level of functioning. Delirium can be a symptom of a serious medical condition and must be investigated aggressively with further testing. Older adults with mental health concerns can experience an environmental delirium simply because they moved to a new home. They may be disoriented and confused for a period of time or it may continue into a more serious long-term condition. I understand it is sometimes difficult to differentiate between depression, delirium and dementia. It can be a process of eliminating other more easily detectable disease processes or environmental stresses to gain a clearer understanding of what is happening.

As explained in other areas of this report there needs to be a reason for an assessment. It seems that some physicians feel uncomfortable diagnosing their patients with a dementia and prefer Elderly Services to assess, diagnose and develop a treatment and care plan, especially if there are challenging behaviours or a complicating legal question of capacity. Frequently the team will receive a request for a financial capacity assessment because an individual has not paid his rent for several months, is being evicted from his home and or has questionable friends who seem to have some influence about how he spends his money. An assessment of this nature includes a series of questions that reflect the clients' knowledge of their whole financial picture. This is a common scenario because many lonely 'elder orphans' (Carney, 2015) living in the community are vulnerable, desperate for companionship and unable to assess a risky, unhealthy relationship.
Physicians commonly agreed that one of the most debilitating symptoms of a dementia are deficits in executive functioning. This seriously compromises an individual's ability to:

- plan and set goals
- initiate, organize, and follow through on a task
- think abstractly and problem solve
- shift mindset and adapt
- avoidance of new situations that requires processing new and complex information

This understanding, for me, is a key to determining what practical supports are needed for people to live independently if they are capable. Effective supports minimize risks and enhance the ability to cope.

It was crucial to document and record any interactions and information into SYNAPSE, an electronic database. This information provides the basis for 'continuity of care' which means that a clinician can go to the notes and pick up where another employee left off. The new employee on-line training is designed to teach how to navigate the site effectively to record concise notes. This can be either for direct service like accompanying clients to appointments with their physicians or indirectly gathering collateral information and service planning. This is where a history of interactions recorded by previous staff, physician notes, diagnosis, and assessments are kept regarding specific client situations. Paper files were also kept in a locked file room. As a student I was able to review pertinent client files including lab reports, x-ray results and other medical diagnostic assessments. My understanding of medical terminology grew and I learned to decipher acronyms on requisition forms and recognized why there was a need for basic blood tests. For example, I
learned having a lower B12 level can affect cognition. In some files there were many programs contributing such as acute care, adult detoxification unit, ER department, and various specialty physicians' tests and notes. This information was important to a diagnosis and pertinent to follow-up.

**Connecting with Individuals**

As indicated earlier I had the privilege of getting to know several older adults who presented with an array of health issues. Their needs were diverse and most of them had little or no family. Most of the time they had complicated, often traumatic histories, reflecting their life course and impacting their current health status. These narratives were stories about important life events. It was vital to listen carefully to how each person viewed life and their underlying assumptions as these provided clues to engaging in respectful conversations. I know that my mature status, diverse life experiences, and inherent curiosity were an asset when connecting with older adults who needed help.

**Ethical Dilemmas and their Implications**

I encountered situations that challenged my values as a social worker and left a lasting impression on me. As a social worker, I discovered one of the biggest challenges for me ethically was the delicate balance between supporting the value of a person's right to practice self determination and the practical reality of promoting further risk and self-neglect. This stage is at a time in the disease process where an individual has not lost capacity from a legal standpoint, but is scrambling to maintain a quality of life and make decisions about the future. Working effectively with older adults, one must be able to have time to spend with a person and get to know them and listening to a detailed history over a period of time helps to understand their family dynamics. From my observations many families are supportive, however, some strive to control or manage their family member. Those in need of case
management like 'elder orphans' (Carney, 2015) with pre-existing mental illnesses or substance misuse, or those with alternative, non-traditional lifestyles are at risk falling between the cracks. Geriatric social workers can provide leadership to a team by engaging in ethical discussions about lifestyle choice and right to self-determination in a safe environment. Gordon Jack (2012) described this frustration well, unfortunately it is all too easy for practitioners faced with this complex array of interrelated issues to exercise a form of selective hearing, perhaps unconsciously, which reflects the requirements, procedures, and service arrangements of their employing organizations rather than capturing the full reality of people's lives (p, 135).

**Supervisory Meetings**

I was able to participate in several daily conversations with my supervisor as we shared an office. It was a privilege to observe and shadow a true professional at work who has high ethical standards of practice, sharp critical thinking skills, an innate ability to be authentic with older adults, and very well connected professionally in the community. There were many opportunities to learn incidentally in various practice situations. I was challenged by thought provoking questions, encouraged to express my point of view and supported to be creative and think outside of the box. There were opportunities to confront the challenges of what to document about clients without violating their trust. There was a framework for mental status evaluations, and there are common terms to describe behaviour useful in documenting an encounter with a client.

In the following chapter I highlight areas of my practical experience with Elderly Services and the influence on future work with older adults.
Chapter Five: Implications for Practice

This practicum placement provided practical learning opportunities with the Elderly Services team. In this concluding chapter, I describe how this experience informs and guides my future social work practice with older adults. I specifically reflect on the following topics areas: Health Authority experience, legislation rules and regulations, adult protection, case management, interprofessional team work, assessments and documentation, ethics and community resources.

Northern Health Work Experience

Working with the team at Elderly Services was an opportunity to experience coordinating the care of older adults who have a complicated mental health issue. This fast paced work environment provided learning opportunities within the health system in areas of direct client service, team planning, coordination of professional and supportive services. I learned health care clinicians, with the appropriate training, provide standardized assessments for application to the Public Trustee guided by the Adult Guardianship Act. This is a result of changes to the adult guardianship legislation.

The lack of supportive housing for older adults with mental health or addiction challenges created tension between programs as the demand appeared to be greater than availability. There were long waitlists for supportive housing programs with life skill workers. Through this experience it became evident that there were many clients who were physically capable but mentally unable to care for themselves without home support. It was valuable to understand and work on specific situations where older adults were struggling to find a home or maintain their residence without family connections. At times identifying client care needs in areas such as getting to appointments, grocery shopping, and lab work,
people were able to remain in their homes longer. It appears that without enhanced home support there may be more people referred to residential care settings.

It was apparent that there was very little addiction counselling for older adults and is an underserved area of care for people. There were opportunities to ask various addiction workers about older adults and many acknowledged the need, but few had insight as to who, if anybody, was offering services specifically to older adults. The literature and research encourage and support health officials to develop programs for the predictably high substance misuse cohort, the baby boomers. There is evidence older adults benefit from early intervention and counseling for addictions. Elderly Services had previously offered addiction counselling but the new revamped social work position has a more general community social work focus. It would be important for the social workers to have the understanding of substance misuse in older adults, the signs, symptoms, and treatment. Clearly, from my experience, older adults and their families would benefit from a counselor who had the compassion and skill to work in developing an addiction recovery program that suited the needs of an older client and their families in the community. Such a program could be a benefit in the long run because problem solving, planning, and support might prevent frequent high service use and also be cost effective. A small step would be to raise awareness with physicians and have them screen for misuse of substances.

Geographic location impacted the amount and type of service available to clients. The service area boundaries of Home and Community Care presented challenges. If someone needed follow-up nursing care after day surgery and lived outside of the service area, they may have to arrange private follow-up care. This experience showed me that there are high unmet needs of older adults with mental health issues in rural areas. Many lack a connection to a physician and do not have regular check-ups. It is the responsibility of a
case manager to work in creative ways by using available community resources and life skill workers to support clients.

**Legislation Rules and Regulations**

This practicum placement provided learning opportunities for the application of various pieces of legislation and rules clearly guiding the process of protecting vulnerable adults, along with certificates of incapability and health care consent decisions. There was incredible value in witnessing the process from investigation through to medical and psychosocial assessment, and then working with families, friends, landlords, and community service groups to mitigate the effects of a mental health concern. This was particularly significant in situations where a person has lost the mental capacity to make safe decisions. Through this experiential learning process, I understand with more depth effective support and the delicate balance of working with older adults, their families and friends during the transition of declining insight and ability to make sound judgments. Family support with interventions that assist in planning with older adults for their future care needs to be the focus of work with older adults.

**Adult Protection**

This practicum experience enriched my understanding of the role of an adult protection worker and how to respond to adult protection concerns. Referrals received from other health care programs along with calls to the adult protection hot-line were responded to in a timely manner. This experience provided many examples of calls from concerned neighbours and community members, ER social workers, and estranged family members. All were worried for the well-being of a vulnerable older adult who was homeless, without family or friend connections and or living with a mental health challenge that compromised the ability to make sound, safe judgements regarding survival. It appears solutions to such
problems are different for every situation, as are the interventions. In practice it is important to understand why and how an abusive situation develops by spending time with the older adult in their home, assessing the environment, speaking with family members, community services, banks, and other financial institutions. Staff members conducting adult protection investigations have the legal authority to access relevant information in any situation. Respect and dignity for the client underpins any investigation.

In general, during my practicum placement I found differing concepts of tolerable risk, with safety concerns a dominant reason for intervention. From a human rights and legal standpoint, if an adult is capable of making decisions, they have the right to live at risk. It will be important to express this distinction to others when questions arise regarding society's role in caring for older adults.

**Case Management**

This practicum experience provided several opportunities to learn the role of each case manager on the Elderly Services team. After referrals were triaged they were distributed to team members. Despite the many changes in staff, the core team provided stability for clients, many over several years. Under the direction of my supervisor I worked directly with several clients representing a wide variety of classic case examples. Of particular interest was the opportunity to critically think about what support worked for clients to abstain from alcohol, the benefits of a harm reduction approach with family support, and addiction counseling specifically for older adults. As a direct result of working with the team I understand that case managers are vital to clients who live on their own without family or friend support and especially those who experience a dementing illness or mental health concerns affecting cognition and the ability to live independently.
I encountered many older adults during my placement who amazed me with their resiliency, determination and resourcefulness to remain as independent as possible. Some of those people are society's 'elder orphans' (Carney, 2015), those without family and few community connections. Self-neglect in this population is an increasing concern for those who experience issues with executive functioning (e.g., ability to problem solve and reduced decision making skills). For example, I witnessed several cases of people living alone with an early stage dementia presenting at the emergency room because of a psychosis due to urinary tract infection. I learned these individuals needed closer monitoring to ensure they drank enough fluids to maintain health hydration.

I also shadowed several case managers who were monitoring individuals' capacity to make sound, safe judgements. At times it was important to manipulate the environment to make it safe (e.g., disable electric appliances, prompt meal delivery and provide in-home medication support three times a day). It was fascinating to witness the creative process with clients in developing solutions so that older adults could remain in their homes longer.

**Interprofessional Team Work**

There were ample opportunities during this practicum for working together with various other health care workers, the many different programs that affect older adults, and to experience the value of interprofessional teamwork. It was helpful to learn the protocols for accessing each program and the criteria for referral. For example there were opportunities to work with hospital staff, home and community care staff, residential care workers and with specific programs like stroke, diabetes, arthritis, dialysis, and respiratory clinics. Typically several different health disciplines worked together to support an older adult with complex and multiple health conditions. I developed a strong knowledge base of various psychiatric illnesses and related dementias, neurological disorders, numerous chronic diseases and other
physical disease processes along with understanding of the complex interactions. As an advocate for older adult clients, it was vital to build a network of contacts, key people working in various programs who could provide clear information, communicated well and worked efficiently when supporting clients to access their programs.

An important entry point to the health system for older adults is their physician. At times there is a role for case managers to work with physicians to mitigate health consequences and work together to provide treatment. A social worker experienced in working with older adults and mental health decline, is a valuable addition to any primary health care team.

Assessments and Documentation

This practicum experience provided opportunities to review many case files and reflect with team members on several clinical assessments. It was of benefit to review the various aspects of treatment including medication recommendations and suggestions for behaviour management. A common reoccurring theme of many assessments was deficits in executive functioning. It is vital to clarify whether the motivation for assessment is for diagnostic purposes or a capacity evaluation. This ensures an ethical approach to caring for an older adult by safeguarding dignity and privacy. I found that documenting interventions was important to the continuity of service.

Ethics

During my practicum placement I was exposed to several situations that were ethically challenging. Consistent with working with adults in an ethically sound way, it is vital to value the client's viewpoint. At times this was difficult because some individuals were losing the capacity to make decisions on their own. Particularly difficult were those situations where family dynamics were stressful and older adults were estranged from their
families or had few community connections. People with dementia, in particular, need advocates or surrogate decision makers from the community to assist when there are no other options for support and guidance.

This practicum placement had a tremendous impact on me both personally and as a social worker for older adults. As part of the self-reflection process I needed to acknowledge my mature status, age, and stage of development within my life course and the impact on my future work. As a result, I wondered many times what I would do without my family and friends to enrich my life and give me a sense of belonging as I continue on my own life path. I have learned that it is imperative to start planning my own future care needs by appointing a power of attorney and identifying a representative that would ensure my future health care needs are met according to my wishes.

**Community Resources**

During this practicum placement it was imperative to learn about the resources in the community for older adults. There are several strategies to help keep people independent and one way was to access affordable supportive programs. Another way was to utilize community resources including: a free dental clinic at the Friendship Centre, programs and support from the Prince George Council of Seniors, supportive housing programs at Friendship Lodge and life skill workers from other programs. The annual Prince George Senior's Fair is a display of information about various service groups, non-profit organizations, self-help advocacy organizations and several agencies with resources for hire specific to older adults who live in the Prince George area. In addition to local resources, there are important contributions by provincial non-profit organizations in support of older adults and their families. Nidus provides personal planning guidance and registry, the BC Centre for Elder Advocacy and Support assists with legal advice and elder abuse, BC Mental
Health Association and the Alzheimer Society of BC provide community based programs and mutual aid support groups.

**Conclusion**

This practicum learning experience was extremely rewarding as it provided a constant flow of challenging situations where older adults required mental health and addiction support services from the Elderly Services team. These were real people with real lives, struggling to cope with their changing mental health status and the influence on subsequent health care decisions. In the future it would be helpful to work and support those with a mental health concern to live safely in their communities. My philosophy of care is to be proactive and to not view an older adult as a medical enigma but a person with psychological, social and spiritual needs as well.

It was an incredible opportunity to observe the larger systemic shift by attending meetings of the Integrated Health Services. This process brought together a number of Northern Health geriatric services where a tremendous amount of information was recorded about the function of various services to older adults including the function of work processes. It was a unique learning opportunity to watch the process evolve over a four month period of time.

The rewards of this practicum were the opportunities for a diverse learning experience. It was of benefit to witness the macro level of planning for older adult services and the micro level of understanding of what it means to live with a mental health or substance misuse issue.

My future work with older adults will be emphasized by my social work practice values of human dignity and right to independence. According to life course theory, it is a
natural desire to move towards health and wellness and it is under this premiss I continue my work with older adults.
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