A Needs Assessment: Identifying the Barriers to Admission and Supports in Long-Term Care Facilities for the Mentally Ill Elderly in the Region of London-Middlesex, Ontario.

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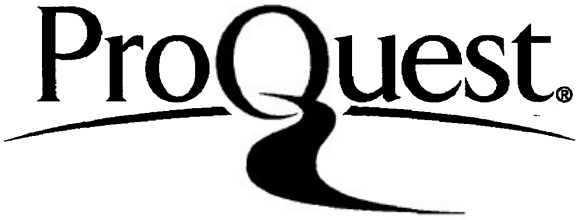

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Statement of the Problem

There are increasing demands for long-term care (LTC) homes to admit elderly persons with mental health illness who are unable to be cared for within the community. This project examined the barriers to admission to LTC homes and supports required in these homes for the elderly who experience mental health illness. No longer is LTC simply for the frail elderly population, but current trends now include a younger population with mental health needs, an increased male population, residents with dementia and difficult-to-manage behaviours, developmentally challenged residents, and other residents with a variety of mental health diagnosis that may also include concurrent substance abuse and medical issues. These facilities face unique challenges when providing care for the geriatric mentally ill population not only because of these trends but also because of issues with staffing recruitment and retention; a need for appropriately trained staff in mental health; and unmet interdisciplinary staffing needs, inadequate psychiatric supports, environmental needs, and fiscal constraints.

Older adults who suffer with mental health illness are at an increased risk for experiencing the inequalities within our health care system. This is a very vulnerable population because their medical and psychological needs related to aging are more complex than those of the youth and adult populations. Older adults with serious mental illness face discrimination and stigma both for their mental health disorders and for their age. These facts, in turn, are just some of the barriers facing admission to LTC homes for this population. The increasing senior population, especially in the 85 and older age category, gives precedence to the urgency of assessing the community resources available to meet their needs. The statistics show an alarming incidence of mental health illness within the geriatric population, with the frequency being as high as one in five being

affected over the age of 65 (Jeste et al., 1999, as cited in Bartels, Dums, et al., 2002). It is anticipated that the number of people over the age of 65 who will suffer with a mental health illness will "more than double by the year 2030, from 7 million in 2000 to 15 million" (Jeste et al., as cited in Bartels, Dums, et al., ¶ 2).

It is well documented in the literature that the rate of residents living in LTC facilities who have some sort of mental health illness is moderate to high. The Canadian Mental Health Association (CMHA, n.d.) and Streim, Oslin, Katz, and Parmelee (1997) identified the rate of mental health illness in residents in LTC facilities as between 80% and 90%. The most common forms of mental health illness within the geriatric population in LTC settings are depression, bipolar disorder, schizophrenia, schizoaffective disorders, anxiety, and dementias (Bartels, Dums, et al., 2002; Reichman et al., 1998; Streim et al.). The significance of some of the behaviours related to these conditions and the inability of the LTC settings to provide sufficient support and interventions has resulted in denials for admission to LTC for individuals within this vulnerable population. LTC homes do not have adequate resources to support the needs of the geriatric population who suffer with significant mental health illness. A needs assessment was conducted by the researcher to further examine the paucity in LTC resources that directly relate to barriers to admission and quality of care to LTC homes for this specialized population group.

Purpose and Objectives

The purpose of this study was to complete a needs assessment with the LTC homes within the London-Middlesex Counties that will identify the barriers to admitting and supporting elderly clients with mental health illness. This project examined the

barriers to admission to LTC homes and supports required in these homes for the elderly who experience mental health illness. In alignment with the findings in the literature, along with the fundamentals and key factors of the mental health collaboration framework, the researcher was able to meet the objectives of this needs assessment.

The objectives of this needs assessment are to:

1. Assess the barriers to admission to LTC homes for the elderly with a mental illness.
2. Identify psychogeriatric services and supports for residents and the staff.
3. Identify LTC homes staffing needs and deficiencies.
4. Identify the availability and utilization of psychiatric services in LTC homes.
5. Identify the academic and specialized training levels and needs of staff providing care within the LTC homes.
6. Identify and evaluate the inequities and gaps in LTC services provided to the elderly with mental health illness.

The findings from this study will provide opportunity to:

1. Enhance access and admission to LTC homes for elderly with a mental health illness.
2. Reduce the stigma related to ageism and mental health illness.
3. Improve the quality of care for the psychogeriatric population within the LTC setting.

The health care system must continue to support the exploration of options and interventions to provide an integrated, seamless approach to moving mentally ill elders through the system and ensure the necessary access to appropriate care and housing. LTC

homes are the residences for a significant number of elderly, and they must be provided with the appropriate resources to care for such a diverse and acute population, especially individuals with mental health challenges.

Conceptual Framework

Mental health reform in Ontario emphasizes the need to deinstitutionalize people and to provide adequate resources within the community (CMHA, n.d.). The mental health reform process has identified the need to maintain clients at the centre of the system of care and ensure that mental health services are effectively meeting the needs of consumers. The Ministry of Health and Long-Term Care (MOHLTC, 2003) identified the importance of ensuring that "all parts of the system work together to ensure service users receive the most effective and efficient services/supports, and organizations/programs achieve their stated goals" (p. 5).

When considering the process of mental health reform and its impact on the LTC sector, a useful model to support the purpose and objectives of this needs assessment is the Canadian Collaborative Mental Health Care Initiative (CCMHI, 2005). In alignment with the perspectives of mental health reform and client-centred care, this framework places the goals of the consumer at its centre. When exploring the barriers to LTC admissions and providing appropriate mental health care to the psychogeriatric population within this environment, the CCMHI shares similarities with the goals of the outcomes of this project:

1. Increased access
2. Decreased burden of illness
3. Optimize care.

Figure 1 outlines the fundamentals and the key elements of this framework:

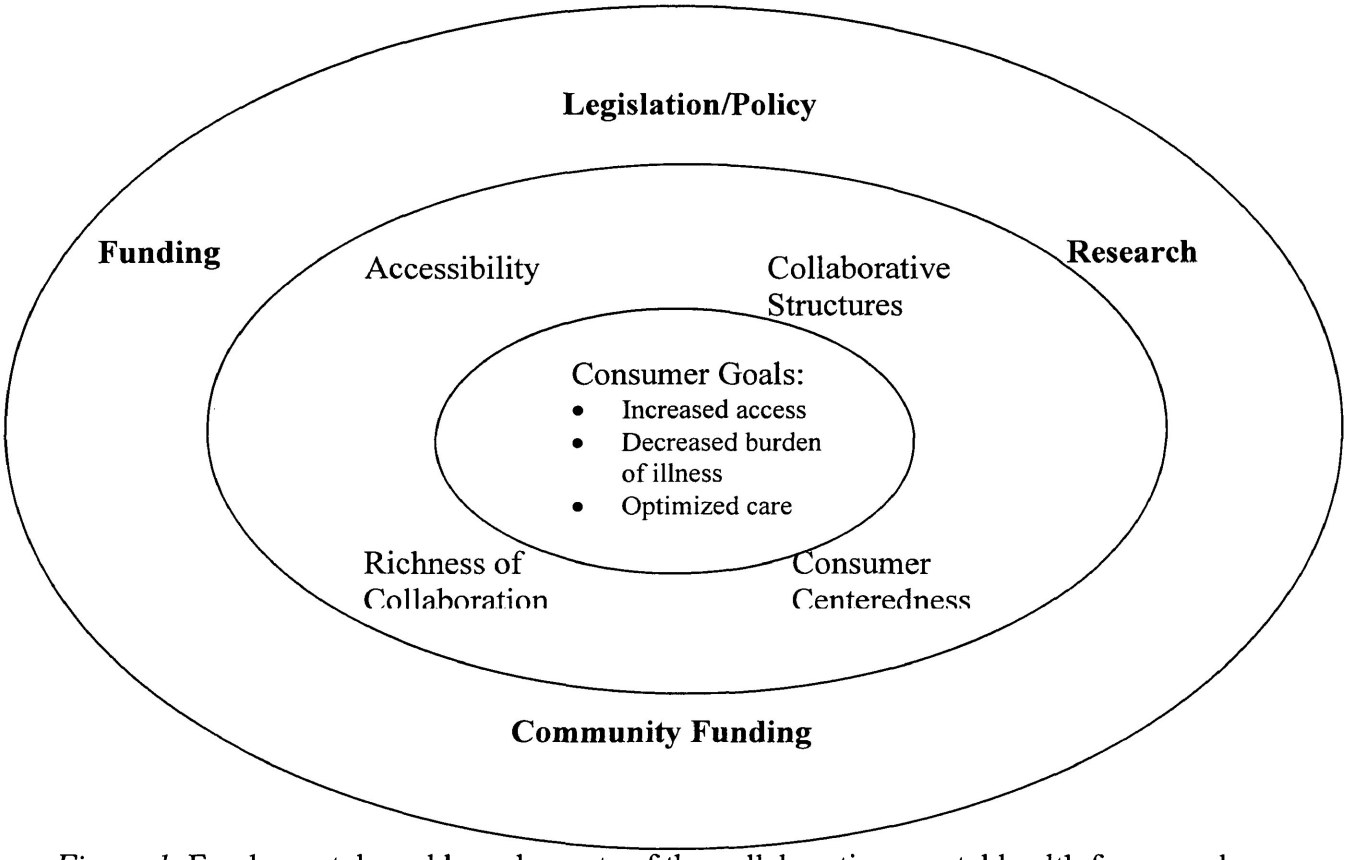

Figure 1. Fundamentals and key elements of the collaborative mental health framework. (Source: CCMHI, p. 2)

Fundamentals of the Framework

The four fundamentals of the CCMHI (2005) include legislation and funding regulations and congruent policies, sufficient funding, assessment of community needs and resources when initiating collaborative initiatives related to best practice implementation, and evidence-based research.

Key Elements

The key elements of collaborative mental health care are accessibility, richness of collaboration, consumer centredness, and collaborative structures. The element of accessibility incorporates ensuring the provision of "access to mental health promotion, prevention, detection and treatment in primary health care setting, or 'bringing the

services closer to home'" (CCMHI, 2005, p. 3). Accessibility also includes joint assessment by a variety of health care providers and the inclusion of the consumer and the family or other care providers (CCMHI). This element supports the objectives and outcomes of this needs assessment because it is inclusive of a flexible, portable, and multidisciplinary approach that strives to meet the needs of consumers in the LTC setting. It utilizes realistic and available resources in the planning of the delivery of mental health services. This element is applicable to the need to provide quality mental health services in LTC homes at all stages of health promotion.

The second element of this framework is richness of collaboration, which encompasses the utilization of the knowledge transfer among health care partners, consumers, and caregivers. The knowledge transfer occurs via various educational opportunities and ongoing communication (CCMHI, 2005). The emphasis of this element is the utilization of a broad range of partners. When providing care to a complex population group such as psychogeriatrics, this element supports the need assessment in addressing the benefit to a multidisciplinary, integrated approach to mental health care.

The third element of this framework is consumer centredness. The focus of this element is on consumers and ensures that they are "involved in all aspects of care, from treatment choices, to program evaluation, and for initiatives to be designed to address the needs of specific groups; in particular, those that are often underserved" (p. 5). This element can be applied to this needs assessment when identifying the involvement of the consumer and/or substitute decision maker in the biopsychosocial and environmental needs of consumers within the LTC setting. This element creates an environment of empowerment for consumers, and it can also have implications for identifying the

specialized care needs of consumers and supporting the education, training, and other resources for the caregivers in the LTC setting. This element, which ensures that consumers are considered as individuals, supports an environment of service provision that is client centred.

The fourth element of the collaborative mental health framework is collaborative structures. This element addresses the systems that are in place to support the ways that individuals will work to meet the goals of the consumers, such as service agreements between care providers and the identification of systems to support the type of service to be provided. Referral strategies, information technology, and evaluation instruments are identified as useful systems to implement in order to provide effective collaborative mental health care. Collaborative structures will help when assessing the current supports and systems in place for LTC homes with regard to identifying the appropriate create provider to involve in care and the process by which to do so.

The collaborative mental health framework is an appropriate conceptual model to utilize for the purpose of conducting and analyzing the proposed needs assessment because the findings can be efficiently categorized and the deficiencies and barriers identified within the system will be allocated to particular fundamentals and elements for further investigation and evaluation. Through the utilization of this framework, effective and efficient resources can be identified and supported, and the areas of noted deficit could be more readily prioritized. This framework fits with the overall purpose of mental health reform and supports the efficient use of mental health resources by enabling an environment of collaboration to individualize care and provide the portability to provide service to individuals living in the community.

Literature Review

This literature review is comprised of research from Canada, the United States, the United Kingdom, Australia, and New Zealand. It includes reviews of evidence-based practices, best practice guidelines, a meta-analysis, and research on the key findings. A review of the literature provides a wealth of knowledge and implications for further research, policy development, systems development, and professional educational development in addressing the care needs of the geriatric population who suffer with mental health illness in the LTC setting. Key areas evident in the literature are the establishment of best practice interventions, models of effective staff and client support, and LTC staffing issues. These are expanded upon in the following sections.

Prevalence of Mental Health

Best Practice Guidelines

Selected literature has explored best practices in providing mental health care to the elderly in LTC homes. Elderly people are faced with many challenges to having their health care needs met. This situation becomes even more complicated when they are faced with dealing with the issue of mental health illness.

The term *best practice* was described by Orb et al. (2001) as "an ongoing commitment to the continual evaluation of current practice and the development of new practice initiatives" (p. 11). Best practice guidelines are also referred to as clinical practice guidelines that facilitate the decision making process for health outcomes and the improvement of health care (Orb et al.).

Exploring best practices is relevant when identifying the unmet needs and barriers of the mentally ill elderly in the LTC setting. LTC is a service, and quality of care is

frequently evaluated. Institutions are becoming more conscientious about implementing best practice guidelines when developing new practice initiatives. "The interest of healthcare professionals in developing best practice models comes from the urgency of healthcare institutions to offer quality and continuous improvement of the services provided" (Orb et al., 2001, p. 11).

Orb et al. (2001) cited the difficulties in identifying best practice interventions in the area of psychogeriatrics because of the lack of literature in this area. They suggested that this could be the result of a lack of academic support and insufficient training of clinicians, and inadequately staffed LTC homes. They also argued that this may be due in part to the stigma related to mental health and the lack of data available in this area. When considering the achievement of best practices, Orb et al. recommended "flexibility, clarity of goals, familiarity with the delivery of services, the presence of a multidisciplinary team and the involvement of the stakeholders [as being] the essential ingredients in a best practice model" (p. 17). Implementing a best practice model of care for this population will "assist health care workers to identify the focus and goals of practice" (Orb et al., p. 13). The researchers focused their discussion on the need to implement a model of best practice care for psychogeriatrics and incorporate the elements of assessment process, mode of service delivery, range of interventions and stakeholders in order to facilitate the outcome of best practice.

Bartels, Dums, et al. (2002) discussed the need for expertise in the field of geriatric psychiatry and identified this as one of the greatest challenges in this area of health care. They asserted, "This gap is the result of inadequate training in geriatric care and a failure to incorporate contemporary research findings and evidence-based practices

into usual care" (¶ 5). This study also identified, via the results of a meta-analysis, the recommended interventions and treatments according to disease specific diagnosis. These included psychosocial therapies; pharmacological, behavioural, and environmental modifications; and models of service delivery. These interventions and treatment foci all have implications relating to the need for specialized training in the areas of mental health and geriatric care, and incorporating best practice guidelines. When exploring the literature relevant to best practices for specialty geriatric mental health outreach services, the findings that can be relevant to supporting clients in LTC homes around the framework of shared care are divided into four elements, including awareness, accessibility, action, and accumulation (Sullivan, Kessler, Le Clair, Stolee, & Berta, 2004).

A recent report by the Canadian Coalition for Seniors Mental Health (CCSMH, 2006) supported the concept of implementing best practices in LTC homes. "Ideally dedicated internal staff would be available to provide leadership in this area, including the development and delivery of best practices" (CCSMH, p. 40). Teams of professionals that provide support to the mentally ill elderly need to be aware of the advances in care interventions for this population. They must also continue to identify methods of improving accessibility to implementing and disseminating their knowledge and skills, and to find effective processes of evaluation and documentation (Orb, et al. 2001). Best practices support the ability for programs and services to implement achievable and measurable goals and provide a means for evaluating practices (British Columbia Ministry of Health Services, 2002).

Overall, the literature illustrates the importance of implementing best practices when providing psychogeriatric care in LTC homes. Along with the implementation of such practices is the need to provide adequate resources, education, and staffing. When reviewing the applications for best practice guidelines within LTC home settings, various models of care were recommended as supporting the specialized needs of this population. The most commonly discussed models in the literature include psychiatrist-centred, multidisciplinary, and nurse-centred models.

Models of Care for Effective LTC Staff and Client Support

Because of the change in the client population in LTC homes, including more mentally ill elderly clients, the challenges that these facilities and staff face in providing care to this group have resulted in the denial of admission of the mentally ill elderly to these facilities. The literature that was explored for the purpose of this study identified various models of care that provide support to staff in LTC homes and a greater quality of mental health assessment and support to the clients who reside in these homes. Common models identified in the literature include psychiatrist-centred, multidisciplinary, and nurse-centred models.

"Observational studies suggest that mental health consultation services in nursing homes may be associated with better outcomes for residents, however few randomized controlled studies of programs have been conducted" (Bartels, Dums, et al., 2002, p. 12). A model of care identified in the literature as psychiatric consultation-liaison nursing practice has proven to be a valuable option in providing support to LTC homes and/or medical facilities (Anderson & Holmes, 2005; Collinson & Benbow, 1998; Pajarillo, Sers, Ryan, Headley, & Nalven, 1997; Yakimo, Kurlowicz, & Murry, 2004).

This model can adapt to offer varying levels of support to patients from low intensity support to high intensity support. It involves collaborating and facilitating with services, health care providers, families, and clients to provide quality, effective, patient care. The psychiatric nurses offer recommendations for patient care, staff, patient and family education; formulate individualized care plans for mental health strategies to meet patient care needs, and liaise with the psychiatric physician.

One example of a positive outcome from this practice is effectiveness in "identifying and treating depression and delirium within hospitalized elderly" (Kurlowicz, 2001, as cited in Yakimo et al., 2004, p. 222). Other positive outcomes identified in the evaluation by Yakimo et al. were the ease of accessibility of the psychiatric nurse, timely response, usefulness and clarity of strategies provided for patient care, education, and objection used in judgement due to being an external resource to the hospital. However, Pajarillo et al. (1997) discussed the benefits of the consultation-liaison nurse being a staff member of the facility. They commented:

> Being unit-based provides the psychiatric and mental health APRN with an understanding of the functioning of the unit and an awareness of each staff members' role and level of knowledge (and then) incorporates this understanding into individual contacts with the staff. (pp. 26-27)

The overall benefit to this type of model is the decrease in problematic behaviours and psychiatric symptoms of the patients (Pajarillo et al.; Yakimo et al.).

The need to have the psychiatric consultation-liaison nurse available at all hours every day of the week was identified as an increased benefit in the literature. The benefits of the consultation-liaison model have been well documented in the literature, with some

variation. Researchers have cautioned that the consultation-only model has limitations, namely, a slow response time, a low priority of service, poor adherence to recommendations, and a lack of provision of staff education (Anderson & Holmes, 2005). The benefits of the combination consultation-liaison approach include education and collaboration with staff and utilization of a shared care approach (Anderson & Holmes).

Another model of care that has been effective in the management of psychiatric illness in nursing homes has been the incorporation of the role of nurse practitioner (NP) to fill the void of the primary care physician in some areas (Eisch, Brozovic, Colling, & Wold, 2000). This study was conducted over a period of 1 year and evaluated the outcomes of NP recommendations for 175 residents who displayed agitation, disruptive behaviour, depressive symptoms, or decline in activities of daily living. Five nursing homes participated in this study. The NPs developed protocols related to patient care needs regarding some mental illnesses and prepared educational materials to enhance collaboration and education within all of the levels of staff. Referrals to the NPs could be made by various disciplines, but they required the approval of the primary care physician. The NPs were able to identify negative behaviours that may be related to a mental health illness or medical condition and then provide appropriate interventions, support, and follow-up to the residents and the staff members who were providing care. Findings from this study identified the effectiveness of NPs identifying and treating depression, delusions, and delirium in nursing home residents. (p. 154) The findings also concurred that collaboration amongst NPs, physicians and nursing homes is beneficial for nursing home "residents, staff, families and attending physicians." (p. 154) Another outcome

"resulted in positive behavioural changes in 62% of residents" who were referred to the NP. (p. 150)

In Eisch et al.'s (2000) study, collaboration with the physicians was measured. With regard to compliance with the recommendations of the NPs, "60% of physicians complied, 21% complied with some, and 14% complied with none" (p. 153). This level of physician compliance showed that although nurses and physicians can collaborate effectively for patient care, improvement is still needed to facilitate the continuity of support and interventions provided by health care professionals for resident care. In a study by Teitelbaum, Cotton, Ginsburg, and Nashed (1996), poor physician compliance was also evident in supporting the recommendations provided by psychogeriatric consultants. The findings of low physician compliance rates with the recommendations of NPs suggest an opportunity for further development of consultation and collaboration with the new healthcare role of the NP in the assessment and treatment of the elderly with mental illness. The utilization of NPs in LTC homes was a positive finding in the literature and was identified as a beneficial model of patient care in these settings.

The transitional discharge model (TDM) is another effective method of providing support to residents and staff in LTC homes. This model is applied to residents who are initially inpatients in a psychiatric hospital and then discharged to a LTC setting or the community. Although there was some variability in this type of model within the literature, the common feature was the overlap of care provided to the residents within the inpatient setting and then followed through to the LTC setting or the community, as well as the provision of peer support (Forchuk, Martin, Chan, & Jensen, 2005; Reynolds et al., 2004). The common features of this model include a relationship that is built with

the resident within the inpatient setting and then developed with the LTC staff. The purpose of the TDM is to reduce psychiatric hospital readmissions, reduce the societal burden of mental health illness by effectively managing the symptoms of mental health illness within the community setting, and improve the quality of life of the individual suffering with a mental health illness by facilitating a successful transition into the community setting (Forchuk et al.; Reynolds et al.).

The study by Forchuk et al. (2005) examined the cost and effectiveness of the TDM. The model in this study "consisted of: (1) Peer support for one year and (2) Ongoing support from hospital staff until a therapeutic relationship was established with the community care provider." (p. 556) The participants (n = 390) were interviewed at various intervals from hospital discharge. There was no significant improvement with the quality of life or post-discharge costs between the intervention group and the control group. However, "intervention subjects were discharged an average of 116 days earlier per person *and* based on the hospital per diem rate this would be equivalent to $12M *in* Canadian hospital costs." (p. 556). Although there were challenges with contamination and implementation with the study, the results indicated significant cost savings to the government and earlier discharge times for inpatients.

Reynolds et al. (2004) supported previous research studies in identifying the benefits to psychiatric patients developing strong interpersonal relationships with peers and discharge caregivers in order to enhance the success of maintaining independent living in the community and reducing the rate of readmission to a psychiatric facility. However, because of the small sample size (n = 19) of the study by Reynolds et al. (2004), the findings did not yield the significance, as did a larger study by Forchuk in

2005. Patients who had been discharged from an inpatient mental health hospital within a particular time frame were included in this study. The TDM was provided over a five month time frame and assessed data on mental health "symptoms, functional ability, re-admission rates and quality of life." (p. 83) The findings of this study concluded that the TDM maintained individuals within the community who may have otherwise been readmitted to hospital. Significant improvements in the severity of symptoms and overall functioning were identified. Recommendations from this study highlight the need to replicate this study with a larger sample size.

With recent trends in mental health care reform transitioning individuals into community living options, as opposed to extended lengths of stay in psychiatric institutions, the TDM appears to support the emotional, physical, and psychosocial needs of individuals with a mental health illness to make a successful transition to community living. This type of model in mental health care incorporates the need for multiple stakeholders at various levels of care to provide a significant role in facilitating positive change for individuals with mental health illness when transitioning into the community. This model can be considered when transitioning geriatric residents between inpatient mental health hospitals and LTC homes.

Another model of care with some similarities to the transitional discharge model is referred to as the shared-care model, which involves multiple avenues of support in the provision of care for the elderly. A shared-care intervention project provided evidence of being an effective model for the care of the geriatric population with depression in LTC homes (Llewellyn-Jones et al., 2001). The key elements of this intervention included removing barriers to care, health care provider education, and health education and

promotion to the residents. These elements involved multidisciplinary collaboration, primary care, regular team meetings, case-based education, marketing to minimize the stigma of depression, monthly newsletters, health promotion activities including exercise, and a volunteer program (Llewellyn-Jones et al.). Many elements of this model identify its applicability to the various aspects of providing care to elders with mental health illness in the LTC setting. Collaboration within a multidisciplinary team can improve outcomes of residents with mental health illness in the LTC setting. Leo, Sherry, DiMartino, and Karuza (2001) suggested "the psychiatrist, working collaboratively with geriatric physicians, social workers and nursing staff, can improve the recognition and treatment of depression among residents" (p. 787). "LTC homes should obtain mental health services from local practitioners or multidisciplinary teams, with interest and expertise in geriatric mental health issues" (CCSMH, 2006, p. 41).

The literature supports various models to support the care of the elderly with mental health illness. When assessing the needs of a particular LTC home, one should consider the resources available within the community and the applicability of the benefits of each of these models. LTC homes can utilize the resources that these models offer in order to meet the care needs of this specialized population.

LTC Staffing Needs

With respect to meeting the health care needs of this age group who experience symptoms of mental health illness, the demographics related to the shortage in health care professionals available and the lack of specialized training for this population are causes for concern (Bartels, Moak, & Dums, 2002). This is a specialized population group requiring that caregivers be trained with an integrated expertise in geriatrics and mental

health. The accepted practice when caring for this population is that "medical assessment should precede management of behavioural disturbance" (Eisch et al., 2000, p. 150).

Within the literature is evidence of the deficiency in specialized psychiatric support and service in LTC homes (Bartels, Moak, et al., 2002; Reichman et al., 1998; Snowdon, Vaughan, & Miller, 1995). "Historically, few nursing home residents have received specialized mental health services despite their demonstrated need" (Reichman et al., p. 321). Many nursing homes find that geriatric care provided by primary care physicians is limited. Although psychiatrists provide services to LTC homes with regard to diagnosing and pharmacology, the need for nonpharmacological interventions and other staff-related functions are not addressed by psychiatrists and have been identified as necessary areas for support (Reichman et al.). Still, psychiatry support in LTC homes is lacking and insufficient to meet staff members' and residents' needs (Reichman et al.). Some nursing homes have incorporated the role of NPs with specialized training in geriatric psychiatry to help fill this void (Eisch et al., 2000). The lack of mental health training of LTC home staff and physicians is identified as an obstacle in providing appropriate care to residents within the LTC setting (Reichman et al., 1998). Bartels, Dums, et al. (2002) stated, "Training in assessment and management of behavioural problems has been shown to reduce turnover of clinical staff and improve knowledge and performance of nursing staff" (¶ 43). The statement by Sullivan et al. (2004) that "continued ... development that is designed to advance practitioners' knowledge, skills, and experience in relation to the diverse population they serve and to advance approaches to shared care, education, and systems development" (p. 464) refers to supporting the needs of caregivers providing geriatric mental health services, and it provides validity to

the necessity of ongoing training for the nursing staff who must manage this challenging population group. The need for LTC home staff to be trained in behavioural management techniques and ongoing educational sessions pertaining to mental health issues, particularly dementia care issues, is prevalent in the literature (Bartels, Moak, et al., 2002; Reichman et al.; Snowdon et al., 1995).

This need has strong implications for the resources and training that LTC staff should have because the staff compliment consists of a majority of nursing assistants and personal support workers and a limited number of registered nurses and skill levels vary significantly among these disciplines. The need to address the level of expertise required for providing care to the psychogeriatric population is significant. "A substantial portion of nursing home care is provided by nursing assistants who have little formal mental health-related education...*and* no preparation for managing mental health problems" (Kennedy, Covington, Evans, & Williams, 2000, ¶ 3).

Although external resources and/or teams may be available to LTC homes for support, the frontline staff providing the day-to-day interventions requires the preparedness for dealing with the difficulties in managing the behaviours of the mentally ill elderly. "Emphasis on the importance of focusing training *initiatives* on the staff members who have the greatest direct contact with residents" was suggested in studies reviewed by Bartels, Moak, et al. (2002, p. 1394). Leo et al. (2001) identified the evidence of how useful accurate nursing assessments are. They asserted that "nursing home staff assessment of resident depression can be a valuable source of information for the consulting psychiatrist" (p. 787) due in part to the fact that "nursing home staff spend large amounts of time with residents and have a longitudinal perspective of a resident's

behaviours" (p. 787). However, in this study, Leo et al. found that the assessment skills of the nurses in detecting depression appropriately were poor and that the depressive behaviours that manifested in these patients were misunderstood" (p. 785). These findings supported the ongoing need to enhance training and education initiatives for care providers working with the elderly who experience mental health illness in order to provide the knowledge to accurately recognize symptoms of particular illnesses and ensure appropriate treatment. Because of the complex needs of the elderly with mental health illness and the deficiencies in understanding of and training for behaviours and symptoms related to mental health illness, there has been "a long history of inadequate and inappropriate diagnosis and treatment of nursing home residents, including wide spread misuse of psychotropic drugs and physical restraints" (Streim et al., 1997, p. 285). These researchers also suggested that the "deficiencies in assessment and management of residents with psychiatric disorders have been attributed in part to inadequate access to mental health services in the nursing home" (p. 285).

A CMHA report (n.d.) cited statistics from Conn, Lee, Steingart, and Silberfeld (1992) describing "in Ontario, 88 percent of nursing homes receive only five hours or less of psychiatric care per month for the entire institution" (¶ 8). The role of the psychiatrist within nursing homes is pivotal. Not only can the psychiatrist be the leader of the multidisciplinary teams within the homes but he/she can also fulfil the role of the primary care provider (Streim et al., 1997). This study also supported and identified the need for an education and training liaison role of the psychiatrist and the LTC home staff.

A crucial need for physician training in both geriatrics and mental health was identified in the literature as an urgent priority. Psychiatrists have training in geriatric

psychiatry, but general practitioners who are usually the primary caregivers should also have training in the mental health needs of the geriatric population (Streim et al., 1997). Therefore, the literature supported the need for increased training for all professional disciplines in the area of psychogeriatrics and strongly recommended the enhancement of care provision within the LTC setting.

Summary

The research supports the need for the identification and incorporation of best practice guidelines with regard to psychogeriatric care. This is a rapidly growing population cohort, and the importance of continued research in this area is significant in order to provide quality care to these elders. Best practice guidelines will assist in providing high-quality, accountable care with measurable outcomes. When considering the achievement of best practices, Orb et al. recommended "flexibility, clarity of goals, familiarity with the delivery of services, the presence of a multidisciplinary team and the involvement of the stakeholders [as being] the essential ingredients in a best practice model" (p. 17). Implementing a best practice model of care for this population will "assist health care workers to identify the focus and goals of practice" (Orb et al., p. 13). When considering the implementation of these guidelines, various models of care can be considered to fit with the resources of the community. The literature reviewed encompassed psychiatrist-centred, multidisciplinary, nurse-centred, and shared-care models. "LTC homes should obtain mental health services from local practitioners or multidisciplinary teams, with interest and expertise in geriatric mental health issues" (CCSMH, 2006, p. 41). The allocation of professional resources and availability of

trained professionals in the area of psychogeriatrics will be key components in supporting these models of care.

The literature was reviewed for the assessment of staffing needs within LTC homes to provide care to mentally ill residents. The findings identified that education and training of professionals and staff that provide care within LTC homes is inefficient to meet the challenges of psychogeriatrics. Recommendations included the need to provide educational and training opportunities in various forums and disciplines to enhance the assessment, intervention, and treatment components for elderly with mental health illness. It was suggested in the literature that staff retention rates might increase as the result of increased training and resources for staff. The recruitment of physicians into the area of psychogeriatrics is also a challenge. Continued research in the area of psychogeriatrics will help to define successful care needs and strategies of this population and hopefully influence societal and political accountability in supporting the increased demand for LTC.

Providing mental health care to the elderly in LTC facilities is challenging. Research has indicated a variety of models, interventions and staffing challenges related to psychogeriatric care in LTC. However, the needs of this population and of the LTC industry continue to evolve and require further evaluation, intervention and support.

Needs Assessment

This project comprised a needs assessment that identified and evaluated the current barriers that LTC facilities encounter when considering admission of and supports required to provide care for the psychogeriatric population. The awareness about LTC homes being under funded by the government is increasing (National Advisory Council on Aging, 2003). The need to evaluate the quality of care and support to Ontario's LTC

homes is emerging. The final report to the MOHLTC by the Southwest Mental Health Implementation Task Force (2002) discussed the challenges and needs for LTC homes in their region and supports the adequate resources for acute and LTC sectors. Also found within this report was the recommendation for "the MOHLTC to attend to recruiting and retaining mental health professionals as well as 'to promote' the development of broad skills sets, including skills for provision of multi-cultural and diverse populations supports and services" (p. 38).

Demographic Data

The geographical area that will be included in this needs assessment is the London-Middlesex Region in Ontario, Canada (see Appendix A). A brief community survey of psychogeriatric services currently available within this region is attached to this proposal (see Appendix B). According to Statistics Canada (2001), the demographics of the seniors in the metropolitan area of London identified 30,095 individuals between the ages of 65 and 74. The age group of 75 to 84 totalled 20,720, and the population 85 and over totalled 6,130. The cumulative percentage of Londoners over the age of 55 was over 22%. Population projections for London identified a 31% growth in the age category of 65 to 69 by 2011 (Bowen & McManus, 2005).

Bowen and McManus (2005) shared the views of London's seniors that were derived from various focus group sessions. Health and mental health were identified as one of the top priorities to be addressed in the action plan. Mental health was identified as a barrier to accessing service, and the recommendation to establish linkages between geriatric and mental health services was highlighted (Bowen & McManus). The need to explore the barriers to admission and support to LTC homes for the elderly who suffer

with a mental health illness has also been identified by other health care focus groups. The difficulties that LTC homes experience when caring for the elderly with hard-to-manage behaviours that are related to a mental health illness is becoming more prevalent in the London-Middlesex region. This issue has been brought to the attention of the MOLTHC, and a local task group has been established to further explore this problem. The Southwest Mental Health Implementation Task Force acknowledged in their report of November 2002:

> The shortage of mental health professionals is compromising the quality and accessibility of services and supports. The adequate and appropriate mix of human resources in both the community and hospital sectors is key to providing the comprehensive continuum of services and supports. Professionals must receive adequate and equitable remuneration for service delivery. (p. 39)

Other political forces related to LTC in the Southwestern region of Ontario that can positively influence adequate and effective support mechanisms and quality care provision within the LTC home sector in London-Middlesex include the Local Health Integration Networks (LHINs 1 and 2); reports of the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario the CCSMH; the Canadian Nurses Association (CNA); the Registered Nurses Association of Ontario (RNAO); St. Joseph's Health Care London; London Health Sciences Centre; and the Community Care Access Centre (CCAC).

Currently, three geriatric psychiatrists provide regular service to the LTC homes in London-Middlesex. One psychiatrist provides service only to one LTC home in London-Middlesex. Another psychiatrist provides support to residents in LTC who are

registered outpatients with the discharge liaison team (DLT) from Regional Mental Health Care London. The third psychiatrist provides support to all 18 LTC homes, but there is a 6- to 8-week wait list for this service. Outreach teams from various hospital-based programs within specialized geriatric services (SGS) provide mental health support to LTC homes as well. The DLT provides support only to residents who have transitioned from Regional Mental Health Care London into LTC. This team consists of four registered nurses (RNs), three registered practical nurses (RPNs), and a geriatric psychiatrist. The London Health Sciences Centre's team, the Geriatric Mental Health Outreach Team, is comprised of two RNs, two social workers, and one geriatric psychiatrist. The Regional Psychogeriatric Program (RPP) from St. Joseph's Health Care is comprised of advanced practise nurses, who consult with the multidisciplinary geriatric outreach teams.

Performance Measurement and Evaluation

Ethical review boards from Lakehead University; the University of Western Ontario; and the Clinical Research Impact Committee of St. Joseph's Health Care in London, Ontario, approved the research proposal for this needs assessment to be conducted. The following logic model in Table 1 was used to guide and evaluate the performance of this needs assessment.

Table 1

Assessing the Needs and Barriers of LTC Homes Logic Model

Purpose of the Study

To identify the needs and barriers to admission in LTC homes for the elderly with mental health illness in the London-Middlesex Region.

▼

Target Population

LTC homes in the London-Middlesex Region. Seniors over 65 years with a mental health illness.

▼

Objectives

- To assess the barriers to admission to LTC homes for the elderly with a mental illness.
- To identify psychogeriatric services and supports for residents and staff.
- To identify LTC home staffing needs and deficiencies.
- To identify the availability and utilization of psychiatric services in LTC homes.
- To identify the academic and specialized training needs of the staff providing care within the LTC homes.
- To identify and evaluate the inequities and gaps in LTC services provided to the elderly with mental health illness.

▼

Long-Term Outcomes

- Enhanced access and admission to LTC homes for elderly with a mental health illness.
- Reduced stigmatism related to age and mental health illness.
- Improved quality of care for the psychogeriatric population within the LTC setting.

▼

Indicators

- Increased admission rates to LTC homes for elderly with mental illness.
- Decrease in psychiatric hospital readmissions.
- Stigma no longer a barrier to access.
- Positive attitudes and satisfaction toward care by consumers, staff, and administrators.
- Improved collaboration and communication among residents, families, staff, and administrators.
- Psychogeriatric needs being met within LTC settings guided by best practice interventions.
- Application of education by staff, families, and residents.

Research Methodology

The administrators or designates of 18 LTC homes in the London-Middlesex County were the selected participants for this needs assessment. A survey questionnaire (see Appendix C) was the method of data collection that was administered to participants via telephone interview or independent completion and then returned by mail. Precontact phone calls were placed to begin the process of engaging the facility in the assessment (see Appendix D). Once the questionnaires, cover letter (see Appendix E), and consent form (see Appendix F) were mail-delivered to the LTC home administrators, phone contact was made by the researcher to provide the opportunity for them to participate in the study by completing the questionnaire via a telephone interview and to arrange a convenient time for the interview.

The questionnaire entailed questions that were qualitative and quantitative in nature. The purpose of the qualitative questions was to allow specific and relevant information to be collected that might require further explanation or clarification by the administrators. For example, descriptive responses of the referral processes for various services, description of types and quality of services provided, and discussion about barriers to service and deficiencies within the LTC and health care systems was provided by qualitative responses. The quantitative questions were utilized for comparison and measurement purposes when analyzing the data. Such questions elicited responses about staffing ratios, types of mental health diagnosis, types of behaviours of mentally ill residents, kinds of psychiatric services available, and types of barriers to admission to LTC settings. Utilization of these types of questions allowed the researcher to capture the practical and the theoretical aspects of answers from the participants.

Anonymity and Confidentiality

Anonymity and confidentiality were accounted for within the participant consent form and the covering letter that was provided to the participants in this project. All data collected from this study will be securely stored in a locked cupboard for 7 years at Lakehead University as per the university's policy. There will be no identifying participant information collected within the scope of this study.

Data Analysis

Statistical analysis of the quantitative data was completed using SPSS for Windows version 11.5. The results of the analysis provided valuable information regarding the variations and commonalities of service needs and provisions within the LTC sector in the London-Middlesex County. Minimum and maximum ranges, as well as the frequencies of responses to the quantitative questions, enabled the identification of gaps in supports and barriers to LTC residents and also identified some of the strengths in caring for the elderly with mental health illness. Constant comparative analysis was the methodology used to draw knowledge and themes from the qualitative data produced within the survey questionnaires.

Results

Survey questionnaires were sent to the 18 LTC homes in the London-Middlesex County. Two phone call reminders were made to LTC homes administrators to provide those who did not respond with the opportunity to complete the survey. Two participants declined the telephone interview and instead completed the questionnaire independently and returned the completed questionnaire by mail. Four administrators declined to participate in this study and cited their rationale as being "too busy." Five LTC

administrators did not respond to the request to participate in this study. Administrators from 9 of the 18 LTC homes completed the surveys, resulting in a total response rate of 50%. There were a total of 1,500 beds in the 9 LTC homes included in this study (range = 78-394, median = 157, mean = 166.67), representing 58% of the total number of LTC beds in the London-Middlesex LTC sector.

Seven of nine LTC homes reported a prevalence of serious mental health illness in at least 31 to 45 of the residents in their facility. Three of the nine homes reported that 76 to 100, or more than half, of their residents have a serious mental health illness. One home reported that at least 75% of its residents have a serious mental health illness. The most commonly reported mental health diagnoses of the residents in LTC homes, in order of prevalence, included dementia, depression, anxiety, delusional disorders, bipolar disorder, and personality disorder. The results of this needs assessment are considered in alignment with the key elements of the CCMHI (2005), accessibility, richness of collaboration, consumer centredness, and collaborative structures.

Accessibility

The most common barriers relevant to seniors and their admission to LTC homes in order of significance were identified as aggressive behaviours; smoking; type of mental health diagnosis; restraint use; lack of external community mental health support (i.e. outreach teams); and finances. The most frequent barriers to receiving mental health support that residents in LTC homes encounter are inadequate mental health training of staff, a lack of crisis intervention strategies and supports, the psychiatric referral/assessment process, and the referral process to outreach teams.

Services that are currently needed, but are not available, to enhance mental health support for this population were identified as more mental health training, education, and support for LTC caregivers; increased staffing and increased staff-resident ratios; increased availability of psychiatric hospital beds; improved coordination of acute psychiatric services between health care systems (LTC, acute care, emergency departments and tertiary care centres); and more psychogeriatricians to provide increased access for assessments and follow-up. Prioritized areas of need to accommodate this population are staff education, financial, environmental, staff recruitment and psychiatric support.

Richness of Collaboration

The nature and quantity of mental health support that is provided to the LTC facilities was assessed (see Table 2). All of the LTC homes in this study reported having the services of either a recreation therapist or an activities coordinator. Occupational therapy, kinesiology, and physiotherapy services were received on a contract basis, and the hours of service provided varied. Only one LTC home identified having the services of an NP, but information regarding the number of hours of service to residents with metal health illness was not provided.

Five of the nine LTC homes identified receiving 4 hours or less of psychiatry service per week. Only one of the nine homes identified receiving support from a geriatrician (4 hours per week), and all homes reported receiving no hours of psychological services. The family physician or general practitioner (GP) for the LTC homes provided the most physician support, which ranged from 1 to 15 hours per week.

Three of the LTC homes did not report any service from the GP. Other

professionals who provided mental health support were identified as pharmacists, dieticians, spiritual care staff and the DLT, and the other specialized geriatric outreach services. One LTC home reported having 4 hours per week of service of an advanced practice nurse for mental health residents. Another home reported receiving mental health services in art therapy, music therapy, and horticultural therapy. Volunteers were also mentioned from 2 participants as providing mental health support to the LTC residents on a weekly basis. From the responses provided, it was evident that the multidisciplinary services provided to the residents in LTC homes were not usually considered to be separate for mental health residents. Therefore, allied health care service hours were difficult to decipher between mental health residents and the rest of the population in LTC.

Table 2

Hours per Week of Mental Health Service to LTC Homes in London-Middlesex

Discipline	Range of hours per week of service	Mean	Median
NP	0	0	0.0
RN	3 – 168	61.14	40.0
RPN	3 – 168	63.00	30.0
Psychiatrist	0 – 4	2.14	2.0
Geriatrician	0 – 4	0.57	0.0
Family Physician	1 – 15	7.50	5.5
Psychologist	0	0.00	0.0
Social Work	0 – 35	15.83	15.0
Pharmacist	1 – 8	3.33	1.0
Spiritual Care	0 – 15	4.33	1.5
Non-Professionals (volunteers, High intensity needs funding, etc.)	2 – 12	8.00	10.0

The number of RNs working a day shift rotation ranged from 1 to 10 and from 1 to 2 during the night shift. The number of Registered RPNs working a day shift ranged from 2 to 9 and from 0 to 10 at night. Health care aides (HCAs) or Personal Support

Workers (PSWs) dominated the staffing compliments. The number of PSWs in the daytime ranged from 3 to 39, and the range for the night shift was from 3 to 12. Increased staff ratios and increased registered staff were common recommendations retrieved from the needs assessment.

Only 22% of the nine LTC homes reported having nurses on staff who had specialized certification in mental health nursing. All of the LTC homes reported having nursing staff that had received P.I.E.C.E.S. training. P.I.E.C.E.S. stands for Physical, Intellectual, Emotional, Capabilities, Environment, Social, and represents the philosophy of this care approach. This is a framework that teaches caregivers to understand why individuals behave the way they so and what resources they have available to build on. This strategy was developed to address the needs of the elderly who have a mental health illness. Four of the nine LTC homes reported having staff trained in gentle persuasive approach (GPA), and other LTC homes indicated being in the process of planning for this training. GPA is an intervention that is taught to caregivers of individuals who have dementia and related behaviours.

The learning needs of LTC home staff were assessed, including opportunities for learning and frequency of educational opportunities provided as well as learning needs. Educational priorities that were identified by the participants from the nine LTC homes, in order of significance, were interventions for managing behaviours (especially aggression); disease processes (signs and symptoms, diagnosis of various mental health illnesses); and pharmacology of psychiatric medications. Seven of the nine LTC homes stated that nursing journals related to geriatric care and mental health were available to staff. Hours of training per month varied greatly across the LTC homes (range 1-20 hours

per month). The type of educational opportunities provided to staff also varied to include daily case-based resident reviews to inservices provided 3 or 4 times per year. A theme emerged related to the skilled level of care required for the complex psychogeriatric population who reside in LTC. Recommendations to include more geriatric mental health care education within the university and college programs was repetitive, as was the need to provide more mental health training for PSWs related to the theoretical components of disease processes and supportive interventions.

Consumer Centredness

As mentioned previously, the assessment of residents needs was conducted with qualitative and quantitative questioning. How the mental health needs of the residents were met was explored by reviewing staffing assignments and the biopsychosocial care interventions for the residents. The most frequently displayed disruptive behaviours from residents with mental health illness were identified as verbal aggression, medication noncompliance, physical aggression, inappropriate sexual behaviours, and self-injury.

The staffing of the units varied across the LTC homes, but the determining factor for the number of staff working on a unit depended on the time of day (day or night), the number of residents located in a space, and the physical care needs. One LTC home had a dedicated therapeutic recreation staff, and another had extra staffing on one of their units from 7 a.m. until 11 p.m. Administrators discussed the option of applying for high intensity needs funding from the MOHLTC to provide 1:1 staffing for short-term support for a resident with intensive mental health needs.

When assessing the ability of the LTC homes to meet the emotional mental health needs of the residents, 78% ranked their ability as good to excellent. The role of the

social worker was repeatedly identified as valuable in meeting these needs. Family councils; case conferences; and education for staff, families, and residents were discussed as effective practices to support the emotional needs of the residents experiencing mental health illness. Enhanced mental health counselling, support, and education for nursing staff were cited as areas of need.

When rating the ability of the LTC homes to meet the physical mental health needs of their residents, 89% considered their facilities as good to excellent in this area. Newer facilities were described as being more successful in meeting the physical needs for residents because of environmental layouts and improved privacy and personal space. Areas for further development were identified as being able to offer more recreational activities and acquire increased staffing and funding to provide for more effective care.

The ability to meet the spiritual needs of mental health residents was rated as good to excellent by 78% of the LTC homes. Positive attributes were the availability and flexibility of spiritual care services. Spiritual care providers were sometimes active in resident conferences, and this was considered very supportive. Increased services and training specific to mental health issues were acknowledged as areas for improvement.

The theme of increased education related to mental health illness did not pertain only to LTC home staff but was also inclusive of families and residents. Increasing awareness of mental health illness was cited as a need. The participants in this study considered mental health care as requiring a "highly trained calibre of staff" because this population has "complex" needs, and the participants described LTC as "not even being in that league."

Another theme evolved in the element of consumer centredness, and this was about the integration versus the segregation of individuals with a mental health illness. Comments pertaining to the difficulties of working with "mixed populations" and the challenges experienced with this relayed the frustration that LTC homes were experiencing when providing care for elderly with a mental health illness. A common example cited in the participants' responses regarded older, frail residents who may have decreased mobility and are living in a setting with the "young-old" who are strong and aggressive with a mental health illness. They also cited challenges with this mixed population as the result of the escalating behaviours of residents with mental health illness and unpredictable changes in the milieu in LTC dayrooms and units. One description of a resident's perspective was as follows:

> In the old days, people with a mental health illness went away and they were never seen. Now we are forcing the elderly to live with the people that they used to send away. They are not familiar with mental illness and are, instead, fearful of it.

There is fear in LTC homes for residents who have never been around individuals with a mental health illness. Some administrators remarked that individuals with a serious mental health illness do not belong in LTC homes. "If it is not a short illness, then it should remain in another area." Although most LTC homes were focused on an integrated approach to care, some comments about segregation of the mentally ill geriatric population were indicative of the complexity of the care involved. "It's like putting oil and water together and it doesn't mix; it's a recipe for disaster. Mental health institutions served a purpose, and this is where they need to be." The compelling outcome

was that LTC homes are not equipped to support the complex needs of elderly with a mental health illness.

Collaborative Structures

Mental health supports from external sources to LTC were assessed. The results indicated the most commonly utilized resources were support from the tertiary care centre DLT, SGS, geriatricians, psychiatrists, and the emergency department, and other less formalized resources such as contract professionals, the Alzheimer's Society, and the MOHLTC for high-intensity needs funding. There was mixed feedback regarding whether or not these resources met the needs of the mentally ill residents in LTC homes, and the balance favoured a more positive response than not.

Deficiencies cited with these resources were the length of wait times for assessment and follow-up by the psychogeriatrician, the lack of consistency with psychiatry support from the DLT, and the ineffective mental health treatment for residents who have been sent to the emergency department and then returned to LTC within a very short turn-around time. The need for more resources to help with residents who have escalating behaviours to prevent a crisis situation or to provide assistance when a crisis situation evolves was also identified in the needs assessment. Positive findings for these resources were the methods for the referral processes, the support provided to residents from the DLT and the SGS, and the benefits provided by psychiatry consultation for the pharmacological needs of residents in LTC.

The management of pharmacological interventions for the residents in LTC was assessed in order to identify the consistencies, inconsistencies, and benefits to this area of care. All nine LTC homes responded that the GP managed this intervention for their

residents. The responses from the LTC homes assessed the effectiveness of pharmacological management by these physicians as fair (33.3%), good (33.3%), and excellent (33.3%). Five of the nine homes reported the geriatrician as also managing pharmacological interventions. The effectiveness of this support ranged from good (33.3%) to excellent (22.2%). A psychiatrist was identified by seven of the nine homes as participating in the pharmacological interventions, and the effectiveness of this support ranged from good (33.3%) to excellent (44.4%). A pharmacist was frequently identified as a resource in the pharmacological management of residents with mental health illness in LTC; six of the nine homes identified their involvement in addressing the pharmacological needs of the residents. The effectiveness of the pharmacist in this intervention ranged from fair (11.1%), to good (11.1%), to excellent (44.4%). These results indicated an important aspect of the potential benefits of collaboration for the effectiveness in the pharmacological management of psychiatric medications for mentally ill residents in LTC by the good to excellent ratings across the disciplines.

Discussion

This needs assessment was designed to identify the barriers to admission to LTC homes and supports within LTC homes for elderly with a mental health illness. The results indicated that a significant portion of elderly with a diagnosis of mental health illness live in LTC homes in London-Middlesex. One LTC home identified that 75% of the residents who live there have a serious mental health illness. The mental health diagnoses varies, with the primary diagnosis being dementia, followed by depression, anxiety, delusional disorders, bipolar disorder, and personality disorder. This needs assessment highlighted the perceptions of LTC administrators that psychogeriatric care is

complex and requires access to a highly trained calibre of professionals to provide appropriate mental health supports to the residents in their LTC homes. Access to external supports and consistent, effective systems of care for this population are regarded as necessary and beneficial to LTC homes in providing care for the elderly with mental health illness. A multidisciplinary approach to care was evident in the responses provided, and this finding was consistent with the recommendations in the literature reviewed for this study.

The findings from this study are reflective of some of the barriers to admission to LTC and supports in LTC for elderly with a mental health illness in the London-Middlesex County. These were primarily related to behaviours of mental health illness, types of diagnoses, and lack of community supports. Barriers to residents receiving mental health support in LTC included inadequate mental health training of LTC staff, lack of crisis intervention strategies and supports, the process for psychiatric referrals, and the referral process for outreach teams. The paucity of mental health knowledge and skills of LTC homes staff, an inadequate number of specialized mental health clinicians, and improved coordination of mental health services were themes that evolved in this needs assessment. An increased registered staffing ratio for residents in LTC was also unanimously cited as a need across the LTC sector.

It was also evident in the findings that the LTC sector is attempting to meet the needs of this population and that it is also very aware of the weaknesses and strengths within facilities and the health care system. The administrators indicated that they are effective in meeting the emotional needs (78%), the physical needs (89%), and the spiritual needs (78%) of the geriatric psychiatry population. This was supported by the

consideration of including a multidisciplinary client- and family-centred approach. It was suggested in the literature that the inclusion of consumers is an important consideration when identifying best practices in psychogeriatric care. Consumers are considered to be families, guardians, or carers (Orb et al., 2001). The LTC homes in this project showed evidence of consumer-centred care of their residents.

The educational need of the LTC staff was cited as a definite area to meet in order to effectively provide for the care demands for the elderly with mental health illnesses in their facilities. The implementation of evidence-based practices is an evolving trend within the health care field as the need to "evaluate and continuously improve the quality of the (delivery of) healthcare" is acknowledged (Orb et al., 2001, p. 17). "Identification of evidence-based practices should be considered as a starting point for improving the quality of care" (Bartels, Dums, et al., 2002, ¶ 48). The LTC homes in this study are incorporating some of these concepts, but they will require further supports to sustain and develop the initial investments in training and incorporating strategies and interventions for care. Each of the nine LTC homes that participated in this needs assessment acknowledged that they have at least one P.I.E.C.E.S. trained staff member, and four of the nine acknowledge having staff who are trained in GPA, whereas other LTC homes are in the process of planning for this initiative. The primary educational need that was identified for LTC focuses on interventions for managing aggressive behaviours. The aforementioned interventions will help significantly with this identified need. However, in order to implement and sustain the training, adequate funding will need to be available

There appears to be room for improvement in the availability of mental health supports and within the systemic approach and resources when trying to meet the needs

of this population within the LTC setting. This needs assessment suggests that currently, resources are not available, are inconsistent, and/or have long wait times to provide appropriate assessment and follow-up for these residents in LTC. Some services, like the DLT, are only available to residents who have been transitioned from a tertiary care centre. They offer availability 24 hours a day, 7 days a week, to the residents on LTC homes, but their availability is mandated to individuals who have been transitioned from the regional mental health hospital. All other residents with ongoing or escalating mental health needs must be referred to other resources within SGS where they encounter long wait times for assessment and intervention.

It is understood from the reports of LTC administrators that mental health support that is provided to LTC homes in London-Middlesex is not sufficient. Psychiatric and geriatrician services are minimal, and there is no support from the discipline of psychology. The role of the pharmacist in the pharmacological management of psychiatric medications was described as a valuable resource and should be considered as a necessary resource in LTC. There are a very limited number of advanced practice nurses in the county who provide mental health care to LTC homes, and a there are a minimal number of RNs certified in psychiatric nursing who are employed in LTC homes. This paucity in professional specialized mental health resources for LTC requires further evaluation and gives support to the impression of LTC home administrators that the environment in LTC is not adequately equipped to cope with the increasing demands to care for elderly persons with mental health illness. This outcome is consistent with the findings in the literature.

The lack of mental health training of both LTC home staff and physicians was identified as an obstacle in providing appropriate care to residents within the LTC home setting (Reichman et al., 1998). With a minimum of registered staff and a dominance of PSWs providing daily care in LTC homes, the staffing compliments should be re-evaluated and resourced suitably. Support for and consideration to educational programs in universities and colleges will need to consider the curriculum to include more emphasis on the study of geriatric psychiatry. Funding from the appropriate government ministries will need to exist in order to accommodate the need for increased registered professionals and specializations to support the needs of geriatric psychiatry in LTC. External outreach and consultation teams were described as meeting the needs of LTC for the majority of cases, but concerns with inconsistencies in follow-up with consulting nurses and psychiatrists, some access issues and long wait times arose.

Recommendations

Further evaluation of the needs for LTC to provide mental health care to the elderly should consider identifying standardization in staffing compliments and the allocation of multidisciplinary resources. Consistency in the treatment of mental health residents between health care systems is another notable area for enhancement and especially pertaining to mental health crisis interventions and support. The various models of shared care, transitional discharge, and consultation all proved to be valuable to LTC homes, as cited in the literature. The results of this needs assessment concurred with the findings in the literature, suggesting that various models of care can provide efficient mental health support and intervention to LTC homes. This also allows for

flexibility and creativity with the utilization of resources available to provide mental health care to the elderly in LTC.

It is important to critically evaluate the results and the whole study. The present study has certain limitations that need to be taken into account when considering the study and its contributions. A larger sample size may provide further analysis and validity of specific models of care that are effective in supporting the mental health care of individuals in LTC. Further studies should look at what interventions and psychiatric treatments are the most cost effective and what skills and training are necessary requirements for LTC staff (Bartels, Moak, et al., 2002). These studies could incorporate a broader sample size of LTC homes within southwestern Ontario to provide more conclusive findings. A comparative analysis study between LTC homes in urban versus rural locals would be an interesting method to further identify the elements of the present needs assessment. Other factors not considered in this needs assessment were the amount of government funding provided per resident, the recorded and types of risk events in the LTC homes, the number of resident transfers to the emergency departments due to mental health issues, and the number of elderly with mental health needs who are on a wait list for LTC placement. Another limitation of this study is the perspective adopted, that is, self-assessment results versus an external assessment. Potential sources of bias include administrator ratings and, therefore, exclude staff and consumer interests.

Summary

Senior citizens will account for 21% of the population by 2026, compared with 13% in 2000. By midcentury, they will represent virtually one quarter of the population. This is evident in the population projections by Statistics Canada (2001) for the elderly in

London, Ontario, as a 31% increase in individuals between the ages of 65 and 69 is expected by 2011. Systematically, health care is experiencing the impact of this increased shift in health care needs.

LTC homes have witnessed their population demographics change significantly over the years. An increased demand is now being placed upon them to provide care for elderly persons who suffer with concurrent medical and mental health needs. Many LTC homes are not staffed appropriately to care for individuals with mental health illness. Many barriers prevent elders with mental health issues from being accepted for care in LTC homes. The literature identified these issues, along with strategies to overcome them. Variations in the provision of services to LTC will depend on available health disciplines, nursing and physician shortages, funding constraints, implementation and follow-up strategies, geography, and demand for services. The approach of LTC homes in the London-Middlesex County to supporting the elderly with mental health illness in their facilities is consumer centred, multidisciplinary, and integrated.

Addressing the current needs of LTC homes will require a systems approach. Leaders from various systemic levels will need to collaborate to identify and implement the necessary changes that need to occur within the London-Middlesex region. The compelling response from LTC homes was that LTC is not a setting that is equipped to support the complex needs of elderly with a mental health illness. "Mixing" populations of the mentally ill with frail elderly who do not experience mental health illness is considered problematic.

LTC administrators, health care infrastructure managers, and government officials will need to assess the inventory of services, systems, and fiscal needs in order to

adequately support this gaping area of need in elder mental health care. Consideration of the paucity of health care professionals available to deliver services will also have to be evaluated when planning strategically for this sector. Reference to the priorities in mental health reform and the associated framework will assist in fulfilling this systematic approach. The conclusions and the limitations of this study also bring forth some interesting possible avenues for future research that might be needed in relation to the theme of the study. The most important avenue for further research obviously lies in the continuing elaboration of the elements of the needs assessment to other LTC homes in southwestern Ontario.

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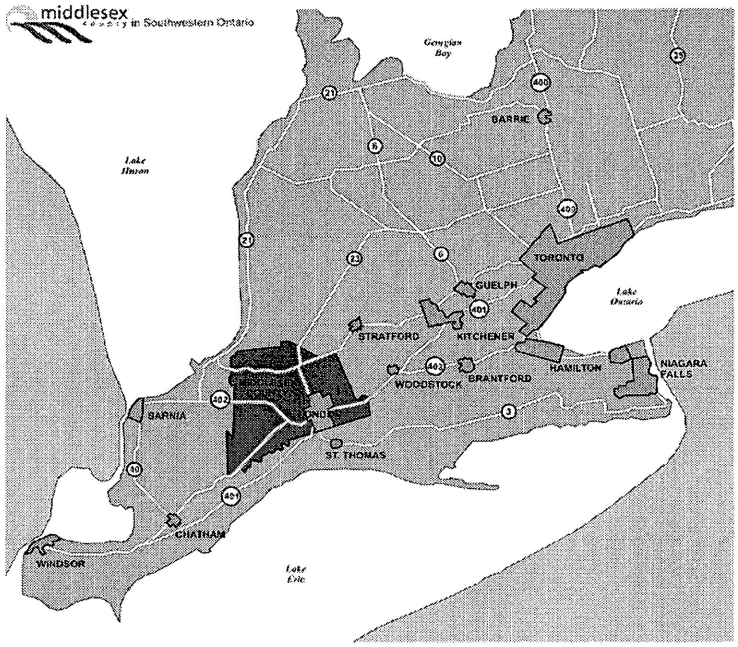
APPENDIX A: MAP OF MIDDLESEX COUNTY AND CITY OF LONDON



Source: My Community Info.ca

APPENDIX B: GERIATRIC MENTAL HEALTH SUPPORT SERVICES IN LONDON, ONTARIO

Agency/Service	Interventions Available	*Contact Person*
ST. Joseph's Health Care London Regional Mental Health Care London **(RMHC – L)**	Assessment, treatment, rehabilitation prevention, family/community support and education provided by a multidisciplinary team, addressing the mental, spiritual, cultural and psychological and social aspects of aging. **Outreach Services** - consultation, assessment, treatment and evaluation, education. **Outpatient Services** - one-to-one support for clients/patients and their families to maintain community living and to minimize the need for readmission to bed-based care. **Inpatient Services** - 138 beds in London. **Day Treatment Program (London)** - provides continuing care through the use of occupational therapy interventions for clients who are on the threshold of community integration or who have been discharged from the bed-based care. Medical or agency referral required. Admission preassessment by team members. **Eligibility** Seniors, 65 years and over, with long-term or late onset mental illness or severe behavioural disturbances.	**Karen Berger** (519) 455-5110 ext. 47374 **Jennifer Speziale** Coordinator, Outreach Programs, Geriatric Psychiatry (519) 455-5110 ext. 47691 **Judy Wakem** Coordinator, Inpatient Programs, Geriatric Psychiatry (519) 455-5110 ext. 47244

St. Jospeh's Health Care London **Third Age Outreach for Seniors**	A network that links geriatric / geriatric mental health assessment teams in the 10 counties of southwestern Ontario. Multidisciplinary teams link with local resources to provide geriatric and geriatric mental health assessment and treatment options in or near the client's home. **Eligibility** Self-referrals (participation of family physician is preferred and a signature may be required) Seniors, 65 years and over, living in the community with complex, multiple health problems who are experiencing difficulty coping on their own, or are recently bereaved or hospitalized with behaviour difficulties. Agreeable to a referral by a physician.	**Centralized Intake for London and Middlesex** (519) 685-4046 ***Catherine Glover*** Program Coordinator
London Health Sciences Centre (LHSC)	Assessment and treatment of mental health and/or the psychiatric aspects of medical problems related to aging. Services are provided in the home, clinic or residential facility. The multidisciplinary team, which includes psychiatrists, social workers, and nurses, works closely with family doctors and other health care providers. Referrals to other services and inpatient psychiatric department if required. Crisis coverage for current clients is offered during office hours. Medical referral with letter. **Eligibility** Seniors, 65 years and over, experiencing a mental health disorder or who are dealing with the psychiatric aspects of mental problems that are related to the aging process.	**Mental Health Care Program – Geriatric Mental Health Outreach Service.** ***Lynda Parker*** (519) 661-1620 **Dr. David Harris**, Physician Leader (519) 667-6693

Senior's Help line	Anonymous, confidential and nonjudgemental telephone support for seniors and their caregivers needing to talk to someone. Discusses options and makes referrals to other appropriate agencies if necessary. Crisis intervention. The line is staffed by trained volunteers. Service is provided through a partnership of the London and District Distress Centre, Committee on Abuse and Neglect of the Elderly and others. **Eligibility** Seniors and those who care for them.	Office: (519) 667-6710 (Administration) Crisis: (519) 667-6600 **Jean Knight** - Executive Director - Distress Centre
PIECES Network	Regulated health professionals working in LTC facilities with responsibility for providing care to persons with Alzheimer Disease and related dementias and have an active role in the day-to-day assessment, planning, and delivery of direct care.	Long-Term Care Homes P.I.E.C.E.S. Nurse
Community Care Access Centre (CCAC)	Application to enter an LTC facility must be made through the Community Care Access Centre. The Community Care Access Centre of London and Middlesex, working in partnerships, helps people access health and support services and resources by providing: Program and services information, care at home and in school, access to LTC facilities and evaluation, education and research.	***Barbara Whipps*** **Community Placement Coordinator** (519) 473-2222 or toll free at 1-800-811-5146 ***John McClelland*** Manager, Client Services (519) 641-5459
London Mental Health Alliance	They work to create an environment for a comprehensive, coordinated, seamless system of service, education and research that facilitates client-centred support and intervention toward recovery and wellness. They are also a proactive leader in the planning and implementation of mental health services. They consist of a close network of services	**Diehl Elkin** CEO WOTCH Community (519) 668-0624

	working to meet identified needs, address service gaps, and advocate for change.	
Canadian Mental Health Association (CMHA)	It is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. The London-Middlesex branch does not offer services targeted at the older adult population, but family support services and support for general mental health needs is offered.	**London-Middlesex Branch** (519) 434-9191

APPENDIX C: QUESTIONNAIRE

Questionnaire: "A Needs Assessment: Identifying psychiatric supports and service barriers for the geriatric mentally ill population in long-term care facilities in London, Ontario."

This questionnaire is being provided to Administrators of Long-Term Care Facilities to collect data with relevance to the needs of providing care to the geriatric population who experience symptoms of mental illness. Your participation in this process is greatly appreciated. This researcher will contact you by telephone by **DATE** to provide you with a convenient time answer this questionnaire and will schedule a telephone interview with you. Completing this questionnaire should take approximately 20-25 minutes. Thank you in advance for your time.

Questions:

1. Approximately how many residents are living in your facility?

   _____

2. Approximately what number of your residents has a serious mental health condition?

   ☐ 0 ☐ 31 – 45 ☐ 76 - 100
   ☐ 01-15 ☐ 46 – 60 ☐ More than half
   ☐ 16-30 ☐ 61 – 75 ☐ other _____

3. Which of the following mental health diagnoses do the residents in your facility experience? Please rank in order of highest to lowest prevalence.

   __ Depression __ Personality disorder
   __ Dementia __ Schizophrenic/Delusional
   __ Anxiety __ Bipolar Disorder
   __ Other

4. What is the number of staff scheduled to work on a day shift rotation at your LYCH? (i.e., number of RNs, etc).

   RN's _____ Health Care Aid (PSW)_____
   RPN's _____ Recreation Therapist _____
   Social Worker _____ Other _____

5. What is the number of staff scheduled to work on a night shift rotation at your LTCH?

RN's	_____	Health Care Aid (PSW)	_____
RPN's	_____	Recreation Therapist	_____
Social Worker	_____	Other	_____

6. Are all of your resident units staffed the same, or different? Explain.

_____

_____

_____

7. Approximately how many of your nursing staff have specialized certification in mental health nursing?

_____

8. How many PIECES Resource Consultants (PRC) do you have at your LTCH?

_____

9. Approximately how many of your staff has received PIECES training?

_____

10. Approximately how many of your staff has received training in Gentle Persuasive Approaches (GPA)?

_____

11. What are the most frequently displayed disruptive behaviours by residents in your facility? Please rank in order of most to least frequent behaviours displayed.

____ Physical Aggression
____ Verbal Aggression
____ Self Injury
____ Refusal to take medications
____ Inappropriate Sexual Behaviour
____ Other

12. What professional disciplines provide mental health support ***within*** your facility, and what is the approximate number of hours per week of service provided to the clients? Please check all that apply:

DISCIPLINE	**Number of Hours/week of service**
❑ Nurse Practitioner	_____
❑ RN	_____
❑ RPN	_____
❑ Psychiatry	_____
❑ Geriatrician	_____
❑ GP - Family Physician	_____
❑ Psychology	_____
❑ Social Work	_____
❑ Occupational Therapy	_____
❑ Recreational Therapy	_____
❑ Pharmacist	_____
❑ Spiritual	_____
❑ What non-professionals	_____
❑ Other _____	_____

13. What barriers to mental health support do your residents encounter? Please rank in order from most frequent to least frequent.

_____ Psychiatric referral/assessment process
_____ Medical referral/assessment process
_____ Referral to Outreach/Discharge Liaison Team (DLT)
_____ Crisis intervention/support
_____ Pharmacology support
_____ Inadequate mental health training level of nursing staff

14. What barriers are there to admission to your facility for geriatric referrals with significant mental health behaviours? Please rank in order of significance.

_____ Aggressive behaviour
_____ Smoking
_____ Finances
_____ Wandering
_____ Age
_____ Gender
_____ Type of mental health diagnosis (i.e. Bipolar disorder, schizophrenia, etc).

(Continued on next page...)

____ Lack of external/community mental health support (i.e., Discharge Liaison Team or Outreach Team).
____ Restraint Use
____ Other _____

15. Please identify any services that are currently needed, but are not available for the mentally ill geriatric population within the Long-term care sector in the region of London/Middlesex.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

16. What would you suggest are the areas of need for your facility to accommodate this population? (i.e., Staffing, education, environmental, financial). Please rank in order of importance.

____ Staff Education
____ Environmental
____ Financial
____ Staffing Recruitment
____ Staffing Retention
____ Psychiatry Support
____ Other Staff Support _____
____ Other _____

Comments

_____
_____
_____
_____

17. a). What are the top 3 educational priorities for your staff with regard to providing effective mental health care to your residents?

1. _____
2. _____
3. _____

b). Are nursing journals related to geriatric care and mental health available to staff at your long-term care home? Please check your answer below.

☐ Yes ☐ No

18. Approximately how many hours of training/education is provided to your staff per month related to caregiving for residents who have a mental illness?

_____
_____
_____

19. i) Is mental health support provided to your residents from an external source?

- ❑ Yes
- ❑ No

ii) If yes, then please identify the source and discuss the referral process to this source.

_____
_____
_____
_____
_____

iii) Would you describe the service provided by this source as meeting the needs for your residents?

☐ Yes ☐ No

Comments

_____
_____
_____
_____
_____
_____

20. What types of restraints are used in your facility?

☐ Physical
☐ Chemical
☐ Other
☐ Environmental
☐ No restraints are used

21. If restraints are used, what are the reasons for their use?

☐ Physical aggression
☐ Verbal aggression
☐ Self-injurious behaviour
☐ Falls prevention
☐ Other _____

22. How often are restraints used with your residents?

☐ Never ☐ Seldom ☐ Often ☐ Frequently

23. Who manages the pharmacological interventions of your residents with mental health needs? Please check all that apply.

☐ GP – Family Physician
☐ Geriatrician
☐ Psychiatrist
☐ Nurse Practitioner (NP)
☐ Other _____

Comments

_____
_____
_____
_____
_____

24. Please rate the effectiveness of the above pharmacological management (i.e. assessment and management of side effects, monitoring of therapeutic response, appropriateness of drugs prescribed, timeliness of assessment and treatment, etc) for each of the following disciplines.

GP – Family Physician ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Geriatrician ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Psychiatrist ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Nurse Practitioner (NP) ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Other _____ ☐ Poor ☐ Fair ☐ Good ☐ Excellent

25. Please rate the effectiveness of your facility in meeting the spiritual mental health needs of the residents (i.e., provision of spiritual care, incorporation of individual residents' spiritual values into care, acknowledgment and respect for spiritual needs).

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Comments

_____

_____

26. Please rate the effectiveness of your facility in meeting the emotional mental health needs of the residents (excluding pharmacological). For example, provision of counselling services, compassionate nursing care, family involvement, etc.

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Comments

_____

_____

27. Please rate the effectiveness of your facility in meeting the physical mental health needs of the residents (excluding pharmacological). For example, environment, resident mix, recreation, personal effects/space, etc.

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Comments

_____

_____

28. Please provide any other feedback or comments that will be helpful in identifying the service needs of this population with regard to accommodation in long-term care facilities.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
_____
_____
_____
_____
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_____
_____
_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE.

Please direct any questions or concerns to:

Jennifer Speziale, RN, BScN
Student, Master in Public Health Program, Lakehead University, Thunder Bay, ON
Phone Daytime: 519-xxx-xxxx ext. xxxxx
Evening: 519-xxx-xxxx

Mail Address:
xxxx xxx
London, ON

OR

Dr. Darlene Steven,
Professor, School of Nursing, Lakehead University, and
Graduate Coordinator, Masters of Public Health Program, Lakehead University
Phone Daytime: 807-xxx-xxxx

APPENDIX D: PHONE SCRIPT

Good morning/Good afternoon,

My name is Jennifer Speziale, and I am a graduate student with Lakehead University. I am currently conducting a research needs study that will identify the barriers to admission to long-term care for the elderly with a mental illness. The focus of this project is the London-Middlesex Region. Have you received a questionnaire related to this project in the mail? Have you reviewed the information provided to you in the mailed package? Do you have any questions?

The purpose of my call today is to arrange a convenient time with you to complete this questionnaire with me over the phone. Would you like to participate in this study?

(Arrange time/date with call recipient). If they decline to participate, then thank them for their time and encourage them to contact the conductor of this research should they change their mind or have any further questions.

If they accept to participate, then continue as follows:

I would like to thank you for your time and attention to this study and I look forward to speaking with you on DATE. Should you have any questions for me, please refer to the contact information in the survey package that you have received, and I will be pleased to speak with you at that time. Please sign the consent to participate form that is within your package of information and return it to me in the self-addressed, stamped, envelope.

Thank you once again. Bye.

APPENDIX E: INFORMATION LETTER

"A Needs Assessment: Identifying psychiatric supports and service barriers for the geriatric mentally ill population in Long-Term Care facilities in London, Ontario."

Date

Dear Administrator:

A needs assessment is presently being conducted as part of a graduate student project to identify psychiatric supports and service needs and barriers for the geriatric population with regard to long-term care placement.

The purpose of this study is to complete a needs assessment with the long-term care homes within the London/Middlesex Counties and identify the barriers to admitting and supporting elderly clients with mental illness. The objectives of this study are:

1. To assess the barriers to admission to LTCH for the elderly with a mental illness.
2. To identify psychogeriatric services and supports for both the residents and the staff.
3. To identify LTCH staffing needs and deficiencies.
4. To identify the availability and utilization of psychiatric services in LTCH.
5. To identify the academic and specialized training levels and needs of the staff providing care within the LTCH.
6. To identify and evaluate the inequalities in LTC services provided to the elderly with mental illness.

The findings of this needs assessment will be utilized in order to promote the opportunity to:

1. Enhance access and admission to long-term care homes (LTCH) for elderly with a mental illness;
2. Reduce stigmatism related to ageism and mental illness and
3. Improve the quality of care for the psychogeriatric population within the long-term care setting.

Jennifer Speziale, a registered nurse and a Master in Public Health graduate student from Lakehead University, is conducting this study.

Your role as an Administrator of a long-term care home is valuable in relation to providing important information for the purposes of this study. Your participation will be greatly appreciated. The commitment that is requested of you for this study is to review the attached questionnaire. You will then be contacted by telephone to arrange a convenient time to participate in a telephone interview to answer the questionnaire with Jennifer Speziale. You may decline to answer any question on the questionnaire and your participation in this study is voluntary.

You may withdraw from this study at any time. No identifying information related to yourself or to your facility will be included in this evaluation. Your participation will be kept strictly confidential. All of the information collected will be securely stored in a locked cabinet at Lakehead University for seven years as per Lakehead University Policy.

Your feedback is very valuable and will be very beneficial in the identification of service needs for the mentally ill geriatric population, and for the long-term care facilities who provide support to this population in the area of London, Ontario. The implication of the findings from this study will be to provide opportunity to: (1) improve the quality of care for the psychogeriatric population within the long-term care setting; (2) reduced the stigmatism related to age and mental illness, and (3) enhance access to LTCH for elderly with a mental illness.

The information provided in this evaluation may be used for further research studies.

UPON COMPLETION OF THIS PROJECT, THE RESULTS WILL BE AVAILABLE TO YOU UPON YOUR REQUEST. THE RESULTS OF THIS STUDY MAY PRODUCE FINDINGS FOR FURTHER RESEARCH, AND THEREFORE MAY BE PUBLISHED OR PRESENTED PUBLICLY.

THIS RESEARCHER WILL CONTACT YOU BY TELEPHONE WITHIN THE NEXT WEEK PHONE TO PROVIDE YOU WITH THE OPTION TO ANSWER THIS QUESTIONNAIRE BY PHONE OR BY MAIL. COMPLETING THIS QUESTIONNAIRE SHOULD TAKE APPROXIMATELY 20-25 MINUTES.

Thank you for your participation in this process. Upon completion of this project the results will be available to you upon your request.

Please complete and return the attached consent form and questionnaire by (date) to:

Jennifer Speziale

xxxx xxxxx xxxxx

London, ON xxx xxx

If you have any questions please contact me at:

Phone: Daytime (519) xxx-xxxx ext. xxxxx

Evening (519) xxx-xxxxx

OR

Dr. Darlene Steven,

Professor, School of Nursing &

Graduate Coordinator,

Master in Public Health Program

Lakehead University

955 Oliver Road

Thunder Bay, ON P7B 5E1

(807) xxx-xxxx (office)

(807) xxx-xxxx (fax)

APPENDIX F: CONSENT FORM

Needs Assessment: "Identifying the barriers to admission in Long-term care facilities for the mentally ill elderly in the region of London-Middlesex, Ontario."

Consent to Participate

I have read the information letter attached to this form regarding the purpose of this study and the expectations of myself as a participant.

I have been informed by the researcher of this project of my right to voluntarily participate in this study.

I have been informed of my right to confidentiality of my personal information. I understand that I may with draw from this study at any time without penalty.

I understand that there is no potential risk of harm, physiological or psychological, that can occur to me as a result of my participation in this study.

I am aware that the data collected in this project will be securely stored as per Lakehead University policy.

My signature below indicates that I am a willing participant in the needs assessment entitled, "Identifying the barriers to admission in Long-term care facilities for the mentally ill elderly in the region of London-Middlesex, Ontario."

Signature of Participant	**Date**
Signature of Witness	**Date**