Collaborative Research Grant Initiative: Mental Wellness in Seniors and Persons with Disabilities

Ideas Fund Final Report

Maintaining Mental Health in the Community: Outcome Evaluation of a Geriatric Mental Health Day Treatment Service

October 12, 2012 – Christine Knight, Ph.D., R.Psych.
EXECUTIVE SUMMARY

A Geriatric Mental Health Day Treatment Service (GMHDTs) was opened in May 2008 with the goals of expanding treatment options available to seniors with mood and anxiety disorders, and of promoting independent living by providing an alternative to hospitalization and rapid access to outpatient psychiatric assessment and stabilization in the community. Clients enrolled in the GMHDTs attend three days per week for 10 weeks and participate in intensive group therapy and one-to-one support offered by a primary mental health therapist and psychiatrist. The goal of this project was to conduct an outcome evaluation of the efficacy of the new GMHDTs to assist with program planning and development. A retrospective chart review of all clients who attended the GMHDTs since its inception was conducted. Focus groups were also run with clients who attended the GMHDTs during the previous 12 months, to delineate the strengths of the program and to identify areas for improvement. Results show that access to the GMHDTs was much quicker than to the standard Community Geriatric Mental Health Program, circumventing weeks of wait time (4 weeks versus 10 weeks, on average). Analysis of clinical outcomes clearly showed a significant reduction in depressive symptoms and psychological distress among clients who completed the program and focus group participants overwhelmingly described the GMHDTs as very beneficial, even life-changing. However, the desire for ongoing follow-up was clearly articulated by focus group participants, potentially along the lines of a peer support model. A step-down or follow-up model of care might further enhance outcomes, particularly at a community connection level. Other potential solutions include creation of a follow-up group within the broader program, or identifying a community partner willing to fill this void.

RESEARCH OVERVIEW

Objective(s)
The goal of the project was to conduct an outcome evaluation of the efficacy of a relatively new Geriatric Mental Health Day Treatment Service, to assist with program planning and development.

Background
The need for more timely access to psychiatric services for seniors has consistently been recognized as a significant gap in the mental health continuum of care (Calgary Health Region, 2007). In response to this a Geriatric Mental Health Day Treatment Service (GMHDTs) was opened in May 2008 with the goal of providing timely access to psychiatric assessment and stabilization in the community for seniors suffering from anxiety and depressive disorders. The Service was also intended to expand the mental health treatment options currently available. Specifically, the GMHDTs was intended to serve as intensive transitional community support for clients being discharged from inpatient services, and as an alternative to hospitalization for clients whose needs for timely intervention could not be met through existing community services (Calgary Health Region, 2007). The primary program objectives consist of: 1) providing timely access to mental health and psychiatry services; 2) providing stabilization and support to seniors; 3) assisting family and caregivers of the affected individual to understand and cope with the psychiatric disorder while maintaining the person at home; and 4) assisting the client in connecting with appropriate community services.

While anecdotal reports from other geriatric mental health day programs are quite positive, little research on the effectiveness of this psychiatric model of care is available (Dasgupta, Clarke, & Brymer, 2005; Corcoran, Guerandel, & Wrigley, 1994).

An internet search by Rutherford (2009) identified geriatric day hospitals in Edmonton, Ottawa, London (Ontario), Hamilton, Toronto, Sherbrooke (Quebec), and Baltimore (Maryland). The Psychiatric Day Hospital (PDH) operated by Baycrest in Toronto is most similar to GMHDTs. As described by Mackenzie et al. (2006), the PDH operates three and a half days per week during a
planned admission of 16 weeks. Staffing includes a core group of two psychiatrists, two nurses, a social worker and an occupational therapist. The program integrates psychodynamic, interpersonal, cognitive-behavioural and pharmacological approaches focusing on seniors with mood disorders. Results of retrospective admission and discharge data for 708 patients over a 16-year period revealed an improvement in mood, as rated on the Geriatric Depression Scale and the Hamilton Depression Rating Scale. The main conclusion from this study was that “…day hospital programs are beneficial for a wide range of depressed elderly adults” (p. 631).

In February 2009 the Information and Evaluation Unit of Mental Health and Addictions, Alberta Health Services, Calgary Zone completed the initial phase of program evaluation with GMHDTD, focusing on determining which clients are best suited for day treatment services and whether clients’ urgent needs can be responded to within 3 working days, a goal that was initially set by the program. Key stakeholders agreed that an examination of client outcomes and specific aspects of programming, as they relate to program objective, were best left for a second phase of evaluation. The present project serves as the 2nd phase, or outcome evaluation of the GMHDTD.

**Approach and Methods**

**Program Setting**

The GMHDTD was started as a pilot project in 2008 and has received considerable operational support from the Community Geriatric Mental Health program in Calgary, Alberta throughout its tenure. This has included the inclusion of a program facilitator, clinical supervisor, psychologist, and outreach worker. Referrals are received by the main program with a strong focus on rapid access. Potential clients are contacted by program staff and a triage interview is completed over the phone to determine suitability. An initial intake assessment is subsequently arranged, where a final decision is made regarding client suitability for the program. Important considerations include diagnosis and cognitive functioning.

There are three full-time staff members, including one nurse, one social worker and a recreation therapist. Two psychiatrists provide regular consultation to the program, including involvement in a weekly case conference meeting.

Clients enrolled in the program attend three days per week for 10 weeks and participate in intensive group therapy and one-to-one support offered by a primary mental health therapist, psychiatrist and recreational therapist. Weekly goal-setting meetings involve the program facilitator, clinical supervisor, psychologist and outreach worker. Structured groups are provided on Tuesdays and Thursdays that include a mix of psycho-education, cognitive-behavioural, interpersonal, and leisure recreation programming. All clients registered to the program meet with their assigned mental health therapist on a regular basis to review treatment goals. Clients attend a community outing on Monday mornings with a focus on behavioural activation and practicing social skills. Individual support is provided by the recreation therapist, as appropriate, to assist with specific community connection goals.

The program is situated in a community clinic setting near downtown Calgary, with easy access to public transportation and free parking. The program was originally co-located with the main Geriatric Mental Health service at a downtown clinic and problems were noted by clients in terms of transportation and parking. Lunch is provided on group days, including on the community outing day.

**Triage, Intake and Outcome Assessment**

The triage process involves confirming the reason for referral and the client’s willingness to engage in a fairly intensive, group-based program. With this in mind, clinicians inquire about transportation issues and potential barriers to attending a clinic-based program. The intake process involves a review of the client’s presenting issues as well as formal psychiatric assessment in which the psychiatrist makes a clinical diagnosis and assigns the client a GAF score (Global Assessment of Functioning, American Psychiatric Association, 2000). The intake process also included the use of the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005), a brief test of cognitive skills (e.g. memory, executive function) to screen for cognitive impairment. A cut-off score of 22/30 is used
to rule out Mild Cognitive Impairment. The primary outcome measures administered included the 15-item Geriatric Depression Scale (GDS; Sheikh & Yesavage, 1986) and the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Evans et al., 2000), see below.

**Global Assessment of Functioning (GAF)**

The GAF considers psychological, social and occupational functioning on a continuum of overall functioning. It is a commonly used measure of adaptive functioning/impairment in mental health settings, and is part of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial system reflected on Axis V. The scale ranges from 0 (inadequate information) to 100 (superior functioning). At the lowest range (1-10), an individual is considered to be a persistent risk to self or others OR is persistently unable to maintain personal hygiene. At mid-range (41-50), an individual is considered to be experiencing serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR is experiencing serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). At the highest range (91-100), an individual is described as free of all symptoms and is effectively able to manage life’s problems.

**Geriatric Depression Scale (GDS)**

The 15-item GDS (Sheikh & Yesavage, 1986) is a reliable and valid self-report measure of depression in older adults. The instrument excludes certain somatic symptoms which might be due to medical illness, and makes use of a simple response format (yes/no) which facilitates easier use by individuals with impaired cognitive functions. Scores of 0-4 are considered normal, 5-8 indicate mild depression, 9-11 indicate moderate depression, and 12-15 indicate severe depression. This instrument was administered to clients enrolled in DTS both at intake and discharge as a measure of depression.

**Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM)**

The CORE-OM is a 34-item self-report questionnaire designed for use as a baseline and outcome measure in psychological therapies (Evans et al., 2000, Evans et al., 2002). The CORE-OM is commonly used to derive a single score, distinguishing between healthy (1-20), low level (21-33), mild level (34-50), moderate level (51-67), moderate to severe level (68-84), and severe level (85-136). Underlying subscales have been defined as Subjective Well-Being, Problems and Functioning domains. The Subjective Well-Being domain focuses on questions regarding optimism, tearfulness, contentment and feeling overwhelmed. The Problems domain comprises four clusters of psychological symptoms: depression, anxiety, physical discomfort, and symptoms of trauma. The Functioning domain comprises three clusters involving general coping, social interactions and interpersonal reciprocity. Finally, there is a measure of risk to self and others reflected in a Risk subscale score.

**Program Participants**

A total of 255 clients were referred to the GMHDTS since it opened in 2008. Of those individuals referred to the program, 34 (13.3%) were triaged, but not formally assessed for reasons including not meeting diagnostic criteria, transportation difficulties, requiring inpatient admission, or refusing treatment. Fifty-one (20%) clients dropped out of treatment. Specifically, they were admitted to the program but discharged less than 9 weeks later and did not complete any discharge outcome measures. The remaining 170 (66.6%) clients attended for more than 9 weeks and completed at least a portion of the discharge outcome measures package. Table 1 provides demographic information for these 170 GMHDTS clients who completed the program.
Table 1. Admission characteristics of clients who completed the GMHDTS.

<table>
<thead>
<tr>
<th>VARIABLE (sample size)</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for Referral (N=154)</strong></td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>107 (62.9)</td>
</tr>
<tr>
<td>Anxiety symptoms</td>
<td>43 (25.3)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (2.4)</td>
</tr>
<tr>
<td><strong>Referral Source (N=146)</strong></td>
<td></td>
</tr>
<tr>
<td>Alberta Health Services (AHS) programs</td>
<td>57 (39)</td>
</tr>
<tr>
<td>Geriatric Mental Health program</td>
<td>24 (16.4)</td>
</tr>
<tr>
<td>Physician/GP</td>
<td>27 (15.9)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>21 (12.4)</td>
</tr>
<tr>
<td>Hospital (inpatient/emergency)</td>
<td>11 (6.5)</td>
</tr>
<tr>
<td>Community services</td>
<td>6 (3.5)</td>
</tr>
<tr>
<td><strong>Psychiatric Diagnostic Category (N=170)</strong></td>
<td></td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>103 (60.6)</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>35 (20.6)</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>17 (10.0)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>7 (4.1)</td>
</tr>
<tr>
<td>Cognitive Disorder</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (3.5)</td>
</tr>
<tr>
<td><strong>Admission GAF ratings (N=153)</strong></td>
<td></td>
</tr>
<tr>
<td>31-40</td>
<td>5.3</td>
</tr>
<tr>
<td>41-50</td>
<td>24.7</td>
</tr>
<tr>
<td>51-60</td>
<td>48.8</td>
</tr>
<tr>
<td>61-70</td>
<td>11.2</td>
</tr>
<tr>
<td><strong>Admission outcome measures (N)</strong></td>
<td>M (SD)</td>
</tr>
<tr>
<td>MoCA (N=77)</td>
<td>24.61 (3.39)</td>
</tr>
<tr>
<td>GDS Total Score (N=134)</td>
<td>46.76 (22.87)</td>
</tr>
<tr>
<td>CORE-OM Total Score (N=115)</td>
<td>15.12 (8.81)</td>
</tr>
<tr>
<td>CORE-OM Functioning subscale score (N=122)</td>
<td>15.12 (8.81)</td>
</tr>
<tr>
<td>CORE-OM Well-Being subscale score (N=121)</td>
<td>7.47 (4.05)</td>
</tr>
<tr>
<td>CORE-OM Problems subscale score (N=119)</td>
<td>22.89 (10.57)</td>
</tr>
<tr>
<td>CORE-OM Risk subscale score (N=120)</td>
<td>1.60 (2.69)</td>
</tr>
</tbody>
</table>

The demographic characteristics of these three groups (triaged only, drop-outs, completers) were comparable, with the only significant difference being the diagnostic category that the majority of clients fell into. Specifically, the percentage of clients who had a Depressive Disorder or an Anxiety Disorder varied according to whether they dropped out of the program or completed the program, \( \chi^2(5, N = 221) = 13.38, p<0.05 \). For instance, the percentage of individuals with an Anxiety Disorder was 35% for the drop-out group versus 20% of the completer group, and the percentage of individuals with a Depressive Disorder was 43% for the drop-out group versus 60% for the completers.

The average age of clients who completed the GMHDTS program was 73.17 years (SD=6.30). The majority of this sample was female (68%) and married (45%). A sizable portion of this client population was divorced (23%) or widowed (21%), and living alone (41%). A large number of these clients were referred to the GMHDTS by other Alberta Health Services (AHS) programs (39%), including the Geriatric Mental Health Program (16%). Only a small number of referrals (7%) originated from acute inpatient or emergency department sources. The reason for referral in the
majority of cases was related to depressive symptoms (63%), naturally corresponding to the high proportion of cases diagnosed with a primary depressive disorder at initial assessment (61%). Perhaps because of the apparent attrition of anxiety cases through the triage and assessment phase of the program, there were a much lower number of cases with diagnosed anxiety disorders that completed treatment in the program (21%).

The average years of education for the completers sample was 12.07 (SD=2.84) and the average score on the MoCA was 24.61—well above the established cut-off for mild cognitive impairment of 22. The average GDS score at admission for these clients was 7.43, which is in the mild depression range. Likewise, their average Total score on the CORE-OM was rated at the mild level (46.76). However, these self-report outcome measures appeared somewhat more optimistic than the GAF ratings provided by psychiatrists at initial assessment, where the majority of clients were rated in the serious (41-50) to moderately impaired range (51-60) in terms of psychological, social and occupational functioning.

Focus Group Participants
All GMHDTS clients who participated in the program between January 2011 and January 2012 (n=50) were assigned a random number between 1 and 50, and a research assistant telephoned these clients, in sequential order, and invited them to participate in a series of focus groups to identify the strengths and weaknesses of the program, and the impact, if any, that the GMHDTS had on their lives. Sampling was completed once 24 clients agreed to participate in the focus groups. A total of 18 participants ended up attending one of three 2-hour focus groups - 11 women and 7 men. Informed consent was obtained to audio-record the focus groups for analysis, and participants’ were given pseudonyms. Focus group themes identified are reported in aggregated form, with representative quotes included to highlight the findings. The focus group questions can be found in Appendix A.

All 24 clients who initially agreed on the telephone to participate in a focus group were also asked to identify a family caregiver who might like to participate in a separate caregiver focus group, to help delineate the strengths and weaknesses of the program from a caregiver's perspective, and to discuss how the program impacted the life of the family member. However, only three clients identified a family member who might be interested in participating. These three family caregivers were then contacted by telephone and invited to participate in a caregiver-only focus group, but only two agreed to attend. The caregiver focus groups were therefore cancelled due to lack of interest. Instead, the caregiver focus group questions were turned into a 2-page questionnaire, which focus group participants were invited to give to their family members, if desired, with the understanding that their responses would remain anonymous and could be sent back to the principle investigator in the self-addressed, stamped envelope provided. Sixteen focus group participants took questionnaires for their family members, but only one was returned. The caregiver questionnaire can be found in Appendix B.

Statistical Analyses
Quantitative data was analyzed using SPSS 19.0 for Windows. Changes in mood among clients who completed the program were examined by: (1) comparing admission and discharge scores on the GDS and CORE-OM using paired samples t-tests, (2) identifying the number of participants who experienced at least a 50% reduction in the number of symptoms (GDS), or 50% improvement in level of functioning (CORE-OM) and; (3) indicating how many participants were in remission at discharge, defined as a GDS score of less than or equal to 4 or a total CORE-OM of less than or equal to 33. Qualitative data was analysed using NVIVO 10.0 for Windows, by identifying key themes and patterns in the responses provided by the participants of the focus groups using a grounded theory approach (Strauss & Corbin 1990). The themes provided by the client focus groups included information about the areas of strengths and weaknesses of the program, as well as community resources utilized that were facilitated by their involvement in the Day Treatment Service.
Key Findings

DTS Effectiveness
As shown in Table 2, GDS scores for clients who completed the program improved an average of 3.97 points from admission to discharge \([t(74)=10.11, p<0.001]\). Participants improved an average of 22.18 points on the total CORE-OM from admission to discharge \([t(62)=11.42, p<0.001]\). Significant improvement over time was also found on the each of the CORE-OM subscales: CORE-OM Well-Being \([t(68)=8.68, p<0.001]\); CORE-OM Functioning \([t(68)=10.07, p<0.001]\); CORE-OM Problems \([t(69)=9.42, p<0.001]\); CORE-OM Risk \([t(68)=4.65, p<0.001]\).

Sixty-one percent (61.8%) of clients who completed the program experienced at least a 50% improvement in mood symptoms on the GDS from admission to discharge, and 41.3% showed at least a 50% improvement from admission to discharge based on their CORE-OM total scores. At discharge, 69.5% of the clients met GDS criteria for remission (GDS scores ranging from 0-4), and 72.7% of clients fell in the “healthy” or “low level” of psychological distress, according to CORE-OM total scores (CORE-OM scores ranging from 0-33).

Table 2. Indicators of improvement in mood from admission to discharge.

<table>
<thead>
<tr>
<th>Total Sample</th>
<th>N</th>
<th>Admission Mean (SD)</th>
<th>Discharge Mean (SD)</th>
<th>Mean Change (SD)</th>
<th>&gt;=50% Improvement</th>
<th>% in Remission at discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Depression Scale</td>
<td>75</td>
<td>7.48 (4.04)</td>
<td>3.51 (3.41)</td>
<td>3.97**</td>
<td>61.8%</td>
<td>69.5%</td>
</tr>
<tr>
<td>CORE-OM Total</td>
<td>63</td>
<td>47.13 (22.90)</td>
<td>24.95 (17.09)</td>
<td>22.18**</td>
<td>41.3%</td>
<td>72.7%</td>
</tr>
<tr>
<td>CORE-OM Well-Being</td>
<td>69</td>
<td>7.25 (3.95)</td>
<td>3.68 (3.55)</td>
<td>3.57**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CORE-OM Problems</td>
<td>70</td>
<td>23.47 (10.01)</td>
<td>13.87 (8.98)</td>
<td>9.60**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CORE-OM Functioning</td>
<td>69</td>
<td>15.30 (8.89)</td>
<td>8.16 (7.43)</td>
<td>7.14**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CORE-OM Risk</td>
<td>69</td>
<td>1.72 (2.95)</td>
<td>0.59 (1.39)</td>
<td>1.13**</td>
<td></td>
<td></td>
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</tbody>
</table>

** = \(P<.01\)

Focus Group Findings
In general, clients who attended the GMHDTST felt that the program was very beneficial. For many participants, the program changed their lives. For example:

- I can’t say enough good things about that program. It turned my life around. I went in there so tearful; I didn’t think it was going to do anything for me, and I came out of there feeling whole, not totally, totally whole, but as close to full and happy as I did a long time.

Clients felt that the socialization and opportunities for sharing provided by the program, and the feeling that they were not alone in their experience, was particularly helpful for them. For example:

- I think it was very helpful, because similar people were talking about similar problems that, in society, we hide from everybody. So, you were sitting there with people that you respected and they could honour what you were saying. You feel more human about some of your problems.
Many clients reported that the program taught them to become more aware of the relationship between their emotions, thoughts and behaviour, and how to change their thinking. For example:

*I found one of the very interesting things that was helpful was a method of changing my thinking. I had a habit of thinking about the same problem over and over and churning away at night, they showed me how to get away from it. That was a big, big problem.*

Although most focus group participants reported that they didn’t have any specific expectations about the program before enrolling, most did express “maybe a little fear and trepidation going in”. It seemed to take approximately two sessions before most clients felt really comfortable in the group. Most clients identified that they very quickly felt a connection with other group members, because of the shared experience, but for a few, the changing membership of an open group was difficult. Note, however, that for the most part, the same minority of individuals who struggled with the changing faces of the group members, were also those who identified that a group environment, and therefore GMHDTS, wasn’t a particularly good fit for them. In fact, only a small minority of the focus group participants (3/18) reported that the program was not particularly helpful for them. Discussion revolved around how the group program is aimed quite generally at dealing with depression and anxiety, and as a result, means “less intensive work” around each person’s specific issues. The three individuals who did not feel that GMHDTS was a good fit for them identified that it was perhaps because they were each dealing with very long-standing issues that simply required more intensive and long-term individual-work. As one participant stated:

*I’ve suffered from anxiety and depression all my life, so some of the reasons are really deep. And with the individual worker sometimes she’d hit the right spot and I’d spend the hour crying, kind of thing. So I think I’m very guarded in a group probably, not to lose control. So maybe I didn’t give the program enough time to work with me.*

Interestingly, however, even these three participants stressed that although the program was not particularly effective in alleviating their particular mental health issues, it was nonetheless a very valuable community resource that can be very helpful for other people.

Regarding the role of family members in GMHDTS, while most clients expressed a desire to have their mental health issues better understood by their family members, they were not particularly keen to have them involved in the program in a formal way. Some expressed that they didn’t feel comfortable talking to their families for fear of being misinterpreted or having them set up unreasonable expectations, while others stated that they simply didn’t want to involve their family members in their problems. A few clients speculated that problems with family may actually be the reason why a person is attending GMHDTS. As one participant stated:

*I almost have the feeling, most people in the group, their biggest problem is dealing with their family and that probably for them, to try to discuss with their families. I always had the feeling that the family is saying “Well, get over it” and they didn’t really try to appreciate their role in your problem.*

When asked about what new community resources or supports they were introduced to while in the program, clients usually described the Monday outings to seniors’ centres or the Zoo or Science Centre. While these outings were generally identified as enjoyable, there were a few participants who did not feel they were a good use of time. Instead it was suggested that clients should be provided with information about resources specific to their own community, so that follow-up would be more likely. However, of those participants who reported receiving information on interesting and relevant community resources (e.g. yoga, seniors’ centres, groups), most expressed that they never actually followed-up on getting involved, mainly because they were now “too busy”!
The clients reported being very satisfied with the availability of the psychiatrists. They all reported that they had immediate access to them if needed and that speaking to them was helpful. Clients also felt supported by the therapists. There was general satisfaction with the location, availability of parking, and although some had to drive quite a distance to get to Bridgeland, the commute wasn’t described as too much of a burden.

When asked if 10 weeks was sufficient time to achieve their goals, many clients began talking about the need for better follow-up. As one participant stated, “I agree with everyone, it’s great, but after 10 weeks you’re cut loose.” When asked how the program could be improved, clients overwhelmingly asked for better follow-up after discharge. As one participant described:

Well, I was also promised follow-up. That never happened…..I was told there would be. So I kind of looked forward to that, it never happened. I feel after an intense 10 weeks, maybe it could slowly wind down somehow.

Some clients did eventually end up in another group through the Community Geriatric Mental Health Program (Wellness or monthly follow-up group), but this was not consistently offered to clients, and for some people, it was not a good fit. Some clients indicated that even just a follow-up telephone call from GMHDTS staff would have been helpful, as a check-in, or to open the door to another referral, if needed. But other clients were quick to point out that the needs of individual clients needs to be considered too.

Approximately half of the focus group participants reported that they still keep in contact with other members of the group. However, there were clients in each of the three focus groups who felt that they were discouraged from connecting with co-members outside of group. As one participant stated:

Correct me if I’m wrong, but we are told making friends is not your purpose in being here and basically we weren’t supposed to share names and phone numbers and so on, so it was almost like, we did, but it was sneaky.

Other suggested areas of improvement include better advertising of the program, as many clients felt that their family doctors didn’t know about it and they had to be referred by a psychiatrist, after a long time struggling with their mental health issues.

**Conclusions**

The GMHHDTS model combines group and individual treatment approaches, emphasizing behavioural activation and socialization within the context of a specialized psychiatric program for older adults. Access to DTS was much quicker than to the standard Community Geriatric Mental Health Program (CGMH), circumventing weeks of wait time (4 weeks versus 10 weeks, on average). Analysis of clinical outcomes clearly show a significant reduction in depressive symptoms among clients who completed GMHDTs, and focus group participants overwhelmingly described the DTS as very beneficial, even life-changing.

The original philosophy of GMHDTs was to provide rapid access to community-based mental health services, facilitating, and even speeding up, discharge from acute care and specialized inpatient rehabilitation programs because of the availability of psychiatric follow-up. In fact, a large proportion of referrals did come from other AHS services after a period of treatment and/or stabilization. Thus it makes sense that clients referred from other programs have relatively low self-reported GDS and CORE-OM scores at admission. Within this context, the GMHDTS may be considered an important part of the continuum of care in further solidifying the gains obtained in other parts of the mental health system.

Families did not have a voice in this study, but this was because clients did not see them as a necessary or important part of their care team, at least at this place along their continuum of care. Are we being ageist or paternalistic to think that family should be involved in the care planning, or the evaluation of services, for our geriatric clients? Would we automatically want to include family in the care of a 35-year-old client? We should probably conclude that family involvement with clients going
through GMHDTD should be on a case-by-case basis, and not assumed to be a necessary component of care.

**Implications for Policy or Practice**

Certainly, the desire for ongoing follow-up was clearly articulated by the focus group participants. It was also a challenge for the staff as they prepared to discharge clients from the program. While the more unstable clients were referred to the Geriatric Mental Health Program for ongoing psychiatric follow-up, the more stable individuals who no longer met criteria for an Axis I disorder did not clearly meet the admission criteria for follow-up within a specialized mental health program. While there did not appear to be a need for psychiatric treatment, the focus group participants clearly identified a desire for additional social and community support—potentially along the lines of a peer support model. The transition or transfer of low-intensity cases from the GMHDTD to the larger program and/or other community-based services continues to be an area for further exploration. One potential solution would be to create a specific follow-up group within the broader program. Another solution would be to seek a community partner willing to fill this void. The dilemma in the former scenario is to further engage clients in the formal mental health system, although they may not need such an intervention. The advantage is that momentum gained in the program is maintained via continued involvement in a coherent continuum of care. The obstacles to creating a follow-up group within the broader community is ensuring continuity of care (and momentum) with service providers who are effectively “outside” the mental health system. The obvious advantage of this approach is creating supports within the community and reinforcing access to available senior-friendly services in the clients’ neighbourhoods.

From its inception, the concept, structure, and function of the GMHDTD has been in flux. The original concept emphasized rapid access—within three days—which heavily shaped the intended focus of the program as a crisis response intervention. However, the program’s co-existence within the larger Geriatric Mental Health service and its reliance on the existing intake system complicated adherence to such a model of care. It nonetheless shaped early work done within the program in responding to stakeholders requests for such an intervention strategy. At the same time, the program offices moved locations on two occasions to makeshift locales before finally being housed at the current site—the intended site. Finally, a small budget existed for the program, leaving little room for coverage or accommodation, at times leaving the program short-staffed. Within this context, there was some uncertainty in the development of the program, which at times impacted on service delivery. It is testament to the staff supporting this program that quality outcomes were nonetheless generated, but it highlights the potential pitfalls inherent in the start-up of new initiatives where policy and operational issues dovetail with service delivery. While this may be par for the course in terms of mental health program development, it is important to acknowledge it’s impact in the creation of new initiatives.

**Directions for Further Research**

While results highlight the effectiveness of the GMHDTD model, more formal research would help clarify the impact of various treatment considerations. For example, it would be useful to distinguish between rapid access, presenting diagnostic issues, concurrent medical and psychosocial challenges, as well as the impact of specific treatment approaches on clinical outcomes.

**Knowledge Dissemination and Translation Activities**

The results of this project were shared with service providers within Alberta Health Services via oral presentations to the Geriatric Mental Health Day Treatment Service staff, the Community Geriatric Mental Health Program staff, the Geriatric Mental Health Consulting Service staff and individuals from the wider AHS community who attended an oral presentation sponsored by Seniors’ Health at Rockyview General Hospital in Calgary. The findings were also presented to the attendees of the Joint Conference of the Canadian Academy of Geriatric Psychiatry and the Canadian Coalition of Seniors’ Mental Health as a poster session. The poster is currently up outside the Community Geriatric Mental Health Office at the Sheldon Chumir Health Centre, and the plan is to later place the poster in the Lobby of the Bridgeland Seniors’ Health Clinic, where the Geriatric Mental Health Day Treatment Service is
located, so that the general public may read about the project. Finally, we are in the process of writing up the project for submission to an international geriatrics journal.

**PRINCIPAL APPLICANT (TEAM LEADER)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position Title</th>
<th>Topics of interest</th>
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<tbody>
<tr>
<td>Christine Knight,</td>
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<td>Ph.D., R.Psych.</td>
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<td>impairment, decision-making capacity, program evaluation</td>
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**PROJECT PARTNERS (TEAM MEMBERS)**

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<thead>
<tr>
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<th>Role</th>
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<tr>
<td>Richard Alarie, M.A.,</td>
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<td>project development, database</td>
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<tr>
<td>R.Psych.</td>
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<td>development, data synthesis, data analysis, report writing</td>
</tr>
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**OTHER PARTNERS**

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<th>Position Title</th>
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<tbody>
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<td>Michele Fercho, Psy.D., R.Psych.</td>
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<td>University of Calgary</td>
<td>Member</td>
</tr>
</tbody>
</table>

**PUBLICATIONS AND PRESENTATIONS**

Knight, C. & Alarie, R. (2012, September). * Maintaining mental health in the community: Outcome evaluation of a geriatric mental health day treatment service.* Poster session presented at the Joint Conference of the Canadian Coalition on Seniors Mental Health and the Canadian Academy of Geriatric Psychiatry, Banff, AB.

Knight, C. (2012, August). *Maintaining mental health in the community: Outcome evaluation of a geriatric mental health day treatment service.* Presentation to the Geriatric Mental Health Day Treatment Service Staff, Alberta Health Services, Calgary Zone.

Knight, C. (2012, September). *Maintaining mental health in the community: Outcome evaluation of a geriatric mental health day treatment service.* Presentation to the Community Geriatric Mental Health Program Staff, Alberta Health Services, Calgary Zone.


ABOUT THE ALBERTA ADDICTION AND MENTAL HEALTH RESEARCH PARTNERSHIP PROGRAM

The Alberta Addiction and Mental Health Research Partnership Program is comprised of a broad-based multi-sectoral group, representing service providers, academic researchers, policy-makers and consumer groups, working together to improve the coordination and implementation of practice-based addiction and mental health research in Alberta.

The mission of the Research Partnership Program is to improve addiction and mental health outcomes for Albertans along identified research priority themes, by generating evidence and expediting its transfer into addiction and mental health promotion, prevention of mental illness, and innovative service delivery.

The Research Partnership Program sets out to increase Alberta’s excellence and output of addiction and mental health research findings, and to better translate of these findings into practice improvements.

REFERENCES


APPENDIX A – Focus Group Questions

- Do you feel that participating in the Geriatric Mental Health Day Treatment Service was helpful for you? If so, how? If not, what were you hoping to receive from the program that you did not get?

- Did you learn any new skills or coping strategies at the Geriatric Mental Health Day Treatment Service? If so, what new skills or strategies did you learn?
  - What kinds of things have you been doing differently because of these new skills or strategies?
  - Is the way that you think about things different now because of the new skills or strategies you learned? How so?
  - What have been some of the barriers or challenges to adopting these new skills or coping strategies?

- What were the best aspects of your experience at the Geriatric Mental Health Day Treatment Service?

- What were the least positive aspects of your experience at the Geriatric Mental Health Day Treatment Service?
  - What did you think could have been done better?
  - What would you do to improve the program?

- What were your expectations coming into the program?
  - Were your expectations for care met? In what way were they or weren’t they met?
  - What else do you feel the Geriatric Mental Health Day Treatment Service could have done to support you in your mental health?

- What role do you think family could play at the Geriatric Mental Health Day Treatment Service?

- What, if any, new community connections for ongoing support did you receive while in Geriatric Mental Health Day Treatment Service?
  - Were you able to follow-up with these community connections after you were discharged?
  - If not, what were some of the barriers to you connecting with these resources?

- How was it for you to come to group?
  - How long did it take you to feel comfortable in the group?
  - How was the size of the group?
  - Was 10 weeks a sufficient amount of time for you to achieve your treatment goals?

- How did you feel about the availability of your psychiatrist?

- If you found that the Geriatric Mental Health Day Treatment Service had a positive impact on you, how has it been for you to maintain those improvements? To maintain what you learned there?

- Would you have been interested in attending an After Care group, if one had been available?
  - Do you still keep in touch with anyone who participated in the Geriatric Mental Health Day Treatment Service with you?

- Is there anything else you would like to add about your experience at the Geriatric Mental Health Day Treatment Service?
APPENDIX B – Caregiver Questionnaire

Family Member Questionnaire
Outcome Evaluation of the Geriatric Mental Health Day Treatment Service

1. Do you feel that participating in the Day Treatment Service was helpful for your family member? If so, how? If not, what were you hoping they would have received from the program that they did not get?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

2. From your perspective, what were the most helpful aspects of your family member’s experience at the Geriatric Mental Health Day Treatment Service?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

3. From your perspective, what were the least helpful aspects of your family member’s experience at the Day Treatment Service?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

4. What did you think could have been done better? What would you do to improve the program?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

5. What were your expectations of the program? Were they met? In what way were they or weren’t they met?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

6. What else do you feel the Geriatric Mental Health Day Treatment Service could have done to support your family member in their mental health?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
7. Were you in any way involved in your family member’s treatment and care planning at the Geriatric Mental Health Day Treatment Service? Please circle YES or NO. If yes, how were you involved? If you were not involved, how would you have liked to have been involved?

________________________________________________________________________________

________________________________________________________________________________

8. If there had been a family education evening, would you have attended? Please circle YES or NO. How do you think that a family education night could have been helpful for you?

________________________________________________________________________________

________________________________________________________________________________

9. Has your family member’s participation in the Geriatric Mental Health Day Treatment Service had a lasting impact? How so?

________________________________________________________________________________

________________________________________________________________________________

10. Is there anything else you would like to add about your family member’s experience in the Geriatric Mental Health Day Treatment Service?

________________________________________________________________________________

________________________________________________________________________________

11. Please indicate your relationship to the person who attended the Geriatric Mental Health Day Treatment Service by checking one of the following:

   □spouse □child □friend □other _______________

12. Do you live with the person who attended the Geriatric Mental Health Day Treatment Service? Circle YES or NO.