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

Ideas Fund Final Report

August, 2013 – Colleen Woods

Burdened – The Weight of Caring – Burnout and Compassion Fatigue in Family/Friend Caregivers of Seniors with Dementia
EXECUTIVE SUMMARY
There are more than 2 million informal caregivers in Canada, many of whom provide critical support to their family members. According to Canadian Institute for Health Information (CIHI), “one in six people providing informal care to seniors experiences distress and those caring for seniors with moderate to severe cognitive impairment are most at risk” (Canadian Institute for Health Information, 2010b).

This project explored the experiences of burnout and compassion fatigue in older adult family/friend caregivers who provide care to older adults in two communities in rural Alberta. The care recipients were afflicted by dementia. The study also considered what support was available to caregivers. The project consisted of a qualitative research approach whereby information from older adult caregivers was elicited using focus groups and individual interviews.

The results showed that this group of caregivers experience situations that put them at risk for compassion fatigue and burnout. These risk factors affect their mental well-being in various ways. Implications for service provision include the following:

- Coordination of human services.
- Identifying interventions that can be undertaken by the caregiver to alleviate perceived suffering.
- Development of support groups with formal support provided to ensure continuity.
- Development of a seniors advocate program.
- Implementation of health promotion activities at the community level.
- Educational sessions for the general public.
- Accessible built environments designed for those with dementia that provide competent staff at appropriate levels.
- Developing tools to assess caregiver strengths.

Further research streams include knowledge exchange methods and the value of support groups.

RESEARCH OVERVIEW
Objective(s)
The overall purpose of this project was to explore the concept of burnout and compassion fatigue in family/friend caregivers of those afflicted with dementia. It also included an examination of existing community resources and supports that aided these caregivers in their caregiving role.

The areas explored were:

- How caregivers in rural communities in Alberta describe their experience as caregivers of those with dementia
- What helps them maintain their role within these communities
- What satisfies them in their role as caregivers

Background
Problem description: In 2008, 40,000 Albertans had been diagnosed with Alzheimer’s disease, the most common form of dementia affecting seniors. Several factors affect the care setting for those afflicted. In some cases, there is a desire by caregivers to maintain their family member at home. Some of those afflicted are awaiting placement in long-term care facilities. Others, even though assessed as needing facility care, are being cared for at home because the family is not ready to admit them. Seniors with dementia are often a challenge to care for in the home setting, placing the
caregivers under an unending, emotionally charged strain. This situation has the potential to create negative health outcomes in the older caregiver.

There are few, if any, support groups functioning in the rural communities identified to offer support to the caregivers. The ability of the caregiver to maintain care at home can be negatively influenced by burnout and other negative consequence resulting from prolonged caregiving responsibilities and continuous exposure to the suffering of others (Peacock, et al., 2010). Burnout involves a gradual wearing down of the caregiver over time (Magraith, Benson, & Yunti, 2005). It is a term often associated with formal caregivers and occurs in response to negative work environment triggers such as workload and the inability to achieve work goals (Sabo, 2006). Compassion fatigue (CF) was defined by La Rowe as a “debilitating weariness brought about by repetitive, empathic responses to the pain and suffering of others” (2005, p. 21). Compassion fatigue is considered a “natural” consequence of caring for people who are suffering. While CF has been well documented in formal caregivers (nurses, social workers etc.), there has been little research done to explore this concept in families and friends of older adults who are providing care outside of facilities. Is compassion fatigue an issue in the community setting for older adults who find themselves providing care for a loved one? How is it manifested?

**Importance of Addressing the Problem:** Caring for someone afflicted with dementia can include dealing with behavioral disturbances such as aggression, agitation and wandering. CF and burnout may negatively affect the older caregiver in their ability to maintain care in the home setting. This may lead to premature admission to facility care, transfer of care to another family member thus increasing the probability of compassion fatigue and burnout in others or, in extreme cases, neglect and abuse. The negative health effects on the caregiver also result in decreased quality of life and poor health outcomes as well.

This project sought to provide a greater understanding of the experiences of seniors caring for seniors with dementia in rural Alberta in the home setting and explore the existence of CF and Burnout.

**Approach and Methods**
The project, conducted from May 1, 2011 to August 31, 2012, was a direct response to stories shared at sessions during Mental Awareness Week in 2010. Seniors caring for those with dementia brought to light the incredible challenges involved in keeping loved ones at home as well as maintaining their own health.

Ethics approval was received from Human Research Ethics Review Process (HERO), University of Alberta and Athabasca University.

**Study Design:** An exploratory study design was used to gain a deeper understanding of seniors caring for those with dementia. Qualitative methods were used to gather data through focus groups and personal interviews (by phone or face-to-face) if participants were unable or unwilling to attend a focus group in person.

**Sampling:** The initial intent was to interview 10 participants in each of the rural communities of Ponoka and Vegreville in a focus group setting to discover how participants managed caregiving in this particular group. Respite care was offered to provide opportunity for those participating to be away from their caregiving responsibilities during the interviews/focus groups. Signed consent was obtained from all participants prior to initiating the focus groups, telephone interviews and face-to-face interviews.

In total 11 individuals participated in the project. Two focus groups were held (one in Ponoka and one in Vegreville), with six participants attending. Five participants were interviewed either face-to-face or over the telephone. The focus groups were held at local hospitals and public health units in comfortable surroundings. Face-to-face interviews were held in the home of the participants at their request.
Participants were to self-identify as a family/friend care giver of someone who had problems with memory or judgment and was living in the community. Short announcements about the project were distributed by health care professionals, seniors groups, community groups such as Family and Community Support Services and church groups. The call for participation also went out in the form of advertisements in the local newspapers in each community. Health care professionals were asked to distribute an information letter only and encourage the potential participants to call the investigator to answer any questions.

The message indicated that participants should be elderly (age 65 years and older) and be caring for a family or friend in the home setting. However the responses included others who wanted to share their caregiving stories. These included family members whose loved one was now in facility care as well as care givers who were 55 years and older caring for parents at home or in a communal living setting such as a Seniors Lodge. This response necessitated a shift in the original criteria to include these participants as well.

Once the respondents had more information about the project and agreed in principle to participate, a consent form with information was mailed including a return self-addressed envelope. Some participants chose to bring their completed consent forms with them to the focus group. Participants were enrolled and asked whether they wanted to attend a group session or to have a telephone interview. There were two participants who preferred to meet face-to-face in their home or work setting and two participants chose to be interviewed over the telephone. This request was accommodated as well. None of the participants required care giving.

Focus group discussions and personal interviews were recorded for analysis. Each participant was assigned a series of letters to protect their anonymity while identifying the particular situation of the caregiver.

**Population:** Table 1 outlines the demographics of the participants.

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>Living with care recipient</td>
<td>6</td>
</tr>
<tr>
<td>Not living with care recipient</td>
<td>6</td>
</tr>
<tr>
<td>Rural Vegreville area</td>
<td>2</td>
</tr>
<tr>
<td>Rural Ponoka area</td>
<td>1</td>
</tr>
<tr>
<td>Age 55-69</td>
<td>6</td>
</tr>
<tr>
<td>Age 70+</td>
<td>6</td>
</tr>
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<td>Town Vegreville</td>
<td>2</td>
</tr>
<tr>
<td>Town Ponoka</td>
<td>6</td>
</tr>
<tr>
<td>Caregiving parent</td>
<td>4</td>
</tr>
<tr>
<td>Caregiving spouse</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Attended Focus Group</td>
<td>6</td>
</tr>
<tr>
<td>Attended Phone Interview</td>
<td>3</td>
</tr>
<tr>
<td>Attended face-to-face</td>
<td>2</td>
</tr>
<tr>
<td>Withdraw participation</td>
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</table>

**Measures:** The session was introduced as a conversation about the experiences the participants had regarding their caregiving experiences. Conversations began with the question, “Can you tell me who you are caring for and how long you have been the care-giver?” and “Can you tell me what it is like to provide care at home to someone who has troubles with memory or displays poor judgment?” Questions also probed what the specific challenges and rewards were in caregiving. In two instances the participants were no longer providing care in the home. Their responses were based on their
memories of their caregiving experiences as well as the ongoing challenges of “caring from a distance”.

Data Analysis: Verbatim transcriptions of the recorded individual and focus group interviews were thoroughly reviewed and imported into NVivo 10 (QSR International). Some of the conversations were not clearly captured on the recordings which resulted in incomplete transcriptions for portions of two interviews. Various categories and nodes were developed from the data and refined further as the transcriptions were re-reviewed. Using the NVivo software package, a thematic content data analysis was performed until a saturation point regarding theme detection was reached. The word frequency NVivo query proved to be highly instrumental in the coding and organization of the data and in helping to identify themes. Careful attention was paid to differentiate participants’ words from interviewers’ words. Core themes and subthemes were validated with relevant quotations from participants. Data analysis was undertaken by a research assistant different from the researchers who conducted the interviews. Recurring conversations with the principal investigator prompted numerous revisits to the NVivo data to truly capture the themes expressed by the participants, and guided the ongoing data analysis process. This separate analysis with post-discussion consensus helped to ensure rigour.

Key Findings
Three key themes with additional subthemes emerged from the interview data. These themes and subthemes are highlighted in the table below and explored further in their individual categories. Suggestions from participants on how to improve caregiving experiences provided valuable insight from a caregiver’s perspective. Many of these suggestions have been included in this section. Given the small sample size of 11 participants, and in order to preserve participant confidentiality, full sentence participant quotes were not used. Participant statements were summarized with careful attention awarded to reflecting the true essence of their content.

Table 2. Themes and Subthemes

<table>
<thead>
<tr>
<th>Physical, emotional, social and financial challenges</th>
<th>Role reversal</th>
<th>Caregiving / Caregiver support</th>
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<tbody>
<tr>
<td>• Fatigue and exhaustion</td>
<td>• From parent to child-like</td>
<td>• Formal support deficiencies</td>
</tr>
<tr>
<td>• Feelings of guilt, empathy, anger, or frustration</td>
<td>• From passive to active</td>
<td>• Informal caregiver support</td>
</tr>
<tr>
<td>• Social impact</td>
<td>• From an equal partner to primary decision-maker</td>
<td>• Positive support</td>
</tr>
<tr>
<td>• Financial challenges</td>
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Physical, emotional, social and financial challenges
Participants expressed how caring for their mentally compromised loved ones impacted them on so many different levels. Aside from the physical strain involved in the management of a dependent’s health care and activities of daily living, emotional, social and financial aspects of caregiving also constitute serious challenges faced by caregivers. Emotional experiences of the participants ranged from feelings of empathy to outright anger. Altered social living and financial burdens were noted to be additional stressors in an already difficult situation.

Fatigue and exhaustion
The actual term “exhausted” was only used by three participants, two instances of which were in direct response to questioning regarding feeling exhausted. However, most (eight) participants experienced some form of physical distress related to caring for their loved ones. These physical manifestations were described in such terms as being ‘drained’, not having the energy to do anything beyond priorities, feeling stretched, and being too tired or very tired. One participant emphasized that the degree of exhaustion experienced may not even be fully realized until the actual caregiving burden has been lifted or removed. This statement provided an excellent example of the potential insidious nature of caregiver exhaustion, where only in the absence of the daily routine or demands of caregiving do some caregivers take a moment to examine their own emotional or physical wellbeing.
In one instance the emotional toll of caregiving was so great that the caregiver was unable to attend family functions.

**Feelings of guilt, empathy, anger, frustration**

It was interesting to observe the frequency with which guilt was mentioned in relation to caring for a loved one or placing a loved one in care. Guilt was conveyed as both something that had already been dealt with or placed under control, and as something that was an ongoing struggle. One caregiver expressed feeling guilty about being so short-tempered with their loved one. Another participant referenced guilt as a general experience of caregivers and families who have no choice but to place loved ones in certain facilities. For two participants, the source of guilt seemed to emanate from a combination of not being able to keep their loved one at home and from concerns regarding the quality of care and attention their loved one receives in care. In one instance the adult child caregiver who did not live with their parents expressed guilt in their lack of awareness about how difficult it was for a parent without dementia to be caring for a parent with dementia day after day. Only when the child took over the care giving responsibilities did they become aware of the magnitude of the task.

Empathy was expressed in a number of ways. For example, participants reflected on the inability of the care recipient to enjoy a long awaited retirement, or becoming a shell of the person they once were. Participants also felt bad or embarrassed for loved ones who had to be accompanied to the bathroom in public. One caregiver explicitly voiced that they empathized with what their loved one is going through. Empathy was also expressed when interpreting care recipients’ behavior. Participants related to the panic felt when a care recipient got lost and could no longer find their way home. It was described as being a terrible experience for the care recipient. The caregivers in this instance felt the fear and disorientation that their loved ones experienced.

Feelings of anger and frustration in dealing with the rigid nature of legal and health care structures were not directed towards loved ones, but rather towards the ‘system’ (medical/health care system, government, immigration, banks). Some caregivers were also frustrated within the relationship and with the situation in which they found themselves – trying to give the best care they can with so many things appearing to work against them. These responses resembled expressions of burnout similar to how a formal caregiver may describe an intolerable work situation.

**Social impact**

It was apparent in the data that the social impact of caregiving can be quite devastating to both the caregiver and the care recipient. Lifestyle changes and feelings of isolation, whether self-imposed or circumstantial, were voiced as challenges to some participants. Some care recipients seemed to lose their desire to go out or socialize. In many cases, fewer and fewer friends would come around. One participant described their loved one as being lonely since their friends dropped them. The lack of any formal support groups was noted. Groups that had existed in the past had ceased to exist as the needs of the membership changed. Caregivers often became overwhelmed with the task of caregiving and no longer had the energy to convene or attend a group.

Even though respite care was provided in some situations, this did not necessarily increase opportunities for socialization. The caregivers often used the respite time to spend by themselves or deal with factors outside the home like banking, or running errands for example.

There was some evidence that strong family support mitigated social isolation. Grandchildren were a great source of joy to both the caregiver and the care recipient. Being able to provide favourite meals to family members also was noted as a favorable social experience.

**Financial challenges**

Financial woes which were incurred as a result of caregiving demands were of major concern to a few caregivers. In one instance the care recipient’s disease-related cognitive impairment influenced poor judgment regarding home and business affairs, resulting in a dire financial situation for the family. Another participant spoke of having to remortgage their home to help cover caregiving expenses.
Others sold property and items of value to be able to focus more on their caregiving role. Although finances were not an issue for some of the participants, they were readily able to appreciate the potentially destructive power of financial burdens.

At least three participants found the burden of dealing with financial institutions difficult. It was not that they lacked funds; it was the banking demands (proof of care recipient's mental status, for example) necessary to carry out their daily affairs that proved to be very challenging.

**Role reversal**

*From parent to child-like*

Role reversal was an interesting theme which some participants elucidated in both subtle and distinct ways. Two participants conveyed that the mental changes experienced by their parent required that they now had to relate to their loved one in a manner similar to how one would relate to a child. These participants felt they had basically taken on the role of a parent to their parent.

*From passive to active*

Another type of role reversal occurred with spousal caregivers where the party who had been more passive or reserved in handling certain affairs in the relationship now had to take on more of a leadership or authoritative role. For example, they may not have handled bill paying or driving. They now had to take on these responsibilities which proved to be a significant adjustment for some participants.

*From equal partner to primary decision-maker*

Other changes in roles occurred because couples had lived as equal partners, sharing decisions and everyday choices. The caregiver ultimately had to be the one to decide whether or not to place their loved one in care. The fact that the care recipient could no longer fulfill the partnership role was a profound difference. This loss of partnership was grieved.

**Support**

The topic of support of both a formal and informal nature was raised repeatedly during the course of the interviews. Although participants were grateful and appreciative of respite workers and home care, it was felt that these services could still be improved.

**Formal support deficiencies**

In terms of formal support, limitations regarding what respite workers could, and could not do proved to be a source of malcontent for at least two participants. There were also expressions of insecurity concerning where a loved one might be placed and the type of care they would be receiving from formal caregivers. Another deficiency in formal supports exists in the immigration system regarding the ease at which foreign caregivers can be hired in a timely manner. Two instances where a coordinated resource was lacking to provide all of the information needed by the caregiver were identified. This sort of resource would have helped the caregiver in their role. There was also some discussion regarding a lack of access to information from the physician.

**Informal caregiver support**

It quickly became apparent that informal caregiver support can be critical to the survival of not only care recipients and caregivers, but also to families as a whole, especially in a home setting. In one instance, the loss of friends and decreased support from family members in caring for a loved one led to the destruction of family relationships. It was observed that at least four participants were able to garner support from their church community. Meals were provided and home modifications were undertaken to accommodate the changing needs of the care recipient. This allowed care recipients and caregivers to maintain a connection with their church friends. Family support however seemed to be the most welcomed support in most cases.
Positive support
There were some instances where support was considered positive. As a positive formal support, connections with the community mental health clinics and outreach nurses were identified. Information from the Alzheimer’s Society was also described as being positive.

Participant’s suggestions on how to ease the stress of being an older adult caregiver
In addition to the themes distilled from the data, suggestions made by participants regarding what they felt could be done to help them or other caregivers manage the stress and challenges of their caregiving role, are included. With their first hand caregiving experiences and challenges participants were well positioned to offer meaningful insight into what can be done to better assist caregivers in their noble and sometimes underappreciated role.

Care facilities and staffing improvements
Although only two of the twelve participants had loved ones in care, a number of participants expressed concern regarding certain deficiencies encountered, or “heard about” in some care facilities. These concerns of care facilities inadequacies may understandably play a role in the reluctance of some participants to place loved ones in care, despite increasing challenges in caring for their loved ones at home. This also influenced their decision to seek short term respite care in facilities. There seemed to be an impression that there were not enough facilities specifically for dementia or Alzheimer’s clients, and that some of the staff in available facilities had language barrier issues and lacked training. Further, the sometimes unreasonable distance of suitable care facilities from a caregiver’s home was mentioned. There also seemed to be a sense that rural facilities were not as equipped, up-to-date, or well staffed as other more urban facilities. Instances of facilities in other jurisdictions where care was perceived as optimal highlighted the deficiencies in some of the local facilities. Even when the family was pleased with the care being provided in one acute care facility, there was the constant fear that their loved one would be transferred to another facility seen as sub-optimal.

Availability of family washrooms in public places
A very valid point regarding the challenge of maintaining community involvement was raised by two participants. These participants felt that there were not enough public washrooms which accommodated families. Something as simple as this was a determinant in whether or not a caregiver would take a care recipient out. It also limited the number of places they could go.

Education for informal & formal caregivers
Teaching informal and formal caregivers how best to interact with dementia patients could prove highly instrumental in promoting effective visits. It is well known that virtually any type of information can be retrieved from the internet. Nonetheless, it is important to recognize that many caregivers of older adults with dementia are seniors themselves who may not have the resources, means, or techniques needed to access or navigate the internet. Making pertinent information regarding care recipient diseases and caregiver resources readily available, and in a format appropriate for various education levels, would greatly benefit caregivers.

Legal implications of patients with dementia
One aspect which arose more than once was the lack of proactive information and support resources available regarding all of the legal hoops family members must jump through in managing the lives of the patient along with their own lives and family affairs. Participants expressed that much distress could have been avoided had they known in advance about the legal requirements involved in caring with someone with dementia.

Positive aspects of caregiving
It was encouraging to also discover positive aspects in caregiving expressed by participants. Just having their loved one still at home with them surfaced as a positive element for some participants, even amidst the arduous task of caregiving. Seeing people come together to help both care recipient and caregiver through family support or support from a church community was also positive. Caregiving provided a sense of worth in two situations. This has the duel effect of having a positive
effect on the caregiver’s health status as well as keeping the care recipient in their own home. This was possible because the care recipient did not display any disruptive behaviors.

Discussion: Older family caregivers in rural Alberta who provide care to loves ones suffering from dementia comprise a unique group of individuals at risk for burnout and compassion fatigue. They often have had prolonged exposure to the perceived suffering of their loved one, grieve the loss of their future together, lack a sense of satisfaction in providing care and are faced with no hope of improvement in the condition of their loved ones. Compassion fatigue results. Elements of burnout emerge when caregivers have to deal with external factors such as banking, legal issues regarding property rights, personal directives and the restraints of the health care system (i.e. admission forms, transfer forms).

The burden of care coupled with the added dimension of compassion fatigue increases the risk of premature admission to care facilities for the loved one, increased physician visits by the care givers in an attempt to deal with the stress of the situation and/or relinquishing care to other community resources or family members. Financial burden on the health care system results. Services that moderate compassion fatigue and burnout then make sense from a moral as well as a health care systems perspective.

Conclusions
Compassion fatigue is an influencing factor on the health and well being of older family care givers in two communities in rural Alberta. The fact that family members are empathetic, loving and concerned about their loved ones is in itself a risk factor for developing compassion fatigue. Burnout adds to the stress and is evident when discussions turn to the day-to-day management of affairs outside of the home.

The burden of care is increased by services that are too far away to be accessed. Transportation to services also creates barriers. Many caregivers are dependent on friends well into their eighties to drive them to big urban centres for appointments and specialized care. The lack of facilities designed specifically for those suffering from dementia contribute to feelings of hopelessness and despair in family members. The loss of friends and neighbors who take the time to continue to visit isolates the care givers and their loved ones.

Strong community and church connections are identified as meaningful resources that help maintain and support these community members who care for their loved ones at home.

The experiences of the participants in this study have provided valuable information regarding compassion fatigue and burnout. Their willingness to share their life stories will add to the knowledge of compassion fatigue and burnout and encourage the development of interventions that lessen the burden of care.

Implications for Policy or Practice
Results from this project have implications for policy and practice development. Collaboration between all human service providers is required from numerous sectors to remove barriers, decrease challenges and support older caregivers of those with dementia. This collaboration could address services that moderate compassion fatigue and burnout such as:

- Developing interventions that decrease the perceived suffering of the loved one. Access to medication that improves memory and interventions that improve the general health of the care recipient may provide some comfort to caregivers in this situation. It may change how the caregivers see their loved one and provide some hope of improvement.
- Accurate information on what can be expected may also give the caregiver a sense of control.
- Development of interventions that can be provided by the care giver to alleviate perceived suffering will have a dual effect: increasing feelings of satisfaction by the caregiver as well as improving the condition of the care recipient.
• Feelings of isolation can be relieved through the development of support groups on a formal level. Specifically a physical location to meet could be provided as well as a staff member to coordinate the activities of the group in terms of arranging transportation, providing information and insuring a sense of continuity to the group as members come and go.

• Services that minimize caregiver distress may be developed to help the caregiver come to terms with the limits of their abilities to care for their loved ones and accept the limitations of changing the course of the dementia.

• Respite care provision that is flexible and accommodating would allow some rest from the constant care giving.

• Long range planning and implementation of health promotion activities at the community level to decrease social isolation.

• Educational sessions that teach visitors strategies to help them continue to visit with those suffering from dementia would help normalize the home situation.

• Built environments that support those afflicted with dementia will lessen the fear of placing a loved one in care as well as decrease the guilt felt by caregivers. Knowing their loved one is well cared for by competent staff and with appropriate staffing levels would be reassuring as well. Courses on English as a second language to support foreign workers would also decrease communication barriers.

• It is also important to consider the intrinsic rewards of caregiving starting with the assessment of caregiver strengths. Health care providers can build on these strengths, once identified to mitigate the effects of caregiving.

**DIRECTIONS FOR FURTHER RESEARCH**

Suggested research projects in this area include the exploration of:

• Measures of overall health in caregivers who access support groups
• Measures of compassion fatigue and burnout in caregivers who access respite care
• Research investigating the length of time caregivers can maintain their loved ones at home and predictors for admission to facility care

**KNOWLEDGE DISSEMINATION AND TRANSLATION ACTIVITIES**

• A copy of this research project will be sent to all stakeholders involved with this initiative including:
  • Participants
  • AHS representatives and community groups who offered letters of support including: Government of Alberta Seniors Department and Members of the Legislative Assembly for Ponoka and Vegreville
• Lunch and learn sessions will be offered to promote discussion and explore possible actions at the local level
• Presentation at conferences and submission to an academic journal will be considered
**PRINCIPAL APPLICANT (TEAM LEADER)**

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<tr>
<th>Name</th>
<th>Position Title</th>
<th>Topics of interest</th>
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<tbody>
<tr>
<td>Colleen Woods</td>
<td>Formally Addiction and Mental Health Promotion and Prevention Coordinator</td>
<td>Well Seniors</td>
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**PROJECT PARTNERS (TEAM MEMBERS)**

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<tr>
<th>Name</th>
<th>Position Title</th>
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<tr>
<td>Dr. Margaret Edwards</td>
<td>Profession and Director of Graduate Studies, Athabasca University</td>
<td>Advisor</td>
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<tr>
<td>Dr. Beth Perry</td>
<td>Associate Professor, Centre for Nursing and Health Studies, Athabasca University</td>
<td>Advisor</td>
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<tr>
<td>Mae Kroeis</td>
<td>Health Promotion Coordinator</td>
<td>Research Assistant</td>
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<tr>
<td>Marcia Bailey</td>
<td>Athabasca University Masters Student, BScN and Senior Specialist, Medical Information and Pharmacovigilance</td>
<td>Data Analyst</td>
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**PUBLICATIONS AND PRESENTATIONS**

N/A

**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:

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