Health Advocacy for Medical Residents

This workshop package includes information to assist with the development and delivery of a workshop on health advocacy for medical residents that is co-created and co-taught by representatives from community-based advocacy organizations.

Health Advocacy Workshop Package

September 2014

DRAFT

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Health Advocacy Workshop Outline

Workshop date and location:
Notes: the workshop is designed to last to last 1 hour 45 minutes, though could be extended to allow more time for discussion of the cases. The room should be large enough to accommodate whole group interaction plus small group discussions.

Participants: residents and ideally Program Director

Facilitators: 5-6 representatives from community-based organizations who do advocacy work plus faculty.

Objectives:
1. Describe different forms of health advocacy and give examples of how residents could assist with these different forms.
2. Describe how to find resources in the community.
3. Give examples of how residents could fit in or augment the advocacy that others are doing (e.g. professionals, community, self, family).

Workshop outline:
Welcome, introductions, workshop objectives and activities (10 minutes)
Notes: Put agenda on flip chart. Brief introductions (have bios and contact information for community members on a take away handout for future reference).[Example Appendix 1]
Set expectations: overview of how residents can get involved with what’s already going on. They don’t have to do it (all) on their own. How residents can find out what’s going on in the community and where to start.

Presentation of Carlisle’s framework for health advocacy (10 minutes)
Carlisle has a useful framework to talk about different forms of health advocacy. Faculty should introduce the framework and invite a community representative to add comments from a community perspective. The purpose is to illustrate different forms of advocacy (e.g. individual, systemic; self-advocacy, advocacy with) and the idea of collaboration. [Appendix 2]

Discussion of cases (40 minutes)
Divide the group into groups of 2-5 residents each with a faculty and community co-facilitator. Ideally the community facilitator will be the person who has generated the case based on a real or typical experience. Depending on time, number of residents and number of cases, each group may discuss the same or a different case. Other faculty and community representatives may serve as resources to the residents during the case discussion.

Allow time for residents to read through case first.
Questions to pose:
- What are the specific points at which advocacy occurred (and by whom)?
- What are the points at which advocacy should have occurred but didn’t (and by whom)?
- Relate the types of advocacy that were done or could have been done to Carlisle’s framework (go back to the chart)
- Where did or could physicians have played a role either directly or through indirect influence and collaboration?
- What similar situations have residents been involved in?

Notes: Cases may be extreme examples of people slipping through the cracks and not getting services as they are meant to illustrate various opportunities for different kinds of advocacy by different individuals and groups. They are also intended to present a different (community) perspective on cases that residents may have seen. Though they are individual patient cases they should also highlight bigger system problems. Cases should be annotated by the case writer to indicate opportunities for advocacy taken or missed and relate the types of advocacy to Carlisle’s framework. Residents should be work from the unannotated cases in the discussion but can be given the annotated versions for take home reference. [Examples of annotated cases Appendices 3 & 4]

Panel discussion: residents pose their questions to community panel members (30 minutes)
Invite brief opening remarks from each panelist about the advocacy work they do, followed by time for questions from the residents.
Note: residents may be canvassed before the workshop about the questions that might be addressed and these could be given to the panelists in advance and / or used (anonymized) by the moderator to get the discussion going.

Close: key messages; next steps (10 minutes)
Revisit objectives
Closing question: What has this workshop done to your thinking about advocacy and how you might play a role?
Provide a list of community organizations: what resources they can make their patients aware of.[Example Appendix 5]. Advise that you will be sending out a short evaluation questionnaire by e-mail [Example Appendix 6].

Resources required
Agenda and brief information / contact details about each community organization [Appendix 1]
Diagram from Carlisle’s paper [Appendix 2]
Copies of the two cases (unannotated for case discussion; annotated for take home) [Appendices 3 & 4]
Community resources information sheet [Appendix 5]
Evaluation questionnaire [Appendix 6]
Appendix 1: Geriatric Psychiatry Health Advocacy Workshop

1:00 to 2:45 pm, Thursday 3 July. GPOT 5th floor conference room, Centennial Pavilion, VGH.

Objectives
1. Describe different forms of health advocacy (use case to identify) Give examples of how they could assist with the different forms.
2. Describe how to find the resources in the community.
3. Give examples of how they could fit in or augment the advocacy that others are doing (e.g. professionals, community, self, family).

Workshop outline:
1:00: Welcome, introductions, workshop objectives and activities
1:20: Discussion of two cases
Case 1: Kay co-leaders: Susan Moore & Bill Godolphin, residents David and Jeanine. Resource people: Maria, Sheila, Rebecca.
   - What are the specific points at which advocacy occurred (and by whom)?
   - What are the points at which advocacy should have occurred but didn’t (and by whom)?
   - Relate the types of advocacy that were done or could have been done to Carlisle’s framework (go back to the chart)
   - Where geriatric psychiatrists did or could have played a role either directly or through indirect influence and collaboration.
   - What similar situations have residents been involved in?

2:00: Panel discussion: residents pose their questions to community panel members
Brief opening remarks from each about the advocacy work they do, followed by time for questions from the residents.

2:35: Close: key messages; next steps
Information about Workshop Facilitators and their Organizations

LINDA FORSYTHE
Linda is a member of the Board of Directors of 411 Seniors Society, an organization that serves seniors in Information and Referral, Healthy lifestyles (exercise, nutrition) and hearing and BP screening, outreach etc. 704-333 Main Street, www.411seniors.bc.ca. She is also a past Executive member of COSCO (Council of Senior Citizens' Organizations), presently a delegate. COSCO does mostly system advocacy (some individual) www.coscobc.ca. Linda is also a member of Voices of Burnaby Seniors, an organization of service providers and individuals working on seniors issues. lindajforsythe@gmail.com

MATTHEW LAING
Matthew Laing has worked in various mental health settings across his career. A great portion has been spend in direct service roles in community mental health psychosocial rehabilitation (PSR) programs (such as Clubhouses and Supported Housing programs), where various forms of advocacy are employed daily. He has also spent time in a managerial position with similar programs. Matthew managed a lab at UBC Psychiatry, overseeing the logistics for a study examining cognitive contributions to Obsessive-Compulsive Disorder and is currently the co-coordinator for BC's first Psychosocial Rehabilitation Advanced Practice - an education and training institution designed to promote and refine the application of PSR principles and approaches in all mental health settings across the province, and to effect positive change in provincial mental health policy. A major component of PSR work is empowerment advocacy, as it centres the individual and their support network at the pivotal position of change-making leading to recovery.
Further information on the Advanced Practice, as well as the Canadian and American PSR national bodies can be found at:
www.psyrehab.ca - BC PSR Advanced Practice
www.psrrpscanada.ca - PSR/RPS Canada
www.uspra.org - Psychiatric Rehab Association (US)
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SUSAN MOORE
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REBECCA MORRIS
Advocacy Analyst, Alzheimer Society of B.C. Direct Line: 604-742-4939; Email: rmorris@alzheimerbc.org.
www.alzheimerbc.org
Rebecca works in the Advocacy & Public Policy department at the Alzheimer Society of B.C. She is passionate about providing people with the tools and information they need to be effective self and system advocates and is dedicated to working toward a smoother dementia journey for everyone affected by this disease. See below for further information about the advocacy activities of the Alzheimer Society.

SHEILA PITHER
Sheila is the Workshop Coordinator for the COSCO Seniors’ Health & Wellness Institute. We have 42 health related workshop topics that are available for groups of seniors anywhere in the Province. The workshops are free of charge and facilitated by volunteer senior presenters. Since the program's inception in 2007 more than 1,100 workshops have been presented to over 18,000 seniors.
HEALTH ADVOCACY PROJECT TEAM:

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Our Vision
A West End community that inspires and supports older adults to live involved, vibrant and fulfilling lives.

Our Mission
WESN improves the quality of life of adults aged 55+ by providing social, educational and recreational programs and services that foster connection and inclusion in the broader community.

The West End Seniors’ Network (WESN) was founded more than 30 years ago by a group of seniors who wanted to make life better for their peers. Incorporated in 1982, today WESN provides programs, services and support for the approximately 11,000 seniors (55+) living in Vancouver’s West End neighbourhood. We offer over 30 programs and services at three locations, supported by a staff of nine (4 full time and 5 part time) and more than 200 dedicated volunteers.

The majority of our programs and services are based at Barclay Manor, a city-owned heritage site, where we host a variety of programs and activities that focus on senior engagement, socialization, recreation, participation, entertainment, health information and education. Our Life Unlimited program mobilizes a volunteer force to help frail and home bound seniors in our area through friendly visitors, daily safety callers, accompaniment to medical appointments and a weekly grocery shopping program. The West End Better at Home program offers subsidized light housekeeping, a volunteer driver program, and a weekly grocery shuttle that transports low-income seniors to sources of low-cost groceries.

Our Kay’s Place office, located a few blocks away in the Denman Place Mall, provides information and referral services for older adults. Volunteers can help with pension and housing questions and forms/applications, refer seniors to a range of services and offer a friendly ear and a cup of tea or coffee. The Kay’s Place manager also coordinates the Senior Peer Support program, which matches trained volunteers with seniors seeking extra support during times of particular stress.

Finally, our Clothes & Collectibles Thrift Shop in the Denman Place Mall provides much-needed revenue, as well as providing volunteer opportunities for over 40 volunteers, more than half of who are themselves seniors. The store also functions as a place where isolated seniors, many of whom live on very low incomes, can stop by to say ‘hi’ and purchase small items at very reasonable prices.
Alzheimer Society, British Columbia: Advocacy & Public Policy Activities

Appendix 2: Carlisle’s Framework


| **Representation** | focus on individuals or groups  
|                   | enacted by “experts”  
|                   | objectives: behaviour and lifestyle change (‘medical health promotion’) and delivery of information or speaking for others in order to meet their health needs  
|                   | individuals or groups represented are unable to participate as partners in these activities  
|                   | e.g., a campaign by a medical organization urging individuals to get more exercise  |

| **Social policy reform** | focus on policy  
|                         | enacted by “experts”  
|                         | goals of prescription and protection; minimise health inequities via social and policy-level changes (‘social health promotion’)  
|                         | e.g., introduction of legislation that restricts tobacco purchases to those of the age of majority.  |

| **Community activism** | practitioners tend to operate as partners or peers rather than as experts  
|                       | partnerships between communities, organisations and health and other sectors are promoted  
|                       | tackling the source of health inequities through empowerment of communities to self-advocate for changes to policy  
|                       | e.g., a community lobbies the government for changes to policy regarding assessment of environmental impact of mining.  |

| **Community development** | practitioners tend to operate as partners or peers rather than as experts  
|                          | characterized by working toward addressing community health needs by enablement, empowerment and community contribution  
|                          | e.g., an organization consisting of people with a particular illness, advocating for better access to affordable housing.  |
Appendix 3: Case Study: Harold

Background
Harold is a 77 year-old Caucasian male. He has lived all his life in a suburb outside a large city in British Columbia, and has seen his community change a great deal over this time. Harold worked for a large city department for over 25 years and, as such, collects a pension amount that is significantly higher than many of his peers. He owns his own home, and was driving his own truck until recently, when his license was revoked for unsafe driving. Harold would like to obtain his license again, though his truck is in need of repair and is no longer running.

Advocacy notes: Opportunity here for a Case Manager or Seniors’ Advocate to work with Harold around re-applying for his license (COMMUNITY DEVELOPMENT ADVOCACY).

Harold has been married for 42 years to his wife, Marlene. They maintain a companion-like relationship, though they are often separated as Harold spends significant time with his younger girlfriend, Bernadette. Bernadette is a source of tension in Harold’s marriage, and he and Marlene frequently fight, sometimes escalating to the point of physical conflict. As such, Harold often spends time at a trailer he has purchased. The trailer has recently suffered a break in the septic line, and has flooded several times. Unfortunately, Harold also owes money for several drug debts, and so is unable to maintain the home or repair his truck.

Advocacy notes: Opportunity here for a Community Advocate or Financial Expert to work with Harold to better manage the funds he is receiving, so that he may pay off debt and attend to necessary repairs (COMMUNITY DEVELOPMENT ADVOCACY).

In the early 80’s Harold was connected with a local Mental Health Team, where he saw a case manager and a psychiatrist for treatment and support surrounding major anxiety disorder and associated depressive symptoms. Harold has recently lost his wallet, and thus has no ID.

Advocacy notes: Opportunity here for Community Advocate, MH Support Worker, or Seniors’ Advocate to provide Harold with the necessary information to re-obtain his ID, access any crisis funding, receive bus tickets etc. Such calls should be made by Harold, but with the support and guidance of a worker, if necessary (COMMUNITY DEVELOPMENT ADVOCACY).

Physical Health Challenges
Harold is in chronic pain. He requires replacement of both hips, and sees a specialist sporadically.

Advocacy notes: Were a Geriatric Psychiatrist involved, this would be an essential opportunity for REPRESENTATION ADVOCACY within the health system. Harold requires priority health treatment, but is suffering as the process does not appear to be moving at a sufficient pace, or with due efficiency.

He takes large doses of narcotics to control his pain, which impairs his cognition, results in a highly irritable mood, and significantly lessens his coordination.

Advocacy notes: This may be an opportunity for a Geriatric Psychiatrist to provide education around health medication management, as well as potential referral to Substance Use services to support Harold with any abuse that may be occurring (REPRESENTATION ADVOCACY).

He has fallen several times, both on the sidewalk along the road, and at home. He walks slowly, using a cane. Additionally, Harold experiences urinary and fecal incontinence. He is unable to maintain basic personal care, and so seeks this support from his wife, which causes increased strain on the relationship. Harold has been a heavy smoker for all of his life and has been diagnosed with emphysema. He is approximately 50lbs overweight and does not currently maintain a healthy diet.

Advocacy notes: This constellation of complicated health problems may be interrelated to Harold’s pain and medication use, or it may be independent. Either way, a great many advocacy opportunities exist here, from Community and Seniors’ Advocates to work with Harold to connect with HomeCare or other personal care services, to additional supports outside his wife and the MH day program (COMMUNITY DEVELOPMENT ADVOCACY). Were a Geriatric Psychiatrist involved, they may take the opportunity to meet with Harold and
his GP (and possibly a MH worker), in order to ensure everyone on Harold's support team is well-informed as to his needs and the steps involved in supporting Harold's care. (REPRESENTATION AND COMMUNITY DEVELOPMENT ADVOCACY).

Mental Health Challenges
Despite his file being closed at the Mental Health Centre for over 10 years, Harold continues to face significant challenges in his mental health.

Advocacy notes: Were Harold to see a Geriatric Psychiatrist, the doctor could support Harold in advocating that his file be re-opened and an intake with the Geriatric MH Team take place (REPRESENTATION ADVOCACY).

His anxiety and depression persist, and his cognitive abilities have declined. He is often confused and disoriented, and his irritability can, at times, carry over into inappropriate verbal or minor physical aggression. His primary support is his wife, however, their relationship is not dependable. Elsewhere, Harold has been connected with a specialized, referral-based drop-in mental health program for over 20 years. He is very familiar with the program, knows many of the staff and other program participants, and is very comfortable there.

Advocacy notes: Despite the indicated level of comfort and perceived ease of engagement with this resource, a Geriatric Psychiatrist could do much by reaching out to this program and setting up a brief meeting between a program staff or coordinator, Harold, and him/herself. Supporting Harold to arrange this meeting personally would be an even better step (COMMUNITY DEVELOPMENT ADVOCACY).

However, Harold has experienced significant challenge at the program as of late, owing to his behavioural difficulties, extreme pain, impairment, and low personal care capacity. Additionally, the contracted mandate of the program has shifted significantly over recent years, with a trend towards active participation requirements and “transitioning” older adults on to other community services. This pressure is a major source of strife, both for Harold and the program coordinator.

Advocacy notes: As this trend is resulting in social exclusion leading to possible crisis, a Geriatric Psychiatrist aware of this case could petition the MH service contractors to augment their policy in order to more efficiently support older adults with major mental health concerns (SOCIAL POLICY REFORM ADVOCACY).

Current Status
Recently, Harold has encountered greater challenge. He sold his trailer for a fraction of its worth, in order to pay back some of his debts.

Advocacy notes: While advocacy did not occur at this juncture, were the opportunity to connect with local legal advocate services, Harold may have been able to achieve more a more adaptive outcome in this situation. Were a Geriatric Psychiatrist involved, they may have been able to facilitate such a connection (COMMUNITY DEVELOPMENT ADVOCACY).

However, Marlene will no longer see him, and several calls to police at their former residence have resulted in Harold being banned from the property.

Advocacy notes: An additional opportunity to engage in advocacy around legal services exists here. OPTION: Were a Geriatric Psychiatrist involved, they might facilitate Harold’s effort to repair his relationship by supporting his connection to further individual or marital counseling services (COMMUNITY DEVELOPMENT ADVOCACY).

He stayed with some friends for a short time, but was kicked out after he was incontinent on the couch several times.

Advocacy notes: This statement clearly indicates cracks in the broader health system. While there is likely nothing a Geriatric Psychiatrist could do directly here, it would be possible at professional meetings,
conferences, and through interdisciplinary engagements to raise the issue of long-term MH service follow-up, of establishing/maintaining adequate housing crisis response resources, and of the education and promotion of such tools (SOCIAL POLICY REFORM).]

After a while, Harold ended up at a homeless shelter an hour outside of town. He is currently still there. **Advocacy notes:** The fact that Harold’s stay at the homeless shelter is apparently more than short-term indicates an opportunity for advocacy by a local Homeless Outreach Program. Generally, these staff work to support individuals to find suitable housing in a combination of REPRESENTATIVE/COMMUNITY DEVELOPMENT ADVOCACY.

Harold expresses great despondency and frustration as a result of his current state. He is very anxious and hopeless, and describes a skepticism regarding renewed contact with professional mental health services. He is also very stressed about the prospect of losing connection with the mental health drop-in program, though this may be a pending reality given his required level of support. Staff at the drop-in have attempted to connect Harold with local seniors’ resources, though he has not kept any appointments, and is overwhelmed by the idea of applying for personal support. He does not wish to live in a facility. **Advocacy notes:** MH Program staff worked with Harold to research and book opportunities to connect with other community resources (COMMUNITY DEVELOPMENT ADVOCACY).

**Overall Comments**

While this presentation of the case does not include many direct opportunities where advocacy *did* occur, it clearly shows a great many of sources of potential advocacy.

Conversation may also centre around broader COMMUNITY ACTIVISM and SOCIAL POLICY REFORM advocacy opportunities for Geriatric Psychiatrists through personal and professional initiatives such as:

- sitting on local community advisory committees
- petitioning local government to increase supportive services directed to seniors with complex needs
- joining Boards of Directors for local seniors programs and resources, and non-profit MH agencies
- composing/contributing to reports to regional and provincial government authorities on the current status of seniors with complex needs
- participating in educational opportunities and attending conferences related to seniors resource development, Geriatric MH care, and social policy development affecting older adults

All opportunities identified could occur in varying combinations of independent advocacy, as well as (and optimally) with community groups of various composition. In this way, the importance of interdisciplinary and collaborative advocacy practice is emphasized.
Appendix 4: Case Study: Kay

First Contact Date Aug 15 2013

Contact Information (if available):

Address:

Telephone: cut off due to lack of payment

Email:

Referred by:

Name:

Contact information

Relationship to Client

Background

Client Profile

Kay has been in to see Susan previously. Presents as somewhat confused, says she has no money to buy food but doesn’t understand why there is no money in her bank account. Doesn’t want groceries or a Tim Horton’s card as she “only eats at McDonalds”. Says she is too dizzy (from an injury incurred on a fall on a bus) to cook.

Client Needs

See notes below.

Referrals/Resources Provided to Client

Summarize steps taken to provide information as needed by the client

Action Plan

List additional follow up required, include dates if needed

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<th>Person Responsible</th>
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Aug 15, 2014

Kay asked for help in getting her phone reconnected. She was unable to provide information regarding phone number or address. She provided Susan with a copy of her bank card as her ID and then thought it was her bus pass.

Susan was able to find Kay’s phone number and address in Kay’s wallet and called the telephone company on her behalf. They confirmed that the phone and cable bill have not been paid since connection. Kay would be required to pay the outstanding balance ($418 plus reconnection fee) before service would be provided.

Kay complained of being dizzy, ‘Stupid’, falling and not sleeping. She reports not being able to sit still for long, is bothered by noise. Kay was unable to remember her phone number or recognize her ID which contained that information.

Susan wrote a note to the bank explaining that Kay would need to pay the balance in order to receive service and to help Kay with the bill payment.

Susan completed a referral to Vancouver Central Intake requesting an assessment of Kay because of her memory loss, headaches and dizziness. Central intake reported back that they would not take the referral as Kay was already being supported by mental health.

**Advocacy notes:** Susan advocated for Kay with Vancouver Coastal Health to have a medical assessment completed by the local Health Office. Following the referral process established by VCH did not result in the desired outcome as a result of internal policy. Geriatric Psychiatrists could be influential in advocating for referrals made to Vancouver Central Intake being forwarded to the appropriate psychiatrist for review. Employing the ‘Representation’ type of health advocacy, the Geriatric Psychiatrist would “…represent the rights and health needs of those unable to speak for themselves.”

September 15

Susan accompanied Kay to her bank and talked to a teller. He printed out a list of her banking activities. She makes multiple ATM withdrawals in one day that eventually add up to her being overdrawn by $100. The bank cannot advance her any more cash – the teller explained that he and Kay had discussed this many times before.

Kay gave Susan her daughter’s name and telephone number and permission to call her. Susan called and left a message for her daughter and then issued Kay a $25 No Frills card (although she wasn’t thrilled about it – she wanted money to go to McDonalds).

Her daughter called Susan shortly after her mother left the office. She and her brother are very frustrated with their mother. She stated her mother “manages her money poorly”, has had a gambling problem for years, frequently goes out drinking and to restaurants, has been brought home by the police at least once when she got into an altercation.

The daughter believes her mother may be mixing prescription drugs and alcohol. She stated her mother consistently lies to her and her brother to try to get more money out of them. Says they have offered to buy her any groceries she needs but her mother only wants money.
Susan gave the daughter the phone number for VCH’s Act Adult Protection Program, which is the line people call to report people they suspect are incapable of managing/getting help on their own. Susan also told her to call the office at any time.

**Advocacy notes:** Susan provided Kay’s daughter with resource information which if actioned, should have resulted in Kay being assessed by a specialist from VCH. We are unsure if the daughter ever contact VCH’s Adult Protection Program.

Susan’s recommendation is no more grocery cards to support Kay. Her monthly income (about $1500/month) should be more than enough to support her, given that she lives at BC Housing and pays $495.00/month rent. It sounds as though her daughter and son are willing to follow up with VCH et al. to try to get the situation addressed. However, her daughter did note that it had been several weeks since she had seen her mother and that her mother “won’t call her because she knows her lies won’t work” (or words to that effect). Also said her mother tries to play her and her brother against each other.

Note: Susan also initially emailed the Social Worker at VCH to see if Kay was on their ‘list’. Susan did not hear back from the social worker.

**Advocacy notes:** Susan’s attempts to connect Kay with the appropriate supports were not providing results. The communication being received back from VCH workers was either non-existent or denying support. This again is another area where Geriatric Psychiatrists could be influential with health advocacy in changing administrative policy. If the physical condition of mental health patients is being reported as deteriorating, Geriatric Psychiatrists could request policy changes allowing patient files to be forwarded for review. This form of health advocacy would fall into the category of ‘Social Policy Reform’ as it “...demands that the advocate practitioner possesses a degree of ‘expert’ knowledge and authority in order to have credibility.” It may also result in “The strategic influencing of governments and large organizations to reduce health inequalities through changing their policies and practices...”

**October 1**

Kay has come into Kay’s Place multiple times each week to report that her telephone and TV aren’t working. She doesn’t seem to remember that she needs to pay the bill and is unable to confirm if bill payments have been made but she did present a slip from the bank showing payment issued to the telephone company at the end of August. The telephone company has no record of the payment. Susan accompanied Kay to the bank and was able to confirm that 3 payments had been made but into the wrong account.

Susan followed up with the telephone company to advise that the payments needed to be credited to the correct account and scheduled the dates for phone reactivation and cable re-installation. Susan wrote out all dates and times for Kay and asked that Kay read the information back. Kay was able to read the note but forgot the information within moments (asked what the paper was for).

**October 15**

Kay came in to complain that she didn’t have TV. She explained that she had fallen and hurt her leg. She didn’t know where or when she fell.

Susan asked if the telephone company reconnected her telephone or TV. She reported that her phone was working but not the TV. Susan asked if anyone had arrived to connect the cable as scheduled. Kay said that she waited until 1:00 but nobody came so she left the apartment. Susan explained again that Kay would need to stay in her apartment until the cable person arrived as scheduled – between 1:00 and 3:00. Kay said she couldn’t stay in the house that long – she gets crazy, head hurts, needs to go out, needs to walk.
Susan called BC Housing outreach worker to ask for help in providing telephone company access to Kay’s apartment. BC Housing Outreach Worker expressed concern about Kay’s safety and capacity. BC Housing had made referrals to Vancouver Central Intake but had not been successful in getting assessments completed. The Outreach Worker expressed concern that Kay was ‘living at risk’.

Advocacy notes: BC Housing Community Support Workers had documented attempts at trying to get mental health and medical assessments completed. They reported receiving the same response from Vancouver Central Intake – the issue is mental health and addiction. Geriatric Psychiatrists could create the opportunity to work directly with housing communities serving seniors who are living ‘at risk’ – facilitating direct referral, case review or community outreach.

October 16

Kay came into Kay’s Place complaining of headaches and dizziness. Susan helped Kay book an appointment with her family GP. Susan also called Kay’s daughter to advise that Kay was not feeling well, having problems with her memory and to advise of the schedule for reconnecting the TV (and problems in being able to do so). Kay’s daughter was very frustrated by her mother’s actions and by receiving calls from multiple organizations expressing concern over her. She reiterated that her mother was a drinker, had a gambling problem and could be very aggressive and stubborn.

Advocacy notes: Kay’s family is not responding to community requests for medical support. They believe the medical reports received previously relating Kay’s behavior to issues of alcohol and medication abuse/misuse. Family members should have been following up on referrals made by community organizations directly with the health authority and/or Kay’s family doctor.

October 20

The front desk clerk from Kay’s GP called to advise that Kay arrived one hour early for her appointment, got angry when another patient was served before her, and then left without being seen by the GP. The clerk said that this is normal behavior for Kay and that even when she does see the doctor, she doesn’t follow through on medications (refuses to take the pills). The doctor has said that if Kay doesn’t follow through on recommendations, there is nothing she can do.

Advocacy notes: Kay’s GP did not complete a referral for either a mental health assessment or physical health assessment. They recognized that Kay had not been able to follow through on appointment scheduling or medications. The GP could have advocated for more in-depth review at this, and previous, instances.

November 1

Kay came to Kay’s place complaining of headaches and being dizzy. She didn’t know where she lived and wasn’t able to have much of a conversation. She said she went for a glass of wine. She complained about not having any money. She also said that she didn’t have a bus pass and when she tried to get one, they told her “no”. She couldn’t explain who “they” were.

Susan called the provincial bus pass program to inquire about Kay’s eligibility. Kay had not filed income taxes and for that reason was not eligible. Susan called the Canada Revenue Agency to confirm when Kay last filed taxes. CRA confirmed that taxes had not been filed for 2 years. Kay was no longer receiving Pharmacare subsidy.

Susan called Kay’s daughter to report that taxes had not been filed and that they needed to be done in order for Kay to stay eligible for all the benefits she received (bus pass, GIS, BC Housing, Pharmacare, etc.). The daughter was frustrated but said she would help her mom get the taxes completed.
Susan called the mental health outreach nurse to see if Kay was receiving any support. The nurse knew of Kay but wasn’t able to find any information on the computer system to confirm that she was in active treatment or receiving support from any mental health teams or practitioners. The nurse was going to try to coordinate a home visit by a psychiatrist on her team.

**Advocacy notes:** We do not know if an appointment or home visit was made. Kay’s history reflected significant challenges for any type of home visit to be completed because of her need to walk. No communication or follow up was received from the mental health outreach nurse.

**November 30**

Susan saw Kay on the street. Kay was confused, didn’t recognize Susan and was looking for her home. She gave Susan an address that was not where she lived. Susan explained where she lived and provided her directions to her home. Kay gave Susan a letter from the hospital confirming an upcoming appointment for assessment.

Susan called the hospital and spoke with a geriatric social worker. Kay had been admitted to the hospital the previous week and had undergone inpatient assessment. She was discharged back into the community after the assessment. Susan explained that she met with Kay on the street and that Kay didn’t know where she lived.

**Advocacy notes:** The geriatric team could have communicated with the referring agencies regarding Kay having been assessed and again released into community. This would have given community agencies the opportunity to be better prepared to support Kay.

**December 15**

Susan received a call from the mental health nurse confirming that Kay was back in the hospital for assessment. The police had found her lost and wandering 4 times over the course of a weekend. The nurse advised that testing confirmed that Kay had suffered a number of strokes and was in the advanced stages of dementia. She also advised that Kay might be released back into community but that they were trying to find her space in a long term care facility.

<table>
<thead>
<tr>
<th>File Completion</th>
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<td>Closed: Yes/No</td>
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Name:

Date:
## Appendix 5: Health Advocacy for Seniors in British Columbia: Community Resources

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td><strong>BC211</strong></td>
<td>Phone: 2-1-1  <a href="http://www.bc211.ca">http://www.bc211.ca</a></td>
</tr>
<tr>
<td>Source to find community, social and government services. Free, confidential, multi-lingual and available 24/7.</td>
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<tr>
<td><strong>BC Centre for Elder &amp; Advocacy Support</strong></td>
<td>Phone: 1-866-437-1940 or 604-437-1940  &lt;www.bcceas.ca&gt;</td>
</tr>
<tr>
<td><strong>Aboriginal Friendship Centre</strong></td>
<td>Phone: 604-251-4844 1607 Hastings Street  &lt;www.vafcs.org&gt;</td>
</tr>
<tr>
<td>Elders’ Wisdom: number of programs including those on health.</td>
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<tr>
<td><strong>BC Seniors Health Care Support Line</strong></td>
<td>Phone: 1-877-952-3181  <a href="http://www.seniorsbc.ca">http://www.seniorsbc.ca</a></td>
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<tr>
<td>Information on health services, Medical Services Plan, finances, transportation, housing and other government services.</td>
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<tr>
<td><strong>Better Meals Program</strong></td>
<td>Phone: 1-888-838-1888 or 604-299-1877  &lt;www.bettermeals.ca&gt;</td>
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<tr>
<td>Serving Greater Vancouver, Fraser Valley, Greater Victoria, Mid-Vancouver Island and parts of the Okanagan.</td>
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<tr>
<td><strong>Crisis Centre of BC Seniors’ Distress Line</strong></td>
<td>Toll-free: 1-800-784-2433 (1800-suicide)  Phone: 604-872-1234  &lt;www.crisiscentre.bc.ca&gt;</td>
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<tr>
<td>(24 Hours and Confidential)  Crisis Intervention and Suicide Prevention Centre.</td>
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<tr>
<td><strong>Food Banks BC</strong></td>
<td>Toll-free: 1-855-498-1798  &lt;www.foodbanksbc.com&gt;</td>
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<tr>
<td><strong>Health and Seniors Information Line</strong></td>
<td>Toll-free: 1-800-465-4911</td>
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<tr>
<td>Provides assistance with cases of elder abuse.</td>
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<tr>
<td><strong>HealthLink BC</strong></td>
<td>Phone: 8-1-1  For deaf and hearing-impaired assistance (TTY), call 7-1-1  &lt;www.healthlinkbc.ca&gt;</td>
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<tr>
<td>24-hour health information line, medical advice, assistance with navigating the system, and a translation service in 130 languages.</td>
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<tr>
<td><strong>Qmunity</strong></td>
<td>Phone: 604-684-5307 1170 Bute Street  &lt;www.qmunity.ca&gt;</td>
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<tr>
<td>For LGBT persons. Counselling available</td>
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<tr>
<td>Provides assistance to adults who need support for financial and personal decision making.</td>
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<tr>
<td><strong>MealCall Program</strong></td>
<td>Check white pages of local telephone directory for meal programs.  &lt;www.mealcall.org&gt;</td>
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<tr>
<td>Locations of most Meals-on-Wheels and senior meal programs.</td>
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<tr>
<td><strong>MedicAlert® Safely Home®</strong></td>
<td>Toll-free:1-855-581-3794  &lt;www.medicalert.ca/safelyhome&gt;</td>
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<tr>
<td>A nationwide program designed to help identify the person who is lost and assist in a safe return home. This is a partnership between the Alzheimer Society of Canada and MedicAlert.</td>
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<tr>
<td><strong>Mental Patients’ Association</strong></td>
<td>604 482 3700  &lt;www.mpa-society.org&gt;</td>
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<tr>
<td>Advocacy &amp; Social Justice, court services, homelessness and outreach 122 Powell Street</td>
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<tr>
<td><strong>Immigrant Services Society</strong></td>
<td>Settlement &amp; support services for immigrants &amp; refugees. 45 languages</td>
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<tr>
<td><strong>MOSAIC</strong></td>
<td>advocacy for immigrants &amp; refugees. Seniors’ club.</td>
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<tr>
<td><strong>The Bloom Group</strong></td>
<td>In the Lower Mainland, the Bloom Group (formerly St. James) offers financial management assistance to individuals who are on pension income, such as Old Age Security and Canada Pension Plan. Individuals may be referred because they have been deemed incapable of managing their finances, financial abuse or exploitation is suspected, or where clients are behind on their rent and bills and are at risk of eviction.</td>
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<tr>
<td><strong>Vancouver Native Health</strong></td>
<td>Comprehensive medical, counseling &amp; social services. Deals with con-current issues of substance abuse, mental health, homelessness</td>
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<tr>
<td><strong>Alzheimer Society of BC</strong></td>
<td>Information, education &amp; advocacy for people living with Alzheimer or dementia. Dementia helpline</td>
</tr>
<tr>
<td><strong>Council of Senior Citizens’ Organizations of B.C.</strong></td>
<td>An umbrella organization with 85 affiliate senior groups. Advocacy is provided for health, housing and economic issues affecting seniors.</td>
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<td></td>
<td>COSCO Seniors’ Health &amp; Wellness Institute provides health and safety workshops for senior groups province-wide. Visit the COSCO website at coscobc.ca to view the list of topics.</td>
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<td></td>
<td>Contact: Sheila Pither, Workshop Coordinator, 604-684-9720.</td>
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**Other Services**

1. West End Seniors Network, Barclay Manor, 1447 Barclay, 604-669-5051 and Denman Place, 604-669-7339. Senior support programs for issues of coping with health, isolation and mental health.

2. South Granville Seniors’ Centre, 1420 West 12\(^{th}\), 604-732-0812. Programs and services to break social isolation and depression.

3. 411 Seniors Centre, #704-333 Terminal, 604-684-8171. Regular hearing and blood pressure clinics. A large Information and Referral program giving individual help for all aspects of seniors’ lives. Outreach program.

4. City of Vancouver, 604-873-7000 (TTY 711). City provides local community centres that often include seniors programs and services. Also City has Mental Health and addiction services for seniors that include alcohol, drugs, gambling and hoarding.
Appendix 6: Evaluation Survey

Geriatric Psychiatry Health Advocacy Workshop July 3, 2014

Evaluation Survey

Compared to other educational experiences I have had about health advocacy, on a scale of 1-5; this workshop was: (Check One)

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One of the worst experiences

One of the best experiences

I have not had other learning experiences about health advocacy

How useful was the introduction to Carlisle’s Framework for health advocacy? (Check One)

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Not very useful

Very useful

Please comment on the reason for your rating and any suggestions you have for improvement:

How useful was the case discussion? (Check One)

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Not very useful

Very useful

Please comment on the reason for your rating and any suggestions you have for improvement:

/Continued...
Please comment on the reason for your rating and any suggestions you have for improvement:

In what ways has the workshop made you think differently about health advocacy?

Do you have any other suggestions for us?

Please send your completed form to Cathy Kline (cckline@mail.ubc.ca)
Suggested Workshop Development Process

1. **Identify potential community-based organizations involved in health advocacy of relevance to your residents**
   Program directors and preceptors may already have connections to community organizations. Other suggestions can be sought through existing community contacts using a snowball approach.

2. **Hold an Information Forum** This is an opportunity for representatives from community organizations to find out more about opportunities for involvement and for you to find out more about who might be best suited to help with the development and implementation of the workshop (or any other roles you might have in mind). Topics covered could include the CanMEDS competency framework and Health Advocate role, basic structure of the residency program, outline of the workshop planning process, time commitment and recognition [See Appendix 7]. A sign-up sheet at the end of the Forum will allow community representatives to indicate their level of interest.

3. **Hold Planning Meeting #1** Faculty and community representatives should work together to draft the workshop objectives and brainstorm possible activities. Carlisle’s framework (see workshop outline) should be introduced and applied to the health advocacy activities that the community organizations do. A planning template may help to keep the discussion on track [Appendix 8], and can be added to as the planning process evolves and used as the basis for the workshop agenda. Volunteers should be identified to develop cases for the workshop if these are to be used.

4. **Review proposed workshop with program director or other workshop sponsor** This will ensure the workshop will meet the program’s expectations. Residents may be canvassed for their interests and questions, e.g. What are you particularly interested in learning about health advocacy? What questions do you have about health advocacy for [population served] especially those that representatives from community-based agencies could help with?

5. **Develop workshop materials** These may include discussion cases, resource lists and bios / contact information for community facilitators. These can be drafted and finalized by e-mail.

6. **Hold Planning Meeting #2 (about 2 weeks before the workshop)** All workshop facilitators should be present to review and finalize the workshop agenda and materials, decide who is doing what and confirm housekeeping arrangements.

**WORKSHOP**

7. **Evaluation and Debriefing** Post-workshop evaluations should be completed by participants and facilitators, summarized and reported back either by e-mail or through a debriefing meeting.

**Notes:** It would be appropriate to offer an honorarium to community representatives for their time in planning, materials preparation and workshop facilitation. Parking should be reimbursed and refreshments provided for planning meetings (which are likely to be held at the end of the working day). Planning Meetings could also include a resident or two.
Appendix 7: Information Forum
Seniors Health Advocacy Forum 3 April 2014: 4.30 – 6.30 pm
Room 4223, Diamond Health Care Centre, VGH

Purpose
This is an exploratory forum at which we will provide information about the Division of Health Care Communication (DHCC) initiatives to involve community members in the education of health professionals at UBC (http://meetingofexperts.org/), including a specific opportunity in relation to a health advocacy training workshop for a group of geriatric psychiatry residents in July.

We will have representatives from 5 or 6 community organizations involved in advocacy for seniors at the meeting and would like to hear about their work and ideas for potential collaboration, not only for the July workshop but other future opportunities. We anticipate following this initial meeting with a planning meeting a couple of weeks later for those who are interested in helping with the workshop.

Agenda
4.30 – 4.40: Introductions

4.40 – 5.00: Overview of activities of the DHCC to bring patient and community voices into the education of health professionals at UBC

5.00 – 5.30: Health advocacy education for trainee doctors
- current situation
- summary of health advocacy project
- future opportunities for community involvement

5.30 – 6.15: Community round table: health advocacy for seniors
- how are physicians / other health professionals involved in your organization’s activities?
- how could they be more involved?
- what opportunities are there for your organization to be involved in educating trainee doctors?

6.15 – 6.30: Summary and next steps
Invited attendees:
Eric Kowalski Executive Director, West End Seniors' Network executive директор@wesn.ca

Susan Moore, Manager Kay’s Place Office, West End Seniors’ Network kaysplace@wesn.ca

Rebecca Morris, Advocacy Analyst, Alzheimer Society of B.C. rmorris@alzheimerbc.org

Sheila Pither, Secretary – Treasurer, Council of Senior Citizens Organizations of BC (COSCO) pither470@shaw.ca

Linda Forsythe, Secretary Council of Senior Citizens Organizations of BC (COSCO), Board Member 411 Seniors Centre Society lindajforsythe@gmail.com

Suzi Kennedy, Operations and Information and Referral Manager, 411 Seniors Centre Society skennedy@411seniors.bc.ca (TBC)

Carol Dickson, Manager, Seniors Community Support Services, Volunteer Richmond Information Services cdickson@volunteerrichmond.ca

Michelle Kotowski, Project Coordinator, Downtown South Neighbourhood Helpers Project, Vancouver Second Mile Society michellek@vsms.ca

Lisa Bui Assistant Project Coordinator, Downtown South Neighbourhood Helpers Project, Vancouver Second Mile Society

Project team:
Cheryl Hewitt, former CEO, PeerNetBC cherylhewitt54@gmail.com

Sue Macdonald, Coordinator Consumer Involvement and Initiatives, Vancouver Community Mental Health & Addiction Services, Vancouver Coastal Health sue.macdonald@vch.ca

Maria Hubinette, Department Family Practice, UBC maria.hubinette@ubc.ca

Bill Godolphin, Co-Director, Division of Health Care Communication, UBC wgod@mail.ubc.ca

Cathy Kline, Research Coordinator, Division of Health Care Communication, UBC cckline@mail.ubc.ca

Angela Towle, Co-Director, Division of Health Care Communication, UBC angela.towle@ubc.ca
Appendix 8: Planning Template

Geriatric Psychiatry Workshop: Planning Worksheet

Workshop date and location:
Participants:
Facilitators: TBD

A Framework for Health Advocacy (Carlisle, 2000)¹

Objectives

Activities

Resources required