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ORIGINAL RESEARCH

Psychogeriatric care: building rural community capacity

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ABSTRACT

Introduction: Since the late 1980s, British Columbia (BC) Canada has been undergoing a process of regionalization of health services which includes decentralization and the demand for self-sufficiency with respect to caring for people with mental health issues. In BC, regionalization has meant the continued downsizing of its one large provincial psychiatric hospital Riverview, which has resulted in relocating patients from this hospital to cities and towns throughout BC, and the establishment and/or renovation of psychiatric tertiary-care facilities to treat local community members who experience mental ill health. In the context of the relocation of psychiatric tertiary care, communities in northern BC face the specific challenge of having to provide these specialized services in remote settings, not only for people transferred from Riverview, but also for the increasing number of people 'aging-in-place' in a region that has the fastest growth of older adults in BC. Little is known about the capacity of these remote communities to manage change, develop broader models of care, and integrate people with psychogeriatric mental health issues with residents at existing facilities.

Methods: This study employed a qualitative research design which involved field research in the rural community where people were transferred, and interviews and focus groups with key people involved in the transfer process. In the analysis of the data a

gender-based lens was applied to clarify the differing needs and concerns of male and female patients and to attend to possible needs relating to culture and ethnicity.

Results: The findings illustrate persistent 'hinterland–metropolis' and 'front-line versus administrative staff' tensions, with respect to resource distribution and top-down governance, and demonstrate the need for more transparent and comprehensive planning by health authorities with respect to instituting mental health reforms in a northern context, as well as improved communication between administrative and front-line staff. The research suggests that it is important to attend to the differing needs of women and men in the context of psychogeriatric care, as well as to other factors such as ethnicity and culture, in order to provide appropriate care. Finally, building community capacity to deal with the complex needs of patients is severely hampered not only by facility and regional health authority staff turnover, but also the stresses inherent to working in northern communities which include geographic, social and economic challenges.

Conclusion: Increased local engagement is a way to identify and address challenges related to relocating psychogeriatric care to northern and remote settings, and to enhance psychogeriatric care provision in similar locales. While provincial and regional level 'big picture' planning is a necessity, study participants highlighted the critical role of local perspective and expertise.

Key words: gender and mental health, geriatric psychiatry, mental health, psychiatric tertiary care.

Introduction

Since the late 1980s, British Columbia (BC) Canada has been undergoing a process of regionalization of health services which includes decentralization and the demand for self-sufficiency with respect to caring for people with mental health issues[1-3]. In this context, each region of the province is required to develop relative self-sufficiency (p.12)[1]:

> *...in its ability to assess and treat episodes of acute psychiatric illness in its population ...[and]... have sufficient inpatient psychiatry beds to meet the needs of the acutely mentally ill population.*

The stated intent of regionalization as a key mental health reform is to improve the overall quality of mental health care by providing care in the community 'closer to home'[2]. In BC, regionalization has meant the continued downsizing of its one large provincial psychiatric hospital Riverview, which has resulted in relocating patients from this hospital to cities and towns throughout BC, and the establishment and/or renovation of psychiatric tertiary-care facilities to treat local community members who experience mental ill health. Thus, each of the five regional health authorities is now required to provide the full range of mental health care, including specialized psychiatric care.

Covering 600 000 km^2, the Northern Health Authority (location of the research site) serves a population of approximately 300 000, 17.5% of whom are Aboriginal – the highest proportion in BC[4].

In the context of the relocation of psychiatric tertiary care, communities in northern BC face the specific challenge of having to provide these specialized services in remote settings, not only to people transferred from Riverview, but also to the increasing number of people who are now 'aging-in-place' in a region that has the fastest growth number of older adults in BC[4-6]. Little is known about the capacity of remote northern communities to manage these changes, develop broader models of care, and integrate people with psychogeriatric mental health issues with residents at existing facilities.

While the alleged goal of decentralization and integration is to provide improved quality of care for mental healthcare recipients, it has posed challenges for healthcare providers

unaccustomed to providing complex care requiring new skills and shifts in the configuration of services. Although the integration of psychogeriatric patients with the general aging population has occurred in other jurisdictions[7], the benefits and challenges in the Canadian context are not well known; these services are often offered within urban settings and from an urban perspective, limiting their application to rural and remote settings[8]. Further, research on health reform has shown that hospital closures and the subsequent rearrangements of care have a disproportionate impact on women, who are both the majority of care recipients and the majority of care providers[9,10]. Evidence also suggests that the mental health needs of women are significantly different from those of men, and that application of gender-based analysis is therefore critical to research in mental health[11,12].

Although transfers from Riverview occurred in a variety of towns in the north, the present research was concerned specifically with the transfer of 14 patients from Riverview to an existing care home for the elderly (called 'Jennings Lodge' for the purposes of this study) in a small town ('Northtown' in this study) and on the respective needs of staff, management and the individual women and men as they settled into this new context[13]. Northtown is a regional service area for the surrounding rural communities and has a population of about 6000 residents.

The goals of this research were:

1. To investigate the impact, including gender differences, of moving older men and women living with serious and persistent mental health issues from Riverview to a remote community in Northern BC.
2. To investigate the impact on care providers of having residents who challenge the local capacity for caring for older adults diagnosed with serious mental health issues in both continuing care and community settings.
3. To bridge gaps in inter-agency communication regarding the ability to collaboratively provide quality care for older adults living with serious mental health issues.
4. To help guide a community capacity building process for the development of a gender-sensitive psychogeriatric care model that supports the goals of psycho-social rehabilitation and is sustainable over time.

The findings illustrate persistent 'hinterland/metropolis' and 'front-line versus administrative staff' tensions, with respect to resource distribution and top-down governance, and demonstrate the need for more transparent and comprehensive planning by health authorities with respect to instituting mental health reforms in a northern context, as well as better communication between administrative and front-line staff. Research suggests that it is important to attend to the differing needs of women and men in the context of psychogeriatric care[11,12], as well as factors such as ethnicity and culture in order to provide appropriate care. Finally, building community capacity to deal with the complex needs of new residents is severely hampered not only by facility and regional health authority staff turnover, but also the stresses inherent to working in northern communities which include geographic as well as social and economic challenges.

Context

Although the goals of regionalization and the downsizing of Riverview Hospital have been articulated in policy and planning documents for several decades, the most recent articulation of these goals can be found in the 'Riverview Redevelopment Project' which began in 2002 and is expected to be completed by 2012[14-18]. The process involved transferring people from Riverview hospital to towns and cities throughout BC. As people were transferred so were the resources to develop and/or enhance psychiatric tertiary care (including tertiary acute, rehabilitation, and specialized residential care) in each region.

In the context of northern BC, the redevelopment of Riverview brought with it specific challenges which include pre-existing mental health and geriatric service shortages, a lack of specialized professionals, gaps in staff training, housing

options, care facility beds, and support services and programs[19,20]. These challenges are embedded in the larger issue of inadequate and often inappropriate social infrastructure in northern, rural remote communities. Implementation of southern/urban per-capita-based funding and staffing formulas impact all aspects of service development and delivery, training, and innovation as well as staff recruitment and retention[21]. For example, the range of mental health services considered conducive to post-deinstitutionalization support of those with complex needs is simply not available when, according to southern/urban norms, a region's population size is too small to support such services.

In Northtown, Jennings Lodge has a history not dissimilar to other facilities of its kind in the north. Originally designed to provide support to local seniors, the facility has in recent years had to adapt to provide care to frailer, older residents with complex care needs. The introduction of residents from Riverview hospital has placed new demands on the management, staff and residents to provide care to individuals with both complex health and mental health needs.

Methods

A 2006 pilot study provided groundwork for this research. Specifically, preliminary conversations with mental health managers in the northern health region led to a collaborative relationship between the researchers and the manager of Mental Health in one of the northern areas. The resulting pilot study documented the experience of transferring patients from Riverview to Jennings Lodge, where 14 psychogeriatric beds had recently been opened due to the transfer of funds from Riverview. Nine qualitative interviews with key informants (facility managers, psychologists, physicians, and nurses) and one focus group with staff (nurses, recreational therapists and mental health workers) at Jennings Lodge were conducted in 2006. This preliminary data suggested that a study of larger scope was necessary. The researchers secured further funding in 2007 and partnered with representatives from the Northern Health Authority in Mental Health and Addictions (MHAS) and in Home and Community Care (HCC), and formed an advisory committee (the Community Action Committee [CAC]) made up of key mental health service providers and advocates. The MHAS has jurisdiction over mental health and substance use services and was responsible for facilitating transfers to the region from Riverview. Home and Community Care has jurisdiction over residential care as well as palliative and end of life care. Working with this group of people, the researchers set out to explore the experiences of staff, community members, and residents related to the transfer from Riverview to Jennings Lodge.

The research received ethics approval through Simon Fraser University, University of Northern BC and University of Windsor's' Behavioural Ethics Boards, and through the Northern Health Authority. The researchers note that the ethical concerns of this study were accentuated due to the small size of the community and greater concerns therefore about maintaining anonymity. To address these concerns participants were guaranteed confidentiality but not anonymity.

The study design was meant to foster dialogue among service providers (registered nurses, recreational therapists, psychiatrists, and mental health workers), policy-makers and planners who were working under different health authority mandates (MHAS and HCC).

The CAC members were responsible for providing direction to the project and participating in a process meant to build the capacity for better ongoing care of the psychogeriatric population. Citizen engagement, through the CAC, was seen as a key mechanism for building community cohesion and fostering the necessary social infrastructure to support this undertaking. The CAC members not only helped guide the research process, but also contributed to the development of the final research report and the subsequent presentation made to Northern Health Authority representatives from MHAS and HCC.

Data collection

Four site visits to Northtown and Jennings Lodge were conducted between January and October 2008. The recruitment strategy for key informant interviews employed a purposive sampling technique where Northern Health research collaborators from HCC and MHAS, suggested interview participants. The interviewees included registered nurses, mental health workers, psychiatrists and physicians who had direct experience with the Riverview transfers and in managing and/or providing direct care to people with psychogeriatric needs. From there, the individuals recommended by other study participants were contacted.

Additionally, interviews and a focus group were conducted with current staff at Jennings Lodge. In some instances, staff members were interviewed in small groups of two or three to accommodate staffing needs and time constraints. In addition, a focus group was held with community-based mental health advocates who either currently or in the past had provided support for older adults who were Jennings Lodge residents, or who had experience working with people with mental health issues. The participation was also sought of residents at Jennings Lodge who had been part of the transfer from Riverview. Two residents were able and agreed to participate. Although the researchers had hoped for the participation of more residents, the residents were in the process of settling into their new homes after a move that, for many, was likely to be stressful. Although limited, the involvement of these residents added another dimension to the research that would not otherwise have been captured. None of the participants were given incentives for participation. A summary of the interviews and focus groups, including those conducted during the pilot study is provided (Table 1).

All interviews and focus groups were audio-taped with the participants' permission. Interview duration ranged from 15 min to 1.5 hours. Both focus groups were of 90 min in length. Open-ended semi-structured questions were used with all participants. Interview guides were tailored to reflect the respective roles and responsibilities of the research participants, but in all instances included questions related to the experience of the transfers from Riverview, the challenges of providing psychogeriatric care in the current context, and suggestions for change. For example, questions for staff included: 'As staff were you involved in the decision making process with respect to the transfers of clients from Riverview to Jennings Lodge?' 'Do you face any ongoing challenges with respect to integrating Riverview clients at Jennings Lodge?' and 'Can you tell me what a typical client's life is like at your facility? For a man, and for a woman? What types of activities are they engaged in? What kind of responsibilities do they have, if any? What kind of interaction do they have with their families and the community?'

Data analysis

Using a three-stage process identifying codes, then grouping codes to create categories and then finally grouping categories to create themes, an initial coding framework was developed using the thematic areas that appeared in the interview and focus group guides. Data (interviews, focus groups and field notes) were coded and organized thematically according to the emergent themes from each individual interview and focus group. Data from each type of study participant (manager, front-line staff, resident, etc) was then examined to find cross-cutting and divergent themes. Inter-rater reliability was established by having four researchers independently review the data. Their individual findings were then contrasted and compared with those from a team data-analysis meeting to ensure accuracy in representation of the overall findings. A lens of gender-based analysis was used to review the data for any information about the differing needs of men and women[22-24]. Gender-based analysis aims to also understand the origins of these differences in the social context in which they are occurring[24]. For example, would women residents experience more concerns about safety at Jennings Lodge than men? Would women have more substantial social networks and connections to their families than men? Would staff treat men and women differently based on stereotypical gendered roles?

Table 1: Summary of interviews and focus groups

Interviews/ group	*N*
Individual and small group (managers, recreation therapists, occupational therapist, mental health workers, physicians, nurses and psychiatrists)	27
Residents with psycho-geriatric needs	2
Staff focus group	5
Community based advocates focus group	5
Total participants	39

Results

Profile of people transferred from Riverview Hospital

Ten men and four women ranging in age from 54 to 81 years were transferred from Riverview Hospital to Jennings Lodge between the years 2004 and 2006. By the completion of the present study eight of these people had died and the remaining six (2 women and 4 men) continued to reside at Jennings Lodge.

Findings according to categories

The findings are divided into three content related categories: governance and planning; resources; and gender, stigma and discrimination, and one process related category: building community capacity.

Governance and planning: Decisions within Northern Health were driven by wider provincial mandates with respect to regionalization of psychiatric tertiary care. The Ministry of Health in consultation with the Provincial Health Services Authority (PHSA) initiated the Riverview redevelopment process and ostensibly worked with each of the health authorities in implementing the changes, which meant a transfer of resources and patients from Riverview to each health authority. The enactment of this relationship in the northern context illustrates the gap that exists between health authorities in the south and those in the north, between larger cities and smaller towns, and between higher level administration and front-line staff.

As such, there was an overall sense from the participants that provincial mandates were the main driving force for the changes and, in particular, for the manner in which the changes were initiated, with little northern control. A psychiatrist said:

> *So now we have something, this guy [a man being transferred from Riverview] potentially going to this place [Jennings Lodge], with an inappropriate environment, with untrained staff, under [trained], not only training-wise but number-wise staff and they [the provincial health authority] still want to push to get this thing…*

Another example arose from front line care staff who indicated they felt disconnected from higher level management within Northern Health during the planning process leading up to the transfers, which were meant to involve them. That is, early on in the transfer process, a community advisory committee was instituted and its members believed their recommendations would be upheld by management. They were unaware that there were decisions being made at a higher level without consulting, involving or informing the advisory committee. A consultant asked to review the process said:

> *I think you need to put into place a model where when those complications occur that everyone at the table is on the same*

level. The problems that you run into is that there is difference given to different professionals and different administrators or whatever else, that the only time that you're going to get really good dialogue is when people feel free to dialogue.

The process was also complicated by a high turnover at all levels of management in the Northern Health Authority. This resulted in managers not always being clear about their respective roles and accountability. This affected communication mechanisms between management and staff:

We didn't really have anybody at the higher management level that was spearheading this. It seemed to be different people, I was involved and I wasn't, you know, that sort of stuff. And it's kind of like, I don't know if there was anybody just piecing the whole thing together, because kind of after [name of manager] left there was a long time that there wasn't anybody, and that [name of manager] was here for, you know, 18 months and then [name of manager] gone. You know, a lot of like interim stuff so that that continuity and that overall planning thing, I don't think was there. (Healthcare manager)

Furthermore, during the tenure of this project there were two interim directors for Jennings Lodge attempting to take on the responsibilities of the longer-term care manager who relinquished this position (for unrelated health concerns). This position remained unfilled as of the last site visit in October 2008, leaving a significant management gap.

There were also financial and practical constraints, as well as misunderstandings and differences of opinion, all of which surfaced during the planning process and impacted on decisions about the type of environment necessary for people with psychogeriatric needs:

I don't think that it was because the intention wasn't good. I don't think it was because nobody really planned on not listening. I just think the reality of what we had to work with didn't match what people expected. Like I mean, you had a building that was built a certain way, you only had so much staffing, you only had so much money, so I think those are the reasons. Like I don't think it's just because there's a blatant disregard for what people wanted. (Healthcare manager)

The transfers coincided with a renovation to one wing of the facility that had not been upgraded to complex care specifications in the past. This wing was never intended solely for Riverview residents; however, there was much confusion about this, as concurrently there were also opposing views that represented differing philosophical beliefs about the most appropriate design for a psychogeriatric population. In addition, the decision to integrate Riverview residents throughout the facility was 'top down'. From the perspective of many front-line workers, this meant that there was a significant gap between the needs of mental health residents and the environmental design of the facility:

However, the Lodge is not appropriate for its own population group. It was designed in an era where IC-I [Intermediate Care] and IC-II were the predominant admission. So everybody was ambulant, there wasn't a wheelchair in sight, and people were way high functioning. So now you've got a facility that not only, I mean it doesn't suit the Riverview people, but it doesn't suit the residents who are in there anyway. (Healthcare manager)

It's inappropriate, the whole set-up from the beginning was inappropriate. So I'm not sure who got involved with that prior, but based on the pattern of stuff that I've seen, not only up there [Northtown] but also all over BC, is people are making decisions without bringing in and getting input from the people at the ground level. And I'm not just talking about the doctors, I'm talking about the nurses, the occupational therapist, the physiotherapist, the OTs, dietary, everybody. (Psychiatrist)

Resources: ***Training*** The majority of the mental health training for staff appeared to have unfolded in and around the time the transfers took place, rather than in advance of the residents arriving. Training was provided initially primarily for nursing staff (through a course developed at a college) and was systematic. Other types of staff (occupational therapists,

recreational therapists and healthcare workers) were given some limited opportunities to attend onsite training sessions, but not all were able to take advantage of these sessions which were offered during break times and/or on staff days off:

> *And like just recently I had a six-week full-time block, I was covering for somebody, and it was over there [in a wing with primarily people with psychogeriatric needs]. And I have never had any training in dealing with aggressive residents or mental health residents, and I was just expected to go with the flow, you know, just kind of figure it out as I went, or whatever. And that kind of frustrated me because, you know, even the people that were being given a little bit of education, it really wasn't enough. Like I could tell from what they said. So, I mean, yeah, it's not safe. I don't think it's ever really safe…* (Healthcare worker)

Safety concerns for staff and residents related to lack of training were a recurrent theme of the interviews. A psychiatrist on call described staff concerns as follows:

> *But you have to understand you don't, I'm not an administrator so I don't try to administer, but I will say what I need to do my job properly, and I'm not going to continue to work in places where I can't do it properly, because that puts not only, and I think not only about the patient population at risk, and especially about this population because they're vulnerable as it is, but the staff at risk. And there were some major things that were going on with the staff there. I mean you could just see it, it really was not well prepared.*

At the time of the completion of the study, because of resource issues, not all levels of staff have received training in geriatric mental health. As a result, staff had learned on the job and, especially in the early days after the initial transfers, handling aggressive and difficult behaviours was challenging and at times put staff and residents at risk.

Staffing The findings related to staffing needs show there is a lack of consistent psychogeriatric leadership in Northern Health. There were several changes in the psychiatrists responsible for the mental health residents at the continuing care facility, at times resulting in gaps in psychogeriatric care. In addition, the nurse educator role at the facility was discontinued. This role was seen as valuable because of its potential to provide onsite training and wider community education. Staff also noted the need for a social worker on site to handle public trustee issues. And finally, appropriate staff-to-resident ratios were not always able to be maintained, again raising safety concerns for both staff and residents. Further, the lack of staff seriously affected training because there was insufficient coverage to release staff for education opportunities:

> *I don't know, generally it's a kind of, it would take a systemic change, and that there hasn't been a lot of, or not so much interest or energy to do that. You have an understaffed situation where they are barely keeping their head above water and so they're going to do exactly what they did before. I mean the changes that you put into place are going to cause more problems than help us out on the short-term.* (Consultant)

Gender, stigma and discrimination: When asked about addressing individual needs in different ways, staff members said that insufficient thought had been given to this. Given that training was scarce and inconsistent, it is not surprising that the differing needs of men and women were not taken into account in service planning or staff training. Issues related to women's safety were mentioned as a concern that had not been adequately addressed. Needs relating to culture and other social locations were not part of the planning process. Individual staff members made efforts to provide culturally specific meals for example, and to link First Nations residents with members of their communities, but these individual efforts did not appear to be linked in any way to the transfer planning process or a program of care.

Due to a lack of training and education specific to mental health, staff struggled to understand how best to work with people with psychiatric needs, which created an environment where care decisions were sometimes based on fear. The fear appeared to be based on stigma and discriminatory attitudes about people with mental illness, and also a concern that

introducing residents from the outside the community would affect staff's ability to work with local community members:

> *I think the staff was frightened, and when you work in a place like Riverview and you have that training, it's not an issue, you know. You can look at it professionally, but I think it broke the bubble that the staff had here, of working with elder folks, and they weren't able to maintain a professional stance. And so I think there was, it seemed, just again from my distant viewing in, there was anger, there was a desire not to work with these people, and from the community I certainly heard that this was a big change for the facility… We're going to get more people like this from the community. They're our neighbors, they're our family. But I think they weren't prepared for that.* (Healthcare manager)

Building community capacity

The attempts to establish an ongoing communication mechanism that would foster discussion between MHAS and HCC and between front-line staff and management in the form of the CAC were hampered by a number of factors. Although the CAC met on three occasions, early on it became evident that not everyone who had committed to the process could follow through, which meant that not all levels of the care and management system were adequately represented. This situation made it difficult to fully implement the mandate of the CAC, which was to help facilitate communication across all levels of HCC and MHAS. Participating members expressed concerns that the work done at the CAC would not be taken up by senior management and this sense of disempowerment was evident at every meeting and was a serious limitation of the CAC.

Discussion

The research findings suggest that a number of barriers related to governance, planning, and resources severely hampered a smooth transition of people from Riverview to Jennings Lodge, especially from the perspective of front-line staff and local management.

Governance concerns

The top-down approach to decision-making with respect to the way transfers would occur was apparent in the stories of most of the research participants. The result was a facility that was unprepared initially to meet the needs of the newly arriving patients, causing stress and safety concerns among staff and, in some instances, fueling the stigmatising of and discrimination against new residents.

Planning challenges

While the intent to deliver exemplary care was apparent in discussions with management and health workers alike, the difference of opinion regarding how best to care for people with tertiary, psychogeriatric, and complex care needs were not adequately addressed in the planning phase of the transfers. More careful planning might have alleviated some of the tensions associated with these transfers in that issues could have been dealt with more appropriately further up in Northern Health management, rather than developing 'on the ground' as the transfers began. For example, discussing the kind of environment that might be most suitable for people with tertiary psychiatric needs, and not proceeding with the transfers until an agreed solution was reached, might have created a safer home for residents and a better work milieu for staff.

Limited resources and training

Communication challenges were exacerbated by the high turnover of senior and middle management across Northern Health, contributing to lack of clarity regarding roles and responsibilities, which made accountability and transparency difficult. As a result, comprehensive mental health staff training was not fully in place prior to the transfers. In spite of this, front-line staff demonstrated an exemplary ability to learn on the job, although many were yet to be trained, leaving staff and residents at risk if safety related issues arose. In addition, while residents have adjusted to the new facility, and staff to their new care demands, the findings indicate that residents are not being cared for at a level which might

enhance their capacity as individuals to engage and become valued members of Jennings Lodge and the greater community. Current support models in mental health are oriented towards a 'recovery framework', which is strengths- rather than deficits-based, and is meant to help individuals realize their full capacity regardless of their physical and mental health status. The ability to actualize current best practice in mental health care needs to be supported by further training and better communication mechanisms between HCC and MHAS.

Stakeholder engagement

Given that mental health beds are now a permanent feature of Northern Health, engaging in a process where the staff of facilities, residents and family involvement in transfer planning is valued is likely to address some of the problems faced in this community in a more proactive manner. For example, transparent discussions about the addition of mental health services to existing complex care facilities, particularly when the facility is not designed or equipped to care for residents with psychiatric care needs, might lead to different outcomes.

Public education

With respect to the broader community, mental health anti-stigma and discrimination education would be useful to help communities come to terms with the care needs of their members. Current research suggests that public education strategies need to be targeted at and involve one-on-one contact between people, rather than large media campaigns[25]. Currently, care issues as they relate to gender and diversity (eg culture, ethnicity) are not addressed in any systematic way. Education and specialized resources are needed to make this an integral part of current care models.

Contextualizing challenges and solutions

Finally, acknowledging the particularities of providing and accessing healthcare services in rural settings is a critical aspect of contextualizing this project. In northern and remote communities, staffing challenges in recruitment and retention result in frequent staff turnover, but also in ongoing or periodic shortages of needed expertise and complex transition between old and new employees. Difficulty locating and retaining staff with proficiency in psychogeriatric care has a profound impact on the remaining front-line and management staff who are forced to take up the slack for vacant positions and, as a result, have little time to deal with problems or develop new initiatives. Culture can also impact the accessibility of services, especially for First Nations clients, partly because Aboriginal individuals are under-represented among healthcare professionals[26].

Compounding these challenges is the seeming inability of provincial-level governments to grasp the complexities of delivering services in remote regions of the north, over multiple geographies with relatively sparse populations. Funding formulas and service plans constructed by decision-makers in southern, more urban settings fail to address the specificity of northern needs and, as a result, these southern solutions are unsuccessfully imposed on northern problems. A perhaps less obvious disparity is that felt by managers, care providers, care recipients and community members in smaller northern communities in relation to larger urban centres in the north, where the administrative leadership of Northern Health is located. Similar to the sense among northerners that a southern-based governing structure cannot meet the specific needs of rural, remote, northern communities, there is a sense in smaller towns and regions that those who reside in the north but administer the health needs of residents from a large centre, also fail to grasp the particular needs of non-urban residents. Both these features of current healthcare administration call for greater local community control over health service programming and delivery in northern locales.

Conclusion

Local engagement - a way forward

The study findings suggest that increased local engagement represents a way forward, not only to identify and address

challenges related to relocating psychogeriatric care to northern and remote settings, but also to enhance psychogeriatric care provision in similar locales. While provincial and regional level 'big picture' planning is a necessity, participants in the study highlight the critical role of local perspective and expertise.

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