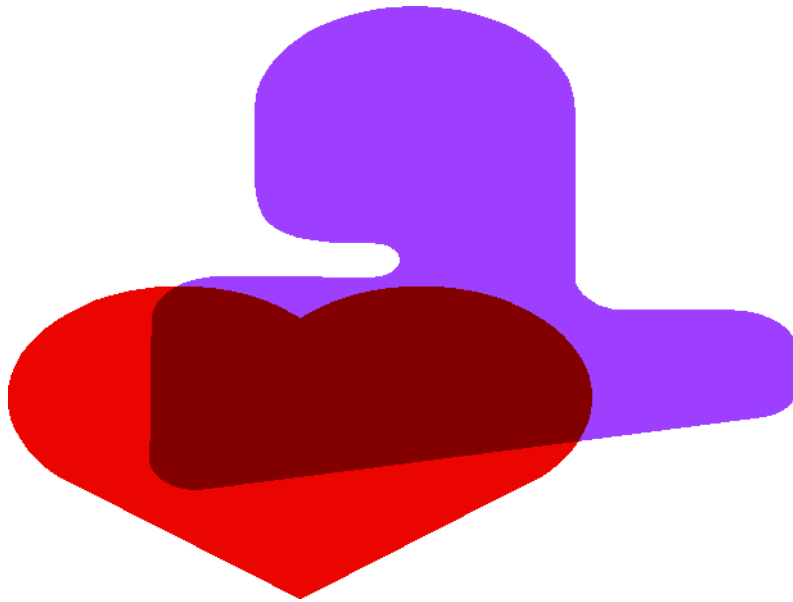


Clinical Case Management and Problem Solving Therapy:

Treating Home Bound Elders in Need.



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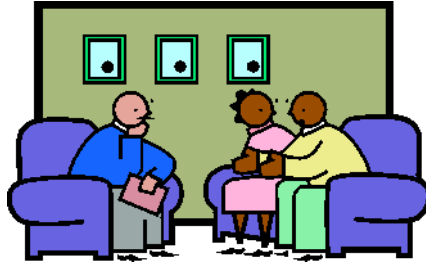
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Chapter 1

Clinical Case Management and Problem Solving Therapy for Depressed, Disabled, Low-Income Elders



Managing depression in low-income, disabled elders can be a humbling endeavor. There are no simple formulas. There are no easy answers. The plethora of problems faced by low-income, disabled elders can be overwhelming and management of their problems is often fraught with frustration. Service systems are fragmented and under funded. Programs are overburdened, resulting in long waiting lists. Clients are too depressed, sick and demoralized to advocate for themselves. As a result, clients in need end up feeling hopeless and fearful for their future.

This demoralizing state of affairs grossly interferes with the ability to engage in active treatment of depression. Although antidepressant medication and psychotherapy are helpful in treating late-life depression in well-resourced elders, evidence is emerging that these treatments alone are insufficient to treat depression in impoverished elders. While medication and psychotherapy can reduce depressive symptoms enough to mobilize depressed elders to make use of services, these treatments do not impart greater knowledge of the service system, nor do they break down the system level barriers that make accessing these services feasible.

Fortunately, managing depression and psychosocial problems in low-income, disabled people is possible through the process of combining clinical case management with Problem Solving Therapy (PST). Case management helps clients in need by linking them with programs that meet their need. To be successful in this endeavor, case managers must have a full understanding of social programs, the potential barriers that may interfere with use of these programs, and they must be in a position to advocate on their clients' behalf. PST helps clients in need by imparting to them a set of skills that will make them better managers of their environment. When people in need are successfully linked to services and learn new self-management skills, treating depression in low-income elders can be rewarding.

Clinical case management has been in existence since the 1960's and thus is not a new model of care. While several approaches to clinical case management exist, they all share in common the goal of improving quality of life through linkage and

advocacy. Surber (1994) describes case management as a process of care that occurs in three stages (1) comprehensive assessment and action planning (2) linkage, monitoring of service use and advocacy (3) and care coordination. Case managers collect information about unmet need from a variety of sources, such as the client, the family and any existing providers. From this information, case managers, in collaboration with clients, create an action plan to overcome barriers that interfere with meeting needs. Once the plan is created, the case manager uses it to create a link between the client and the services they need. The case manager, then, monitors the clients' use of services, encouraging them to attend programs, complete needed forms, or any task that would help overcome their problems. Case managers continue to advocate for clients and coordinate services to address their needs until case management assistance is no longer required.

While PST does not have the same history that clinical case management has, it too, has substantial support as an efficacious intervention for treating late-life depression. PST consists of seven stages that efficiently address psychosocial problems. These stages are (1) selecting and defining the problem, (2) establishing realistic and achievable goals (3) generating alternative solutions (4) implementing decision making guidelines, (5) evaluating and choosing solutions (6), implementing the preferred solution and (7) evaluating the outcome. The unique feature of PST over other psychotherapies is its fit with the case management process. Case managers can use these stages in creating a link between their clients and social programs, and in doing so, demonstrate the PST process to their clients with the intent of clients using the process to solve non-case management problems. Thus, case managers and clients work together, using the same logic model to solve both social and psychological problems.

This manual describes how case managers can help their clients over a period of three months, how they conduct assessment and make action plans, how they link clients to services and encourage their use of services, how they coordinate care and advocate for client needs, and how to teach clients to use PST. The manual is the result of 15 years of research at UCSF on the implementation of clinical case management in public sector settings serving older adults and on the delivery of PST to older adults with medical illnesses and mild cognitive impairments. What is presented here is a standardization of typical clinical case management after incorporation of useful suggestions from successful case managers who have worked with depressed, older adults. It also contains the PST manual to be used by clients and case managers.

Chapter 2 of the manual describes clinical case management and details activities that should take place at each stage of clinical case management. In Chapter 3, we described the problem solving process. In chapter 4 we provide general information regarding of aging resources and organizations should help in developing a case management network. In chapter 5, we discuss issues related to working with older adults, including the impact of ageism on motivation for change and how disability

affects treatment.

This manual also includes a number of appendices, with information that can be helpful to case managers in this study. The first appendix presents the short CANE. The second appendix is the problem list. The third appendix presents the PST form. These three forms are described in Chapter 2.

In summary, low-income, disabled elders with depression face continuous adversity. Social service programs exist to help these clients, but accessing these services is a complex process. Effective treatments for depression are available but their effects compromised by continued social strain. Case managers can facilitate linkage by identifying programs and overcoming barriers to service use. They can treat depression by imparting useful problem management skills that clients in need require to become better coordinators of their lives.

Chapter 2

How To Provide Clinical Case Management and PST (CM-PST)



In this manual, we divide case management into three stages, based on Surber's classification in Chapter 1. Our only modification to Surber's stages is the addition of patient education in Stage 1, the inclusion of PST as a component of case management, and a description of the termination process in Stage 3. Each stage is comprised of tasks the case manager completes during weekly, face-to-face meetings with the client, and tasks the case manager engages in between meetings.

Therefore, in this manual, CM-PST is broken down into the following stages:

- Education, comprehensive assessment, action planning and training in PST
- Linkage, advocacy, monitoring and PST review
- Case coordination and termination

These stages, and their companion activities are described in detail below.

Stage 1: Education, Comprehensive Assessment, Action Planning and PST training

Stage 1 typically occurs over the course of three weeks. In the first week, the case manager educates clients about depression and the case manager's role in their care, conducts a comprehensive needs assessment, collects information from potential services and programs and from family members and existing providers in order to create an action plan, and introduces clients to the PST process. The second week is dedicated to finalizing the action plan, identifying potential obstacles to utilization (transportation, waiting lists), making appointments for the client, and continuation of the PST training. The third week is dedicated to assisting the client in attending any appointments that are made, updating the client about any pending tasks and reviewing client progress in PST.

Week 1: The following activities are to be completed in the first week of case management:

Face-to-face meeting activities:

- Introducing the client to CMPST
- Completion of the Beck's Depression Inventory Primary Care (BDIPC)
- Providing an overview of depression through symptom description
- Completing/updating the CANE and Problem List
- Creating a preliminary action plan with the PST form

Between meeting activities

- Finalizing the case management action plan
- Create a health action plan

The week begins with a face-to-face meeting with the client. This meeting lasts one hour.

Introducing clients to CM-PST. Clients are more likely to collaborate with case managers if they have a clear understanding of how CMPST works. When educating clients about CMPST, it is important to emphasize that CMPST has two main goals, (1) to help improve quality of life by identifying services that will meet the clients' needs and (2) to teach clients how to systematically solve those problems that are under their control. Case managers emphasize that the process is collaborative and that there will be some problems that the case manager is primarily responsible for solving, and others that clients are primarily responsible for solving. Case managers explain that they will be using the same problem-solving model to solve problems. The case manager should point out that using the same model of problem solving serves as an opportunity for clients to learn PST by watching how the case manager uses the model to solve social service problems. Finally, case managers explain that they will meet with clients once a week for twelve weeks to discuss how their needs are to be addressed, to monitor client satisfaction with services, to track clients' depressive symptoms, to encourage use of services and the PST process to improve day to day living.

Depression assessment: Case managers will have access to clients' Hamilton Depression Rating Score obtained by the research assistants of this study, but will also reassess clients using the BDIPC. This assessment occurs at every meeting to track clients' symptoms. While several good measures of depression exist, we use the BDIPC because it is brief and it has been found to be a reliable and useful

instrument in people with medical problems.

Overview of depression: After completing the BDI-PC, case managers use the score and the symptoms clients endorse to provide a brief education about depression. This includes a discussion of how biology, psychology and the environment contribute to depression and how CM-PST works to help overcome the symptoms, i.e. through a process of helping clients to meet their needs and by learning a new way to manage the problems they face on a day-today basis.

Clients vary in the degree to which they understand depression. Some will have no knowledge of the disorder, and thus more time is needed in education. Others will have had previous experience with depression diagnosis and treatment, and will require less explanation. Case managers should always ask clients their experience with depression in order to pace how much time to spend on this part of the initial session and to dispel any faulty beliefs about the disorder.

Needs Assessment. The tools the case manager uses to conduct a comprehensive assessment are the Camberwell Assessment of Needs for the Elderly (CANE) and the Problem List. The CANE is used to identify case management needs, the problem list is used to organize and prioritize needs.

The CANE is a case management assessment tool that determines the areas of need a client has and whether or not the needs are being met. Each area of need is classified as:

- No need indicates that the person has no problems in that particular area. This category is scored as "0".
- Met need means the individual has a problem for which they are receiving an appropriate level of help. This category is scored as "1".
- Unmet need means the person has a problem for which they are not receiving appropriate assistance. This category is scored as "2".
- Over met need means the person is receiving more assistance than their problem requires. This category is not scored.

Any area that receives a "2" is to be addressed in the problem list, discussed below.

Once the CANE has been completed, case managers and clients divide the problems into two different lists, one that the case manager is responsible for and one that clients are responsible for. Case managers and clients create these **problem lists** by ranking the areas of need by degree of importance/urgency. This list is the basis for the case managers' and clients' action plans, discussed below.

An important part of the needs assessment is determining if other providers or family should be involved in the case management process. For instance, clients may say that they prefer their physician treat depression, and thus the case manager has to determine whether the client should talk to the physician, a family member

should, or if the case manager is the best person to notify the physician. If clients

identify other people who should be involved in case management, these people should be contacted during this stage, preferably in the first week.

Creating a preliminary action plan. By this time, the client and case manager will have decided which problems need immediate attention and which do not. Case managers then begin explaining the problem solving process by creating an action plan for the first problem on the case manager list, using the **PST form**.

Case managers show clients how to complete the form in the first meeting. Therefore, case managers must leave ample time in the meeting to review the PST steps. Case managers illustrate how to apply the PST process by completing one form to create the case management action plan, and then another form to create the client action plan for the week. Any difficulties clients experience with the process are reviewed, and noted for follow-up discussion in the next meeting. Because of the details involved in using the PST form, the specifics of how to complete it are described in chapter 3.

Case managers end the meeting by reviewing the working relationship, reviewing the case managers' and clients' action plans, and encouraging clients to use the PST form to create an action plan for another problem. This project offers clients a 24-hour emergency number. Instructions for use of the emergency number are given at the end of the first session.

Crisis Intervention. Poverty level clients are often at risk for crises. The most common crises we have encountered tend to be eviction, foreclosure, neglect, victimization, and severe depression. If clients are in crisis during the first meeting, the case managers initiate a plan of action during the meeting. For **housing crises**, case managers first identify safe shelter, then immediately begin the process of postponing eviction until alternative plans can be arranged. For **foreclosure or financial crises**, case managers begin the processes of advocating for the client and again postponing action until a plan for reimbursement can be detailed. If there is evidence of **victimization or neglect**, Adult Protective Services (APS) must be called in during the session. Finally, if clients appear to be more **severely depressed** than when initially referred to the project, case managers should help them access voluntary treatment, with consideration for involuntary intervention only when there is risk of harm to themselves and/or others, or if there is a profound inability to care for themselves.

Given the nature of depression and the potential for suicide, continued assessment of suicide risk and documentation is critical. In the event that a client is considered a high risk for a suicide attempt, the case manager will contact the Study Psychiatrist for consultation and an appropriate plan for the patient will be decided jointly.

If involuntary evaluation is deemed necessary, case managers will work closely with local emergency services to provide thorough clinical information and

history about the client, advocate for treatment interventions, and to help clinical staff assess client readiness for discharge and the appropriateness of plans.

Activities in week 1. Action planning. During the first week, case managers will be engaged in finalizing the action plan and will begin the process of linking clients to services. Case managers will gather information about waiting lists, procedures clients have to perform to be linked to services, forms that are to be filled out by clients or family members, eligibility criteria and so forth. Depending on the problem or the client, case managers may also need to talk to family members or other providers and to gather more information about the unmet needs. By the next meeting, case managers will have enough information to give their clients feedback on the final action plan.

Clients in crisis should be called or seen periodically throughout the week to ensure that linkage to emergency services, such as emergency housing, medical or health care, or APS has occurred and clients are now safe. If the clients remain unsafe, case managers again mobilize needed services.

Creating a health action plan. Geriatric depression, as a rule, afflicts elders with multiple medical problems often requiring complex medical regimens and multiple visits to physicians and other medical and rehabilitation services. The role of the case manager is to facilitate access to medical care. Access to medical care has *two components*. The first component is to make medical care available by arranging medical appointments, transportation, and helping with financing of care. Below, are some examples of how to offer financial help with medication.

Examples include:

- Pharmaceutical company financial relief programs
- Assistance in accessing Medicare's medication benefit program
- Public health programs that relieve medication costs for the poor
- Free samples

The second component of access to care is to help clients with adherence to physicians' recommendations. Depressed clients are likely to be pessimistic about the outcome of their health problems or lack the energy required in order to adhere to physicians' recommendations. As a consequence they may neglect their treatment and allow their conditions to deteriorate. Thus it is critical for the case managers to review in detail all medical recommendations and encourage clients to follow them closely. This process begins in the first meeting but continues on throughout the 12 weeks of case management services, i.e. the case manager reviews difficulties that clients may experience with treatment adherence and encourages them to continue their efforts to follow their physicians' recommendations. During

meetings, clients can use the PST form to create plans to adhere to physician recommendations. As an example, one disabled client was told by her physician to

use her walker around her apartment so that she did not completely lose the strength in her legs. The client did not adhere to this plan and was becoming increasingly more dependent on her wheelchair. Using the PST form, the case manager and client determined that she was not using the walker because it was often sitting in the corner of her kitchen, and she kept putting off using it. Since the walker was not always conveniently located, she often forgot to use it until it was too late, or she was too tired to use it. They then were able to create a plan whereby the client kept her walker by her bed or in her bathroom, thus using it to get out of her bed and perform ADLs in the morning, and using it to perform evening ADLs and get into bed. In this manner, the walker was always available to the client when she woke up and before going to bed, increasing her use of her legs by 20 minutes a day.

As part of depression management, case managers will seek clients' permission to inform their primary physician (the one who sees the client the most and is in charge of their care) that the client is depressed. Case managers will make the physician aware that the client wishes to be off antidepressants, a prerequisite for participation in the study. In addition, case managers will describe the intervention of the study and indicate that they will continue to inform the physician of client progress periodically. Case managers will alert physicians that if a client requests antidepressant medication or if a client's depression worsens, the client may be referred to the physician for care according to clinical indication. The study psychiatrist will be following the clinical state of each client by reviewing the clinical ratings and by receiving reports by the case managers and will intervene if necessary.

Week 2: Week two activities include:

Face-to-face meeting activities

- Complete the BDI-PC
- Review the week
- Review the PST action plans
- Create new action plans with PST form

Between meeting activities

- Finalizing forms

The goal of the next face-to-face meeting is to finalize the choice of service and to detail the steps that are needed to initiate the linkage.

Review of the week. Case managers begin the meeting by checking in with the client about their week, asking if any new problems or issues have arisen since the last meeting and reviewing client progress in implementing their action plan, and updating clients' on the case management action plan. Clients who were in crisis in the first meeting should also be assessed for continued safety and potential for danger in the coming week.

Case management action plan review. To facilitate learning PST, case managers begin the session by updating clients on the case management action plan that was created the week before. Clients learn how new information obtained over the week potentially modifies the original plan, and demonstrates how new information, even failures in linkage, is used by case managers to learn more about clients' unmet needs. Case managers then confirm with clients that the new action plan is acceptable to them, and makes further modifications to the plan based on client feedback. Case managers then reiterate to clients how the PST model was helpful in finding a way to meet client need, and that this process is useful for other problems. By this time, the action plan for this particular need should be final.

Client action plan review. Case managers then turn their attention to the client action plan. Clients are asked if they were able to implement their plan, if they created any new action plans using the PST form, and if clients have any questions about the PST process. They further discuss any barriers to implementing the original action plan, and in using PST to create other action plans. It is imperative that case managers review client plans. If they do not, clients are less likely to use the PST model.

New action plans. The meeting ends after new action plans for case management and client problems are created using the PST process. As discussed

above, the case management plan should be created first, so that clients can observe the PST process, and client action plans created next.

Activities in week 2: The case manager spends the remainder of the week creating a link to the service by contacting the service, finalizing forms to be completed, and making appointments. If a program has a waiting list, the case manager creates an interim action plan for the need while the client is on the list. For example, if a client needs transportation to medical appointments, but Para transit is booked for a month, case managers identify alternative plans for transportation, such as taxi vouchers or assistance from family.

Week 3: The activities in this week are a continuation of the activities in week 2. During the face-to-face meeting, review action plans, create new action plans inform clients of scheduled appointments and discuss and plan around instrumental barriers to attending appointments.

Activities during the week: Case managers begin working on new case management problems and checking with services to see if clients have made their first appointments.

Stage 2: Linkage, monitoring, advocacy and PST review

Stage 2 represents the remainder of the work to be done during case management. In this section, we do not break down this stage by activities for each week, because what occurs during and between meetings in this stage does not vary from week to week like it does in stage 1 and stage 3. Activities for this stage include:

Face-to-face meetings

- Complete the BDI-PC
- Update and modify problem lists
- Review case management and client action plans
- Create new actions plans using PST form
- Encouraging the link to services

Between meeting activities:

- Advocacy

Face-to-face meetings. Case managers begin each meeting reviewing clients' depressive symptoms with the BDI-PC, updating and modifying the problem list, reviewing action plans, and continuing to create new action plans using the PST

form. The majority of the time in these sessions will be spent encouraging the use of

PST, encouraging the link between clients and programs, monitoring client use of the services, and adjusting plans based on these discussions. By the middle of this stage, clients should begin using the PST form independently, with little input from case managers. If clients are still struggling with or not using the PST form by week 6, case managers should consult with the PST experts for advice.

Encouraging the link to services. Older adults who are both frail and depressed experience tremendous, overwhelming fatigue, apathy and anhedonia. While these clients may express a desire to overcome their problems, they may be unable to do so because they lack hope that the service will help them, and lack energy required to access services.

When clients do not link to and subsequently use services, case managers point out the potential utility of the program in meeting their expressed needs. Case managers often rely on the “try-it-a-few times” method to encourage service use. This approach may even require case managers *go with clients to their first appointments*. Sometimes, this is enough to get clients to begin using services. However, sometimes clients refuse to use the service because they still feel too tired or depressed, or are not hopeful that the service will meet their needs. In this instance, case managers can use the PST form to develop a plan to overcome these obstacles.

Weekly activities. Work between meetings consists of creating and finalizing action plans for other unmet needs that need to be addressed (see stage 1) and advocating for clients to overcome system level barriers to linkage and service use.

Advocacy. Because social programs are overburdened, under funded, and resistant to take on new cases, case managers must act as an advocate for their clients to speed up linkage. Advocacy will often involve laying the groundwork for clients by making appropriate contacts to the services. It also involves educating clients about the system, and the usual amount of time it takes to link to services so that clients are aware of what to expect from community services.

Successful case managers have found that getting to know staff members in different programs and using their own social contacts in the community can be useful in advocacy. Case managers must be skilled at building relationships with service providers, advocating for their clients strongly enough to mobilize services but not too strongly that they alienate program staff. The best relationship to create is with the county Ombudsman. This person can often help facilitate linkages, as well as identify the best county programs for the client. Finally, being a member of senior services and organizations such as Coalition of Agencies Serving the Elderly (CASE) is also useful for updated information on new services available for particular problems.

Stage 3: Care coordination and termination

In the final stage of CMPST, case managers finalize the coordination of services clients are using, addresses any outstanding unmet needs, and then terminates the weekly contact with clients. Because case managers in homebased meals programs are typically required to keep all their cases active, termination consists of shifting the amount of contact from once a week to the typical asneeded basis.

Week 11. During the facetoface meeting, in addition to their usual duties, case managers begin discussing termination. In the majority of cases, clients have been linked to services and are actively engaged. For those clients, case managers make sure clients have program numbers and are capable of coordinating their own care. If clients are unsure that they can coordinate their own care, family members or another provider may serve in that role. Clients are also encouraged to use the PST forms on any outstanding problems.

Activities for the week. By this time, case managers duties are fewer and fewer as clients become linked to services and become independent in their use of PST. Much of the activity in this week is to identify a point person to coordinate client needs (if clients are unable to do so themselves) and prepare for the last meeting.

Week 12. The last facetoface meeting is primarily to review progress with clients, review symptoms, and discuss the change in the working relationship. Case

managers should explain that the client may still contact them when needed but they will not be meeting on a weekly basis. Some clients may feel sad over the loss of the weekly contact, as having regular contact for isolated clients can be a source of pleasure during the week. Case managers can discuss these feelings, reassure clients that they will be available to them as needed, but also emphasize the progress made over the three months. Some clients may want to celebrate the end of the work by offering a small gift or sharing a meal. Case managers can engage in this celebration. The work is hard and rewards are well deserved, if they are within reason. In other words, sharing a meal is acceptable. Accepting expensive gifts is not.

Activities for the week. Generally, case managers will not have any additional work to do on terminated cases, other than to update clinical notes. However, in rare cases, some clients will still be waiting for a service to be available or to resolve their unmet needs. In those situations, case managers can be in regular phone contact with clients for three more months to make sure the need is met.

Case management timeline

Even though we have divided the stages of case management into weekly segments, we also realize some stages may take more time than others. The time frame proposed here should be used merely as a guide. However, if a stage of care is taking longer than it should, case managers should discuss the delay with the supervision team.

The table below illustrates which activities should occur from week to week over the three-month period. Case managers should note that these are suggested timelines and will vary from case to case.

week	Introduction	BDI-PC	CANE	Problem List	PST Action Planning	Review of action plans	Linkage	Monitoring	Advocacy	Crisis Intervention	Care coordination	Termination
1	U	U	U	U	U					PRN		
2		U			U	U		U		PRN		
3		U			U	U		U		PRN		
4		U			U	U	U	U	U	PRN		
5		U			U	U	U	U	U	PRN		
6		U	U		U	U	U	U	U	PRN		
7		U			U	U	U	U	U	PRN		
8		U			U	U	U	U	U	PRN		
9		U			U	U	U	U	U	PRN		
10		U			U	U	U	U	U	PRN		
11		U			U					PRN	U	
12		U	U		U					PRN	U	U

Chapter 3

Problem Solving Therapy



The previous chapter discussed how to integrated case management with PST in helping depressed, low-income and disabled elders with their problems. This chapter describes the specific stages of PST and how to use the PST form to solve both case management and client problems.

The Seven Stages of PST Treatment

It is important to review the stages involved in PST. They are

- | | |
|--|--|
| 1. Selecting and defining the problem | 5. Evaluating and choosing solutions |
| 2. Establish realistic and achievable goals solution | 6. Implementing the preferred solution |
| 3. Generating alternative solutions | 7. Evaluating the outcome |
| 4. Implementing decision making guidelines | 8. Activity Scheduling |

Each stage of PST is represented on the PST form (appendix C). This form was created with older adults in mind, with large font to account for vision problems, and big writing spaces to account for graphomotor impairments. Below, we discuss each stage of PST, and how to complete the form.

Stage 1: Selecting and Defining the Problem



The goal for this stage is to succinctly define the selected problem. We feel it is important to note that for case management problems the most pressing and urgent problems should be selected first, working down the list to the least pressing problems. Clients tend to be too distracted by urgent problems to learn PST. By progressing through problem selection in this manner, clients will be ready to learn the PST process.

Selection of client problems, however, should progress in the opposite order. Selecting these less complex problems early on in CM-PST facilitates client

understanding of the model, and gives clients the opportunity to achieve success with the model in relatively short order. In our experience, focusing on a very sensitive problem can distract the client from the learning process.

Most clients will describe their problems in vague and unclear terms. It is not uncommon to hear clients say that their problem is “procrastination”, “being poor” or “being sick”. While the essence of these terms may be true, the details are missing. What does it mean to procrastinate? Is the client complaining about paying rent in a timely fashion or attending to a health plan the physician created? How is “being poor” problem for the client? Is the client having trouble paying bills or can the client pay bills but is unable to purchase gifts for friends? As can be seen, these general terms do not help in determining how to solve the problem.

Defining problems involves the following:

- Discussing the specifics of the problem
- Breaking large problems down into small steps
- Using concrete and observable terms to describe the problem

Discussing specifics of the problem. It is practically impossible to solve any problem without a thorough understanding of the problem to be addressed. If the problem is not thoroughly explored prior to developing solutions then the case manager and client run the risk of generating inadequate, and even worse, irrelevant solutions. For clients, this means having them describe in detail the factors that make their situation problematic. Getting as much information about the unmet needs, why they have not been addressed and all the barriers and obstacles encountered by clients is important before case managers and clients embark on developing an action plan.

Breaking down large problems into smaller and more manageable parts. Problems are often comprised of a number of smaller, yet distinct, interrelated parts. Failure to differentiate these components leads to an overly vague problem definition that in turn leads to an inefficient action plan. Being poor is a large problem, with many potential issues. One client had complained that being poor affected her ability to several things, such as pay her rent on time, purchase medication, buy new clothing, and purchase gifts for her grandchildren. Each of these areas is a problem in its own right, deserving of its own, separate action plan. Further, as can be seen in this example, some problems are case management problems and others are client problems. Case managers can enact a plan to pay for medication, but only clients can enact a plan to buy gifts for family.

State the problem in a clear and objective form. Once the problem has been broken down into smaller parts, and all aspects of the need or problem have been

discussed, clients and case managers can now define the problem or need succinctly. It is important to describe the problem or need into observable terms, such that clients and case managers will know definitively when the problem or need has been met. Examples of defined problems versus undefined problems are:

<i>Undefined</i>	<i>Defined</i>
"Poverty"	"I cannot pay my electricity bill"
"Paralysis"	"I can't get my mail from the mailbox"
"Procrastination"	"I forget to use my walker everyday"

Sometimes clients will identify neurovegetative symptoms of their depression, such as problems with energy, sleep, or motivation, as problems. Although these symptoms are "problematic" they are not objective life problems and therefore are not the best problems to identify for problem solving. Nonetheless, if the client insists that they wish to address these, or there are no objective life problems that appear to exist, then a symptom may be chosen as the problem area as long as the functional correlates of the symptom are identified. The problem definition is then constructed in reference to the functional impairment rather than the symptom. For example, low energy may have the function of decreasing the client's ability to do housework, and in which case the problem definition becomes "trouble getting housework done". Likewise, lack of motivation may interfere with going out of the house to visit with friends, and the problem definition becomes "difficulty doing health care activities." As clients become more effective in resolving these functional problems their depression will begin to lift and the symptoms of low energy and motivation will improve.

Once the problem has been succinctly defined, write it down on line one of the PST form.

Stage 2: Establishing Realistic and Achievable Goals for Problem Resolution



Once the need or problem is defined, the next step is determining what clients would like to see changed. This goal should be as clearly and succinctly defined as the problem or need is. The goal should also be achievable with a reasonable amount of effort and time. Therefore, it is important to take into account the balance between the available resources and the time frame for its achievement. Clients and case managers will have long-term goals that they intend to reach by the end of the 12 weeks. These long-term goals can usually be broken down into steps that can be

accomplished from meeting to meeting. For instance, one client had a long term goal of paying off his debts. This goal was further divided into setting a budget, paying off his utility bills first (before winter), then his credit card bills and finally his medical bills. These were further divided into smaller, achievable steps, such as finding out which financial programs he was eligible for. By breaking the goals into smaller goals that could be reached each week, the client felt a sense of success, more so than if his only goal was to relive his debts.

Setting clear behavioral goals is important during Stage 7 when the success of the solution implementation is evaluated. When the set goal stipulates a specific outcome (e.g. getting transportation, calling one's family) and those outcomes occur, then it is clear that the problem solving plan worked. Once the goal has been defined, this is recorded on line 2 of the PST form.

Stage 3: Generating Multiple Solution Alternatives: Brainstorming



Once the goal has been set, you are now ready to generate a range of potential solutions. Research has shown that depressed people often have a very difficult time generating solutions, partly because they are discounting the effectiveness of solutions before adequately defining them. Teaching individuals to creatively think of a range of possible solutions is based on the premise that the availability of a number of alternative actions will increase the chances of eventually identifying particularly effective solutions. In other words, the first idea that comes to mind is not always the best idea. Therefore, it should be emphasized to the client that they should try to generate as many solutions as possible via brainstorming techniques. Successful brainstorming involves:

.Listing at least five solutions

- Solutions must address the goal
- Clients and case managers must withhold judgment
- For client problems, the solutions must come from the client, not case manager

List at least five solutions. The quantity of solutions generated is important. The greater the numbers of potential solutions, the greater are the chances for successful resolution of the problem or need. Having a large number of solutions also allows clients and case managers to combine ideas when practical to do so.

Case managers using this approach may find it difficult to generate more than one or two obvious solutions for a particular need. For instance, if a client needs to get to medical appointments and is not linked to Para transit, the obvious solution for the case manager is to link the client to that service. However, for the benefit of the client, it is worth while to consider other options so that the client can observe that there is usually more than one way to solve a problem, and the client can observe the case manager employ the decision making strategies described later.

Solutions must address the goal. At times, clients tend to list whatever idea comes to their mind without considering the relevance to the problem. This is a relatively rare occurrence, but does happen. If, when generating solutions, clients begin to list what appear to be irrelevant solutions, case managers should ask how the solution is related to the goal, **even before the brainstorming process ends.** Sometimes clients list seemingly irrelevant solutions because there is another aspect to the problem that was not discussed. In this case, problems should be redefined and goals newly specified.

Withhold judgment until the next stage. Do not judge the ideas until the brainstorming process is completed, otherwise a potentially successful and novel solution may be prematurely abandon. Evaluation of the feasibility of each option is left for the subsequent stage (Stage 4: Implementing Decision-Making Guidelines: Pros and Cons).

The solutions should be listed in the grid on item 3 of the PST form.

Stage 4: Implementing Decision-Making Guidelines: Pros versus Cons



The purpose of stage 4 is to strategically evaluate the alternative solutions by implementing decision-making guidelines. Case managers and clients create a list of the “pros” and “cons” for each potential solution. This involves asking the following questions:

- Does the solution meet long term and short goals
- What is the impact the solution will have on the client, other people and/ or society.
- Is the solution feasible

Does the solution meet long term and short term goals? The main point of this question is to determine the feasibility of case managers and clients being able to implement the solution between meetings. Some solutions may be excellent at addressing a need in the long run, but if selected, should probably be combined with another solution that can meet a short-term goal so that clients experience some success from week to week.

What is the impact the solution has on the client, other people, and/or society? The main point in asking this question is to determine if the solution will create some other, unforeseen problem. For instance, relying on family for transportation may meet a goal of going to weekly physical therapy appointments, but may result in overburdening the family. It is not enough to meet the goal, a good solution also minimizes any negative impact on others.

Is the solution feasible? The main point in asking this question is to determine whether or not clients and case managers actually have the resources to enact the solution. A case manager may be able to help clients with transportation by driving them to appointments, but that is unlikely to be a feasible solution.

As with all of the problem-solving stages it is ideal for the client to derive their own pros and cons list. However, there are two occasions in which it is acceptable for the case manager to introduce information. The first is when the client is overlooking a negative consequence, either for themselves or others, which is extreme. This would certainly include a consequence of significant physical or

emotional harm to oneself or others, and may include episodes of interpersonal conflict, such as with a spouse or co-worker. The second instance is when the client mentioned an advantage or disadvantage earlier during the session, such as during the brainstorming phase, but appears to have forgotten this in the current stage. In this case the client has already demonstrated that they are aware of the issue and the case manager is only reminding them to include it in the decision analysis process. The pros and cons of each solution should be listed in the grid next to each solution under item 3 of the PST form.

Stage 5: Evaluating and Choosing the Solution(s)



The next stage in problem solving is to prompting the client to compare the solutions along their pro versus con dimensions. This involves:

- A thorough examination of all solutions
- Comparing solutions

Determining which solution has the least cons and the

A thorough examination of all solutions. Case managers should begin this stage with a careful review of the relevant pros and cons for each solution. This within-solution evaluation involves determining if a solution has more against it than for it. This process helps to begin weeding out less effective solutions, and opens up discussion for how a weak solution may be strengthened.

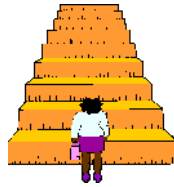
Comparing solutions. After the merits of each solution have been detailed, case managers and clients can then compare the solutions to one another. The solution that should be selected is the one with the least number of negative consequences and the largest number of positive outcomes associated with it.

Some clients find this stage of problem-solving initially difficult to achieve alone, ruminating about possible solutions without being able to choose one, or overlooking important decision-making guidelines established in the previous stage. When clients choose a solution without appropriately reviewing the pros and cons, case managers should point it out and bring the evidence to their attention.

Likewise, if a potential solution is left on the drawing board which seems an obvious choice to the case manager based upon the decision analysis, the case manager should inquire about this to assure that a deliberate reasoning process was used in deciding not to include this as an option. Awareness of using the evidence to choose the solution should be verified by engaging the client in a brief discussion and review of the important decision-making information after they have chosen a solution.

The chosen solution should be written out on item 4 of the PST form.

Stage 6: Implementing the Preferred Solution(s)



Once chosen, the steps required to achieve the solution are identified and planned. This is the **action plan**. To create a clear action plan, clients and case managers must:

- List out the steps in implementing the solution
- Consider all potential obstacles

List the steps in implementing the solution. Case managers and clients consider all the steps it would involve in implementing a solution. As an example, the steps involved in linking clients to Para transit involve calling Para transit and reviewing eligibility, determining if there is a waiting list, collecting the appropriate forms and dropping the off to the client, mailing in the forms, calling to follow-up on the status of the application. Specifying when each task is to take place is also important. Using the same example, case managers may indicate that the first call to Para transit will happen as soon as they return to the office. For clients, determining the timing of steps is very important in supporting adherence to the plan. Clients are more likely to actually implement an action plan if they start the first step as soon as the case manager leaves the home.

Consider all potential obstacles. Clients must identify and choose tasks that they feel comfortable implementing. Case managers should assure that the tasks are sufficient to satisfy the requirements of the solution as well. Sometimes this means that the solution may need to be broken down into more simple sub-steps. In its extreme form this may mean going back to the original problem definition and beginning the process again. More often it requires returning to the decision-

making guidelines and re-evaluating the solutions. A new solution may be chosen if the original solution requires an action the client feels unable to carry out.

This stage is sometimes rushed due to time constraints, as it is the last stage completed during the visit. Case managers should be aware that the action steps are the culmination of all the good work that has preceded it. Therefore, to rush through this stage is to lose the value obtained from having completed the previous stages. The successful outcome of the entire PST process rests upon its proper completion. It is well worth the few extra minutes to do this stage well and assure a successful outcome for the client.

The action plan is fill-out on item 5 of the PST form.

Stage 7: Evaluating the Outcome



The final stage is actually completed at the start of the subsequent meeting. Clients and case managers should have completed or attempted to complete the action plans set in the previous session, and should have recorded the outcome of these tasks on item 6 of the PST form. In addition to determining if a solution met a goal, proper evaluation of outcomes includes answering the following questions:

- Were you satisfied with the outcome?
- Did you learn anything new about the problem?
- Is there anything you would have done differently?

Were you satisfied with the outcome? The review of homework should be followed by asking clients about their sense of satisfaction with their effort and the impact of their success on their mood. Particularly during early treatment sessions, clients may state that the success had no impact on their mood. On these occasions case managers should review the PST model, and emphasize that they certainly are no worse off for having solved a problem. It is important to encourage persistence. When mood improvement is reported, case managers should point out the link between effective problem solving and achieving a positive mood state.

Did you learn anything new about the problem? This question is particularly pertinent to reviewing solutions that do not succeed in meeting needs or goals. In discussing client failures, case managers should always communicate that they see clients' potential for effective coping, and thus facilitate a positive problem-solving

orientation. This is also an opportunity to reinforce that the problem-solving process is useful in failed situations, too, that failures often result in more information about the problem that was not available earlier. Thus, solutions usually don't work out because we didn't have all the facts when solving the problem. And since no one ever truly has all the facts when initially solving a problem, failures are part of the process, part of life, and are really opportunities to improve our ability to cope with the problem.

The final task to be accomplished in Stage 7 is to link the client's efforts to the PST model and reinforce their understanding of the rationale for the intervention. If clients continue to be a motivated participant in treatment and is to continue to apply the problem solving strategy when treatment has ended, they must understand and endorse the value of the approach. When they have been successful and/or they report that they are satisfied with their efforts or their mood has improved as a result of their efforts, this is a perfect opportunity to make the case for the underlying rationale for PST. Before moving on to choosing another problem for the current session the case manager must always make an effort assure that the client understands the connection between problem solving efforts and a positive mood state.

The Role of Activity Scheduling in PST.



Activity Scheduling is a strategy for helping clients incorporate pleasant and satisfying activities into their lives. The procedure is based on the research of psychologist Peter Lewinsohn who showed that depressed individuals engage in significantly fewer pleasurable events than do non-depressed individuals. Lewinsohn's theory of depression postulates that the lack of pleasant events causes the person to become depressed, and because the person is depressed they are less likely to seek out pleasant events. Thus, a downward spiral is established in which lack of pleasant events leads to depression, which in turn leads to fewer events, and therefore worsening depression, and so on.

It is important to note that PST is not always as easy a skill to learn as it looks. It is important for case managers to watch closely for signs that a client is having trouble with a particular stage of the model. In those situations where the client is struggling with a particular step in the process, it may be necessary for the case manager to spend time reviewing exactly what to do at that particular stage. For

this reason, we have developed...and provide...supplemental reading materials and exercises for the case manager to use in these situations. These supplemental materials are not required to be used in while doing PST, but can be used when a client is having a difficult time understanding the process.

Chapter 4

Community Resources

The main ingredient of clinical case management is the resources available to the client. Social services and resources will vary from county to county. Further, availability of resources is often dependent on the economic and political environment. It is important for case managers to remain updated on social services changes. In San Francisco, this can be done through regular contact from the Area Agency on Aging, contact with the division of geriatric mental health in the department of public health, and through the Grey Pages, a county publication that is updated yearly and lists all available resources and social services for older adults.

Suggested resources for case managers are:

- American Association for Retired Persons (AARP)
- National Coalition on Aging (NCOA)
- Area Agency on Aging (AAA)
- Departments of Health and Mental Health
- Adult Protective Services

Membership in local aging organizations is also important, and we suggest strongly that case managers become members. In San Francisco, the main organization for providers for elderly people is the Coalition of Agencies Serving the Elderly (CASE). In Westchester county, the main organization is the Westchester county department of senior programs and services (WCDSPS).

The San Francisco Family Service Agency and the WCDSPS sponsors educational programs on managing older populations. While largely educational in nature, this is another good place to meet other providers and network with agencies.

At your training, we will provide you with the most recent county resource list for aging programs. It is your responsibility to keep this list updated.

Chapter 5

Special considerations when working with older people



Ageism and boundaries

In the American society, aging is seen as a time of despair, disability, and pain. One need only look to the cosmetics industry to see the plethora of products aimed at reducing the appearance or suggestion of age – hair dyes, Rogaine, Botox, wrinkle creams – all products suggesting that the natural course of aging is something to avoid. Ageism is a negativistic belief about older people that is present in people of all age groups. Because most of us grew up with some ideas about older adults, and because our society is rife with stereotypes about aging, our attitudes toward age and aging need to be considered when working with older adults in the context of psychotherapeutic and case management interventions.

An older client's attitudes toward a case manager can take many forms. Indeed, some have noted that because elders have more years of experience, he or she can have feelings about the working relationship that stem from experiences in any life stage, including the family of origin, nuclear and extended family, and other relationships. A case manager must be aware of this range of possibilities, and of the fact that a client can see the case manager as a parent, a spouse, a child or grandchild, or an expert.

For a case manager, ageism will likely arise in work with older adult clients. For many case managers, a lack of professional training with older adults leaves them especially vulnerable to their own fears about aging. Often, these feelings stem from his or her positive or negative stereotypes about older people, and his or her own fears regarding infirmity and aging. For example, one younger case manager observed that she had difficulty interrupting or confronting her elderly clients while conducting PST. She connected this to being taught as a child to be extremely respectful to her grandparents and other elderly people. Once she had identified the source of her behavior, she could more accurately assess the situations that required her to be more assertive with her clients.

Relevant to ageism are the decisions made by case managers regarding boundaries in the working relationship. For good reasons, many mental health professionals were trained to maintain an emotional distance and not accept gifts or

physical contact from clients. However, it is true that among the current cohort of older adults, it may be relatively common to offer a small gift or a hug to the therapist, and to become insulted if this is not handled appropriately. This may be especially true for older adults from certain cultures. For example, one case manager provided in-home therapy to an elderly Filipino couple, who insisted on serving tea and a snack during each session. The case manager did her research and learned that this behavior was typical of this culture and cohort; despite her initial discomfort with the ritual, she assessed the impact on the working relationship to be minimal and decided to allow the tea to continue. The main lesson here is to perform a truly comprehensive assessment when conceptualizing the elderly **client** and making decisions about boundaries, taking into account personal, cohort-based, and cultural factors.

The following questions may be useful in evaluating ageist attitudes and boundaries within the working relationship with an elderly **client**. Several of these were inspired by the “contextual, cohort-based, maturity, specific-challenge” (CCMSC) model of case conceptualization developed by Knight for use with older adults.

Questions to consider about the client:

What cohort does this client come from? How might that affect her interactions with me?
How does it affect her coping strategies?

What is this person’s cultural background?

What is this client’s specific family history independent of age or cohort? What does aging mean to this person?

What is this person’s current social world, and how does it fit with his current needs?

Questions case managers can ask themselves:

What does “aging” and “old age” mean to me?

What are my stereotypes about older people?

How comfortable am I with my own aging and loss of function, and that of my loved ones?

What is my cohort and how does that affect my behavior and my perspective?

What did I learn as a child about older people, and about how to interact with them?

How I do want to be seen by this older person?

Adapting PST for Older Adults

Despite the overall similarities between working with older and younger adults, experienced geriatric providers agree that some adaptations may be needed to make the treatment maximally effective. These adaptations include taking time to socialize older adults to the process of PST, adjusting the pace of PST to account for age-related changes in information processing, and allowing flexibility in the delivery of PST to overcome medical and physical barriers to care. At the same time, older adults bring unique strengths to therapy that case managers can capitalize on such as past experience and wisdom.

Accounting for Changes in Information Processing

Although research shows that older people maintain a significant degree of mental flexibility and can learn new tasks, older adults do learn somewhat differently than younger persons. There are a number of cognitive changes associated with aging that should be attended to when providing psychotherapy to an older client. The most relevant changes to psychotherapy are those associated with cognitive slowing, decreased fluid intelligence, and working memory. Taken together, these changes indicate that psychotherapy – which relies on the ability to draw inferences, process new material, and recall information – often must be delivered at a slower pace, over multiple meetings, and in a multifaceted way.

Cognitive slowing. The speed to which we react to stimuli, and hence process information, slows considerably as we age. Although slowed reaction time does not necessarily interfere with the ability to process new and/or abstract material, new

information should be presented more slowly and over a longer period of time to counteract the effects of cognitive slowing.

Psychotherapies adapted for older populations tend to be structured so that new material raised in treatment is reviewed a number of times and presented through a number of modalities. In PST, this process involves first giving older clients a rationale for a new skill and elucidating the relevance to their problems. Next, the therapist demonstrates the new skill with a generic example, and finally engages the client in the skill using a client example. In following this process, the therapist can check to make sure that the older client understands the application of the new skill and can successfully practice the skill between sessions.

Decreased fluid intelligence. While the overall reasoning ability of older adults is not impaired because of their vast store of previous learning (“crystallized intelligence”), the rate at which they can process new information and make inferences (“fluid intelligence”) is slowed. Although the details of memory functioning among older adults are quite complex, there is consensus that working memory, an aspect of memory functioning that is responsible for processing information prior to long-term memory formation, becomes less efficient with age. Again, providing repeated exposure to new information is important, to help ensure adequate learning. Another useful technique, which makes use of intact crystallized intelligence to improve information processing in psychotherapy, is to rely on clients’ vast stores of previous experiences. *Life review*, a technique commonly found in reminiscence therapies, is an excellent tool for linking new material to older clients’ past experiences. This technique is best illustrated in a case example (see Case Example).

Although this example describes using life review in a relatively unstructured manner, case managers may conduct more targeted life review around specific issues. For example, it can be helpful to talk about previous times when the client faced similar issues and how they managed to resolve or cope with those issues earlier in their life. Ideally, such a review can remind clients of coping skills they already have. Even if clients did not cope effectively with those issues in the past, however, life review discussions can still serve as a valuable learning tool in the therapy.

Contextual Adaptation. As stated previously, for some older adults a number of practical and health-related barriers may exist, requiring certain contextual modifications to the therapy. The most common therapy adaptations to address contextual issues include: a) relaxing the therapeutic frame to accommodate fatigue, illness, and psychosocial demands; and b) adapting psychotherapy elements to address common physical disabilities and coordinate with other care providers.

The therapeutic frame

The traditional therapeutic frame can be a barrier to the delivery of psychotherapy in older populations. The typical expectations that clients come in weekly for appointments, that treatment be delivered during a 50-minute time span, and that it occur in specialty mental health settings may be hard for many older clients to meet. The therapeutic frame must remain flexible with regard to treatment location, session length, and access. Because many older adults are coping with care giving crises, temporary disability due to short-term illnesses or the exacerbation of chronic illnesses, or ongoing medical illnesses that require a number of appointments, being able to participate in regular psychotherapy can be a complicated goal to attain. To account for these factors, therapeutic approaches that allow for flexibility in treatment have been developed for late-life psychotherapy. These include modifying psychotherapy for nonmental health settings, briefer sessions, and using the telephone and/or written materials.

Accounting for physical disabilities

Disabilities common in frail elderly (e.g., impairments in vision, hearing, or mobility) also can impede the progress of therapy, when no adaptations are undertaken. Ideally, the therapist assesses disabilities and attempts to facilitate clients' receipt of needed medical and social services (e.g., medical treatment, getting new glasses or dentures). The therapeutic process also may benefit from close, ongoing collaboration with other health care professionals, particularly in working with frail elderly with multiple medical problems and medications.

For clients with reading impairments (due to vision loss or illiteracy), audio taping sessions for at-home review can be used to reinforce session information (30-32). For some clients, treatment forms should be modified with larger print and with larger writing spaces to accommodate changes in fine motor skill (e.g., due to arthritis or stroke).

For clients with hearing loss, hearing problems cannot always be corrected via hearing aids, or clients may refuse to use such devices. When working with these clients, the therapist must be keenly aware of the degree of impairment. In some cases, sitting closer to older clients and near the ear that is less affected by hearing loss can greatly help with communication. Speaking slowly, and in low tones (particularly important for female case managers) also can help the older client hear the material. If these methods prove ineffective, microphones connected to headphones the client wears can be used to amplify case managers' voices. Relying on written communication is another option that has been used successfully in some cases.

Finally, chronic or acute physical impairments may interfere with clients' ability to attend and sit through sessions. Therapy sessions may need to be briefer due to fatigue or pain. Case managers also need to assess for and attempt to correct

any environmental barriers for these clients, such as lack of transportation, lack of wheelchair accessibility, loose rugs, or poor lighting.

In summary, psychotherapy for older adults typically means more sessions to process information. It also mean that new information, whether it is in the form of learning skills or exploration of experience, may need to be reviewed with the older adult to ensure comprehension and assimilation of information. Because of illness and other competing demands on time and energy, the therapeutic frame must be flexible, but not to the detriment of the client. Finally, adaptations to address physical impairments may be important to consider.

Strengths of older adults

In spite of the challenges that may arise in psychotherapy with older adults, older adulthood also can be a time of growth, and older adults often retain strengths that case managers can use to maximize therapeutic benefit of the work together. For example, although some cognitive functions may be less efficient, research suggests that, compared to younger adults, older adults “have a larger repertoire of experience from which to operate, use more effective strategies, and better integrate emotional information”. These findings suggest that it can be beneficial for case managers to explore, together with their older clients, the strengths they have developed over their lifetime and ways to use those strengths to approach current issues. Even “mistakes” or regrets can be used to determine different courses of action for the future. Elders in distress are likely to overlook or minimize their assets and past accomplishments, and the therapist may need to be very proactive in assessing and identifying client strengths during the session. For example, one elderly woman described herself as not accomplishing much in life, then went on to talk about raising three children on her own after her husband’s early death. She minimized her role in raising her children, although further discussion revealed that she had worked very hard and frequently expressed love and support to her children. Such discussions can serve to build elders’ sense of self-worth and encourage them in dealing with current issues.

Another potential strength of older adults is the presence of more complex emotionality (i.e., multiple emotions in response to an event or issue) to explore and integrate in therapy. This ability can be beneficial in psychotherapy and perhaps especially in working on the complex and multi-faceted issues common to old age.

Case Example: life review in PST

Mr. J. was a disabled, 80 year old man referred to problem-solving therapy for major depression. During the course of therapy, Mr. J. learned the steps involved in PST through the “say-it, show-it, do-it” method described previously, but he was still struggling with understanding the process of PST and was not applying the model between sessions. More out of frustration than therapeutic gain, the therapist decided to spend a session letting Mr. J talk about his problems in a free-form fashion. As Mr. J. spoke about his depression, he began discussing the job he had before he became disabled and how good it made him feel to be the “go-to” person for the roadblocks faced by his company when rolling out a new product. As the therapist listened to Mr. J. talk about how he managed to solve problems in one particularly complex situation, the case manager noticed similarities between Mr. J.’s problem solving process at work and the PST model. She then asked, “Is that how you usually solved problems at work? Did you typically follow those steps?” Mr. J. discussed a few more examples of how he solved problems at work, and as he spoke, the case manager tracked the terms he used for his problem-solving steps and used the PST worksheet to record the process Mr. J. took to solve these problems. After a few instances of life review, the therapist then showed Mr. J. what she had done and drew a parallel between his work style and PST. Mr. J. thought for a moment, began nodding his head, and then, as if a light bulb had gone off, he said, “Has this been what you’ve been trying to get me to do? Well, why didn’t you say so?!” By using the patient’s life review material, the therapist was able to successfully teach PST skills to Mr. J. and subsequently help him overcome his depression.

Short CANE

User Name: _____ Date: _____

Ratings: 0 = no need 1 = met need 2 = unmet need 9 = unknown

Interviewee: U = User C = Carer S = Staff R = researcher	U	C	S	R
1. ACCOMMODATION Does the person have an appropriate place to live?				
2. LOOKING AFTER THE HOME Does the person look after their home?				
3. FOOD Does the person get enough of the right type of food to eat?				
4. SELF CARE How does the person look after their self-care?				
5. CARING FOR SOMEONE ELSE Does the person care for another? Can they manage this caring?				
6. DAYTIME ACTIVITIES How does the person occupy their day?				
7. MEMORY Does the person have a problem with memory?				
8. EYESIGHT / HEARING How is the person's eyesight and hearing?				
9. MOBILITY / FALLS How does the person get around inside and outside their home?				
10. CONTINENCE How is the person's continence?				
11. PHYSICAL HEALTH How is the person's physical health?				
12. DRUGS Does the person have problems with medication or drugs?				
13. PSYCHOTIC SYMPTOMS Does the person ever hear or see things other don't?				
14. PSYCHOLOGICAL DISTRESS Does the person have problems with mood or anxiety?				
15. INFORMATION (ON CONDITION & TREATMENT) Has the person had clear information about their condition?				
16. SAFETY TO SELF (DELIBERATE SELF-HARM) Is the person a danger to themselves?				
17. SAFETY TO SELF (INADVERTANT SELF-HARM) Does the person have accidents?				
18. SAFETY TO SELF (ABUSE/ NEGLECT) Is the person at risk from others?				
19. BEHAVIOUR Is the person's behaviour problematic for others?				
20. ALCOHOL Does the person have a drinking problem?				
21. COMPANY Does the person have an adequate social life?				
22. INTIMATE RELATIONSHIPS Does the person have an close emotional/physical relationship?				
23. MONEY/ BUDGETING How does the person manage their money?				
24. BENEFITS Is the person receiving the benefits he/she is entitled too?				
A. CARERS NEED FOR INFORMATION Has the carer been given all the information they needs about the person's condition and treatment?				
B. CARERS PSYCHOLOGICAL DISTRESS Is the carer currently psychologically				
<i>Met Needs: Count the number of 1s in the column (1 to 24 only).</i>				
<i>Unmet Needs: Count the number of 2s in the column (1 to 24 only)</i>				
<i>Total Needs: Add number of Met needs and Unmet needs (1 to 24 only)</i>				



Appendix A

Camberwell Assessment of Need for the Elderly



Appendix B

Problem List



Case management list

Client Name: _____ Date: ___J__J__

Urgent needs (Emergency)

1. _____
2. _____
3. _____

Priority needs

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Needs that can wait

1. _____
2. _____

PST problem list

Family

1 .

2 .

3 .

Home

1 .

2 .

3 .

Financial

1. ____

2.

3.

Social

1.

2.

3.

Health

1.

2.


3.

Appendix C
Problem Solving Form




PROBLEM-SOLVING WORKSHEET


Name:  _____ Date:  _____ Visit: _____

Review of progress: 

1. Problem: 

3. Goal(s) 

5. Solutions 

4. Pros (+) 

Cons (-)

a)	a) +	a) -
b)	b) +	b) -
c)	c) +	c) -
d)	d) +	d) -
e)	e) +	e) -

5. Choice



6. Steps



a)

b)

c)

d) Pleasant

Activities



Day 1:

Day 2:

Day 3:

Day 4:

Day 5:

Day 6:

Day 7:

Rate your satisfaction with homework:



0 1 2 3 4 5 6 7 8 9 10



Next Appointment: