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# Experiencing Community Development: Research-based Insights for Gerontological Nurses

*by Brad Hagen and Elaine Gallagher*

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## Introduction

Nurses, including gerontological nurses who work with older persons in the community, are increasingly being called upon to include community development in the work they do. However, much of the nursing literature on community development is theoretical (Chalmers &Bramadat, 1996; Lassister, 1992), and offers the nurse little in the way of pragmatic or practical suggestions on how nurses, particularly gerontological nurses, might best participate in community development projects. While a few nurses have actually documented the process of various community development projects (English, 1995; Glick, Hale, Hulbok & Shettig, 1996), it is difficult to find sources that offer practical insights for nurses doing community development work, particularly with older populations.

Therefore, the intent of this paper is to offer practical insights and lessons emerging from the experience those involved in a community development project that focused on the establishment of support groups for caregivers of the frail elderly. By reviewing the successes and downfalls of the project, we hope to offer valuable insights for nurses who might be involved in similar community development pro---cts with older persons.

This paper will include an overview of some of the characteristics of community development and a description of the community development project. The methods used to evaluate the project will be presented along with results of the qualitative evaluation. Finally, some insights and implications are offered for gerontological nurses who may be engaged in similar community development projects involving older persons.

## Community Development

It is important to clarify what the authors mean by a community development project since the term has been used in many different ways. Lassiter's (1992) definition of community development was used in the project:

> "Community development is a process of working in collaboration with community members to assess the collective needs and desires for health change and to address these priority needs through problem solving, utilization of local talent, resource development and management" (1992, p. 30)

In addition to this collaborative nature of community development, this particular community development project tried to encourage community self-reliance, which is similar to Dixon's (1989) notion of community development, described as "...the ongoing process of developing self-reliance, both in terms of personal and social group capacities" (p. 82). Also, this project used an empowerment model, which has been noted for its usefulness in community nursing practice (Chalmers & Bramadat, 1996). Wallerstein (1992) describes empowerment as:

> "...a social-action process that promotes participation of people, organization, and communities towards the goal of increased individual and community control, political efficacy, improved quality of community life, and social justice" (p. 198).

Therefore, this community development project undertook a collaborative and empowering process whereby various communities would become more self-reliant in their ability to support community members providing informal care to elderly family members.

## Description of the Supporting Caregivers in British Columbia (SCBC) Project

In 1995, the B.C. government (Ministry of Health) sponsored a community development project entitled *Supporting Caregivers in British Columbia* (SCBC), which has been described in more detail elsewhere (Hagen & Gallagher, 1996; Gallagher 6c Hagen, 1996). Briefly, the project focused on building caregiver networks, including the establishment of caregiver education and support groups in 17 communities throughout B.C. The project was in response to a number of community forums hosted by a provincial caregiver advocacy group, the *Caregiver's Association of British Columbia* (CABC), which found that local communities wanted increased access to education and support groups for family caregivers of the elderly.

A project coordinator/community developer (a nurse) was hired to assist each of the 17 communities in setting up a steering committee and caregiver education and support groups. The nurse's roles included:

- hosting initial community meetings, where caregivers, lay persons, professionals and interested persons were given the chance to discuss local caregiving issues and the SCBC project;
- forming and collaborating with small local steering committees comprisiing both professionals and lay persons who had volunteered to assist with the SCBC project; and
- developing, in consultation with local communities, a caregiver education and support group manual, which communities were welcome to use when planning their own caregiver support and education groups.

The local steering committees were responsible for recruiting group facilitators and caregiver participants, arranging for publicity and community awareness raising around caregiving issues, setting up participant respite and transportation as needed and managing the budget, which was allocated to each local steering committee to perform all these tasks. Although each community group ultimately became responsible for its own unique local problems, solutions, actions and ideas, the nurse project leader was always available for support to the local steering committees and caregiver group facilitators as needed. A description of the research conducted to evaluate the community groups' experiences with community development will now be presented.

## Methods

From the outset it was decided that the evaluation would be primarily qualitative. Qualitative methods are most appropriate when one is studying the process of some intervention or program (Patton, 1990). Qualitative methods also allowed the participants of this community program to tell their stories related to community development. This telling of stories is vital for community research, as McKnight (1987) notes:

> "In universities, people know through studies. In business and bureaucracies, people know by reports. In communities, people know by stories ... professionals and institutions often threaten the stories of community by urging community people to count up things rather than communicate" (p. 58).

Qualitative evaluations not only give the most useful information about community development initiatives, but are most in keeping with the principles of community development, such as empowerment, conscientization, citizen involvement and participation (Harris, 1992). As Hume (1993) also notes, letting participants talk about their experiences of community development is necessary to give us a greater understanding of why community development works so well in some communities and not in others. Thus, the evaluators chose focus group interviews to allow committee members to share their experiences and insights.

Five of the 17 community steering committees participating in the SCBC project were interviewed about their experiences with community development and the SCBC project. These committees were selected for focus group interviews because they had money budgeted for these kinds of focus group interviews. Table 1 on the following page illustrates the composition of each of the five steering committees.

Table 1.

**Steering Committee Compositions**

| Community | Community Size (1 996) | No. of Steering Committee Members | Steering Committee Composition |
|---|---|---|---|
| East Vancouver | 514,000 | Ten | 1 director of care (nursing) |
| | | | 2 mental health nurses |
| | | | 2 continuing care staff |
| | | | 2 family caregivers |
| | | | 2 disease group representatives |
| | | | 1 SCBC project coordinator |
| Terrace | 12,800 | Eight | 1 long-term care nurse |
| | | | 2 mental health nurses |
| | | | 1 home support administrator |
| | | | 1 long-term care assessor |
| | | | 1 former caregiver |
| | | | 2 local seniors |
| Hope | 6,247 | Six | 1 adult day care director |
| | | | 1 head nurse (extended care) |
| | | | 1 hospital social worker |
| | | | 1 mental health nurse |
| | | | 1 long-term care assessor (retired) |
| | | | 1 caregiver |
| Castlegar | 7,027 | F. | 2 family caregivers |
| | | | 1 local senior (non-caregiver) |
| | | | 1 long-term care assessor |
| | | | 1 nurse (long-term care facility) |
| Coquitlam | 101,820 | Ni, | 1 long-term care assessor |
| | | | 1 mental health nurse |
| | | | 1 home care administrator |
| | | | 2 hospital social workers |
| | | | 1 activity director (senior's centre) |
| | | | 1 activity director (disabled centre) |
| | | | 1 caregiver group facilitator |
| | | | 1 SCBC project coordinator |

Each community steering committee was contacted to be interviewed as a group approximately three months after the official 10-week caregiver education and support project was over. The interviews were held at the location where the steering committees met, were approximately 90 minutes long and were tape-recorded. The interviews were semi-structured, allowing for both spontaneous input as well as answers to the following questions, which were used to guide the focus group interview:

- What roles and activities did you fulfill in the process of establishing the caregiver education/support group in your community?
- What do you think were some of your successes in terms of your efforts to get this caregiver project off the ground in your community?
- What unique characteristics to you feel exist in your community which supported or hindered your efforts to establishing and maintaining this caregiver project in your community?
- How did you see the project coordinator's role in this whole process?

For logistical reasons, only five of the six original steering committees were finally able to participate

in the focus group interviews. Individual steering committees ranged in size from four to eight members and actual membership varied, with members representing past and present caregivers, retirees, continuing care and home nursing personnel, social workers, mental health workers, activity coordinators, group facilitators, hospital and extended care personnel, and occasionally the project coordinator herself. Two of the focus group interviews were facilitated by the two co-investigators of the project (the authors), and three were facilitated by two research assistants — registered nurses who had received training in focus group facilitation.

The audiotapes from each of the five focus group interviews were transcribed in their entirety. The authors, along with two research assistants (graduate students in anthropology), reviewed the interviews, examining and re-examining the interview transcripts. The data were initially segmented by responses to interview guide questions. Further coding was completed by the research assistants, under the authors' supervision, using a computer qualitative data analysis project (Text-based Alpha) to identify global themes, events, phrases and concepts. Sub-themes were then identified using the participants' own words and descriptions wherever possible. Categorization and recategorization of data continued until no more logical categories were emerging and the data analysis demonstrated consistencies in patterns (Patton, 1990; Tesch; 1990).

## Findings: Themes and Sub-themes

Using the original semi-structured interview guides, four key themes were identified: keys to success, unique characteristics of the communities that helped, unique characteristics of the communities that hindered and roles of the project manager. Each key theme had a number of sub-themes that emerged from the data.

### *Keys to Success*

This theme included interview data that described factors which participants felt enabled their success as an effective steering committee. The sub-themes included: getting a wide variety of people and "fire lighters" involved; working well together and commitment; soliciting support of local business and media; facilitating word of mouth; and having courage.

**Having a wide variety of people and "fire lighters" involved.** All steering committees mentioned the importance of involving a broad base of people, not only on the steering committee itself, but with all persons the committee was contacting. Participants felt this was important not only to ensure that many different areas and agencies were represented, but also to help avoid any individual, or small group of individuals, from burning out as a result of taking on too much. Participants were quick to point out, however, that not just any person would necessarily do. In particular, participants mentioned it was vital to identify and involve those people who had reputations in their communities as being "fire lighters" — people who could "light fires" under others in the community and get things done.

**Working well together and being committed.** Committee members stressed that once a broad base of people is involved, the next important ingredient is working well as a group together and being completely committed to the group and its community. As one participant put it:

> "...one of the successes was the fact that the people here were committed to the project so that in spite of all the frustration and anxiety, that they were committed to it ...because if you are not committed then it's just too easy to say I'm out of here'."

Another participant described why she thought her steering committee worked together so well:

> "...yeah, and we all worked really well together. We all took on jobs and were able to do that so it was really good. And we did keep in touch with each other — we didn't have any secret or hidden agendas. We were able to communicate with each other, so that was really nice also. We kept track of what we were doing; it was great to have people assigned to jobs and then to have us report back."

**Soliciting support of local business and media.** All groups accredited much of their self-perceived success with actively soliciting the support of their local media and/or businesses. When businesses

were approached (e.g., pharmacies), most proved to be extremely supportive and generous with facilities, supplies and money. Media contacts were especially valuable in the eyes of steering committee participants:

> "The media gave good coverage the way they presented; it was really a big part of the success — the profile and everything. I think the way we worked with the media was the key to the success of the whole thing getting off the ground."

and,

> "It's vital to continue with the media involvement in the process. The issue in *The Vancouver Echo* kept the caregiving issues before everybody in their minds, and then any advocacy you did at the regional health level, you've got a contact in the media whom you can take with you to the meeting when you do the advocacy work. You must keep those media relationships open and active!"

Thus, steering committee members who had connections with the media were highly valued, as many steering committees participants were inexperienced at working with the media.

**Facilitating word of mouth.** While participants were involved in a great deal of public relations and advertising work to raise awareness of their caregiver group project, there was a unanimous feeling that word-of-mouth was the most effective and meaningful way to get other community members involved in the project. This strategy worked particularly well in smaller communities, though all participants felt it was word-of-mouth — that all important personal invitation to become involved — that always got the best results, no matter what their particular task was.

**Having courage.** Finally, participants mentioned that individual steering committee members needed to have courage. In the words of a participant:

> ".. .I think the fact too, that people were willing to participate in a new venture and to have the courage to do that, that was part of the success of the group."

Several participants stated that the project coordinator played a vital role in instilling this courage to try new things — to go out on a proverbial limb:

> "I think a big reason for our success was that people were willing — with a bit of help from the project coordinator — to explore areas that they had never traveled in before, and that was really what made this all possible."

Using various ways to describe it, nearly all groups identified this phenomena of courage as being a key ingredient to successful community development work.

### *Unique Characteristics of the Communities that Helped*

This theme addressed things that steering committee members were able to identify as being unique characteristics of the community they lived in which helped their job of establishing their caregiver project. Taken as a whole, these characteristics included having: a local community senior's centre; a centralized, accessible and coordinated health unit; and a safe place to meet with good transportation.

**Having a local community senior's centre.** One community's steering committee whose caregiver group was particularly popular credited its results to the local community senior's centre. This centre was particularly active and served as a magnet for seniors throughout the community. In addition to offering the caregiver group space and facilities, they were described by a steering committee member as being:

> "...very willing to accommodate us in any way we asked. You know they were flexible and would provide whatever we needed, photocopying, xeroxing, refreshments...and to me that was just unheard of, you know. Anywhere else you go, you have to beg and plead, but they seemed to recognize the need in the community for what we were doing and they accepted it and supported us."

Thus, for this steering committee, being plugged into such a vibrant and caring senior's centre proved central to the group's popularity.

**A centralized, accessible and coordinated health unit.** Two steering committees said that they were

glad to have access to a central and well-coordinated local health unit in their community. This was seen to make their job much easier:

> "...actually, I think what made a major difference too, is that the health unit is pivotal here. Where it is now, it's right in the middle of the community. So when you are looking for support or information of where caregivers are or who needs help, you just phone the health unit and say 'listen, what's going on out there in the community?' And they basically have their finger on the pulse."

Another steering committee described what a pleasure it was to work with their particular health unit, stating:

> "All the agencies, home support, continuing care, long term care, daycare, they are all integrated. They support each other. So then they know, like they are very close knit and they work closely together. They have monthly meetings and they are on the phone to each other a lot. So they see a lot of each other personally and over the phone."

This kind of coordination at the health unit level was seen to be unique to their community and an important reason why their work as a steering committee went much more smoothly.

**A safe place to meet with good transportation.** In one large urban community, an important characteristic and vital to their success was a safe place to meet — for both steering committee members and caregivers — that was accessible by public transportation. Participants stated that had it not been for a safe facility with good bus access, the project would have failed due to people's concerns for physical safety, particularly during the evening.

### *Unique Characteristics of the Communities that Hindered*

This theme reflected participants' views of unique community qualities that made their community development job more difficult. These included: overwhelmed community members; turf wars; cultural/language barriers, community size; and weather/season.

**Overwhelmed community members.** While all communities reported 'overworked' community members, this seemed to be a particular problem in smaller communities, where the pool of available volunteers was smaller:

> "…the downside is that because there are so many things going on here, there probably just aren't enough people around who have the energy to sit down and say 'okay, this works, let's try to keep it going, right?"

and,

> "We have a very small pool of people in the community who will volunteer to be on committees. It's like after a while, you can only ask so much of people. People do burn out, you know, and it always seems to be here that the same people do the same things."

Bigger communities, on the other hand, seemed to have a larger pool of potential volunteers to draw upon, without having to call on the same small group of dedicated persons repeatedly.

**Turf wars.** Again, while all communities experienced the phenomenon of territorialism to some degree, it seemed to be particularly pronounced in two of the communities. In one community, a person who was already running some caregiver support groups came to an SCBC public information meeting and proceeded to heckle and harass the project coordinator while she conducted the meeting. It appeared that somehow the person believed that 'new' caregiver groups in her community would threaten the existing groups she was running.

In another community, a local group was 'boycotting' the SCBC project as a result of being offended that a rival non-profit group was given signing authority for the project budget. Thus, while persons from this group came into contact with many caregivers who could have potentially benefited from the caregiver education and support groups, their support for the project was minimal, and they did not refer any local caregivers to it.

**Cultural/language barriers.** Two communities, due to their unique ethnic mixes, experienced some barriers related to culture and language. These barriers related to the difficulty of not being able to provide

materials and advertising in all required languages (because of budget restrictions). Cultural differences related to care of the elderly also came up in the communities, adding to the challenge of marketing and designing caregiver groups that would have broad cultural appeal in the community.

**Community** size. Like Goldilocks, some communities were perceived to be just right in size; others were perceived to be either too big or too small. In the largest community, the large size of the community was seen to be a barrier in getting an accurate feel of the community from a caregiver point of view:

> "...it was very difficult for us to get an idea of what was available because Vancouver is so big and there are so many resources...um, I don't know, even to get somebody to think about the resources was difficult. It made it all very cumbersome for us."

In other communities, their small size was seen to be an impediment, as there were too few volunteers to go around and people felt overwhelmed.

Weather/season. Finally, one northern community was quick to point out that establishing projects in the North is very difficult due to the narrow window of opportunity the climate presents for citizens to be involved in community activities. That is, northern winter conditions make it difficult and unpredictable for participants to drive to activities in the winter. Then, when spring and summer do arrive, many community members are busy taking advantage of the short summer months to do necessary work around their homes. Thus, only the fall months are seen to be realistic months to try and involve Northern citizens in community development projects, making planning and delivery of these projects much more difficult.

### *Role of the Community Developer/Nurse Project Manager*

This final theme captured interview data in which the steering committee members described their perception of the project manager's role and their experience working with this individual. Participants identified two important roles: manager and motivator.

Manager. All steering committees stated that they understood one of the project manager's roles was to manage the overall project in all the six different communities. They all saw this role as being particularly important in the beginning of the project:

> "(The project manager)... connected us, connecting us people at the very beginning...and then she handed us an idea of what types of individuals and agencies we might want to contact. So the next thing was for us to look for volunteers."

None of the steering committees complained of the project manager assuming control or 'taking over.' Rather, they reported being very appreciative of someone who could take a non-authoritative leadership role and give them direction and guidance as needed.

**Motivator.** The participants emphasized that one of the project manager's most important role was that of a motivator — someone to 'stimulate the communities to take action.' All steering committees maintained that these caregiver groups would never have gotten started had it not been for the project manager's initial determination and involvement. As one participant put it:

> "I mean, she had a tremendous response from the communities. It's not an easy job to walk in cold to a community and sit down with a group of people and motivate them to take local action. And she was able to do that...she was able to motivate all different kinds of people."

Another participant described the project manager's role as a 'cheerleader,' encouraging them when they found the job of community development disheartening:

> "...she seemed very supportive and honestly excited with what we were doing here. 'Oh, you guys are so good!' she kept saying...'oh, you guys are really on top of it or 'oh, you're really doing that...oh wow!' You know, she seemed like a cheerleader, it was wonderful!"

Thus, while the steering committee volunteers were obviously hard-working, it seemed vital to have someone encouraging them as they went along and giving them positive feedback.

## Discussion

A number of important implications for community development emerge from the insights and experiences shared by the steering committee participants in this evaluation. A number of lessons for successful community development projects emerge, many of which are similar to the ones that Hume (1993) has offered in her review of community development projects in British Columbia. These include such things as: effective use of the media; finding key action or "fire lighting" individuals; using a project coordinator/community developer person in the roles of organizer and motivator; personally inviting people to participate through word of mouth; realizing that community members know best about their own situations; and involving people at all stages of the process.

Given the nature of this community development project, a number of practical implications also emerge which are particularly useful for gerontological nurses. For example, the researchers suggest that gerontological nurses implementing community development projects with older populations need to be deliberate in their efforts to involve local community senior's centres. Such centres appear to be offer pivotal resources which can be mobilized around improving the health of older persons in a given community, and nurses need to foster working partnerships with the people who coordinate these centres.

Similarly, local health units and/or home care offices appear to be important key community resources to tap into when doing community development work with older persons. These agencies can offer an important link between older persons and government health bureaucracies, and are vital sources of information, resources and support. As government health and social policies always seem to be changing, partnerships with health units are vital for community developers who need current information on the latest programs and funding available for older persons. These insights and others offered from this research for gerontological nurses involved in community development projects with older persons are summarized in Figure 1.

One final issue is worth a brief discussion. This caregiver project was government-sponsored (and hence controlled), with the provincial government paying the project manager and group facilitators. Yet, according to several authors (McKnight, 1987; Dixon, 1989), government control often hobbles the true spirit and essence of community development. That is, while government-sponsored community development initiatives may purport to be empowering' people, some remain skeptical that governments would actually give citizens complete power and control of a community initiative due to traditional government's concerns with such bureaucratic characteristics as timelines, outcomes and "deliverables" (Arnstein, 1969). Critics have charged that such government-sponsored community development initiatives only seem empowering, but actually strip communities of the ability to solve their own problems. As McKnight (1989) states:

> "The community, a social space where citizens turn to solve problems, may be displaced by the intervention of human service professionals as

**Figure 1**

**Summary of Key Insights for Community Development Involving Older Persons**

- Involve a wide variety of people, especially community "fire lighters
- Encourage commitment among community members
- Solicit support of local business and media
- Facilitate word of mouth within the community
- Encourage and reward "courage" among community members
- Try to involve local seniors' centres in your community development project
- Try to include the local health unit in your community development project
- Consider the importance of a convenient and safe meeting place, with good public transportation
- Be sensitive to overwhelmed community members, particularly in smaller communities
- Anticipate "turf wars" and consider win-win solutions to them
- Consider potential cultural and/or language barriers to the commu nity development project
- Bear in mind the effect community size may have on community development work
- Remember that weather and season may be important considerations for planning
- Realize that excellent community developers must pay particular attention to the roles of manager and motivator when working with community groups

an alternative method of problem solving. Human service professionals with special expertise, technique and technology push out the problem-solving knowledge and action of friend, neighbour, citizen, and association" (p. 9).

Although this caregiver community development project was government-sponsored and did involve a number of'human service professionals' (i.e., the project manager and the caregiver group facilitators), the overwhelming feedback from the steering committee members and the caregivers themselves was along the lines of "thank God someone is finally helping us with this issue!" One of the main messages coming across loud and clear from participants in this evaluation was that solutions to community problems — such as the plight of family caregivers — don't just magically appear out of the community. Gerontological nurses are likely to find that older community members are enthusiastic and willing to work hard on community issues if someone — even it's a 'professional from the government' — is available and willing to help with organization, encouragement and advice. In other words, nurses and government sponsors of community development alike need to consider that "community self-sufficiency" may be a pipe-dream (Labonte, 1993) and that communities often need assistance, however minimal, to initiate community development projects and sustain their impacts over time. GO

## References


Arnstein, S.R. (1969). A ladder of citizen participation. *American Institute of Planners Journal, 35(4),* 216-224.

Chalmers, K.I. &Bramadat, I.J. (1996). Community development: Theoretical and practical issues for community health nursing in Canada. *Journal of Advanced Nursing, 24,* 719-726.

Dixon, J. (1989). The limits and potential of community development for personal and social change. *Community Health Studies, 8(1),* 82-92.

English, J.C.B. (1995). Community development. In M.J. Stewart (Ed.), *Community Nursing: Promoting Canadians' Health* (pp. 513-531). Toronto: W.B. Saunders.

Gallagher E.M. &Hagen, B. (1996). Outcome evaluation of a group education and support program for family caregivers. *Gerontology and Geriatrics Education, 17(1),* 33-50.

Glick, D.F., Hale, P.J., Kulbok, P.A. & Shettig, J. (1996). Community development theory: Planning a community nursing centre. *Journal of Nursing Administration, 7/8,* 44-50

Hagen, B. & Gallagher, E. (1996). Looking out for family caregivers. *The Canadian Nurse, 92(3),* 27-31.

Harris, E.M. (1992). Accessing community development research methodologies. Canadian Journal of Public Health, 83(Supplement 1), S62-S66.

Hume, S. (1993). *Government Sponsored Community Development Initiatives in B.C.: 1988-1993.* Victoria: University of Victoria.

Labonte, R. (1993). *Health Promotion and Empowerment: Practice Frameworks.* Toronto: University of Toronto Centre for Health Promotion.

Lassiter, PG. (1992). A community development perspective for rural nursing. *Family and Community Health, 14(A),* 29-39.

McKnight, J. (1987). Regenerating community. *Social Policy,* Winter, 54-58.

McKnight, J. (1989). Do no harm: policy options that meet human needs. Social Policy, Summer, 5-15.

Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed.). Newbury Park, Sage.

Tesch, R. (1990). Types of qualitative analysis. In: R. Tesch, *Qualitative Research* (pp. 77-102). New York: Falmer Press.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion projects. *American Journal of Health Promotion,* 6(3), 197-205.


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