Old Age Care in France, personal experience

A psychologist in a community social center for elders 60+

The municipality : COLOMBES city

- Paris Suburbs : Haut-de-seine, ville de colombes around 90 000 hab., around 10 000 elderly ;
- 1/3 pop. High class level ; 1/3 pop low class + unemployed ; 1/3 middle class (roughly)
- A community Social Center as in each municipality

The Community Social Center : for which population ?

- Anyone living in the City : from facing social and/or medical difficulties or simply wishing to do some activities provided by the City.
- From Children to Seniors citizens ;
- Physically challenged people ;
- Unemployed persons.

The Community Social Center Services

- Intergeneration service ;
- Housemaid service ;
- Food delivery ;
- “ Fall alert” ;
- Physically Challenged people social service ;
- Crèche and children activities centers ;
- Information and Coordination Center for seniors citizen 60+

Information and Coordination Center for Senior Citizen 60+

- Structure inside the Community Social Center;
- For people of 60+ undergoing social, medical, psychological difficulties and A.D ;
- Wishing to stay at home as long as possible despite the loss of autonomy often associated with social difficulties.

Permanent staff and partnership

- coordinator, welfare assistants, geriatrist, occupational therapists, social secretary ;

- Institutional partnerships : memory clinics, hospitals, family doctors, nurses practices, city social service, department social service, all medical practitioners, old age homes, day care centers, housemaid-caregivers, intergeneration service, elder abuse warning network, End of Life Care network…

MISSIONS 1: a medico-social structure

- Home Stay as long as possible for elders of 60+ undergoing difficulties, A.D. ;
- Providing social and psychological services to help them coping with the loss of autonomy they are facing ;
- To keep them related with the medical practionners when needed ;
- To provide information and guidance through their actions to overcome their difficulties.

MISSIONS 2 : Coordination structure

- Not only providing the services to the person 60+ suffering from a loss of autonomy A.D. but :
- Linking the person and his family to the appropriate supportive services (speech groups, day care centers, memory clinics…) ;
- Connecting the caregivers together, coordinating and adjusting the care according to the evolution and the specificity of the loss of autonomy/disabilities, disease ;
- Doing the follow up on long-term period/span.

SUMMARY

- Municipality structure, proximity structure ;
- For retirees, aged and their family in case of loss of autonomy at Home;
- For professional caregivers involved in the health care of older person at home ;
- Providing information, guidance, support ;
- Coordination, partnership building, link and follow up.

Also :

- Observatory for ageing and loss of autonomy issues ;
- City based structure for education and prevention on ageing topics : speech groups, conferences, forum…
- An efficient partnership, a continuously improving local network.

The psychologist

- One of the worker of this center : coordinator, welfare assistants, geriatrist, occupational therapists, social secretary ;
- Work in team ;
- Home visits jointly or not ;
- Weekly meeting for review.

ROLE 1 :

- Preliminary assessment of the loss of autonomy at Home, physical, AD or mental one ;
- *Contribution to the social and medical issues* faced by the person 60+ undergoing loss of autonomy (curatelle, family position, best orientation) ;
- *Collaboration with doctors* in diagnosis process by providing accurate information and professional opinion on the situation at Home and possible orientations.

ROLE 2 :

- Assessment of treatment consequences on the person 60+ at Home (depression, behavior…);
- Counseling and guiding the person 60+, A.D. to the appropriate services, support of the person and do follow up;
- Informing, guiding and supporting the families ;
- Informing, guiding and supporting the team and professional caregivers in their practices.

A.D. situation in France

- 855 000 persons suffering from dementia and related disorders in 2004 ; today around 1Ms;
- 220 000 new cases/annum ;
- 2040 projection : more than 2Ms ;
- Access to diagnosis insufficient and not systematic

Work and actions taken by the psychologist : home visits, coordinating, adjusting…

- Meeting and accompanying the person for him to stay at Home ;
- Guiding and supporting the family ;
- Assisting the professional caregivers ;
- Informing and coordinating ;
- To provide information and creating awareness about the disease.

Preliminary basic assessment at Home:

- Memory disorder,
- Cognitive disorders,
- Behavioral disorders,
- Mood disorders,
- Delusions,
- Associated pathologies.
- NOT A DIAGNOSIS but a probability of Alzheimer's type of dementia.

Orientation and linking with services

- memory clinics, hospitals, family doctors, nurses practices, city social service, department social service, all medical practitioners, old age homes, day care centers, housemaid-caregivers, intergeneration service, elder abuse warning network, End of Life Care network…

Psy follow up of A.D. patient : early stage

- Accompany him progressively in the understanding of his disabilities, of the disease, symptoms ;
- Support him in finding strategies to fight/compensate the disease, disabilities ;
- Make him learn to use the left/kept abilities (memory, social, praxis…) ;

Building a relationship to go ahead

- Help him cope with anxiety and depressive feeling ;
- Help him cope with self-esteem loss, and himself deteriorating ;
- Re-create a positive image of himself and re-create communication with his family ;
- Build with him a daily life where he still feels useful and able ;
- Follow and support him by staying available, informing, guiding and non-judgmental.

Then only :

- Follow-up the evolution of the disease ;
- Follow-up the different mindsets he is going through ;
- Follow his wishes to accept or not support and advises (despite family’s anxiety and request) ;
- Provide him the appropriate help with his agreement : medical, social, psy testing…

Conclusion

- Trying to cover all stages of the disease : early onset to severe.
- Adjusting help and our interventions according to the evolution of the disease and stage ;
- Though it is more difficult with advanced cases.

respect and dignity

- Always work with the agreement of the person suffering of A.D. because he is still *A PERSON ;*
- Right to take his own decision till it become to risky for him ;
- Right to stay home till he request more assistance ;
- In advanced A.D. cases : decision to move to Old Age Home taken by the family or someone identified by the Judge to take all decisions for the good of the person.

The importance of an efficient network

- Comprehensive approach and “management” of the person suffering of A.D.
- Accessibility of all services when needed ;
- Complementarities of competences, no duplication ;
- Continuity of our actions on long-term care perspective.

THANK YOU

Remember those who cannot remember

NISD-ARDSI

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FRANCE