The CCMHI Toolkit Project

Establishing Collaborative Initiatives Between Mental Health and Primary Care Service for Seniors

Martha Donnelly
Department of Family Practice & Department of Psychiatry
University of British Columbia

Members of the Working Group

- Ken Le Clair, MD, FRCPC – Kingston
- Martha Donnelly, MD, CCFP, FRCPC - Vancouver
- Geri Hinton, B.Sc.N, DStJ – Victoria
- Sarah Kreiger-Frost, RN, MN - Halifax
- Penny McCourt, MSW, Ph.D. - Nanaimo
- Salinda Horgan, Ph.D. (cand.) – Kingston

Population Definition

- Age greater than 65, avg. age 75 (exceptions organic mental disorders).
- All psychiatric disorders but with emphasis on:
  - Dementia with affective and behavioural disorders
  - Mental health problems associated with medical illness
  - Complex B/P/S/F/E problems
  - Families of seniors with mental health problems
- Loss of independent functioning in IADLs/ADLs.
- Often present first to family physician with physical complaints.
- Require comprehensive geriatric assessments.

What do we Need to Know About Seniors?

- Seniors experience the stigma associated with advanced age and mental health needs both in the community and within the health system itself.
- Many seniors are experiencing mental health issues for the first time.
- Many family caregivers are seniors themselves with complex needs.

The Consultation Process – What

- Multi-disciplinary Working Group
- Literature Review
- Qualitative Interviews
- Quantitative Survey

The Consultation Process - Who

Qualitative interviews:

- 6 interviews with family members / consumers.
- 7 interviews with services specific to seniors (specialty psycho-geriatric programs, generic mental health programs, primary care clinic, adult day program).
- 7 interviews with professional disciplines (family doctors, pharmacy, nursing, social work, cultural development, research).
- 2 interviews with policy advisors.

Quantitative survey:

26 surveys of specialty and generic mental health programs and policy advisors.

Presentations at conferences

Interview: Key Learnings

- Comprehensive assessment is needed
- Caregivers need attention
- Risk assessment is important
- More time for assessments
- Transportation is important
- Case management is necessary
- Collaboratives in nursing homes are important
- Functional outcomes are most important in geriatrics

Literature Review – Key Learnings

- On-site primary care and specialty case manager strategies provide better outcomes for seniors than traditional care (particularly for those experiencing mood disorders).
- Consultation with liaison provide better outcomes for seniors than consultation only.
- Approaches embedded in a knowledge transfer framework (evidence based guidelines) provide better collaboration between diverse partners.

Framework for Collaborative Mental Health Care

Key Elements - Accessibility

- Access to services is age, behaviour and mobility dependant.
- Seniors experience stigma associated with historical perceptions of mental health support.
- General lack of awareness of what is available specific to seniors.

Key Elements – Collaborative Structures

- Seniors need time to interact and engage meaningfully therefore slower paced environments are better.
- House calls are better
- Family caregivers need to know what to expect, what will happen next, and how to plan for the future.
- Equally meaningful input from a diversity of stakeholders is needed to ensure a consumer-centred approach to seniors' care.

Key Elements – Richness of Collaboration

- Seniors health needs span a broad range of expertise.
- Important partners are: home care, pharmacy, long-term care, geriatricians, family physicians, nurse practitioners, psycho-geriatric outreach, adult day programs, occupational therapy, physical therapy, bereavement counselors, neuropsychologists, dieticians
- Limited pool of professionals skilled in the care of seniors to draw from.
- Education is an essential service.

Key Elements – Consumer Centredness

- Accessibility is the primary factor in addressing issues of consumer-centredness for seniors
- Senior caregivers also experience complex physical and mental health needs.
- Seniors want to be involved in planning and implementation

Key Fundamentals – Policies, Legislation, Regulations

- Division between different policy departments minimizes efficiencies.
- Lack of policy for the establishment of collaborative planning initiatives results in inconsistent involvement of mental health and senior specialists in care planning for seniors.
- Lack of policy for the establishment of collaborative initiatives for seniors results in inconsistent service delivery provincially and nationally.

Key Fundamentals - Funding

- Current funding structures do not support the integrative collaboration across physical, mental health and social sectors necessary to address the complex needs of seniors especially for family physicians.

- Seniors' accessibility to services is impacted by existing funding structures that do not support integration and transition.

Key Fundamentals - Evidence – Based Research

Consensus based:

- Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders (Health & Welfare Canada, 1988)
- Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities (B.C. Ministry of Health, 2002)
- Guidelines for Specialty Geriatric Mental Health Outreach and Accountability Framework (MOHLTC Ont. 2005)

Key Fundamentals - Evidence – Based Research

Evidence based:

- ID OR is Best Practice for Geriatric Mental Health (WHO technical document)

  (Draper, 2000)
- ID Teams with protocols for care (Bartels)

  Eg: for depression PROSPECT (Reynolds)
- Housing a service in target community better than outside the community (Wasylenki)

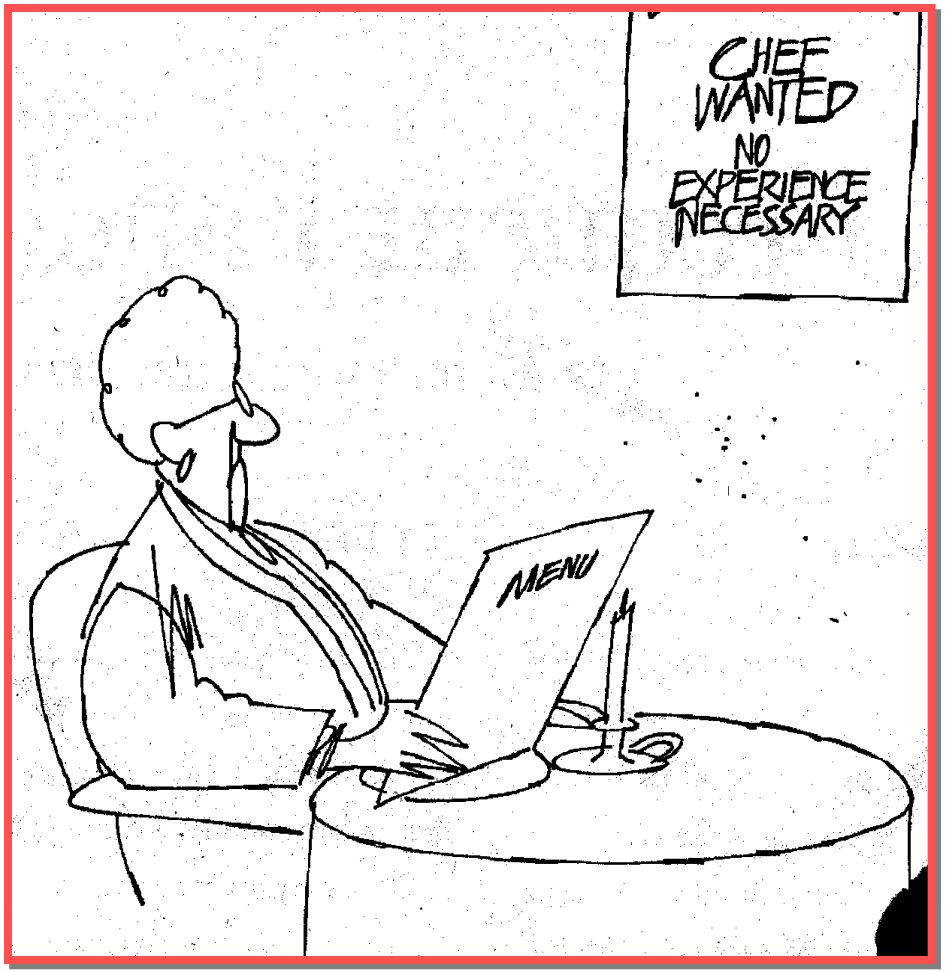
Key Fundamentals – Community Needs

- Greater awareness of the benefits of mental health care for seniors.
- Greater awareness of available services for seniors.
- Greater awareness of risk factors for seniors.
- Greater input into services for seniors by seniors.
- Better accessibility to services.

Planning, Staffing and Implementation

- Seniors are often not represented on mental health policy and planning committees at local levels.
- Many of the essential partners are outside of the mental health care system and not linked through convergent policies and funding (peer services, pharmacists, day programs, public guardians, police, housing authorities and transportation)
- Embedding evaluation of the effectiveness of collaboration is essential for program development.
- Trained staff in geriatric mental health care are essential.

Finding the right staff is crucial



Recommendations

- Enhance collaboration with all professionals that serve health and mental health needs of seniors and their caregivers
- Profile the role of mental health in meeting the needs of seniors with the primary health sector.
- Support increased education (and ID education) in seniors mental health for front line workers

Recommendations

- Funding should be revised to accommodate accessible portable collaborative community-based services in the care of seniors.
- Develop a comprehensive policy and funding program specific to seniors mental health that embeds collaboration with primary care as a fundamental principle.
- Establishment of seniors advisory groups to inform program planning and implementation

The "Ideal" Geriatric Primary Mental Health Care

A family practice network, with family physicians (not on fee-for-service payment systems), RN's and a pharmacist

PLUS

A Geriatric Psychiatry Outreach Team with geriatric psychiatrists (on a mixed fee-for-service and sessional funding blend), a neuropsychologist, RN's and a social worker with easy access to OT and PT through the community health unit, (but not part of the mental health team)

PLUS

Local nursing home served by the family practice network (again on a non fee-for-service funding system).

The "Ideal" Geriatric Primary Mental Health Care

a. A steering committee, including all partners and representative seniors and consumers does a needs assessment in the community and defines the collaborative parameters.

b. Partners meet once a month at the family practice network and once a month at the nursing home:

   i. Discuss cases (indirect consultation) whenever possible.

   ii. The Geriatric Psychiatry Outreach Team psychiatrist and case manager see patients on that day or at a different time, either on site or in the patient's home as needed, with a primary care staff member where ever possible.

   iii. Informal education in case discussions.

   iv. Formal education sessions negotiated according to needs and times available.

   v. Use of expert opinion-based guidelines in care for dementia, delirium, depression, and suicide.

   vi. Following a chronic disease management process with case identification, protocols for care, identified case managers, callbacks and indicators of improvement

The "Ideal" Geriatric Primary Mental Health Care

c. Once every three months there is a one-hour discussion of the process of collaboration and issues for improvement are documented and a plan for putting them into place is written. Seniors and consumers are part of the steering committee for each three-month review.

d. An outside evaluator, as part of a research project, comes in once a year for three-years to document:

   c. The number of patients discussed.
   d. The number of patients seen.
   e. Satisfaction scales by a representative group of patients, caregivers and partners.
   f. An examination of indicators for specific disorders, example: depression.

e. The leadership of this collaborative is defined and refined and shared.

Contact

Dr. Martha Donnelly

marthad@interchange

Dr. Ken LeClair

leclairk@pccchealth.org