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Compendium of Good Practices for Improving Seniors Mental Health in Canada

A resource to support the implementation of *Guidelines for Comprehensive Mental Health Services for Older Adults*

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Mental Health Commission of Canada

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Introduction

In 2011, the Mental Health Commission of Canada (MHCC) published *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (Guidelines)*. Since then, the *Guidelines* has become the gold standard for meeting the rapidly growing demand for geriatric mental health services, being used by mental health services planners and providers across the country (Wilson & Stinchcombe, 2017). The document emphasizes prevention, early intervention, and collaboration while underscoring how an effective and efficient coordination of primary care and specialized health services can help people get the care and services they need.

Based on discussions with leading experts (Wilson & Stinchcombe, 2017) and key informants,[*] however, planners and administrators need more information on how to apply the *Guidelines'* recommendations to improve services in their communities. In particular, they need to know how to achieve results and overcome barriers (such as limited resources) and how to create processes to optimize access to (often scarce) mental health resources in the most cost-efficient manner, whether in urban, rural, or remote areas or when facing the unique challenges of dealing with diverse backgrounds or needs. The discussions also highlighted the need to make the scaling up of integrated mental health services for older adults a priority.

Using Canadian examples of well-integrated or innovative services across a range of resources and demographic profiles, this compendium is meant to help planners implement the *Guidelines'* model of mental health services in their communities and jurisdictions. The Advisory Group guiding the project also asked that it include examples across the continuum of care, from mental health promotion to intensive services. Those used in the compendium came from a review of the literature published since the *Guidelines* and from key informants in seniors mental health. This outreach to informants included annual conference workshop dialogues in the fall of 2018 with the Canadian Academy of Geriatric Psychiatry (CAGP), the Canadian Coalition for Seniors' Mental Health (CCSMH), and the Canadian Association on Gerontology. Workshop follow-up surveys, disseminated through these partners and individual participants, identified organizations and key informants that were able to share examples of good practice services and programs for this compendium.

Without seeking to be comprehensive, the examples used in this compendium illustrate some of the ways services in Canada have begun to implement the *Guidelines*. While many challenges remain with respect to meeting the mental health needs of older Canadians, these findings are encouraging. The hope is that it will inspire and support further developments by building on the experience of the many hard-working health-care providers and planners who had the foresight to establish the model services and programs.

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Wilson, K., & Stinchcombe, A. (2017). Uptake of the Guidelines for Comprehensive Mental Health Services for Older Adults: Environmental Scan. Internal report for the Mental Health Commission of Canada.

[*] At the MHCC's November 21, 2017, Knowledge Translation Planning Workshop: Guidelines for Comprehensive Mental Health Services for Older Adults in Canada.

Model Services and Programs

1. Promotion and Prevention

Recent Literature

> *The 2011 Guidelines recommend developing strategies to engage seniors in health promoting activities, and in decreasing stigma associated with mental illnesses. The sections on promotion (p 30 -35), prevention (p. 36-40) and on community-based programs (p. 52-56) highlight the range of such strategies.*

According to the MHCC's *Guidelines,* mental health promotion and prevention are important elements of a system of care for older adults. Since its publication, several promotion and prevention tools for older adult populations have emerged.

Gough and Cassidy (2017) reviewed the evidence on the benefits of focusing on this part of the continuum and provide results of a peer-led education series based on the mental health promotion materials in the Fountain of Health initiative in Nova Scotia. Gough et al. (2018) found that, in both individual and group-based primary care settings, Fountain of Health knowledge translation (KT) materials improved knowledge of evidence-based mental health promotion initiatives and their application in daily life. Participants reported improvement in their knowledge of the epigenetic (i.e., modifiable) factors that affect health and in their confidence with health-behaviour goal setting, while changes in "self-perceptions of aging scores reached significance in the group intervention" (Results, para. 1).

Examples of Mental Health Promotion and Prevention Tools

Fountain of Health

Description

The Fountain of Health (FOH) was initiated in 2010 by Keri-Leigh Cassidy, MD, and a multidisciplinary team from the seniors mental health program at Dalhousie University's psychiatry department. Cassidy and her team are members of a specialized mental health service for older adults and exemplify the important role of academic centres for KT and the development of educational tools to support mental health promotion and prevention. The team consists of geriatric psychiatrists, seniors mental health nurses, and representatives from 13 multidisciplinary stakeholders, including the Alzheimer Society of Nova Scotia, the CCSMH, the Mount Saint Vincent University Centre on Aging, the province's Seniors and Health departments, Caregivers Nova Scotia, Community Links Nova Scotia, and Dalhousie's division of geriatric medicine.

Over the past three years, the FOH has grown into a national non-profit brain health project with a national team guiding cross-province initiatives. National partners include the CCSMH, the CAGP, International Longevity Centre Canada, and the College of Family Physicians of Canada (CFPC).

Approach

Paper-and app-based behaviour-change tools provide users with encouragement and support on their health goals. Over 80 per cent of the more than 500 users met (some partially) or exceeded their health goals during a four-month follow-up period. Using FOH tools, the CCSMH has been running peer-led groups over the past two years to support older Canadians. A $425,000 grant from the Centre for Aging and Brain Health Innovation is funding an evaluation of these tools in front-line care settings, with 650 participants in Ontario and B.C. in 2019 (a joint FOH and CCSMH project). Other national work includes increased multidisciplinary collaboration with the Alzheimer Society of Canada (ASC) and the Canadian Mental Health Association (National), which are incorporating FOH resources into their educational materials and programming.

Based on Google Analytics data, over the past year more than 7,000 individuals have been served by the FOH initiative. Web activity includes 39,000 page views from users in 10 provinces and two territories, participants in peer-led groups (100), and attendees at brain health presentations (1,000) by the FOH national speakers bureau. More than 500 people used FOH resources in settings where quality assurance was being formally measured through a partnership with front-line clinicians. The clinical resources evaluated include paper tools and an FOH wellness app to invite and support health goals. Followup was also conducted in key health domains known to promote long-term well-being and reduce the risk of dementia and depression.

Current limitations include financial and human resources for increasing the availability and dissemination of FOH clinical and educational tools. Such resources would support peer-led groups in all provinces, fund continuing medical education for clinicians through national and web-based platforms, and make primary care health-behaviour-change tools available nationally in both official languages.

The priorities for addressing unmet needs include forging sustainable long-term collaborations, including grant sharing with major national brain and mental health agencies such as the CCSMH, the ASC, the Canadian Mental Health Association (CMHA), the CFPC, and the CAGP. The FOH's national speakers bureau provides sustainable leadership across the provinces by delivering continuing education for clinicians and the public. Speakers are able to discuss the current science of brain health as well as practical strategies and tools to support long-term well-being. Speakers also provide a train-the-trainer function to make health-behaviour change and prevention sustainable over time (across clinical settings nationally). Increasing the focus on long-term collaborations will support the sustainability of the program through quality assurance research, continuing medical education, and widespread clinical dissemination of FOH brain health resources.

For more information, contact info@fountainofhealth.ca.

Mental Health First Aid Seniors

The Guidelines emphasizes the importance of engaging older adults in decreasing the stigma associated with mental illnesses. Mental Health First Aid (MHFA) Seniors is a leading example of a strategy to improve literacy around mental illness.

Description

MHFA training helps people assist someone who is developing or experiencing a worsening mental health problem or is experiencing a mental health crisis. Just like physical first aid, MHFA is provided until appropriate support is found or a crisis is resolved. The MHFA course helps participants recognize a change in behaviour, respond with a confident conversation, and guide someone to appropriate resources and supports.

As an adaptation of MHFA Basic, MHFA Seniors seeks to increase the capacity of seniors, families (informal caregivers), friends, care-setting staff, and communities to promote mental health, prevent suicide (where possible), and intervene when problems emerge. The materials for this 18-hour course are based on the best available evidence and practice guidelines, which were developed in consultation with Canadian experts in geriatric psychiatry. The curriculum, made available in 2017, was developed for the MHCC at Trillium Health Partners, an organization that prioritizes seniors health and wellness.

MHFA courses were created to help reduce social distance with someone experiencing a mental health problem or crisis, increase awareness of the signs and symptoms of common mental health problems, and enhance participants' confidence to intervene. Course evaluations indicate that these goals are consistently met.

While there are MHFA Seniors trainers in six provinces — British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and Newfoundland and Labrador — one can arrange for trainers in other jurisdictions by contacting the MHFA offices in Ottawa.

As of April 1, 2019, there have been 5,508 MHFA Seniors First Aiders trained since 2017 — 3,425 between April 2018 and February 2019.

For more information, contact mhfa@mentalhealthcommission.ca.

Peer Support Service (Vancouver)

The Guidelines indicates that peer support programs are an important part of initiatives driven by seniors in community-based services and programs (p. 52-53).

Description

This service provides confidential, non-judgmental, one-to-one emotional support for adults 55 or older, who are facing a life stressor such as retirement, illness, isolation, or loss.

While typically offered for health promotion and primary prevention, the service is also open to individuals with mild depression or anxiety and can also offer support to individuals with other health conditions, especially in cases where peer support would be appropriate.

Approach

Clients are matched with a trained volunteer for one-to-one sessions that last up to 15 weeks. The service is located in a local mall (Kay's Place), in partnership with the West End Seniors' Network, and is easily accessible on foot or by using public transit.

For more information, contact Anthony Kupferschmidt at executivedirector@wesn.ca.

Community Outreach Programs to Reduce Isolation and Loneliness

Description

Various community outreach programs to help fight loneliness and isolation among older adults have been developed in different jurisdictions. These include long-standing community services such as friendly visiting, meals on wheels, and wheels to meals and more recent innovations like the Men's Sheds project, funded during a Movember campaign.

In addition, suicide prevention programs like community talk groups for older and middle-age men are increasingly emerging. A facilitator guide for the CCSMH's Late Life Suicide Prevention Toolkit (2016) can be used to support these groups.

Another resource was developed as a one-stop knowledge hub for those working to reduce seniors' social isolation and increase their inclusion. The website, funded as part of Employment and Social Development Canada's New Horizons for Seniors program, showcases resources designed to address these areas at the population level and also offers reports and other resources from around the world.

Continuing Care for LGBTQ2S+ Seniors: Resources for Providers (Alberta)

Description

These web-based provider resources from Alberta Health Services (AHS) include an educational video and tips on safer welcoming care, activity programming, and establishing an organizational "site champion." Their development, over 18 months, included the involvement of community volunteers and experts in sexual orientation and gender identity and expression within AHS.

Other Promotion and Prevention Programs

Examples include:

- Senior Alcohol Misuse Indicator (SAMI): a concise, free screening tool designed to detect existing or potential alcohol problems in older adults without eliciting denial and defensiveness by those being screened, from the Centre for Addiction and Mental Health (CAMH).
- Age-Friendly Communities in Canada: Community Implementation Guide Toolbox: an array of tools to help make communities more age friendly (Public Health Agency of Canada).
- CCSMH National Guidelines for Seniors' Mental Health: a range of clinical guidelines that include recommendations on the risk associated with common mental health problems in old age, such as depression, dementia, suicide, and substance misuse.

- Behavioural Supports Ontario: an initiative created to enhance health-care services for older adults with (or at risk of) responsive behaviours or personal expressions associated with dementia, mental health, substance use and/or other neurological conditions. The program also provides family care partner support in the community, in long-term care, or wherever the individual and/or care partner(s) resides. Resources include a person-centred language initiative, shared educational tools, and information to facilitate the development of specialized services for persons with behavioural and psychological symptoms of dementia.
- Living Life to the Full for Older Adults: a 12-part course developed by the CMHA (Ontario) to help people learn self-management skills through cognitive behavioural therapy (CBT) concepts and techniques.
- brainXchange: a searchable web-based resource with educational and clinical tools that clinical service providers and planners can consult and share. This brain exchange is dedicated to "improving the quality of life and supports for persons with or at risk of having brain health needs related to dementia, mental health and neurological conditions related to aging or have experienced brain health changes earlier in life that are now more complex with aging." Members include the CCSMH, the CAGP, the ASC, the Canadian Consortium on Neurodegeneration in Aging, and others. Resources and tools include:
    - healthy living and recommendations for the prevention of dementia
    - support for family caregivers of persons living with dementia or other neurological or mental health problems
    - information on facilitating aging at home for persons living with dementia, such as tele-home monitoring for rural seniors and the SMILE (seniors managing independently living easily) at home program

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Further Reading

Extensive references for evidence on the Fountain of Health and mental health promotion among older adults.

McMaster Optimal Aging Portal health section resources and literature summaries.

2. Geriatric Mental Health Community and Outreach Services

Recent Literature

Recent papers describing geriatric mental health community and outreach (GMHCO) services, which come mostly from Australia, New Zealand, and the United Kingdom (U.K.), confirm the essential role of GMHCO teams in delivering specialized geriatric mental health services, providing information on resources, and describing outcomes. The U.K. has had a leading role in advocating for and describing specialized geriatric mental health services, going back to the late 1970s. The literature from Australia is particularly interesting because of its many similarities with Canada regarding health systems, population sizes,[†] population spreads,[‡] and the number of older adults living in rural and remote communities. To some degree, both countries have set targets (benchmarks) for the resources needed to serve older adults in a given geographic area or administrative region.

> *The Guidelines adapted these benchmarks for GMHCO services; namely, one multidisciplinary team (includes a psychiatrist) for every 10,000 persons over age 65.*

In Australia and New Zealand, community services serve older adults who have various diagnoses in collaboration with primary care providers.

GMHCO Services in the U.S.

Reifler and Bruce's review (2014) of home-based mental health service models in the U.S. identified a number of distinguishing characteristics to consider when designing programs. Of the ten models examined

- eight operated as part of a community agency, two within a medical school department of psychiatry
- six focused primarily on older adults with mood and anxiety disorders while using a range of individual psychotherapies
- four accepted patients with any psychiatric diagnoses, including dementia and incorporated medication management into their services
- all strongly believed in "the need for the program in their community, an ability to work within the framework of their parent organization and to form partnerships with others, and a commitment to overcome the obstacles that constantly arise" (Discussion, para. 1).

In terms of organizing such a program, the review found that, given the complex needs involved, it "can be integrated within many different types of mental health, health, social, or aging service organizations" (Administrative Issues, para. 1).

While Reifler and Bruce also examined the number of cases seen each year[§] and provided some information about staffing and budget, not enough was said about the catchment area population to

[†] 24.6 million (Australia) vs. 37 million (Canada).

[‡] Population density is 3.1 per sq. km. in Australia, 3.7 in Canada.

[§] 50-300 new cases.

study the percentage of staffing benchmarks reached or the range of services made available to the population.

In addition, a report from the U.S. examined geriatric psychiatry outreach programs that visit older adults living at home who are unable to get to an outpatient treatment facility (Johnston et al., 2010). The mean age of the patients seen was 79.7, with women representing 74 per cent of the patients. The most common psychiatric diagnoses were depression (50%) and dementia (45%) with a mean of 1.4 psychiatric diagnoses per patient. These patients also had a number of medical diagnoses (mean of 4.8), including cardiovascular, musculoskeletal, endocrine, neurological, and gastrointestinal problems, and were taking several medications (mean of 6.8). Patients received 4.2 in-person visits on average and had a mean of 30.2 additional contacts such as phone calls, emails, and faxes.

The patients described in this study are similar to those seen at home by GMHCO teams in Canada: they typically had a complex combination of medical and psychiatric diagnoses and benefit from contacts in addition to face-to-face visits. The most common reasons for the need to provide them with care at home were poor social supports, the inability to drive, caregiver stress, poor physical health, and decreased physical mobility. The model described, which used a geriatric psychiatrist, a geriatric nurse practitioner, and a coordinator with experience in dementia care, is also close to the model used by the GMHCO teams in rural regions of Champlain Health District, Ontario.

GMHCO services in Australia

Crotty, Henderson, Martinez, and Fuller (2014) described the importance of collaboration between GMHCO services, primary care physicians, social services resources, and long-term care homes. The study emphasized the need for clinicians and agencies to have an initial face-to-face contact to learn about each other's services, referral and eligibility criteria, and responsibilities. It also recommended creating opportunities for networking and relationship building through joint educational activities. GMHCO services therefore need to include activities that facilitate collaboration with primary care providers and other mental health, health, social, and aging-service organizations.

George and Bradshaw (2006) and Loi, Bradshaw, and Gilbert (2017) both described a geriatric mental health service in rural Victoria, Australia. Over a ten-year period this service continued to provide prompt consultation (usually within 2-3 days), along with case management and treatment when appropriate. George and Bradshaw examined the staffing needed to provide this service as well as the number of patients consulted, admission rates, and relevant local services (e.g., hospital beds available for admission). In George and Bradshaw, the admission rate ranged from 11.5 to 13.6 per cent. Ten years later, Loi et al. reported that 17 per cent of patients who were seen in consultation required a hospital admission (two-thirds informal and one-third involuntary). This increase may have been due in part to the proportion of patients with a most responsible diagnosis[**] of delirium (15.7%) and psychotic disorders (10%), in addition to depression (31.5%) and dementia (30%).

GMHCO services in the U.K. and France

Ryder (2015) described an initiative by a newly formed mental health community team: the flexible care service. Its aim was "to help older people with mental health problems identify ways to enhance their

[**] That is, the condition responsible for the greatest length of stay.

quality of life, help them access appropriate resources and supports and, when relevant, provide respite to their carers" (p.30-34). While the paper outlined one aspect of GMHCO teams' work, it did not provide information on the resources needed to deliver this type of service in patients' homes.

Krolak-Salmon et al. (2016) documented the impact of a mobile team dedicated to behavioural disorders associated with dementia. They did so by interviewing the referring physicians of 424 older adults (living at home or in a nursing home) about alternative care pathways they would have used if the mobile team had not existed. The primary care physicians indicated that, had they been on their own, they would have hospitalized 51.9 per cent of their referrals (220 patients). With the mobile team in place, however, 181 admissions were avoided and care was provided successfully in the community. There were significant improvements in the Neuropsychiatric Inventory scores one month after the team's intervention. About 18 per cent of the persons being referred still required hospital care, which reminds us that access to hospital care needs to be part of the system of care for older adults with behavioural or mental health problems.

Examples of GMHCO Services in Canada

GMHCO services have gradually become more available in most health-care regions in Canada. Some have been developed with resources from the divestment of the provincial psychiatric hospitals, expanding community services outside of large urban centers, partly to help transition patients back to their communities. In some areas, such as in the B.C. Interior, outreach to nursing homes is described as "in-reach services."

However, to our knowledge, all existing teams have lower staffing levels than the recommended benchmarks in the Guidelines, namely, 5.5 full-time equivalent (FTE) specialized geriatric mental health professionals per 10,000 elderly persons.

Geriatric Psychiatry Community Services in Ottawa

In Canada, some examples exist of geriatric mental health services being integrated within regional geriatric programs, such as at the Institut Universitaire de Gériatrie de Montréal (IUGM) and in London. But most GMHCO services have been developed by and integrated within community or specialized mental health services. In Ontario, mental health services affiliated with academic centres began establishing geriatric psychiatry community and outreach services more than 40 years ago. These services were based on the predominant U.K. model; specifically, using home visits as an important way to achieve a comprehensive assessment. For example, the Geriatric Psychiatry Community Service of Ottawa (GPCSO) was established more than 43 years ago under the clinical leadership of David Harris, a geriatric psychiatrist who trained in the U.K. and was a member of the department of psychiatry at the Ottawa Hospital. GPCSOs mirrored the U.K. model by providing services through home visits.

Stay tuned for…

An upcoming publication will provide a more detailed description of GMHCO services in the Champlain region, including its multidisciplinary staffing, operations, population served, results, and challenges, along with its important role in providing timely access to specialized geriatric mental health evaluation and care. The publication will also illustrate how the CMHCO team benchmarks proposed in the

Guidelines were used to achieve an equitable distribution of clinical resources throughout a given administrative region.

For more information, contact Michèle Tremblay, MD, michele.tremblay@theroyal.ca or Gordon Thomas, MD, gordon.thomas@theroyal.ca at The Royal; or Linda Gobessi, MD, lgobessi@bruyere.org or Vickie Demers, vdemers@bruyere.org at Geriatric Psychiatry Community Services of Ottawa.

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3. Specialized Geriatric Psychiatry Inpatient Services

Recent Literature

Since the 2011 *Guidelines*, very little has been published on specialized hospital-based services, and nothing in Canada. This is perhaps in part because specialized inpatient services were historically located in provincial psychiatric hospitals, which have since reduced capacity or closed their rehabilitation units. While there has been a significant shift toward community-based and other services, such as specialized behavioural units in long-term care homes, as the *Guidelines* describes, specialized geriatric psychiatry inpatient services remain an essential component of comprehensive mental health services for older adults in Canada.

Gomersall (2009) described an intermediate-care community service in the U.K., where a multidisciplinary and multi-agency team was used to assess, treat, and support elderly mentally ill persons in their own residence. Although this seven-day-a-week, urgent-care home service helped reduce pressures on hospital bed occupancy, the author pointed out that the service would not have functioned successfully "without the commitment and support of the older people's mental health inpatient units, day hospitals and community teams" (Conclusion, para. 3).

Madaras and Hilton (2010) described a 12-bed intermediate-care rehabilitation unit in a long-term care setting for older adults with physical illnesses who also had mental health needs. Their diagnoses included delirium, depression, dementia, alcohol problems, schizophrenia, personality disorder, and frontal lobe brain impairments (due to cerebral bleed or the removal of a brain tumour). Delirium, both with and without dementia, was the most common diagnosis. The average length of stay was 55 days, and all patients were admitted from an acute care hospital. This service was therefore developed mostly to relieve pressure on acute care hospital beds and allow a more suitable period of rehabilitation than is usually provided in acute care.

A study by Seitz et al. (2012) of adults discharged from acute psychiatric units (APUs) across Ontario in 2008-2010 compared the treatment needs for older and younger adults. It found that older adults accounted for 8.8 per cent of all discharges and 12.3 per cent of admissions of more than three days, which highlights the continued and significant role of acute psychiatric units in the provision of hospital care for older adults. Depressive disorders (32.1%), dementia (19.5%), psychosis (15.9%), and bipolar disorder (11.3%) were the most common primary discharge diagnoses, accounting for 78.8 per cent of all admissions. While most patients lived in a private residence prior to admission, 10 per cent lived in a long-term care home. However, two thirds of older adults had some cognitive impairment, 47 per cent moderate to severe. A large percentage (46%) of older adults had impairment in at least one basic daily living activity, 22 per cent moderate to severe.

Not surprisingly, Seitz et al. found that older adults averaged 3.3 chronic medical conditions, and 84 per cent had two or more comorbid medical conditions (compared to 20.5 per cent for younger adults). This study highlights the need for acute psychiatric units to have expertise in both high-quality medical care and psychiatric care, while incorporating recommended geriatric best practices for the treatment of the disorders responsible for admissions to APUs. It also shows the absence of specific clinical guidelines for the care of persons with dementia in acute care settings. In addition, given the social vulnerabilities of

older adults, there is a clear need for social supports and post-discharge psychiatric care to prevent the recurrence of symptoms.[††]

Overall, our research found no new published literature on the specialized geriatric mental health inpatient services described in the *Guidelines*.

Examples of Specialized Geriatric Psychiatry Inpatient Services in Canada

Through personal outreach to clinical leads for specialized geriatric mental health services in various provinces, we found that most specialized inpatient units provided effective treatment, with an average length of stay less than 90 days. Exceptions occurred only with clients who needed more intensive inpatient rehabilitation services due to complex and severe psychiatric and/or neurocognitive disorders. For these units, the average length of stay could exceed 90 days (but remained within 120). All these services had the support and collaboration of the long-term or residential care sector, with clear mechanisms to facilitate transfers back to these homes when inpatient care was no longer required or could be continued in those settings.

Some of these mechanisms included written admission criteria and service agreements between acute care hospitals, residential care homes, and specialized units. These related to readmissions to long-term care (LTC) homes or the alternate level of care units in acute care hospitals after treatment were completed on specialized units. They also included provincial policies that allowed a reasonable length of time for residents of LTC homes to keep their bed while they were hospitalized on a psychiatric unit. When specialized inpatient resources were unable to admit and discharge patients within a reasonable time, those inpatient beds were effectively blocked (so others could not access inpatient psychiatric care when needed). At the same time, those living in an LTC or residential care home were at high risk of losing their bed. In most provinces, older adults with complex neurocognitive, behavioural, and mental health disorders had the greatest difficulty accessing proper inpatient care due to the fear that intermediate or acute care beds would be blocked by patients in need of placement. This situation highlights the need to have an adequate range of services and well-designed policies that foster collaboration between the community and residential care sectors, acute care hospitals, and specialized mental health services.

The Royal Ottawa Mental Health Centre's Geriatric Psychiatry Inpatient Service

The centre's inpatient service is a 43-bed unit with an average length of stay that has fluctuated (over several years) between 45 and 65 days. It has been able to provide direct admissions from LTC homes as well as prompt transfers from acute care hospitals or the community when specialized geriatric mental health care is needed. This example illustrates how it is possible to provide equitable and timely access to such care for older adults living in a specific administrative region where there is a range of mental health services. Its success stems from good collaboration between acute care hospitals, geriatric mental health community services, and outreach services to LTC or residential care homes.

[††] Note: this study excluded older adults admitted to long-term or specialized geriatric psychiatry inpatient services during its two-year period.

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The Geriatric Tertiary Inpatient Unit for the B.C. Interior

The geriatric psychiatry tertiary inpatient unit for Interior and Northern Health in B.C. is part of the Hillside Centre in Kamloops. It is a 12-bed inpatient service, developed in 2006 to better serve the central and northern populations as resources from the provincial mental health facility were being divested. This secure inpatient unit provides comprehensive assessment and treatment services using a holistic approach and behavioural care planning. Its current average length of stay is 112 days. This example shows how a small, specialized inpatient service is an essential part of the continuum of care for rural and remote communities, along with the mechanisms that have to be put into place to ensure ongoing access to a very limited resource.

For more information, contact Carol Ward, MD, at carol.ward@interiorhealth.ca.

Stay tuned for…

A paper (in preparation) will describe these two tertiary care specialized geriatric psychiatry inpatient units: one that is part of the continuum of care for older adults of the Champlain region (Ottawa and the surrounding [mostly] rural areas) and one that serves the interior and northern parts of B.C. (Hillside Centre in Kamloops).

As a follow-up to the findings of Seitz et al. (2012), we will describe a new behavioural support service for acute care hospitals in the Champlain region, developed to better respond to the needs of older adults. In future publications, we also hope to highlight acute care psychiatric units that have developed strategies to address the complex needs of older adults.

For information on behavioural support services in an acute care hospital, contact Kiran Rabheru, MD, at krabheru@toh.ca.

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4. Geriatric Psychiatry Day Hospital Services

Recent Literature

> *Day hospital programs allow "more seniors to access the usually very limited specialized inpatient services by shortening the average length of stay on that unit while still providing an opportunity for each patient to achieve maximum potential for recovery (Tourigny-Rivard & Potoczny, 1996)." (MHCC, 2011, p. 63)*

Geriatric psychiatry day hospitals are only currently available in some large academic centres, such as those in Ottawa, Vancouver, Toronto, Calgary, Edmonton, London, and St. John's**.** Day hospitals that are co-located or close to geriatric psychiatry inpatient services have often provided a useful alternative to specialized inpatient care, avoiding inpatient admissions (when feasible) and allowing earlier discharge and safe transition back home with continued ambulatory treatment.

Some day hospitals offer a set number of treatment days and admit a cohort of patients for that period; for example, a 12-week program for mood and anxiety disorders where group cognitive-behavioural therapy is an important part of treatment, as are other psychosocial interventions (Conn, Clarke, & van Reekum, 2000). Other day hospitals use staggered admissions based on the need to transition out of inpatient care or the need for a more intensive treatment program.

> *The Guidelines includes geriatric mental health day hospitals as one of the specialized services to be considered when developing a comprehensive array of mental health services for a given administrative region (p. 63).*

Some geriatric psychiatry day hospitals are co-located or integrated with geriatric medicine day hospitals. For example, at Vancouver General (VGH), the geriatric psychiatry day hospital is part of a geriatric day hospital that includes physicians and team members from family practice, geriatric medicine, and geriatric psychiatry (located near an inpatient unit (STAT Centre) on the same floor as the geriatric psychiatry outreach team). Its main goals are to provide assessment and treatment of frail older adults with the most complex needs, reduce emergency room visits and acute care admissions (through crisis intervention and prompt access to assessment and treatment services), provide services that make earlier discharge from the hospital possible (medical and psychiatric monitoring and rehabilitation), caregiver education and support, and forestall residential care placement by setting up required resources in the home (K. Bell, personal communication, May 2019). The average length of stay at the VGH day hospital is three months.

Knight and Alarie (2017) described a 10-week multimodal geriatric mental health day-treatment service in Calgary, developed for older adults with mild-to-moderate mood and anxiety disorders, where admissions were staggered based on needs. The paper briefly outlined staffing levels for the practice model, which included group-based cognitive-behavioural and interpersonal strategies that emphasize behavioural activation and socialization. After reviewing the charts of 255 older adults over three years and holding focus groups with clients who attended the program in the previous months, the authors showed statistically and clinically significant improvements in symptomatology, based on reductions in

the Geriatric Depression Scale and the Clinical Outcomes in the Routine Evaluation Outcome Measure (CORE-OM). The focus groups indicated that a mechanism for ongoing mental health support after completion of this time-limited program was needed.

Geriatric day programs and Alzheimer day away programs have been developed over several years to support persons affected by dementia.[‡‡] While these programs do not usually provide medical care and tend to be less resource intensive than day hospitals, they help participants maintain the best level of autonomy and socialization while living at home. They also support family caregivers through daytime respite, education, and support on managing mild Behavioural and Psychological Symptoms and are therefore an important part of the continuum of services required by older adults. In Vancouver, a new program called Youville ADP has been developed for older adults with more severe symptoms (which regular Alzheimer day-treatment programs cannot manage). Located in a secure setting, with a large outdoor space and smaller patient/staff ratio, it likely provides a level of care more similar to a day hospital (Vancouver Coastal Health, 2017).

Overall, the literature to date has focused on outcomes for the management of specific disorders and on demonstrating the effectiveness of treating (primarily) mood and anxiety disorders.

Examples of Geriatric Psychiatry Day Hospital Services in Canada

The Royal Ottawa Mental Health Centre's Geriatric Day Hospital Service

The geriatric psychiatry day hospital service in the Champlain region provides evaluation, day treatment, and crisis intervention for older adults who can live safely in the community but require urgent and intensive psychiatric treatment.

The goals of the program are to

- help persons remain at home while receiving more intensive treatment than other mental health services can provide (such as outpatient our community clinics), thereby avoiding an acute care admission to hospital
- help persons return home sooner by continuing a previously established treatment plan and supporting them during the transition from hospital to home
- provide comprehensive multidisciplinary evaluations for persons with complex mental health and cognitive problems when the expertise of various health-care professionals and longer periods of evaluation are needed to develop effective treatment interventions
- support persons with severe and persistent mental illnesses who previously needed years of treatment in provincial psychiatric hospitals by providing treatment with a rehabilitation focus and facilitating access to appropriate community supports.

Description

This day hospital is located in a university-affiliated regional tertiary care facility Ottawa that offers a range of specialized services. Its bilingual programs can accommodate 45 clients, most of whom attend the day hospital two to three days per week. On Tuesdays and Thursdays about one-third (15-18) are

[‡‡] The Ottawa-Carleton Alzheimer Society established Canada's first day away program in 1985.

admitted to the cognitive enhancement and assessment day program (CEAD), while on Mondays, Wednesdays, and Fridays two-thirds (about 30) attend the other available programming. The daily attendance for CEAD is 12 to 15; for the others, it is 18-30.

While the duration of admissions is determined by the needs and goals of each person, the goal is to transition them to less intensive services as soon as it is appropriate. The average length of stay is 114 days (close to 4 months), and 110-130 unique individuals are served every year (an average of 120).

Approach

The basic structure of daily programming relies on psychosocial group processes. However, specific individual and group therapies are available. These include cognitive behavioural and interpersonal therapy, physiotherapy, occupational therapy, pharmacotherapy, and psychosocial interventions. If required, electroconvulsive therapy is also available during admission to the day hospital. Care is provided in collaboration with the person's family physician and other providers of specialized services who may already be involved in their care, such as the addiction programs (of The Royal or the community-based Lifestyle Enrichment for Seniors program) and caregiver support programs of the Alzheimer Society.

To facilitate the transition from the day hospital's relatively intensive therapy, a number of outpatient psychosocial support groups have also been developed, including the Wellness Group for persons with dementia, the Healthy Lifestyle Group, and the Wellness and Recovery Action Plan Group for those with persistent or recurrent mental illnesses.

For more information, contact Michèle Tremblay, MD, at michele.tremblay@theroyal.ca or Sarah Halliday, MD, at sarah.halliday@theroyal.ca.

Vancouver General Hospital's STAT Centre Day Hospital

The STAT Centre provides comprehensive geriatric assessment and treatment services for frail community-dwelling seniors with complex medical, psychiatric, functional, and/or social challenges who cannot have their needs met in a primary care or (community) clinic setting.

The goals of this program are to

- provide assessment and treatment for frail older adults with the most complex needs
- reduce emergency room visits and acute care admissions through crisis intervention and prompt access to assessment and treatment services
- provide services that make earlier discharge from hospital possible (medical and psychiatric monitoring and rehabilitation)
- support caregivers through education and forestall residential care placement by setting up required resources in the home (K. Bell, personal communication, May, 2019).

Description

Clients attend twice each week for a period of three months. About 110 patients are admitted to the program every year. Clients follow a therapeutic activity program based on a psychosocial rehabilitation model while receiving coordinated and expedited individual diagnostic and treatment services.

Approach

The day hospital staff includes physicians and team members from family practice, geriatric medicine, and geriatric psychiatry. To maximize independent living for their clients, the team provides care in collaboration with primary care providers, mental health teams, community case managers, and home support workers through home care nursing and rehabilitation, adult day services, and Alzheimer Society support programs. Being located on (and sharing resources with) an acute care geriatric assessment (STAT inpatient) unit enables seamless transitions of care. Weekly intake meetings allow for the triaging of referrals to ensure urgent situations are addressed in a timely manner. Neuropsychology services are also provided, and including transportation is a key factor in its success.

For more information, contact Kathryn Bell, MD, at kathyrnkathy.bell@vch.ca.

Stay tuned for…

A detailed evaluation of the geriatric day hospital service at The Royal Ottawa Mental Health Centre, including clinical outcomes and the average length of time required to meet the goals of admission, is currently underway. Staffing, operations, population served, results, and challenges will be described in more detail in an upcoming publication, along with the important role of geriatric psychiatry day hospitals in providing timely access to specialized evaluation and care.

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5. Behavioural Support and Transitional Units for Complex Dementia Care

Recent Literature

Since the *Guidelines* was published in 2011, a number of tools have been developed to facilitate the development and implementation of behavioural support and transitional units (BSTUs). These resources include a toolkit on the designation process for specialized units in long-term care (LTC) homes (Porteous, Donskov, Luciani, & Orosz, 2016), a guide on providing person- and family-centred care within BSTUs (BSTU Collaborative, 2018), and a report[§§] on person-centred language and communications from Behavioural Supports Ontario (BSO).

The *Guidelines* highlights that, "with reductions in the number of geriatric inpatient resources and, in some jurisdictions, the closure of provincial psychiatric hospitals, residential facilities have become, de facto, longer-term mental health facilities" (p. 63).

> *"To better support older adults living with persistent mental illnesses or Behavioural and Psychological Symptoms of Dementia (BPSD) some facilities have developed a longer-term stabilization treatment unit or special units designed for behavioural support." The Guidelines recommends the development of such units in at least one local or regional residential care home, "allowing families and friends to participate appropriately in the care of their loved ones" (p. 64).*

Specialized units in long-term care homes addressing populations with special needs are sometimes called transitional or behavioural units. In the section reviewing recommended benchmarks, the *Guidelines* could only find two: one from Australia with 5.1 dedicated residential care beds per 10,000 elderly persons and one from B.C. with 10 beds per 10,000. The table that summarized the benchmarks used an estimate of 7.5 beds per 10,000, which must be confirmed or changed after conducting a fuller evaluation of these units in the current Canadian health-care system.

We have to consider whether longer-term mental health hospital resources are available in a given region and remember that these benchmarks were suggested several years ago, when outreach consultation and geriatric mental health support for residential care facilities were likely not as developed, at least in some administrative regions.

Ontario's experience with the development of these units, which was part of the redesign of its services for responsive behaviours associated with neurocognitive disorders, is well described in Gutmanis, Snyder, Harvey, Hillier, and LeClair (2015). The article included preliminary evidence of the units' effectiveness in reducing responsive behaviours in LTC homes, decreasing the use of acute care services

[§§] See the BSO's *Person-Centred Language Initiative Report*.

by LTC residents, and lowering the number of alternate level of care[***] days. It also described their keys to success, which included

- developing and adhering to a pan-provincial change strategy framework
- supporting effective communication and knowledge exchange
- using a regionally driven planning, development, and accountability process (with provincial review to ensure fidelity).

Implementation was also supported by creating standardized tools, protocols, and communities of practice (e.g., the BSO's BSTU Collaborative, plus their own). Leveraging existing initiatives and providing population-based funding to enhance or develop new services were also critical to the success of this large initiative.

Orosz, Porteous, Donskov, Luciani, and Walker (2016) explored the role of eight specialized units in LTC homes, each serving a well-defined group of residents whose needs go beyond the usual scope of these homes but do not require the complexity and range of care provided in hospitals. The paper looked at the role these units played in health-system capacity planning and described the benefits and challenges they experienced. It concluded that they were a viable option for residents with specialized needs and they had the ability to enhance the continuum of care and help address the health-care system's needs. More systematic data collection, robust evaluations, and cost-benefit analyses are still needed to understand how effectively and efficiently these units can fulfil desired outcomes.

A retrospective chart review of 73 residents of Toronto's Baycrest Centre (Cohen-Mansfield et al., 2017), a 20-bed behavioural support and transitional care unit, showed that those needing admission were predominantly men (74%) who were younger than the average LTC home population (75 years), had severe cognitive impairment, and averaged 2.6 admission goals. The most common goals pertained to physical non-aggressive behaviours (52.1%), physical aggression (52.1%), and verbal aggression (41.1%). The average length of stay on the unit was six and a half months.

The outcome evaluation showed a significant reduction in behavioural and psychological symptoms of dementia (BPSD) but also an increase in the number of central nervous system medications. There were no significant changes in cognition or the ability to perform activities of daily living. The study concluded that persons admitted to the unit had severe BPSD that put themselves or others at significant risk, and they could not be managed with behavioural interventions alone during admission. Whether the need for psychotropic medication can be reduced by adopting different environmental designs or behavioural interventions remains unclear. Further outcome studies of these transitional units are needed.

Examples of Behavioural Support and Transitional Units in Canada

A 2017 environmental scan[†††] by the BSO's BSTU Collaborative listed at least seven units in Ontario. Most were located in long-term care homes and ranged from 12 to 32 beds, with a median of 17 beds. Each unit had a set of criteria to identify individuals who would most benefit from the care model being offered. Once clinical objectives were achieved, discharge destinations were either to a general unit

[***] That is, days in which clients who are not acutely ill occupy acute care hospital beds.

[†††] *Collaborative, Environmental Scan of Ontario's Behavioural Support Transition Units (BSTUs)*

within the same LTC home or to another LTC home. Average length of stay was 201 days (6.5 months), with a median of 166 days. Since the study was completed other units have been added, such as the one at the Ontario Shores Centre for Mental Health Sciences in 2018.

Behavioural or transitional care units for complex dementia care have also been developed in several provinces including:[‡‡‡]

- Manitoba (Deer Lodge Centre special care unit)
- British Columbia
- Quebec (Quebec City and Montreal)
- Saskatchewan (a five-bed dementia assessment unit at Eastview in Saskatoon, the Southern Saskatchewan Dementia Assessment unit in Wascana Rehabilitation Centre in Regina)
- Alberta (Bethany Riverview long-term care home for specialized dementia care in Calgary)

For more information, contact the BSO's provincial coordinating office team at provincialbso@nbrhc.on.ca or 1-855-276-6313.

Stay tuned for…

An upcoming publication will report on the experience of the Champlain region and offer some insight into the number of beds required in a relatively well-resourced administrative region. Most useful to health-care planners, however, would be a pan-Canadian study of existing units to specifically establish Canadian benchmarks.

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[‡‡‡] Note: a comprehensive list is not yet possible, given the great need for these specialized services across the country and the number of units being developed.

6. Geriatric Mental Health Services in LTC Homes

The Guidelines section on specialized seniors mental health services stresses the importance of providing consultation, collaborative care, support, and education in long-term care or residential care settings. (p. 63-64)

Recent Literature

Snowden (2010) focused on models of mental health service delivery and factors that affect the development, persistence, and reduction of symptoms of distress. Once noting the advantages of consultation-liaison arrangements and telepsychiatry, Snowden concluded that mental health problems must be recognized promptly by a facility team that is available to deal with them. Commonly, facility staff develop such multidisciplinary teams by linking with visiting mental health professionals or services, so he urged health-care jurisdictions themselves to develop these services. Since studies also show that quality of care is affected by the organization, attitudes, and education of facility personnel, he concluded that the "provision of optimal mental health care in LTC settings is dependent on adequate funding, availability of expertise and education, positive and caring attitudes, recognition of needs, and supportive teamwork. The latter should also include cooperative links between well-resourced and under-resourced regions" (Conclusion, para 1).

Molinari, Hedgecock, Branch, Brown, and Hyer (2009), through a survey of 70 per cent of nursing home administrative personnel at four Florida training conferences, found that the homes had substantial mental health services, with psychologists, psychiatrists, and other MDs consulting on a weekly basis. The survey respondents expressed high satisfaction with the mental health services provided, although they indicated that psychotherapeutic services were most difficult to provide, whereas pharmacotherapy was the easiest.

Krolak-Salmon et al. (2016) evaluated a mobile team dedicated to behavioural disorders associated with neurocognitive disorders that helped prevent hospitalizations. Another study (Chan et al., 2018) found that establishing an acute outreach service to nursing homes "decreased emergency department presentations by 10 per cent compared to the subacute service" (para. 1). Cost-benefit analysis showed that five dollars was saved for every dollar spent. A similar study by Street, Considine, Livingston, Ottmann, and Kent (2015) showed "a significant reduction in the median length of stay, fewer hospital admissions and fewer repeat visits for people from residential aged care following implementation of in-reach nursing services" (Conclusions, para. 1).

The Canadian Context

Over the last 10 years, a significant amount of health services planning work has been focused on long-term care. In Ontario, this work started a decade earlier based on a recognition of the need for better support, consultation, and education in LTC homes. Separate initiatives for older adults in the province have led to a number of incremental additions to the mental health resources of LTC homes:

- province-wide funding for psychogeriatric resource consultants to provide education and support

- education for primary care providers and staff through the Alzheimer Disease and Related Dementias strategy
- an Aging at Home strategy that increased funding for geriatric mental health community teams that included, to a limited extent, persons living in LTC homes
- BSO funding for Local Health Integration Networks (LHINs) to develop or expand services that respond to the behavioural and mental health needs of older adults (included broader education and mental health services in LTC, opportunities to develop BSTUs and increase the capacity of geriatric mental health community teams)
- renewal and redesign of some LTC homes (helped provide better environments for an increasingly frail population with complex physical, cognitive, and mental health problems)

Most provinces included some or all these different elements in their health planning strategies and created knowledge exchange sites with helpful tools for their development and implementation, such as the BSO and brainXchange websites.

Examples of Geriatric Mental Health Services in LTC Homes in Canada

Geriatric Psychiatry Outreach Services to LTC Homes in the Champlain Region

The first core team of this program consisted of a geriatric psychiatrist and a nurse providing a consultation-liaison service in Ottawa LTC homes once or twice a month almost 30 years ago. Over the last 10 years, specific resources for behavioural support, consultation-liaison, and mentoring of LTC staff were added, and this enabled closer collaboration between geriatric mental health community services, acute and tertiary hospital-based inpatient units, and all LTC homes in the Champlain region.

For more information, contact Michèle Tremblay, MD, at michele.tremblay@theroyal.ca or Gordon Thomas, MD, at gordon.thomas@theroyal.ca.

Regional Knowledge Coordinators — Complex Behaviours, LTC Network, B.C. Interior

This service has four FTE specialized mental health nurses. They provide "in-reach" behavioural consultation and support front-line LTC staff working with residents with complex mental health disorders, including dementia and related responsive behaviours. These regional knowledge coordinators for complex behaviours (RKC-CBs) are able to provide telephone support, on-site visits, behavioural consultations, coaching, and education. They promote the use of the Gentle Persuasive Approach, the P.I.E.C.E.S. learning and development model, and the B.C. behavioural and psychological symptoms of dementia algorithm, among other initiatives. In addition, they share best practice knowledge and support with LTC staff for the development and/or revision of behavioural care plans and the implementation of non-pharmacological interventions for challenging responsive behaviours. The RKC-CBs support referrals to the tertiary geriatric mental health inpatient unit at Hillside Centre, when admission to hospital is required, and collaborate with geriatric psychiatrists who also provide in-reach consultations to LTC homes in their catchment area.

For more information, contact Carol Ward, MD, at carol.ward@interiorhealth.ca or 250-314-2598, or project manager Petra Bader at petra.bader@interiorhealth.ca or 250-808-0364.

Stay tuned for…

A more detailed description of these two different specialized geriatric mental health services is being developed. It will provide more details on staffing resources, populations served, activities, partners in care, and the challenges of implementing these programs in Residential or LTC homes.

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7. Telepsychiatry

Recent Literature

Since the 2011 *Guidelines*, the number of older adults served through tele-mental health programs in Canada has increased significantly, either in direct services (consultation, followup, and therapeutic interventions) or collaborative care, through the education and mentoring of primary care providers.

A survey of 209 Canadian geriatric psychiatrists on providing telepsychiatry services, presented at the October 2018 Canadian Academy of Geriatric Psychiatry-Canadian Coalition for Seniors' Mental Health (CAGP-CCSMH) Annual Scientific Meeting in Halifax (Conn et al., 2018), had the following results:

- 62 geriatric psychiatrists (in nine provinces) completed the survey (29.7% response rate).
- Nearly half the respondents (47%) said they provided telepsychiatry services, linking mostly with hospitals (30%), nursing homes (30%), and community agencies (27%), while 9% were seen from a private residence.
- About two-thirds (66%) indicated that they use telehealth for new assessments and followup visits, 20% offer case reviews without the patient present (likely mentoring a local health-care provider), and 9% offer more formal educational sessions.
- The most frequently cited barriers were lack of infrastructure, administrative support, funding, and access to equipment. About three-quarters (77%) of those not currently providing telepsychiatry services said they would be interested in doing so in the future.

A review of tele-mental health services by Hilty, Srinivasan, and Rabinowitz (2018) described various models of telepsychiatry that have been evaluated. The authors grouped these models under three intensity levels: "low" (tele-education, formal case reviews, and in-person, telephone, or email doctor-to-doctor "curbside consultations"); "moderate" (integrated mental health screening programs, therapy on site, and tele-psychiatric consultations with continuing education and training for primary care providers); and "high" (disease management module for a specific health problem in collaboration with a primary care provider, using a long-term approach to build relationships with those in specific catchment areas). The key findings from this review are that telepsychiatry is increasingly used with geriatric populations and seems to be as effective as in-person care, based on outcomes evaluated to date (although studies are limited).

Psychiatric assessment and treatment via telemedicine can be done from various locations, including the person's home, extended or long-term care facilities, and clinics and hospital settings, given the increasing availability of high-quality video conferencing. Cheng Tsallis et al. (2018), in a review of a recent pilot project from the Baycrest Centre for Aging and Brain Health Innovation, showed the feasibility of using secure web-based personal video conferencing technology from the Ontario Telemedicine Network to provide psychiatric assessment to homebound geriatric patients.

A program of 33 telementoring sessions over two years, using Project ECHO (extension for community health-care outcomes) GeMH (geriatric mental health), linked 154 primary care clinicians in 10 New York counties with a team of geriatric mental health specialists (Fisher et al., 2017). Participants reported increased knowledge and improvement in treatment practices. Health claims analysis showed a decrease in emergency room costs for patients with mental health diagnoses and an increase in

outpatient visits for patients without pre-existing diagnoses, possibly reflecting an increased ability to recognize and treat mental illnesses in their practice. This study demonstrated the usefulness of telementoring, its potential to decrease emergency room visits, and the significant time it saved for both participants and mentors.

In Canada, the Zoom video-conferencing technology has been used for Project ECHO COE (care of the elderly), a case-based learning program led by a trained facilitator to maximize engagement and knowledge-sharing for over 100 primary care providers across a large area in northern Ontario (Feldman et al., 2019). Interventions successfully provided through geriatric telepsychiatry include the evaluation of depressive and neurocognitive disorders. According to Ramos-Rios et al. (2012) "telepsychogeriatrics appears to be a viable option, well accepted by patients, including those having dementia" (Conclusion, para. 1).

A more recent review of geriatric telepsychiatry (Gentry, Lapid, & Rummans, 2019) listed several Canadian studies published in the last 10 years: four in memory clinics and two using video conferencing to support a group of dementia caregivers. One study showed that video conferencing was more effective than an internet chat group for improving the mental health status of the caregiver (Marziali & Garcia, 2011). Conn et al. (2013) showed high satisfaction levels among outpatients and their referring physicians for telepsychiatry consultations. The paper also concluded that "access to a geriatric psychiatrist has broadened the team's knowledge base, its use of assessment tools, and increased their ability to better construct their patients' treatment plans" (Conclusion, para. 1). It also highlighted some of the challenges and potential barriers of using telehealth, which included difficulty engaging primary care providers (who preferred having in-person visits from the geriatric psychiatrist) and ensuring the implementation of recommendations where continuity of care is limited by the use of locum[§§§] physicians. For Dham et al. (2018), consultants expressed discomfort when using community-based telepsychiatry for older adults with significant cognitive or sensory disabilities, describing such programs as "a useful adjunct for psychiatrist input in the care of older adults" (Conclusions, para. 1).

While the studies rarely describe the human resources required to provide effective telepsychiatry for older adults in detail, these include the need for telehealth coordinators to assist with scheduling and providing technical or in-person assistance (if needed during sessions to maintain communication and safety). Also likely needed are family caregivers during consultations and care providers to develop an effective treatment plan. The time required by these care providers needs to be calculated into program costs, along with the creation of an appropriate model of remuneration for any physicians involved — particularly when indirect services such as mentoring and case-based learning are used to increase their capacity.

[§§§] That is, replacement physicians.

Examples of Telehealth Services in Canada

The Geriatric Telepsychiatry Mental Health Service for Older Adults in Northwest Ontario

The northwest Ontario geriatric telepsychiatry service was developed by the Baycrest Centre in Toronto and CMHA's district mental health services for older adults program based in Fort Frances.

The goals of the program are to

- provide patient-centred consultation, education, and mentoring for primary care physicians and program staff
- help care providers, in collaboration with locally based behavioural support teams, address the behavioural and psychological needs of persons living with dementia and their caregivers.

Description

This service connects two geriatric psychiatrists from a university-affiliated geriatric centre (Baycrest) to the rural psychogeriatric outreach team in six northern communities (Kenora and Rainy River districts), where 36,000 older adults reside. The northwest has the largest land mass of all Ontario health regions (about 47 per cent of the province) and the smallest population (about 231,000 people or two per cent of Ontarians). It also has the largest proportion of Aboriginal people of all Ontario LHINs (21.5%). It is funded by the Ministry of Health and Long-Term Care through the North West Local Health Integration Network (LHIN).

Over the last eight years, additional staff have been added through the BSO program to address the behavioural and psychological needs of older adults living with dementia.

Approach

Staff members from the psychogeriatric teams facilitate each referral, provide their assessment to the referring physician and the consulting geriatric psychiatrist, and attend each consultation or followup session with the patient. After this assessment and consultation, they provide care and followup, in collaboration with primary care physicians or nurse practitioners. They also conduct home visits and see patients at their community-based offices. BSO staff attend most LTC home consultations.

Stay tuned for…

An upcoming publication will describe the resources needed for the ongoing provision of this specialized service, along with the results achieved and the challenges that must be addressed when implementing this type of service.

For more information, contact David K. Conn, MD, at dconn@baycrest.com.

The Telehealth Geriatric Mental Health Education and Mentoring Service

This telehealth education and mentoring service was developed by the specialized geriatric psychiatry team of the Institut Universitaire de Gériatrie de Montréal (IUGM), for the geriatric population residing in various CISSS and CIUSSS regions in the province of Quebec.

The goals of the program are to

- provide patient-centred consultation, education, and mentoring for newly established behavioural support teams (developed as part of Quebec's *Plan Alzheimer*), helping them develop skills and expertise that will serve their local communities
- help address the behavioural and psychological symptoms of older adults living with dementia in long-term care, residential care, and private retirement homes.

Description

The service is a time-limited, moderate-intensity program, specifically designed to help care teams in long-term care, residential care, and private retirement homes address the behavioural and psychological symptoms of persons living with dementia (BPSD). The clinical consultation and education team includes a geriatric psychiatrist, a nurse clinician, and a psychologist from IUGM.

Approach

In collaboration with locally based BPSD teams, team members help evaluate challenging behaviours, by clarifying diagnoses and underlying causes, to develop person-centred care plans. They also follow up on the efficacy of the proposed treatment plan and any barriers to implementation or need for adjustment. In addition, the team offers a two-day education program and year-long monthly telementoring sessions for newly established BPSD teams (part of Quebec's *Plan Alzheimer*) to help them develop the skills to become local BPSD experts. The teams, which consist of at least one physician, one nurse, and a psychosocial professional, are located in various urban, rural, and remote administrative regions (CISSS and CIUSSS) in the province of Quebec.

Stay tuned for…

Results from this project have been presented in a poster (Bruneau et al., 2018) and published in a journal (Dubé et al., 12-13, 2019). An upcoming publication will detail the results, challenges, and resources needed for its successful development and implementation.

For more information, contact

- the IUGM-BPSD team at 514-340-2800, ext. 2226
- Christine Fournier, IUGM-BPSD administrative director at christine.fournier.ccsmtl@ssss.gouv.qc.ca
- Caroline Ménard, psychologist and clinical coordinator for the teleconsultation project, at caroline.menard.ccsmtl@ssss.gouv.qc.ca or 514-340-2800, ext. 2223
- Marie-Andrée Bruneau, geriatric psychiatrist and clinical team co-lead at marie-andree.bruneau.ccsmtl@ssss.gouv.qc.ca.

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8. Collaborative Geriatric Mental Health Services

Recent Literature

Since the 2011 *Guidelines*, more older adults are being served through collaborative care arrangements between specialized geriatric mental health services and primary care providers. The Canadian Collaborative Mental Health Initiative (CCMHI, 2006) sees collaborative care as a response to the "escalating need to develop new service delivery models to better address the interdependent biomedical, psychological, social, functional and environmental needs of seniors experiencing mental health issues" (p. iii). With that in mind, many of the recommendations in Horgan et al. (2009), a paper on collaborative mental health care planning that responds to accessibility needs, and CCMHI (2006), a toolkit to help health-care professionals establish a collaborative practice for the older adults they serve, remain useful for health-care planners and providers. In terms of barriers, the toolkit identified funding and remuneration, the lack of flexibility in existing structures and systems to shift to a different model of care, buy-in, human resources, skills, team development, geography, technology, evaluation, and policy or legislation.

The Guidelines highlights the importance of collaborative mental health care under specialized geriatric mental health services (p. 59-62), describing them as "a specialty resource that provides collaborative shared care that supports community partners, learning and development and service improvement". It is also one of the specific recommendations on intersectoral partnerships and collaboration in the facilitators section of the document (p.84-86).

Other countries have embraced various collaborative mental health care models for older adults. In the U.S., a study by Kaskie and Szecsei (2011) made clear that the rural populations are less likely to access mental health care than those in urban areas. In Australia, Crotty, Henderson, Martinez, and Fuller (2014) identified barriers, such as a lack of awareness about services and eligibility criteria, and too few opportunities for joint education between agencies or collaboration and networking, that needed to be overcome.

Dham et al.'s systematic review (2017) of collaborative care found very few studies that evaluated psychiatric disorders in older adults other than depression. In depression, the study found that "there is some evidence for cost-effectiveness" (Results, para. 1) and that collaborative care "is feasible and beneficial among older adults in diverse settings" (Conclusions, para. 1). Although limited evidence exists for improvements to dementia care and outcomes using collaborative care, further studies are needed for conditions other than depression and for concurrent disorders with or without medical illness. Further research is also needed on cost analysis and other factors that may influence the uptake and sustainability of collaborative care, particularly in settings other than primary care.

Examples of Collaborative Geriatric Mental Health Services in Canada

Across Canada, the P.I.E.C.E.S. learning program has been widely used as a collaborative care tool. It provides frameworks and enables collaboration between all those involved in the care of older adults, including family caregivers. It promotes the surfacing of their collective wisdom, emphasizes the importance of validating all perspectives, and enables a process for acting together (Behavioural Supports Ontario, 2019). P.I.E.C.E.S. is now used in the following jurisdictions: B.C., the Yukon, the Northwest Territories, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, and parts of Newfoundland and Labrador.

For more information, contact Ken LeClair, MD, at leclairk@providencecare.ca.

Stay tuned for…

A paper currently being prepared describes an integrated collaborative care service in Ontario for older adults with dementia and a variety of disorders, called PRISM (primary integrated system model). This primary care initiative offers person-centred care with a focus on prevention, early detection, and collaboration as core elements. Its specialized geriatric mental health consultation and capacity development services are embedded into four primary care sites for effective care coordination in the rural communities of Lanark and Rideau Valley.

PRISM has specialty geriatric psychiatry and community providers from seniors mental health programs and the Alzheimer Society collaborating with the primary care teams and providers, which include family doctors, nurse practitioners, nurses, social workers, and pharmacists. The goal is to help reduce the burden of illness and improve the quality of life for clients. The forthcoming publication will include details of the program's staffing, operations, and results.

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Conclusion

This literature review shows that more studies are needed on specialized geriatric mental health services, particularly those that describe the resources required, their clinical results, and/or their impact on the health-care system. When reaching out to the clinical leads for these services, it was evident that current programs face many challenges, including a rapidly increasing number of older adults who need services, limited resources, important gaps in the range of services in a given administrative region, and the limited time for active collaboration with other health-care partners or researchers.

We hope this review will be a helpful way to connect people, encourage them to learn from each other, and share their strategies for addressing the needs of their aging population. The papers being prepared will further guide planners in developing additional services (even with limited resources) and in determining the requirements for creating or scaling up the clinical services older adults need.

While we are encouraged by the development of services since the *Guidelines* in 2011, it is clear that much remains to be done.

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