Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *seniors*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

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A companion to the CCMHI planning and implementation toolkit for health care providers and planners

A Toolkit

February 2006

OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Preface

Welcome to the CCMHI Toolkit Series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services,* are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Seniors aged 65 and over accounted for 13% of Canada's population in the 2001 census, up from almost 12% in 1991 (Statistics Canada, 2002). It is projected that by the year 2016, more than 16% of Canada's population will be 65 years of age or older (National Advisory Council on Aging, 1999). A greater proportion of Canada's older adult population is also living longer: Those aged 85 and over represent the fastest growing segment of the senior population (Statistics Canada, 2002).

It is estimated that 20% of adults over age 65 have a mental disorder (Jeste et al, 1999), yet there are shortages of family physicians and specialized mental health services for seniors. There is an 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.

The purpose of this toolkit is to assist health care providers to work collaboratively to best meet the unique health care needs of seniors experiencing mental health issues. Highlights of the toolkit include: an overview of an 'ideal' geriatric primary mental health care collaboration; key issues for consideration when planning and implementing an initiative; an extended literature review; descriptions of more then 20 positive practice initiatives; and key websites.

Defining the population

Age is a primary factor in defining this population but not in itself sufficient. Although age 65 is often used as a benchmark, individuals under 65 may be considered part of this population if they experience age-related mental health issues. The definition used in this toolkit includes: primary mental illness with age-related primary health concerns, including individuals with late onset depression or schizophrenia-like syndromes and longstanding psychiatric illness with age-related complication such as stroke, mobility problems or dementia; complex dementia/neurological/medical conditions with associated or comorbid psychiatric illness; forensic patients; and individuals with substance use disorders, concurrent disorders or those with developmental delays who are growing old. Individuals with a longstanding mental illness who grow old with no major age-related issues are not included in this population. The primary mental health care provider must be the ultimate judge of who amongst his or her population is likely to benefit most from collaborative mental health care initiatives.

Consultation process

The members of the Expert Panel have varied personal and professional backgrounds including caregiving, social work, community nursing, geriatric psychiatry, family medicine, policy analysis and program evaluation. The development of this toolkit

involved four key steps: a literature review; 23 in-depth interviews (qualitative); 30 interviews (quantitative survey design); and presentation of drafts of this toolkit at a number of workshops and conferences.

Key messages

- **Access barriers** include factors relating to age, attitudes and values; eligibility criteria; physical mobility; funding issues; and lack of knowledge of options. Access issues are further compounded by difficulties faced by senior caregivers in managing their own health needs; financial issues; and the complex co-ordination required to arrange necessary supports and resources.
- **Accessibility can be enhanced** through greater awareness among consumers and caregivers of available services; increased health professional home visits; co-ordination of transportation and respite care; support to caregivers; and enhanced capacity to advocate with a strong voice.
- **A limited number of primary and mental health care providers have specialized formal training in seniors' health.**
- **Consumer centredness includes** improved access to collaborative services and supports for consumers/family/caregivers with sufficient time to interact and engage meaningfully with providers; enhanced education and counselling; home-based care as needed; and opportunities for input and participation as consumer representatives.
- **Polices, legislation and funding** need to support cohesion among services essential to seniors (e.g. health, transportation and social services); improve the portability of health services; address inconsistent eligibility criteria; and create flexibility in service models so that primary health care providers can adequately address the unique and complex needs of seniors with mental health needs.
- **Evidence-based research** points to best practices that include: consumer centredness; collaboration with health care providers (professionals and non-professionals) and with health and social services; care provided through the primary health care system; the use of interdisciplinary teams and case managers; outcome-based treatment planning; the use of a biopsychosocial model of care; use of established guidelines for care; community outreach, including home visits; and support and education of caregivers.
- **Collaborative structures need to ensure that seniors have time to interact and engage meaningfully and that their care providers are not too busy to address their concerns**. Equally meaningful input from a diversity of stakeholders is needed to ensure the varied needs of seniors are met. Seniors with mental health needs must be represented on collaborative care advisory groups dealing with policy development,

planning and service implementation, and support given to building capacity within the community to ensure the diverse needs of seniors are identified and addressed.

- **How the diverse group of stakeholders relate to and work with each other are critical to the quality or richness of the collaboration**. Meaningful stakeholders can include: (geriatric) psychiatrists; (geriatric) internists; neurologists; geriatric psychiatry outreach teams; family physicians, nurses, psychiatric nurses; practical nurses; psychologists; neuropsychologists; social workers; bereavement counsellors; specialty mood case managers; pharmacists; occupational therapists; liaison and education workers; physiotherapists; dietitians; non-professional health care providers (care aides, home support workers, paid live-in support); informal supports (families, peer support personnel, cultural peer groups, friends, neighbours); a wide range of community health care resources (care facilities, day care, seniors support services); and 'outside-the-health-care-box' supports (police, clergy, coffee shops, libraries, banks, lawyers, etc.).
- **Examples of positive practices** in collaborative mental health for seniors include: interdisciplinary mental health team partnering with a community interdisciplinary team; mental health case manager on-site with family physician practice; nurse practitioner and psychogeriatric outreach team members co-visit with consumers in their homes; centres for seniors' health with integral stakeholders co-located; support worker/navigator assigned to facilitate access to resources; geriatric mental health teams supporting family physicians; direct care liaison team to transition consumers from complex care to long-term care; rural outreach team collaborating with university psychiatry program; seniors' outreach services; interdisciplinary training programs; and innovative senior peer programs.

Introduction

> *"So when you think of the umbrella, you think of … the wires, the appendages [which represent] the different [health] services that seniors need, and it rotates around the person."*
>
> *Toolkit Participant*

The Expert Panel was given the task of identifying how the Canadian Collaborative Mental Health Initiative toolkit, *Collaboration Between Mental Health and Primary Care Services. A Planning and Implementation Toolkit for Health Care Providers and Planners*, could be adapted to best meet the unique health care needs of seniors experiencing mental health issues.

This toolkit includes:

- A definition of the geriatric population for the purposes of this report
- The argument for specialized collaborative initiatives for seniors with mental health needs
- An exploration of the literature and its relevance to this population
- Current challenges and potential strategies for enhancing accessibility, collaborative structures, richness of collaboration and consumer-centred care
- The impact of fundamental structures such as policies, legislation and regulations; funding; evidence-based research; and community needs
- Recommendations for the planning, development and evaluation of collaborative care initiatives for seniors.

Defining the population

For the purposes of this report, it is necessary to first define the population who most benefit from specialty geriatric psychiatry services.

Age is a primary factor in defining this population but not in itself sufficient. The uniqueness of this population centres on the need to address complex, diverse and interrelated biomedical, psychological, social, functional and environmental needs. Although 65 is often used as a benchmark, typically, the average age of seniors who will require unique collaborative health care is 75. Occasionally, however, individuals under 65 may be considered part of this population if they experience age-related mental health issues such as early onset dementia or longstanding mental illness coupled with complications or age-related issues.

This definition includes:

- Primary mental illness with age-related primary health concerns, including individuals with late-onset depression, late-onset schizophrenia-like syndromes and longstanding psychiatric illness with age-related complication such as stroke, mobility problems or dementia
- Complex dementia/neurological/medical conditions with associated or comorbid psychiatric illness, including dementia/neurological conditions with behavioural/mental health issues (e.g, person with dementia who is aggressive) and medical illness with psychiatric disorder (e.g., person with Parkinson's with psychosis; chronic obstructive disease with anxiety).

Also included (and their numbers are increasing) are forensic patients and individuals with substance use disorders, concurrent disorders or developmental delays who are growing old.

Individuals with a longstanding mental illness (e.g., schizophrenia or bipolar disorder) who grow old with no major age-related issues are not included in this population and are best served by adult mental health services.

The primary mental health care provider must be the ultimate judge of who amongst his or her population is likely to benefit most from collaborative care initiatives. It is important to note that the population of potential beneficiaries is very broad and includes not only seniors experiencing depression or dementia, but also anxiety-related disorders, Post-Traumatic Stress Disorder (PTSD), agoraphobia, late-life schizophrenia, late-life bipolar disorder and substance use disorders. Careful collaboration needs to occur between primary care providers and mental health care providers to define the population who will be served in any individual collaborative initiative.

Factors specific to seniors

Factors associated with mental health challenges in late life that can make assessment and management difficult:

Age-related factors

- Changes that occur as part of the normal aging process may significantly affect psychological and social well-being in seniors.
- Physiological changes associated with aging need to be taken into account for any pharmacological treatment.
- Physical health status is strongly correlated with loneliness.
- With age, the prevalence of most physical problems, chronic conditions and dependence increases.

Physical and emotional factors

- Loneliness may affect about 10% of seniors.
- Loneliness, high levels of emotional disturbance, depression, anxiety, one or more physical illnesses, history of stroke, widowhood and living alone are all related to suicide risk.
- Chronic pain, multiple losses, bereavement and social isolation are common among depressed older adults.
- Comorbid chronic medical illness can be a confounding factor and can exacerbate or cause depression.
- Substance abuse or misuse and/or developmental disability can mask other mental illness.

Attitudes and values

- Multicultural and generational attitudes and values can affect how older adults communicate about their mental health.

Ethical and legal issues

- Ethical and legal issues related to competency (driving, self-neglect, elder abuse) require specialized assessment, knowledge and skills.

Caregiver issues

- Caregiving women, especially those caring for an individual with dementia, are at increased risk for depression.
- Caregivers who receive little social support are more likely to experience depression than those with good social support.

Presentation in primary care

Seniors with mental health needs often present first to primary health care providers with physical health ailments. It is only through exploration of the presenting problem that mental health needs begin to surface over time. Major depressive disorders in older persons are increasingly being detected and identified in primary care, however, individuals who present with somatic complaints due to an underlying mental health issue are often missed. In fact, in Canada, over 70% of these individuals may be missed initially by the primary care clinician (Lin et al, 1996).

Most mental health and functional needs in seniors are best understood when they are assessed in their home environments. Spouses and family members are often the first people to identify problems experienced by loved ones.

Lessons from the literature

Canada's population is aging: Seniors accounted for 13% of Canada's population in the 2001 census, up from almost 12% in 1991 (Statistics Canada, 2002). It is projected that more than 16% of Canada's population will be 65 years of age or older by the year 2016 (National Advisory Council on Aging, 1999). A greater proportion of Canada's older adult population is also living longer: Individuals aged 85 and over represent the fastest growing cohort of the senior population (Statistics Canada, 2002).

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

Many older adults, especially those over 85, have complex, interdependent physical, psychological and social needs that individually and together may challenge their mental health, sometimes resulting in mental illness. For example, older adults are at increased risk for poor nutrition due to age-related physiological and psychosocial changes, as well as the added toll of chronic disease; together, these can exacerbate mental health issues. Over the next decade, Canada faces a significant increase in the number of older adults with complex physical and mental health needs. The resources required to meet the needs of these seniors cut across the various social, economic and health sectors. Consequently, the potential impact on all aspects of Canadian society, including the current health system, is significant.

It is estimated that 20% of adults over age 65 have a mental disorder, including dementia, depression, psychosis, bipolar disorder, schizophrenia and anxiety disorder (Jeste et al, 1999). In comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha & Satlin, 1997; Buchanan et al, 1995; Devons, 1996; Schmitz-Scherzer, 1995). Importantly, 50% of suicide attempts by seniors are successful (Gomez & Gomez, 1993).

Older adults with mental illness face increased risk of medical illness due to the long-term effects of unhealthy lifestyles, physiological changes and compounding medical illnesses that decrease the threshold for, and increase vulnerability to, additional medical problems and drug side effects (Dixon et al, 1999; Jeste et al, 1996; Marder et al, 2004). Hence, these individuals often experience higher rates of chronic medical illness and premature mortality. Bartels (2004) states that "older persons who have severe mental illness coupled with complex medical illnesses require intensive specialty psychiatric services and carefully co-ordinated primary and specialty medical care [to meet their needs]"(p.S254).

Unfortunately, older adults with mental illness often face barriers to obtaining basic health care. A major factor affecting access to adequate health care is the increased reliance on the formal health care system due to declines in informal supports from family members (Brown & Birtwistle, 1998). This increased reliance coupled with increased mobility issues present real barriers to gaining access to formal supports (Druss et al, 2002). Additionally, research has shown that older adults with mental illness are more likely to receive poorer quality health care than those without mental health needs (Druss et al, 2001, 2002). Currently, only one third of older adults with mental illness receive mental health services (Dugué, 2003).

Shortages of family physicians and specialized mental health services for seniors further compound the difficulties faced by older adults in addressing health needs (Kasperski, 2002; Kates et al, 1997; Kates, 2002; Rockman et al, 2004). The majority of mental health services for older adults are provided by the primary and long-term care sectors (Brown & Birtwistle, 1998; Wasylenki, 1984). In fact, across the life span, 50% of visits to a family physician are for mental health reasons (Kasperski). Due to the increased proportion of older adults in Canada, family physicians will see increased numbers of seniors experiencing mental health issues (Kasperski; Rockman et al). Although many mental health problems can be managed without direct consultation from specialists, the complex presentation and situations of some older adults can make their mental health difficult to assess and manage (Kasperski; Rockman et al). There is evidence to indicate that depression, substance abuse and suicidality in particular are poorly detected and managed in the primary care sector for this population (Banerjee, 1998; Fischer et al, 2003; Préville et al, 2005).

Clearly, there is an escalating and imperative need to develop new service delivery models equipped to better address the complex, interdependent biomedical, psychological, social, functional and environmental needs of seniors experiencing mental health issues. Concurrently, an important threshold has been reached wherein significant widespread interest in the status of seniors' mental health now exists across economic, health, community, education, judicial and political sectors. Timely attention to seniors' issues within policy, funding and planning initiatives would ensure better access to effective, collaborative care for seniors experiencing complex physical and mental health needs.

Key elements and fundamentals of collaborative mental health care

Accessibility

> *"I suppose I could call [the family doctor] and he'd probably see [my husband]. It's the energy, the thought of okay, I have to get him ready, you know and if I don't have a caregiver there, I have to get him ready. We have to be there at a certain time, which is hard. I have to get him into the car, take him out of the car when we get there, into the wheelchair, back again and up to where this doctor's office is. It is huge energy. It's why I don't do it except if I have the caregiver with me."*
>
> *Toolkit Participant*

- **Access to services requires complex co-ordination.** Many seniors do not use family physician services on a regular basis because of the complex co-ordination required to arrange the necessary resources. For example, a senior who requires the use of a wheelchair must co-ordinate the services of both an attendant (to physically dress her/him) and para-transit (for transportation) in order to visit their family physician. The difficulty in co-ordination is compounded when individuals and their caregivers are exhausted and overwhelmed by the day-to-day aspects of dealing with complex health needs.

- **Family caregivers also experience limited access.** Although continuing care professionals do their best to provide needed respite services for health care emergencies and appointments,

Figure 1 Framework for collaborative mental health care

more is needed to ensure that senior caregivers are able to effectively manage their own complex health issues. Senior family members/caregivers are more likely to let their own health slip because they do not have the physical and mental stamina to take care of both their own health and that of their loved one. Much of the activity engaged in by family caregivers is in relation to the health of their loved one. Regular health check-ups for themselves must be arranged separately yet still require considerable co-ordination to arrange for someone to look after their loved one while they are out or make arrangements to take their loved one with them. Hence, many older family caregivers do not attend regular check-ups for their own often-complex health issues. When one considers that 70 – 80% of the support is by informal caregivers, their health is essential to the health and independence of the older person with mental health needs and must be a focus of consideration in collaborative care initiatives.

- **Barriers to services are age, behaviour and mobility dependent.**
  Seniors who experience mental health issues are limited in their access to a broad spectrum of health and wellness supports. Eligibility criteria or physical environments associated with adult day programs, long-term care facilities, home care, psychogeriatric outreach teams and general mental health services may not facilitate a seamless transition to supports of greater and lesser intensity. For example, access to particular supports may be dependent upon the age of the individual and the degree of physical aid required. The parameters placed on support services, then, do not adequately address changing needs due to emerging or concurrent health needs across physical, intellectual and emotional domains.

- **Funding often dictates where care can happen.**
  In order to ensure that seniors have adequate access to care, mental health care must be available in a multitude of locations including the primary care setting, seniors' homes and public locations such as the local coffee shop. Current funding criteria significantly limit the degree to which mental health care can be carried out in these alternative settings.

- **Seniors are often unaware of their options.**
  Many seniors and their family members/caregivers are not sufficiently aware of the services and supports that are available to them in their communities. Hence, very few seniors and their families know of the existence of programs such as psychogeriatric outreach teams, peer senior support groups, respite care and recreational day programs that may be available in their community.

- **Seniors experience stigma associated with past perceptions of mental illness.**
  Many seniors perceive that they will be subjected to ridicule by their friends, family and other members of society if they reveal they are experiencing mental health

issues. Although stigma against those with mental health needs is still very much present in our society, seniors fear a backlash consistent with how mental illness was viewed in their younger years (i.e., people who experienced mental health needs lived in psychiatric asylums, and were referred to as 'crazy' or 'lunatic'). Hence, seniors may be more likely to resist communicating mental health needs or seeking out psychiatric services than younger individuals. Additionally, seniors in general are subject to stigma at the level of the individual, caregiver, provider and society, all of which affect access to services and supports.

Tips to improve accessibility

- Make seniors aware of services available in your community and where to find resources, even BEFORE they need them.
- Ensure seniors in your targeted population are aware of the specific services offered by your initiative.
- Be conscious of how much your initiative identifies consumers as experiencing mental health needs.
- When possible, increase the extent to which health professionals visit consumers in their homes or other convenient places.
- When possible, offer to co-ordinate transportation and respite services to facilitate consumers' being able to attend appointments.
- Reduce caregiver exhaustion by collaborating with respite care, home care and day program supports.
- Work with other community programs to ensure eligibility criteria do not prevent consumers from obtaining the services and service professionals they require.
- Collaborate with advocacy organizations to enhance their capacity to advocate for the needs of mental health consumers across the life span.

See Appendix D for brief descriptions of positive practice initiatives which enhance accessibility.

Collaborative structures

> *"If there was a client that needed occupational therapy, or an in-house assessment, functional assessment, whatever, we would invite the OT to our meeting, on a consultative basis kind of thing. We obviously didn't want [the kind of model where we had to access these skills externally]. We didn't have any extra money, … ideally we would have, if they gave us money we would have had, you know, an [internal] part-time OT and PT, probably.*
>
> *Toolkit participant*

- **Seniors need time to interact and engage meaningfully.**
  Seniors are sensitive to environments that feel rushed and are more likely to disengage with the process rather than express their need for more time. For example, a senior may be likely to wait and ask their pharmacist about the medication they are taking as opposed to their family doctor who they perceive to be too busy.
- **Equally meaningful input from a diversity of stakeholders is needed to ensure that the varied needs of seniors are met.**
  The needs of seniors experiencing mental health issues are broad and diverse. To ensure a balanced approach, it is essential that seniors have access to a variety of resources when they need them (e.g., home care nursing, nutrition consultations, occupational therapy) and that stakeholders value and respect each other's contributions.
- **Seniors with mental health needs must be represented in collaborative care planning and policy initiatives.**
  Seniors, families and seniors' mental health programs are often excluded from planning initiatives as it is assumed that general mental health services are representative of all persons who experience mental health issues. Hence, the unique and diverse needs of seniors experiencing mental health issues are often not addressed in these fora.

Richness of collaboration

> *"What is rich collaboration? Working in an environment of respect, excellent communication skills, [and] the people are truly comfortable with their role."*
>
> *Toolkit participant*

Tips to support collaborative structures

- Actively collaborate with services that are able to support seniors (e.g., pharmacists, dietitians, home care nurses, seniors' peer groups, volunteer organizations).
- Actively link with and give equal voice and consideration to supports that exist between health care systems (long-term care, community care, mental health, hospitals) and outside the health system (housing, police, fire, legal systems, meal programs).
- Identify what planning boards, etc. exist in your community – ensure there is a voice for seniors with mental health needs and their families/caregivers.
- Adapt practices and/or collaborate with other disciplines to accommodate the need for in-home services.
- Evaluate the collaboration process, not just clinical outcomes. Identify case managers or clinicians who have the knowledge to provide a comprehensive, biopsychosocial assessment.
- Identify and flag issues that may be better addressed and supported by other disciplines.
- Get to know the people to whom you are consulting – their values, culture and expectations.

- **Expertise of stakeholders both internal and external to the health system are equally valuable in the care of seniors with mental health needs.**
  The breadth of stakeholders involved in determining the wellness of seniors experiencing mental health issues is not sufficiently recognized. Prevention strategies that link people who first come into contact with and suspect mental health problems in seniors, such as family members, local libraries, taxi drivers, neighbours and landlords, are just as integral to the collaborative process as are family physicians, psychiatrists, home care professionals, psychologists, dietitians, nurses, physiotherapists and occupational therapists.

- **There is a limited pool of professionals skilled in the care of seniors.**
  There is a limited pool of professionals across primary and mental health sectors who possess specialized formal training in seniors' health. This limits the degree to which collaborators possess specific knowledge regarding the uniqueness of seniors' primary and mental health care needs. Lack of funding for geriatric-specific training affects the availability of specialists in this field.

- **Richness also refers to the collaborative process.**
  Collaboration refers to more than ensuring the presence of a diverse group of stakeholders. The quality of the collaboration between these stakeholders is directly related to how they collaborate with each other: the respect they show for one another, the degree to which they are prepared to learn from one another and their willingness to try things in a new way. The unique, diverse and often overlooked needs of seniors with mental health needs make richness of collaboration particularly important for this population.

Meaningful stakeholders (community carers) may include:

- Health care professionals
  - (Geriatric) psychiatrists
  - (Geriatric) internists
  - Neurologists
  - Geriatric psychiatry outreach teams
  - Family physicians
  - Nurses, psychiatric nurses, practical nurses
  - Psychologists, neuropsychologists
  - Social workers
  - Bereavement counsellors
  - Specialty mood case managers
  - Pharmacists
  - Occupational therapists
  - Liaison and education workers
  - Physiotherapists
  - Dietitians
- Non-professional health care providers
  - Care aides
  - Home support workers
  - Paid live-in support
  - Food services staff in apartment complexes offering meal/snack services
  - Meal delivery program personnel
  - Community Kitchens personnel

- Informal supports
  - Families
  - Peer support personnel
  - Cultural peer groups
  - Friends
  - Neighbours
- Community health care resources
  - Long-term care facilities
  - Day program respite services
  - Community care access centres
  - Guardianship services
  - Telephone support services
  - Interpreters
  - Seniors' recreational programs
- 'Outside-the-health-care-box' supports
  - Transportation providers
  - Police
  - Clergy
  - Housing managers/landlords
  - Local coffee shops
  - Libraries
  - Notaries and lawyers
  - Banks
  - Retail providers (e.g., grocery stores, liquor store clerks)

See Appendix D for examples of initiatives which reflect richness of collaboration.

Consumer centredness

> *"I do know that people who believe in client-centred care use the amount of time they have differently … they are more likely to say 'look we've both agreed that this is what the issue is, what have you tried? What do you think we could try? I have a few [ideas]. Are you interested in [hearing them]? Is it any help?' Now you are not actually using a heck of a lot more time in that case."*
>
> *Toolkit participant*

- **The consumer and their family/caregiver should be at the centre of the team.**
  In a consumer-centred approach to care, the consumer and family/caregiver are active participants in all aspects of care, and services are designed to address their specific needs. The consumer and family/caregiver is the most important member of the team.

- **Accessibility is the primary factor in addressing issues of consumer-centredness for seniors.**
  Access to collaborative services poses the greatest limitation for seniors with mental health issues. Access to health services can be hindered by an individual's physical ability, their mental state, whether or not they have a family caregiver living with them, their knowledge of available services, the location of their residence in relation to support services, their access to transportation, the ability of family caregivers to organize transportation, and encouragement from family members and friends to seek physical and mental health services. Programs providing collaborative care services for seniors must address seniors' limited access to primary and mental health services.

- **Home-based care is preferred.**
  Seniors are most comfortable in their own homes where they control the pace of life. They are more likely to divulge what is bothering them (particularly mental health-related issues) when they feel comfortable and relaxed in familiar surroundings. Their surroundings can provide valuable information for the assessment as well. This is particularly true of seniors who may be experiencing dementia-like symptoms such as memory lapse and/or paranoia.

- **Seniors and their caregivers want to be involved in planning and implementation.**
  Although seniors experiencing significant physical and mental heath issues and their family members can be overwhelmed by the impact these issues have in their lives, many are interested in having input at program, organizational and systems levels. Collaborative care initiatives should offer seniors the opportunity for input or participation as consumer representatives. Additionally, seniors without serious health issues are well equipped to serve as advocates and give voice to seniors' needs on advisory boards and committees.

- **Senior caregivers also experience complex physical and mental health needs.**
  The caregiving role taken on by family members of seniors who experience complex physical and mental health needs can be life changing, exhausting and all-encompassing, particularly for caregivers who are seniors themselves. Consequently, family caregivers themselves are at significant risk for mental and physical illnesses. It is important to recognize and address the health needs of family caregivers in order to ensure quality of life for both the care receiver and the caregiver.

- **Family caregivers need to know what to expect, what will happen next and how to plan for the future.**
  Family caregivers require financial, emotional and practical support to help them cope with the various phases of debilitating illness affecting their loved one. Family caregivers often feel alone and ill prepared to make important decisions for their loved ones (e.g., placing their spouse in a long-term care facility).
- **Aging in place.**
  Seniors need to be able to have their changing needs addressed in one place, rather than constantly having to move to different places.
- **Seniors respond to human contact.**
  Collaborative care for seniors must incorporate human contact as much as possible. This requires time, a broad base of supports and flexibility regarding where care is provided.

Tips to support consumer centredness

- Seek out seniors with diverse cultural, educational, financial and family status to sit on program boards. These individuals will be able to speak to the issues faced by the population(s) they represent.
- Organize a collaborative care advisory group with seniors as a core representative body.
- Offer seniors with mental health needs and their family members the opportunity for input and participation.
- Undertake a community development initiative to educate and connect with groups integral to seniors' mental health.
- Seek ways to make it possible for caregivers to participate with respite options.
- Assess the degree to which your initiative addresses seniors' unique needs for access to formal health services.
- Develop ways to make your service more accessible to seniors through direct changes or through collaboration with more accessible services.
- When possible, incorporate mental and physical health checks for the caregiver into consumer visits.
- Incorporate information/counselling support for caregivers into consumer visits.

Policies, legislation, regulations and funding

> *"There is no organized kind of unit around insuring that seniors get the resources they need, when they need it and so on … it's a lot more fragmented."*
>
> *Toolkit participant*

- **System fragmentation**
  The needs of seniors become lost amongst the various funding and policy sectors into which they fall (i.e., physical health, mental health, developmental delays, addictions, poverty, homelessness). Hence, seniors become a minority group within each policy and funding envelope, their needs never commanding a priority focus in any one sector. It is fundamental that the unique needs of seniors in the areas of health, transportation and social services be recognized.

- **Lack of portability**
  Current policies and funding structures do not support the portability of health services to locations that are accessible and comfortable for seniors (i.e., individuals' homes). Family physicians, in particular, are funded in ways that encourage practices aimed at maximizing the number of individuals seen in a particular day. Hence, family physicians are often limited in their ability to engage in home-based visits.

- **Lack of flexibility**
  Seniors and their caregivers often require greater amounts of time with health professionals in order to explore their complex, interdependent biological, psychological and social needs. Again, funding structures, particularly in the primary care sector, do not facilitate opportunities for seniors with complex needs to have adequate time with primary care providers.

- **Inconsistent eligibility criteria**
  Eligibility criteria across various service programs do not support the transfer of seniors from one type of service to another, as needed. Additionally, the service delivery complement (e.g., occupational therapy, physiotherapy, social work, nursing, family practice, nutrition, psychology, psychogeriatric services) made available to seniors is dependent upon the type of services for which an individual is eligible. Physiotherapists, for example, are less likely to be linked with inpatient psychogeriatric services than they are with primary care centres. Repeated assessments to test for different eligibility criteria can also put undue stress on seniors.

- **Great diversity amongst seniors often goes unrecognized**
  Seniors are an extremely diverse group in terms of their ethnicity, values, work experience, income level, family connectedness, fluency in English and health status. Policies, legislation, regulations and funding need to reflect the unique needs of seniors as well as account for the great diversity of needs that exists amongst this group.

Policy, funding and regulatory structures could better support collaborative care for seniors in the following ways:

- Develop a strategic framework for mental health services for seniors.
- Provide support for the identification and development of core structures that address the complexity of seniors' health needs.
- Make eligibility criteria flexible across the age span and stages of illness.
- Dedicate funding and policies to address the unique needs of seniors.
- Funding must be more reflective of equal expertise across various stakeholder groups integral to addressing seniors' mental health needs.

Evidence–based research

> *"I don't care how much you tell people, or even get them to a level of skill in the educational [and training] program, if the world practice does not support [collaborative care] through mentoring and through valuing it, then it isn't going to happen. It's going to get rubbed out instead of rubbed in."*
>
> *Toolkit participant*

Randomized control trials have demonstrated that enhanced care of major depression improves a consumer's ability to function and is more cost effective than usual care over the long term.

Unützer et al (2002) describe **IMPACT (Improving Mood-Promoting Access to Collaborative Treatment)**, a collaborative care intervention/management program for late-life depression. The intervention provided 12-month access to a depression care manager who offered education, care management and either brief psychotherapy for depression or support of antidepressant treatment management by the primary care physician. The model was found to be significantly more effective in reducing depressive symptoms than usual care for depression in primary care practice. Intervention patients also experienced greater rates of depression treatment, more satisfaction with depression

care, lower depression severity, less functional impairment and better quality of life than patients receiving usual care.

McCusker et al have conducted a feasibility study (funded by CIHR and, as yet, unpublished) of a depression management intervention for seniors in primary care: **Project DIRECT (Depression Intervention via Referral, Education and Collaborative Treatment)**. This intervention is adapted from the IMPACT model, with modifications for the Canadian primary care context. Patients were screened for the study using the PHQ-2. The SCID interview for major depression was conducted by telephone; 68 patients were randomized to usual care or intervention (delivered by depression care practitioners, who offered medications and/or PST). This group is planning a multi-site RCT of the intervention delivered primarily by telephone. See Appendix D (Richness of collaboration) for contact information.

The **Outcome-Based Treatment Plan (OBTP)**, an integrated assessment, treatment planning and outcomes measurement system was compared to usual practice for depression in late life (Brown et al, 2001). The OBTP was designed for use by mental health centre and home health agency clinicians to guide assessment and treatment practice and to capture change over time. Results indicated that the use of OBTP improved clinicians' practice in functioning, symptoms and support assessment domains.

The PROSPECT intervention is described as an effective collaborative approach to managing late-life depression in primary care. The PROSPECT intervention is a depression care manager (supported by a mental health specialist) who assists primary care physicians by providing timely/targeted, consumer-specific clinical strategies and by encouraging consumer compliance with treatment through education and support (Reynolds, 2003).

Evidence-based research pertinent to collaborative care with seniors

- Consultation and liaison is better than consultation only.
- Depression case managers are better than usual care.
- Outcome-based treatment planning is better than usual practice.
- Location within target community is better than outside location.

There is clearly a need for more evidence–based research on collaborative practice for seniors with mental health needs. Given the relative paucity of literature in this area, overarching best practice guidelines can also guide programs in the implementation of collaborative care models specific to seniors with mental health issues. The following provide guidelines for the delivery of services that address the complex, interdependent

biopsychosocial needs of seniors with mental health issues. These guidelines draw on evidence-based research within the field.

Best practices in the primary care system depend on co-ordination and collaboration among caregivers and service providers with as much integration and continuity of service flow as possible. One model that could facilitate the development of such practices is *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* (Health and Welfare Canada, 1988). The *Guidelines* were developed by Health Canada as a planning document to guide communities in developing a comprehensive system to address the mental health needs of older adults. The *Guidelines* focus, in part, on the importance of collaborations and linkages amongst primary social and health services and specialty geriatric mental health services. The vision is broad and identifies, for example, nutrition, housing, caregiver and medical needs as important components of a holistic approach that includes mental health promotion, support, prevention and treatment.

The *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities* (BC Ministry of Health, 2002) provide a template for the organization of mental health services for older adults that spans the primary, secondary and tertiary care systems. These *Guidelines* were developed through consultation with older adults, family caregivers, volunteers, psychogeriatric specialists, health care professionals and organizations interested in seniors with (or at risk for) mental health problems. The *Guidelines* are a set of principles and values that should underpin the care of older adults with mental health problems. Relevant to this discussion are the cornerstones of **consumer centredness**; **collaboration** with health care providers (professional and non-professionals) and with health and social services, in the primary care system; the use of **interdisciplinary teams**; the use of a **biopsychosocial model of care**; community **outreach, including home visits**; **support and education for family caregivers**; **consultation and education to care providers**.

It is important to note that due to the complex and diverse needs of seniors, collaboration has always been an essential component of geriatric mental health care and the foundation upon which effective teams function.

Community needs

> *"I feel that as people get older, and lose a lot of their confidence and their security, I feel a lot of the older people that's why they become depressed and they get lonely, because of nobody coming, nobody visiting."*
>
> *Toolkit participant*

- **Limited capacity across community sectors to meet unique health care needs of seniors with mental health needs**
  There is a tremendous need to develop the capacity of various sectors to better address the unique and complex needs of seniors with mental health needs. Collaborative care initiatives need to incorporate activities designed to educate the public about the unique needs of seniors, risk factors, and available resources and supports.

- **Limited opportunity for community development within health services**
  Formal health services have limited opportunity to engage in large-scale activities aimed at community development as these activities tend not to involve direct care. Hence, any community development that does occur is limited to opportunities that arise within the context of direct care (e.g., informing one landlord about risk factors to look for in seniors). Although this approach to development is beneficial at an individual level, it fails to be effective on a community-wide level (e.g., informing people across multiple sectors about risk factors to look for in seniors).

Building community capacity to support seniors with mental health needs requires collaboration and partnerships within the following sectors:

- Housing
- Transportation
- Education
- Social support (volunteers and community-based organizations)
- Financial support services
- Community seniors' leaders

Activities to increase community development

- Hold regular town hall meetings and invite a broad section of the community.
- Identify senior leaders within your community to provide a bridge between the specific target population and the broader community.
- Incorporate representation from a broad sector of the local community on organizational boards and program committees.
- Conduct a needs assessment to better understand the unique needs for capacity development in your community.
- Seek out students from local universities and colleges for community development or evaluation practicum placements.
- Apply for funding to carry out and evaluate a community development project specific to your local area.
- Seek membership on community boards.

Planning, implementation and evaluation

Planning

When planning collaborative care initiatives for seniors with mental health needs, it is important to think broadly about groups of interest (particularly seniors and families themselves) and to include them in the planning process through participation on organizational boards and steering committees, service agreements and the development of collaborative frameworks for dialogue, discussion and direction.

Implementation

Implementation of collaborative care initiatives for seniors must include active collaboration with pertinent care partners including consumers, family members, family physicians, nurses, psychologists, long-term care facilities, pharmacists, dietitians, occupational therapists, psychiatrists, home care, peer support groups, day programs, etc. Staffing must address the unique needs of seniors experiencing mental health issues - specialist mood case managers and psychogeriatric resource consultants are two examples.

Monitoring and evaluation

The following methods of monitoring and evaluation are suggested for collaborative mental health initiatives for seniors:

- Track the consultative process with representative seniors, consumers and the partners in the collaborative.
- Track the questions asked by the primary care practitioners over time.
- Assess the needs of the local community to provide support for seniors' mental health needs before and after the geriatric collaborative has been established.

Qualitative questions may measure changes in providers' understanding of the collaborative process including perception of increases in:

- Knowledge of diagnosis, treatment and referral sources for seniors with mental health issues
- Skill in diagnosing, treating and referring seniors with mental health issues
- Application of knowledge and skills relevant to the diagnosis, treatment and referral of seniors with mental health issues
- Frequency of linkages with care partners
- Richness of linkages with care partners

Quantitative questions may measure:

- Number and type of direct and indirect consultations
- Number of formal educational sessions and evaluations of effectiveness
- Numbers of liaisons with community services and their effectiveness

An evaluation can also measure the ***satisfaction*** of:

- Consumers/family members/caregivers with services provided
- Primary health care providers, mental health care providers and external partners with the collaborative process

The following measures are specific to evaluating collaborative care initiatives for seniors with mental health needs:

Symptom recognition and/or improvement

- Cognition
  - Folstein Mini Mental Status
  - 3MS
- Depression
  - PHQ9
  - GDS
- Behaviour
  - NPI
- Functioning
  - Lawton and Brodie ADL and IADL scale
  - SMAF

The "ideal" geriatric primary mental health care collaborative

The consumer/family/caregiver, a family practice network, with family physicians (with access to a form of alternate payment), registered nurses and a pharmacist

Plus

A Geriatric Psychiatry Outreach Team with geriatric psychiatrists (on a mixed fee-for-service and sessional funding blend), a neuropsychologist, registered nurses and a social worker with easy access to a clinical psychologist, a dietitian, an occupational therapist and a physiotherapist through the community health unit (but not part of the mental health team)

Plus

Local nursing home served by the family practice network (again, with access to a form of alternate payment).

- A steering committee, including all partners and representative seniors and consumers conducts a needs assessment in the community and defines the collaborative parameters.
- Partners meet once a month at the family practice network and once a month at the nursing home:
  - Cases are discussed (indirect consultation) whenever possible.
  - The Geriatric Psychiatry Outreach Team psychiatrist and case manager see consumers on that day or at a different time, either on site or in the consumer's home as needed, with a primary care staff member, wherever possible.
  - Informal education takes place through case discussions.
  - Formal education sessions are negotiated according to needs and times available.
  - Expert, opinion-based guidelines in care for dementia, delirium, depression, and suicide are followed.
  - A chronic disease management process is followed with case identification, protocols for care, identified case managers, callbacks and indicators of improvement.
- Once every 3 months, there is a 1-hour discussion of the process of collaboration and issues for improvement are documented and a plan for putting them into place written. Seniors (consumers and non-consumers) are part of the steering committee for each 3-month review.

- As part of a research project, an outside evaluator comes in once a year for 3 years to document:
  - The number of consumers discussed
  - The number of consumers seen
  - Satisfaction scales completed by a representative group of consumers, caregivers and partners
  - An examination of indicators for specific disorders, for example, depression
- The leadership of this collaborative is defined, refined and shared.

Linkages outside of the collaborative initiative with the Public Guardian's Office, transportation services, a local multicultural service group and the local health department home care services system are established to improve care for the target population.

A review of community needs is done once every 2 years to answer the questions, "Is the collaborative initiative still working? Is it valid in terms of what the community needs? Is there anything that needs to be added or subtracted based on the evaluations?"

Key issues for consideration

Consumer characteristics

1. Comprehensive assessments are needed because the population is a heterogeneous group (those with medical/neurological disorders with psychiatric symptoms, dementia, depression and anxiety). There is an important physical and psychiatric symptom interdependence which needs to be assessed on an ongoing basis.
2. Geriatrics deals with dyads of care (seniors and caregivers).
3. Geriatrics is a unique developmental stage – the final phase of life, including issues around death, dying and palliation.
4. There is a double stigma in geriatrics of anti-aging and anti-mental illness.
5. Risk assessments (tolerable and intolerable) and competency assessments are important.
6. Screening tools (e.g., for nutrition risk) are a significant part of the assessment process.

Service characteristics

1. More time is needed in care for seniors because of complicated presentations: biopsychosocial, functional and environmental.
2. Transportation is a very important issue. It suggests the need for frequent house calls, as well as the need for case managers to link with public transit as, in fact, part of the therapy for the consumer.
3. Seniors need a unique system of care with case management, interdisciplinary teamwork and connections to home physical care as well as nursing home care.
4. Collaboratives should serve local nursing homes.

Outcomes

Functional outcomes are most important in geriatrics, not symptom improvement. Functional outcomes may include an improvement of quality of life for both consumer and caregiver when the symptoms are irreversible.

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Appendix A: Expert panel

The Expert Panel is composed of individuals located in Central, Eastern and Western Canada who possess varied personal and professional backgrounds including caregiving, social work, community nursing, geriatric psychiatry, family medicine, policy analysis and program evaluation.

Martha Donnelly

Martha Donnelly is currently the Head of the Division of Community Geriatrics, Department of Family Practice, UBC and the Director, Division of Geriatric Psychiatry, Department of Psychiatry, UBC. She also organizes the enhanced skills program for mental health for family physicians in BC. Dr. Donnelly studied family practice and psychiatry at UBC and did a fellowship in geriatric psychiatry at the University of Toronto. She was the Director of the geriatric Short-Term Assessment and Treatment (STAT) Unit at Vancouver General Hospital (VGH) for 10 years. For 4 years, she was medical director of the Continuing Care Clinical Practice Unit at VGH, which included the STAT Unit, extended care units and a transitional care unit. She has participated in the development of many guidelines for BC, including *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities* (British Columbia Ministry of Health, 2002) and *Electroconvulsive Therapy: Guidelines for Health Authorities in British Columbia* (MHECCU and British Columbia Ministry of Health Services, 2002).

Geri Hinton

Geri Hinton has had a wide and varied career in health education and administration. She recently retired from the BC government as Executive Director, Office for Seniors. In that role she co-chaired the initiative across Canada to develop a national framework on aging and a strategic plan for later-life policy that would recognize the demographics of a growing and diverse older population. She also collaborated with key stakeholders to frame the legislative and policy priorities for an aging population in BC.

In 2002, Geri was the recipient of the Victoria YM/YWCA Women of Distinction Lifetime Achievement Award. In the same year, she received the Queen's Golden Jubilee Medal, for public service to the province of BC. In 2003, Geri was invested as a Dame of Grace in the Venerable Order of St. John and is currently the BC Representative to the National Priory of St John.

She has served on many local, provincial and national boards. At the present time she is a public member on the board of the College of Denturists of BC.

Geri and her husband Peter have been sailors for many years and have four children, three grandchildren, and two Burmese cats. Geri took early retirement in 2002 to provide full-time care to Peter, who has been diagnosed with Alzheimer's disease.

Salinda Horgan

Salinda is currently employed as Manager, Program Evaluation – Health Services Development, Geriatric Psychiatry Services, Providence Continuing Care Centre (GPS-PCCC), Kingston, Ontario.

Until her recent appointment at GPS - PCCC, Salinda worked as an evaluation/research co-ordinator in the community mental health field, during which time she co-ordinated two provincially-based evaluation projects: an evaluation of four Assertive Community Treatment Teams in South Eastern Ontario and a project designed to build the capacity of front-line mental health workers to engage in program evaluation for the purpose of program development. The primary activities associated with this project were the development of a workshop series and manual to be used by community mental health teams when engaging in program evaluation/development. Salinda is currently completing her PhD in Rehabilitation Science (Disability in the Community) at Queen's University. Her dissertation is an institutional ethnography examining how community integration practice in mental health becomes shaped by ruling structures that exist at organizational, systemic and social levels.

Salinda's interests include developing theory-based evaluation protocols to guide mental health service delivery, developing and testing models of knowledge transfer and diffusion of innovation operating within mental health services, increasing the capacity of mental health service providers to engage in program evaluation for the purpose of program development and developing policy and evaluation protocols to guide effective community integration practice.

Sarah Kreiger-Frost

Sarah Kreiger-Frost is a community mental health nurse for the Seniors Mental Health team of the Capital Health District in Halifax, NS. She holds a diploma in nursing from St. Martha's Hospital School of Nursing and Baccalaureate and Master's degrees in Nursing from Dalhousie University. Sarah has worked in inpatient mental health units, emergency psychiatry, day hospital programs and with mentally ill youth but has devoted the last 12 years of her practice and education to seniors' mental health. Within a multidisiplinary team, she provides a range of services to seniors in their homes, and in long-term care facilities. Her particular interest is behavioural and psychological symptoms in dementia, and Sarah takes an active role in the education of care providers at all levels.

Ken LeClair

Dr. LeClair is Professor and Chair of the Division of Geriatric Psychiatry and Clinical Director of the South Eastern Ontario Geriatric Psychiatry Services. He has experience in clinical practice, education, operational policy development and service co-ordination, and health and educational research as it relates to shared care in older adults.

He is the former Chair of the Policy Framework and Implementation Guidelines for Seniors' Mental Health, Government of Ontario, former President of the Canadian Academy of Geriatric Psychiatry and presently co-chairs the Canadian Coalition on Seniors' Mental Health.

He has provided leadership in the implementation of innovative approaches in community outreach and province-wide educational strategies and health service innovations.

He is one of the original participants and authors of the Joint Position Paper on Shared Care in Canada. He has over 15 years of knowledge, skills and experience working on behalf of seniors with mental health needs.

Penny MacCourt

Penny MacCourt MSW, PhD, has an extensive background as a social worker on a community psychogeriatric team. She is a research affiliate at the Centre on Aging, University of Victoria and also teaches in the School of Social Work. Her doctorate focused on aging, mental health and service delivery and she is currently involved in research and advocacy, provincially and nationally, in these areas. Current projects relate to models of care, policy development, aggression in long-term care and psychosocial approaches to the mental health challenges of aging. She is the co-chair of the national Seniors Psychosocial Interest Group (SPIG) which is dedicated to (1) developing and promoting a better understanding of the influences of psychosocial factors on seniors' mental health and (2) promoting increased integration of psychosocial and community approaches into the biopsychosocial model of seniors' mental health.

Appendix B: Consultation process

A strategy was developed to ensure multiple perspectives, experiences and insights in the development of this report. This strategy consisted of four steps:

- The identification of current literature relevant to the development, implementation, evaluation and sustainability of collaborative care initiatives for seniors.
- The use of qualitative methods to gather information concerning the lived experience of service users as well as practitioners attempting to develop and maintain collaborative care initiatives. A broad range of stakeholder groups were consulted including consumers/families, general mental health and specialty psychogeriatric outreach programs, general community-based mental health and primary care initiatives, individuals representing multidisciplinary professional groups (family medicine, nursing, social work, pharmacy, cultural development, research and policy and planning) and a panel of specialty geriatric experts. A total of 23 in-depth interviews were conducted with individuals located in seven provinces (Quebec, Ontario, British Columbia, Alberta, Manitoba, Nova Scotia, and P.E.I.)
- A quantitative survey of specialty geriatric and general mental health programs across three provinces (Ontario, British Columbia and Nova Scotia) was also conducted. A total of 30 interviews were completed. (See below for a list of interview participants. See Appendix F for copies of consent form, interview framework, interview guides, survey tools and analysis framework.)
- A draft of this report was presented in a workshop setting at the National Best Practices Conference: Focus on Seniors' Mental Health (Ottawa, Ontario, September 26 – 27, 2005). The workshop was designed to provide a forum for feedback from a diverse group of stakeholders from across the country, including family physicians, case managers and geriatric psychiatrists. Workshop participants were asked for their feedback on the report content and for any additional information they could provide on innovative practices in the field. The feedback received was included in the final report. It is worth noting that participants' overall impression of the report was that it reflected their experiences working collaboratively with seniors with mental health needs. See below for a list of workshop participants.

List of interview participants

Participants were selected based on their experience and expertise with the seniors population.

Two seniors experiencing mental health issues	British Columbia
Four family caregivers (also seniors)	British Columbia

Professional care providers:

Social worker (MSW)	Quebec
Pharmacist	British Columbia
Multicultural psychiatrist	British Columbia
Epidemiologist	Quebec
Occupational therapist, Team leader	Ontario
Psychotherapist	Manitoba
Health services manager	British Columbia
Policy analyst	Nova Scotia
Adult Day Program Long-Term Care Admin.	
Registered nurse	Nova Scotia
Senior policy analyst	
Adult Day Program Long-Term Care Admin.	
Director of Psychogeriatric Program (Nurse)	
Social worker (MSW)	Nova Scotia
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Family physician	Ontario
Researcher	
Social worker	

National best practices conference: Toolkit workshop participants

Participants included individuals affiliated with the following programs and organizations:

Calgary Health Region, Geriatric Mental Health Services	Calgary, AB
Centre de santé et de services sociaux Cote Soutien a domicile	Montreal, QC
Centre for Addiction and Mental Health - Healthy Aging Project	Toronto, ON
Colchester East Hants Health Authority	Truro, NS
Cornwall Hospital	Cornwall, ON
Geriatric Psychiatry Community Services	Ottawa, ON
Haliburton, Northumberland and Victoria Access Centre	Lindsay, ON
Harris & Associate	ON
Lakehead University, Centre for Education and Research on Aging & Health	Thunder Bay, ON
LOFT (Leap of Faith Together) Community Services	Toronto, ON
Mental Health Centre Penetanguishene, Geriatric Services Program	Penetanguishene, ON
Nova Scotia Department of Health, Continuing Care Branch	Halifax, NS
Paramed Home Health Care	Ottawa, ON
Peterborough Community Access Centre	Peterborough, ON
Peterborough Regional Health Centre (PASE)	Peterborough, ON
PIECES	ON
Providence Continuing Care Centre - Mental Health Services	Kingston, ON
Regional Mental Health Care- Geriatric Psychiatry	London, ON
Riverview Hospital Geriatric Psychiatry	Coquitlam, BC
St. Joseph's Hospital/Vancouver Island Geriatric Outreach Program	Comox, BC
Saskatoon Health Region	Saskatoon, SK
Seniors' Well Aware Program	Vancouver, BC
South Shore Regional Hospital Mental Health Program	Bridgewater, NS
Sunnybrook and Women's College Health Sciences Centre - Family Medicine	Toronto, ON
Tri-County Mental Health Services	Cornwall, ON
Vancouver Coastal Health, Stat Centre, VHHSC	Vancouver, BC

West Park Healthcare Centre	Toronto, ON
Winnipeg Regional Health Authority- Psychogeriatrics	Winnipeg, MB

Appendix C: Extended literature review

Overview

It is currently estimated that 13% of the population is 65 years of age and older; by 2011, it is estimated that seniors will represent over 15% of the population (Statistics Canada, 2002). Older adults experience unique physical, psychological and social changes that individually and together may challenge their mental health, sometimes resulting in mental illness. It is estimated that 20% of adults over age 65 have a mental disorder, including dementia, depression, psychosis, bipolar disorders, schizophrenia, and anxiety disorder (Jeste et al, 1999). In comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha & Satlin, 1997; Schmitz-Scherzer, 1995) and 50% per cent of suicide attempts by seniors are successful (Gomez & Gomez, 1993).

Most mental health care, including treatment, takes place in the primary care and long-term care sectors and is provided by family physicians, nurses, rehabilitation therapists, social workers, psychologists, etc. (Dugué, 2003). Although many mental health problems can be managed without direct consultation from specialists, the complex presentation and situations of some older adults can make their mental health difficult to assess and manage. There is evidence to indicate that depression (Banerjee, 1998; Brown et al, 2001), substance use disorders (Fischer et al, 2003) and, in particular, suicidality (Préville et al, 2005) are poorly detected and managed in the primary care sector.

Some of the factors associated with mental health challenges in late life which may make assessment and management difficult, necessitating collaboration between primary and geriatric mental health services, are as follows:

- Chronic pain, multiple losses, bereavement and social isolation are all common among depressed older adults in primary care (Unützer et al, 2002).
- Older adults are at increased risk for poor nutrition due to age-related physiological and psychosocial changes, as well as the added toll of chronic disease. All of these may have a negative impact on adequate food intake and impact on mental health. Health care providers must identify and address nutrition-related problems in a timely manner to correct nutrient imbalances and restore nutritional as well as mental health in this population (Curran, 1990).
- Caregiving women, especially those caring for an individual with dementia, are at increased risk for depression (Livingston et al, 1996). Caregivers who receive little social support and who feel burdened and/or lonely are more likely to experience depression than caregivers with good social support (Clyburn et al, 2000).

- Multicultural and generational attitudes/values can be a barrier to service, affecting how older adults communicate about their mental health and how issues should be addressed (Unützer et al, 2002).
- Ethical and legal issues related to competency, often associated with living at risk, driving, self-neglect, elder abuse, etc. require specialized knowledge and skills for assessment and management.
- Substance abuse or misuse and/or developmental disability have unique social and service dimensions and can mask or masquerade as mental illness or occur concurrently (Health Canada, 2002).
- With advancing age, the prevalence of most chronic conditions increases, as does the prevalence of physical problems and dependency (Wilkins & Park, 1996). The presence of comorbid, chronic medical illness can be a confounding factor in the presentation of older adults (Blazer, 2000) and can exacerbate or cause depression (Fischer et al, 2003). Some medications for the treatment of medical conditions can cause or exacerbate psychiatric symptoms (Unützer et al, 2002).
- Physiological changes associated with aging need to be taken into account for any pharmacological treatment, including psychiatric (Health Canada, 2002).
- Older adults have expressed that the mental health challenges they face could be better met if psychosocial approaches such as support groups and social activities, housing, transportation, health care promotion and prevention, wellness and a holistic model of care were implemented (MacCourt &Tuokko, 2005).
- Changes that occur as part of the normal aging process affect psychological and social well-being in some seniors (e.g., retirement, reduction in income level, physical changes, losses and changes in social support networks) (Lepine & Bouchez, 1998; Samuelsson et al, 1998). Some seniors may become lonely, depressed or even suicidal (Forbes, 1996; Sokero et al, 2005).
- Physical health status is strongly correlated with loneliness (Dugan & Kivett, 1994; Penninx et al, 1999). Loneliness in later life is problematic as it is closely related to depression, which, in turn, is closely related to suicide (Rokach, 2000).
- Psychosocial factors are related to suicide risk, high levels of emotional disturbance, being depressed or anxious, having one or more physical illnesses, a history of stroke, alcohol abuse, being widowed, living alone, fear regarding an inability to influence one's own dying and a certain weariness of life (Schmitz-Scherzer, 1995; Scocco et al, 2001; Sokero et al, 2005; Sullivan et al, 2005).
- Older adults in rural communities have limited access to geriatric mental health specialists and supportive services (e.g., day programs, housing). Collaborations

between services and personnel within rural communities and those outside of the community are important to provide comprehensive care (McGee et al, 2005).

Together, these issues underline the complex intermingling of factors related to older adults' mental health and the importance of approaches that focus on the individual, their relationships and the social context in which they live, singly and together. Clearly, collaborations are required between disciplines, agencies and the primary care and geriatric mental health sectors to promote and support older adults' mental health, and to address mental health issues and illness.

Models and strategies

Best practices in the primary care system depend on co-ordination and collaboration among caregivers and service providers with as much integration and continuity of service flow as possible. One guide to the development of such practices is the *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* (Health and Welfare Canada, 1988). The *Guidelines* were developed by Health Canada as a planning document to guide communities in developing a comprehensive system to address the mental health needs of older adults. The *Guidelines* focus, in part, on the importance of collaborations and linkages amongst primary social and health services and specialty geriatric mental health services. The vision is broad and identifies, for example, nutrition, housing, caregiver and medical needs as important components of a holistic approach that includes mental health promotion, support, prevention and treatment.

*The Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities (*BC Ministry of Health Service, 2002) provide a template for the organization of mental health services for older adults that spans the primary, secondary and tertiary care systems. These *Guidelines* were developed through consultation with older adults, family caregivers, volunteers, psychogeriatric specialists, health care professionals and organizations interested in seniors with (or at risk of developing) mental health problems. The *Guidelines* are a set of principles and values that should underpin the care of older adults with mental health problems. Relevant to this discussion are the cornerstones of **consumer centredness**; **collaboration** with health care providers (professional and non-professionals) and with health and social services in the primary care system; the use of **interdisciplinary teams**; the use of a **biopsychosocial model of care**; community **outreach, including home visits**; **support and education for family caregivers**; **consultation** and **education** to care providers.

Monks et al (2004) provide a description of a psychogeriatric outreach program in rural BC that is a good example of collaborative care between geriatric mental health and primary care services. Their practice is based on Caplan's (1993) mental health consultation liaison model (i.e., consumer-centred, consultee-centred and program-centred consultations) and is consistent with the *Guidelines for Best Practices* (2002) and

with the consensus statement of the World Health Organization and the World Psychiatric Association (Wertheimer, 1997). Responsibility for patient care belongs to primary care catchment resources, which the program supports by reinforcing and enhancing existing skills and by collaborating regarding prevention and care. The program has established clinical, educational and research and community partnerships. Somers (1998) describes the community collaborative planning model used in organizing catchment resources.

Unützer et al (2002) suggest that collaboration between health care providers and community organizations (e.g., religious institutions, seniors' centres, public service agencies, senior housing facilities, consumer organizations) can create and foster social opportunities/support/milieu for older adults at risk of or experiencing mental health problems. Collaborative care between primary and secondary service providers can be fostered through joint training. Integrating training experiences of physicians with mental health specialists and the training of mental health specialists with physicians promotes the teamwork necessary for collaboration (Gallo & Coyne, 2000).

The Chronic Care Model can be applied to collaboration between primary and geriatric mental health services. Unützer et al (2002) identify a number of chronic disease management models that have demonstrated effectiveness in improving the quality and outcomes of depression care in mixed-age primary care populations. He suggests that care for older adults with depression may be improved by adapting components of the chronic care disease management model. These could include education of primary care providers, depression screening protocols, an increased focus on patient education and activation, and practice-based provider support mechanisms such as effective reminder systems and physician extenders who can help with a) patient education, b) outcome tracking and c) improved access to mental health professionals who collaborate with the family physician.

Stock et al (2004) describe a Senior Health and Wellness Centre (SHWC) in Oregon based on the Chronic Care Model that has many of the elements important to collaborative care of older adults with mental health problems. The SHWC model focuses on the care of frail elders with multiple, interacting chronic conditions and the management of chronic disease in a healthier older population. A consumer-centred approach was used to identify service needs. The model emphasizes team development, integration of evidence-based geriatric care, site-based care coordination, longer appointment times, "high touch" service qualities, utilization of an electronic medical care record across care settings and a prevention/wellness orientation. Their practices address the interrelationship of seniors' issues (also relevant to a biopsychosocial, spiritual approach to mental health) including nutrition, social support, spiritual support, caregiver support, physical activity, medications and chronic disease. The authors describe the development of their model

and share lessons learned which would be useful to those designing collaborative care projects related to seniors' mental health.

Bartels (2004) provides an overview of selected research findings on the prevalence and causes of medical comorbidity in schizophrenia and other severe mental illness (SMI), challenges in providing quality health care and suggested models of care for older adults with SMI. He describes an integrated model of psychiatric rehabilitation and health management for older adults with SMI that uses a nurse healthcare case manager who monitors, facilitates and co-ordinates primary medical care. The model is designed to simultaneously address psychiatric and medical needs through rehabilitation and health care management that enhance independent functioning and health outcomes. A pilot study of the model showed high rates of preventative care, detection of undertreated or new medical disorders and improved health management skills by clients after 2 years of intervention.

Collaborative care is effective for older, depressed patients. Models vary, but principles include the use of multi-faceted interventions, identifying a case manager, and flexible collaboration between primary and secondary (specialized) care to improve access to geriatric psychiatrists (Banerjee et al, 1996; Unützer et al, 2002; Waterreus et al, 1994).

Baldwin et al (2003) have developed a guideline for the management of late-life depression in primary care based on best practice. The guidelines recommend collaborative care between primary and geriatric mental health services for the management of older, depressed primary care patients.

There is evidence that the work of specialized depression care managers within the primary care sector can improve both depression outcomes and quality of life for depressed older adults. Randomized control trials have demonstrated that such enhanced care of major depression improves a consumer's ability to function and is more cost effective than usual care over the long term (Von Korff & Goldberg, 2001). Unützer et al (2002) describe IMPACT (Improving Mood - Promoting Access to Collaborative Treatment), a collaborative care intervention/management program for late-life depression. The intervention provided access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a family physician. The care manager offered education, care management, and either brief psychotherapy for depression or support of antidepressant treatment management by the family physician. The IMPACT collaborative care model was found to be significantly more effective in reducing depressive symptoms than usual care for depression in primary care practice. Intervention patients also experienced greater rates of depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment and greater quality of life than patients receiving usual care. Depression case managers

have also been used effectively to increase adherence to depression medications with depressed patients with diabetes or congestive heart failure (Donie, 2004).

A number of recent reviews (Callahan, 2001; Klinkman & Okkes 1998) have concluded that training of primary care providers, provision of informational support and depression screening of older adults may improve recognition and initiation of depression-specific treatments in primary care.

In a randomized clinical trial, an integrated assessment, treatment planning and outcomes measurement system (Outcome-Based Treatment Plan or OBTP) was compared to usual practice for older adults with mental disorders (Bartels et al, 2002). The OBTP was designed for use by mental health centre and home health agency clinicians to guide assessment and treatment practice and to capture change over time. Results indicated that the use of OBTP improved clinicians' practice behaviour in assessing functioning, symptoms and support for older adults with mental disorders.

The PROSPECT intervention is described as an effective collaborative approach to managing late-life depression in primary care. The PROSPECT intervention is a depression care manager (supported by a mental health specialist) who assists primary care physicians by providing timely, targeted, patient-specific clinical strategies and by encouraging patient compliance with treatment through education and support (Reynolds, 2003).

Finally, Llewellyn-Jones et al (1999) have provided strong evidence that a multifactorial intervention for late-life depressive illness has a measurable beneficial effect.

To conclude, effective collaboration between the primary system and secondary geriatric mental health services can maximize older adults' quality of life and the effective utilization of resources, and there are principles and models to guide practice.

Appendix D: Positive practice initiatives

Accessibility

Central point of access

The Winnipeg Regional and Alberta Health Authority have both established a central point of access for providers, consumers and caregivers to obtain information on seniors with complex needs.

Mobile Response Team (Alberta)

Contact: Kim Frache at kfrache@telus.net

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Prevention, Intervention, Education (P.I.E.) Program

This program is an adaptation of the Gatekeepers Project for seniors. The program trains a broad spectrum of community volunteers (e.g., taxi drivers, landlords, librarians, family members, neighbours) to identify risk factors in seniors and to link potentially at-risk individuals with the appropriate resources. Contact: Nona Moscovitz, CLSC Rene-Cassin, at nmoscovi@sss.gouv.qc.ca.

Psychological counselling

By embedding psychological counselling services into primary care settings, "people come and they may see their neighbour in the waiting room but they can just say they are coming to see their doctors – no-one needs to know that they are coming to see the counsellor". Contact: Katheryn Getz, Tachevalade, at kgetz@wrha.mb.ca.

Wellness for Independent Seniors (W.I.S.) Program

This program focuses on wellness for seniors by facilitating independence through community linkages. Contact: Dr. Nick Pimlot, Women's College Hospital, Toronto, ON.

Collaborative structures

Care for Elders modules

An example of an education-based training program specific to seniors' mental health issues. Contact: Dr. Martha Donnelly at UBC Family Practice, marthad@interchange.ubc.ca

Community Nutrition Program

Vancouver Coastal Health Authority, Richmond Health Services

- Work with health professionals (e.g., community health nurses), people who work in food banks, meal program providers, home/family support workers, social workers, teachers, provincial and federal government, and school/facility administrators
- Assesses individual or community nutrition needs
- Consults with community members and professionals

The Community Nutrition Team focuses on

- Health promotion (Foodbank, community kitchens, seniors, heart health)
- Public and professional education
- Consultation, assessment, counselling
- Promotion of healthy eating.

For more information, contact:
Kay Wong, Community Nutritionist, Community and Family Health (Richmond Health Department), 7000 Westminster Highway, Richmond, BC, Tel: 604-233-3150.

House of Cards
Dynamic multidisciplinary team brought together around one individual for their unique needs with a specific issue of immediate importance. Contact: Sarah Kreiger-Frost, QEII, Health Sciences Ctr, Halifax, NS, at kreigers@cdha.nshealth.org

Interdisciplinary practicums
Practicums for pharmacy, family practice, nutrition, social work, occupational therapy, physiotherapy, nursing, residents specific to seniors with mental health needs (Counsell et al, 1999)

P.I.E.C.E.S. (Physical, Intellectual, Emotional, Capabilities, Environment, Social)
Educational training in caring for seniors with mental health needs designed for long-term care, acute care and emergency room staff. Contact: Diane Harris, PIECES Co-ordinator, at dharris@sympatico.org

Raising the P.I.E.C.E.S. Flag
Funding made available to facilities to allow in-house staff time to participate in this educational initiative. Contact: Gail Grant, Peterborough Regional Health Centre at ggrant@prhc.on.ca

Support and Education for Practitioners on the Elderly with Disorders in Mental Health (S.E.E.D.) Project
Education, consultation and mentoring for family physicians in the diagnosis, treatment, referral and support of seniors with mental health needs. Contact: Dr. Ken Le Clair, Providence Continuing Care Centre, Ontario, at leclairk@pccchealth.org

Richness of collaboration

Co-located primary care
Centres for seniors' health with integral stakeholders co-located. Contact Katheryn Getz, Tachevalade, kgetz@wrha.mb.ca

Direct Care Liaison Team
Facilitating transition of complex care consumers to long-term care. Contact: Bonnie Kotnik, St. Joseph's Healthcare at bonnie.kotnik@sjhclondon.on.ca

DIRECT Project
Research project involving depression care manager for seniors in primary care mental health. Contact: Jane McCusker, Quebec, at jane.mccusker@mcgill.ca

Elderly Outreach Service
Short-term assessment and treatment services for seniors. Consults with broad range of professionals and provides education for families, caregivers, home support workers and health professionals about care. Contact: Elderly Outreach Service, 2828 Nanaimo St., Victoria, BC, V8T 4W9

Geriatric Psychiatry Outreach Team, Raven Song partnership
An interdisciplinary mental health team partnering with a community interdisciplinary health care team for mental health support. Contact: Dr. Martha Donnelly at marthad@interchange.ubc.ca

Fellowship Outreach in Geriatric Psychiatry
Rural outreach team collaborating with university psychiatry programs at McMaster and Queen's Universities. Contact: Louise Carrier, Ontario Fellowship Outreach or Gail Grant, PRHC Hospital, at ggrant@prhc.on.ca

PROSPECT Model
Mental health case manager on-site of family physician practice. Contact Leah Robichaud, Providence Continuing Care Centre, at robichal@pccc.kari.net

Psychogeriatric outreach
Nurse practitioner and psychogeriatric outreach team members co-visit with consumers in their homes. Contact Patti Dixon-Medora, Providence Continuing Care Centre, at dixonmep@pccchealth.org

Support worker/navigator
Support worker/navigator assigned to help seniors facilitate access to resources in Alberta Health Authority.

Consumer centredness

Caregiver Training Programs
Prince Henry Dementia Caregivers' Training Programme (Brodaty et al, 1997)

Community Mapping Program
A program in Burnaby, BC designed to ask seniors' opinions on what would help their city or town be a good place to age.

Home from Hospital Program
Peer and professional support for seniors recently discharged home from hospital who are living alone. Contact: http://www.seniorsservingseniors.bc.ca

Senior Peer Counsellors
Peer seniors volunteer to visit and spend time with other seniors.

Seniors Serving Seniors
Links seniors with community and government services through a directory of services, information and referral telephone help line service. Contact: http://www.seniorsservingseniors.bc.ca

Vancouver Community Kitchens Project
This project is led by peers and offers communal cooking programs that address all kinds of social, economic and nutritional barriers. Types include multicultural kitchens, vegetarian kitchens, kitchens for people who are living with diabetes, kitchens for new immigrants, kitchens for people who are single and are tired of cooking for one, kitchens for seniors, canning kitchens, kitchens for people with a disability, family kitchens, single room occupancy hotel kitchens, and gourmet kitchens.

Appendix E: Websites

http://www.seniorsmentalhealth.ca
Seniors' psychosocial interest group aimed at multiple disciplines, front-line practitioners and program managers; provides examples of innovative practice in psychosocial resource manual. Seniors' mental health policy lens provides an analytical tool for anyone wanting to screen a program (current or planned) in terms of its effect or appropriateness from a seniors' mental health perspective.

http://www.agingincanada.ca
Aimed at multiple disciplines, mainly practitioners concerned with seniors, addiction issues and mental health – rich in practical tips.

http://www.cagp.ca
The Canadian Academy of Geriatric Psychiatry is a national organization of psychiatrists dedicated to promoting mental health in the Canadian seniors population through the clinical, educational and research activities of its members.

http://www.ccsmh.ca
The mission of the Canadian Coalition for Seniors' Mental Health is to promote the mental health of older persons/seniors by connecting people, ideas and resources.

http://www.bcpga.bc.ca
The British Columbia Psychogeriatric Association is a professional multidisciplinary interest group founded in 1997 by grassroots clinicians working in the field of mental health in older adults. The BCPGA is comprised of members interested in sharing their experience with the ultimate goal of benefiting persons suffering from a mental disorder in their later life.

http://www.alzheimer.ca/
The Alzheimer's Society of Canada identifies, develops and facilitates national priorities that enable its members to effectively alleviate the personal and social consequences of Alzheimer's disease and related disorders. The Society promotes research and leads the search for a cure.

http://www.dietitians.ca/ or http://www.nutritionrc.ca/
The Dietitians of Canada or the Nutrition Resource Centre websites offer resource sections that contain a variety of tools and practical tips for nutrition for the geriatric population. Consumers and health professionals have access to these resources.

Appendix F: Tools and resources

Interview framework

Conceptual Framework for Understanding the Process of Creating and Sustaining Shared Care Initiatives for Seniors Experiencing Mental Health Issues

Overarching Question: What are the most important factors involved in establishing and maintaining shared mental health care for seniors?						
I.	**Description of Initiative**	**Funding**	**Policies, Legislation and Regulations**	**Evidence-based Research**	**Community Needs**	**Recommendations**
Accessibility	Describe attempts that you made both when *establishing* the initiative and in attempting to *sustain* the initiative to ensure that it was accessible to seniors	What funding structures are necessary to ensure that shared mental health care initiatives are accessible to seniors?	What policies, legislation and regulations are necessary to maximize the accessibility of shared mental health care initiatives for seniors?	What evidence-based research exists to guide us in ensuring that shared mental health care initiatives are accessible to seniors?	What resources need to be present in the community to ensure that seniors have optimal access to shared mental health care initiatives?	What are your recommendations for increasing access to shared mental health care for seniors?

Overarching Question: What are the most important factors involved in establishing and maintaining shared mental health care for seniors?						
I.	**Description of Initiative**	**Funding**	**Policies, Legislation and Regulations**	**Evidence-based Research**	**Community Needs**	**Recommendations**
Collaborative Structures	Describe the collaborative structures that you have implemented to support shared care initiatives for seniors	What funding structures are necessary to ensure the effectiveness of collaborative structures designed to *establish and maintain* shared mental health care initiatives for seniors?	What policies, legislation and regulations are needed to ensure the effectiveness of collaborative structures designed to *establish and maintain* shared mental health care initiatives for seniors?	What evidence-based research exists to guide us in how best to ensure the effectiveness of collaborative structures in *establishing and maintaining* shared mental health care initiatives for seniors?	What resources need to be present to ensure the effectiveness of collaborative structures designed to *establish and maintain* shared mental health care initiatives for seniors?	What are your recommendations for ensuring the effectiveness of collaborative structures in shared mental health care for seniors?
Richness of Collaboration	Describe how you attempted to enrich the collaboration between primary stakeholders in shared mental health care for seniors	What funding structures are necessary to ensure rich collaboration within shared mental health care initiatives for seniors?	What policies, legislation and regulations are necessary to facilitate the richness of the collaboration between primary stakeholders involved in providing shared mental health care to seniors?	What evidence-based research exists to guide us in how best to facilitate rich collaboration between primary stakeholders in the *establishment and maintenance* of shared care initiatives for seniors?	What resources need to be present in the community to facilitate rich collaboration between primary stakeholders in the *establishment and maintenance* of shared mental health care for seniors?	What are your recommendations for enriching the experience of shared mental health care for seniors?

Overarching Question: What are the most important factors involved in establishing and maintaining shared mental health care for seniors?						
I.	**Description of Initiative**	**Funding**	**Policies, Legislation and Regulations**	**Evidence-based Research**	**Community Needs**	**Recommendations**
Consumer Centredness	Describe how you attempted to ensure that the shared mental health care initiative followed the principles of consumer centredness	What funding structures are necessary to ensure that shared mental health care initiatives follow the principles of consumer centredness?	What policies, legislation and regulations are necessary to ensure that shared care initiatives follow the principles of consumer centredness?	What evidence-based research exists to guide us in how best to follow the principles of consumer centredness?	What resources need to be present in the community to ensure that share mental health care initiatives follow the principles of consumer centredness?	What are your recommendations for ensuring that shared mental health care initiatives for seniors follow the principles of consumer centredness?
Planning, Staffing, Implementation, and Monitoring and Evaluation	Describe how you planned, staffed and implemented your shared care initiative Describe how you monitor and evaluate your shared care initiative	What funding structures are necessary to ensure effective planning, staffing, implementation, and monitoring and evaluation?	What policies, legislation and regulations are necessary to aid shared mental health care initiatives for seniors in their planning, staffing, implementation, and monitoring and evaluation activities?	What evidence-based research exists to guide us in how best to plan, staff, implement, and monitor and evaluate shared mental health care activities?	What resources need to be present in the community to aid shared mental health care initiatives in their planning, staffing, implementation, and monitoring and evaluation activities?	What are your recommendations for effective planning, staffing and implementation of shared mental health care initiatives for seniors? What tools do you recommend for monitoring and evaluating shared mental health care initiatives for seniors?

Overarching Question: What are the most important factors involved in establishing and maintaining shared mental health care for seniors?						
I.	**Description of Initiative**	**Funding**	**Policies, Legislation and Regulations**	**Evidence-based Research**	**Community Needs**	**Recommendations**
Recommen-dations		What funding structures do you recommend to facilitate the establishment and maintenance of shared mental health care initiatives for seniors?	What policies, legislation and regulations do you recommend overall for successful implementation and sustainability of shared care initiatives for seniors?	What evidence-based research do you recommend as primary to the implementation of shared mental health care for seniors?	What activities do you recommend to increase the necessary resources in the community to aid in the implementation of shared mental health care for seniors?	

Consent form

CCMHI – TOOLKIT PROJECT

(Geriatric Expert Panel)

CONSENT FORM

I _____, agree to participate in an interview with _____ for the purpose of providing experiential knowledge regarding collaborative mental health care for seniors experiencing mental health issues. I have been made aware that the information I provide will be tape recorded and transcribed in order to ensure that the feedback I give is captured in its entirety. I understand that the feedback I give to the project will be synthesized with information gathered from other key informants in the field into a report that will be submitted to the Canadian Collaborative Mental Health Initiative Toolkit Project on behalf of the CCMHI Toolkit – Geriatric Expert Panel. I have also been informed that my name will not be used in the report or attached to any particular piece of information. Finally, I understand that the Canadian Collaborative Mental Health Initiative's goal is to encourage more collaboration among primary health care professionals, mental health care providers, consumers, families and community organizations and that this initiative is being funded by Health Canada's Primary Health Care Transition Fund.

_____ _____

Interviewee Signature Date

_____ _____

Interviewer Signature Date

Interview guides (specialty geriatric/general mental health programs, consumer/family/caregiver, policy planners):

Specialty geriatric/general mental health programs interview guide

Our aim is to understand, from the perspective of the field, what are the most important factors involved in establishing and maintaining collaborative mental health care for older adults with mental health needs.

I would like you to think about your own specific experiences in facilitating collaborative care for older adults with mental health needs when answering these questions:

1. First, I would like to ask you about Accessibility

   Please discuss issues around accessibility that may arise when engaging in collaborative care on behalf of seniors.

   - How does funding affect access to collaborative/shared care?
   - What policies are necessary to maximize access to collaborative/shared care?
   - What research/best practices inform how you think about accessibility and collaborative/shared care?
   - What particular needs does your community have regarding accessibility to shared care? (i.e., geography, culture, # of FPs)
   - In what ways have you attempted to be creative in order to overcome barriers to accessibility?

2. Next, I would like to ask you about Collaborative Structures.

   Can you tell me about ways that you have attempted to strengthen collaborative structures (i.e., administration, location, shared paper work)?

   - How have funding issues affected attempts to strengthen collaborative structures between primary care and mental health?
   - What policies are necessary to maximize the effectiveness of collaborative structures?
   - What research/best practices inform how you think about collaborative structures between primary care and geriatric mental health?
   - What is unique about your community when it comes to developing collaborative structures between primary care and geriatric mental health?
   - In what ways have you attempted to be creative in order to overcome barriers to creating collaborative structures?

3. I would now like you to comment on issues related to the Richness of Collaboration.

   Do you have any examples of how you may have tried to enrich collaboration in practice between primary care physicians and the Geriatric Mental Health Team?

- What research/best practices inform how you think about rich collaboration between primary care and geriatric mental health?
- What unique aspects of your community affect the nature of collaboration between primary care and geriatric mental health?
- In what ways have you attempted to be creative in order to overcome barriers to rich collaboration?

4. We will now turn to issues related to Consumer Centredness.

   Please comment on principles of consumer centredness and how they relate to collaborative care practices.

- How does funding affect attempts to involve consumers and family members in aspects of care, program development, evaluation and peer support?
- What policies are necessary to maximize the level of consumer/family involvement in these areas?
- What research/best practices inform how you think about consumer centredness?
- What are the unique needs of your community that impact on consumer centredness as it relates to collaborative/shared care?
- In what ways have you attempted to be creative in order to overcome barriers preventing consumer centredness?

5. Finally, I will ask you to comment on issues related to planning, staffing, implementation and monitoring and evaluation.

   a) *Do you have suggestions related to the planning, staffing and implementation of collaborative care activities?*

- How does funding affect planning, staffing and implementation of collaborative care initiatives?
- What policies aid the planning, staffing and implementation process?
- Are there unique needs within the community that affect planning, staffing and implementation of collaborative/shared care activities?
- In what ways have you attempted to be creative to overcome barriers related to planning, staffing and implementation?

   a) *Do you have suggestions regarding the monitoring and evaluation of collaborative care activities?*

- What research/best practices inform how you monitor, evaluate collaborative/shared care activities?
- What tools/methods do you use to monitor and evaluate collaborative/shared care activities?

6. Do you have any further recommendations or comments related to the implementation and sustainability of collaborative/shared mental health care?

Consumer/family/caregiver interview guide

1. If you had a mental health concern about yourself or the person you are caring for, whom would you call for an appointment to discuss the problem?
2. If you saw your family doctor and were advised that you should have a referral to a geriatric psychiatrist for an examination and assessment, would you accept the referral? If not, why not?
3. If the geriatric psychiatrist had other members of the health team (such as a social worker, an occupational therapist or a nurse present, do you feel that you could share your concerns with them?
4. With respect to your progress and recovery, is it important to you that the members of this team follow your progress and check in with you at regular intervals?
5. Do you think that a team approach (shared care) to your health needs would mean a better outcome for you?
6. Would you be more comfortable talking about the mental health problem in your own home?
7. Are you currently on any medications?
   Yes
   No
8. Who provides you with the most information about your medications?
   a) A doctor
   b) A pharmacist
   c) A friend/family member

Policy/planner interview guide

We are hoping to glean from you a better understanding of the challenges and opportunities that exist for collaborative care at a policy level. We are particularly interested in how policies affect the nature of collaborative care experienced by seniors with mental health needs.

1. Do current policies support collaborative care for seniors?

2. From a policy perspective, what are the current barriers to collaborative care for seniors with mental health needs, particularly in the following areas?
   - Accessibility
   - Collaborative structures
   - Richness of collaboration
   - Consumer centredness
   - Planning, staffing, implementation
   - Monitoring and evaluation
   - *(This section will function to prompt interviewee about areas not mentioned in response to above question)*

3. What opportunities might there be for creating policies to better facilitate collaborative care for seniors with mental health needs?

Survey tools (specialty geriatric programs, general mental health programs, policy planners):

Questionnaire – specialty geriatric/general mental health

Our aim is to understand, from the perspective of the field, what are the most important factors involved in establishing and maintaining collaborative mental health care for ***older adults with mental health needs***.

When answering the following questions, please think about your own ***experiences in the field***, ***barriers*** that you encounter and ways you have been ***creative*** in overcoming these barriers:

*In what ways do you ensure that collaborative care services are **accessible** to older adults experiencing mental health issues?*

_____
_____
_____
_____
_____
_____

*In what ways have you attempted to strengthen **collaborative structures** between primary care providers and the mental health team working on behalf of older adults with mental health needs?*

_____
_____
_____
_____
_____
_____

*How do you ensure **richness of collaboration** between primary care providers and the mental health team working on behalf of older adults with mental health needs?*

_____
_____
_____
_____
_____
_____

How do you ensure that collaborative practices follow the principles of ***consumer centredness*** particularly in relation to older adults with mental health needs?

_____
_____
_____
_____
_____
_____

What unique ***planning, staffing and implementation*** initiatives have you implemented in order to promote collaborative care between primary care providers and the mental health team working on behalf of the older adult with mental health needs?

_____
_____
_____
_____
_____
_____

What attempts have you made to ***monitor and evaluate*** *shared care activities* that take place in relation to older adults with mental health needs?

_____
_____
_____
_____
_____
_____

Do you have any further recommendations or comments related to the implementation and sustainability of collaborative care as it relates to older adults with mental health needs?

_____
_____
_____
_____
_____
_____

Description of specialty geriatric/general mental health programs

Please briefly describe a) your service and b) how your service works collaboratively with primary care providers on behalf of older adults with mental health needs.

Name of Service: _____

Position of Respondent:
Admin/Mgt. ☐ PRC ☐ Case Management ☐ Other ☐ _____
Please Specify

Geographic Location of Service:
West (BC) ☐
Prairies (Alberta, Manitoba, Saskatchewan) ☐
Ontario ☐
Quebec ☐
East (New Brunswick, Nova Scotia, Newfoundland, PEI) ☐
North (Northwest Territories, Yukon, Nunavut) ☐

Location:
Rural ☐
Urban ☐
Semi-Urban ☐

Association:
Hospital ☐
Community Agency ☐

Is there a psychogeriatric specialty team in your area? Yes ☐ No ☐
If "yes" how many? ____

Please identify how you define Older Adults within your target group: (check all that apply)

- Individuals over 65 ☐ 75 ☐
- Individuals with longstanding primary mental illness over 65/75 ☐
- Individuals with longstanding primary mental illness over 65/75 with age-related mental and/or physical illness ☐
- Individuals with age-related dementia/neurological/medical conditions and comorbid psychiatric illness over 65/75 ☐
- Other:
  _____
  _____

When you work collaboratively with primary care providers on behalf of Older Adults, which parties are normally present? (check all that apply)

- Family Doctor ☐
- Multidisciplinary Mental Health Team ☐
- Psychiatrist ☐
- Family Member(s) ☐
- External Stakeholders ☐ specify

_____
_____
_____

Please identify collaborative strategies you use when working with primary care providers on behalf of Older Adults (check all that apply):

- Psychoeducation ☐
- Consultation (referrals) ☐ / Letter ☐ In person ☐
- Integrated team meetings ☐
- Integrated practice (doctors' lounge, mentorship, on-site, house calls) ☐
- Other (website/educational sessions) ☐

In working with Older Adults:

- Is shared care a part of the designated activities of your service? Y ☐ N ☐
- Is shared care associated with specific project activities? Y ☐ N ☐

Please describe any shared care projects that are part of your service.

_____
_____
_____
_____
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_____
_____
_____
_____

Policy questionnaire

Key policy strategies integral to a collaborative care framework for seniors with mental health needs have been identified from a review of the shared care literature and service delivery practices at provincial, national and international levels.

We would like to get input from policy makers on these identified policy areas.

1. **Please review the key strategies identified below and state the degree to which you agree or disagree that these policy strategies are an essential part of sustained shared care for seniors.**

   a) Mental health services for seniors must be accessible and as close to home as is consistent with high-quality care.

Strongly Agree	Agree	Somewhat Agree	Disagree
☐	☐	☐	☐

   If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

   If you **disagree**, please state your reasoning.

   _____
   _____
   _____
   _____
   _____

   b) Funding formulas must include a requirement to demonstrate evidence of collaborative care in seniors' mental health services.

Strongly Agree	Agree	Somewhat Agree	Disagree
☐	☐	☐	☐

   If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

   If you **disagree**, please state your reasoning.

   _____
   _____
   _____
   _____
   _____

c) Communication and collaboration between primary stakeholders (consumers, family members, primary and mental health professionals) is complementary and effective.

Strongly Agree	**Agree**	**Somewhat Agree**	**Disagree**
☐	☐	☐	☐

If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

If you **disagree**, please state your reasoning.

_____
_____
_____
_____

d) Mental health services for seniors will be client centred and community based.

Strongly Agree	**Agree**	**Somewhat Agree**	**Disagree**
☐	☐	☐	☐

If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

If you **disagree**, please state your reasoning.

_____
_____
_____
_____

e) Clinical care enhancements for seniors are promoted through training and partnership incentives.

Strongly Agree	**Agree**	**Somewhat Agree**	**Disagree**
☐	☐	☐	☐

If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

If you **disagree**, please state your reasoning.

_____
_____
_____
_____

f) Monitoring and evaluation activities become a central part of the collaborative care process.

Strongly Agree	**Agree**	**Somewhat Agree**	**Disagree**
☐	☐	☐	☐

If you **agree,** please identify specific operational policy strategies that are either in place or need to be in place to enable this strategy.

If you **disagree**, please state your reasoning.

_____
_____
_____
_____
_____

2. Are there any other policies and strategies that are critical for those attempting to implement collaborative care for seniors to consider?

_____
_____
_____
_____
_____

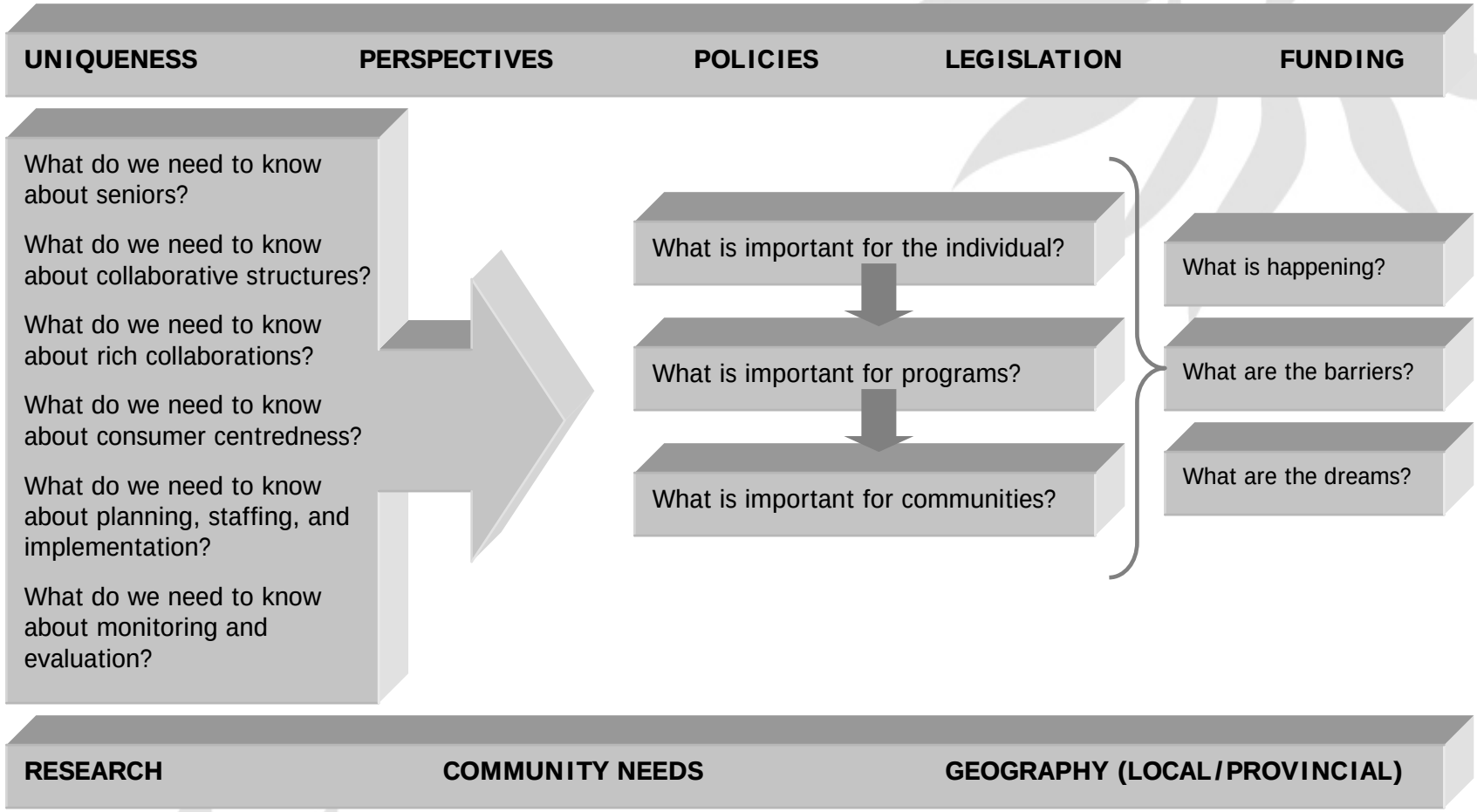
Please identify key operational policy(ies) to ensure the success of suggested strategy(ies).

_____
_____
_____
_____
_____

Canadian collaborative mental health toolkit project

Geriatric Expert Panel

Analysis Framework



Appendix G: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:
Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location

- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist **–** An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

Primary health care - An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres**.** Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

ADL	Activities of daily living
CCMHI	Canadian Collaborative Mental Health Initiative
CIHR	Canadian Institutes of Health Research
DIRECT	Depression Intervention via Referral, Education and Collaborative Treatment
GDS	Geriatric Depression Scale
IADL	Instrumental Activities of Daily Living
IMPACT	Improving Mood – Promoting Access to Collaborative Treatment
MHECCU	Mental Health Evaluation & Community Consultation Unit
NPI	Neuropsychiatric Inventory
OBTP	Outcome-Based Treatment Plan
PHQ	Patient Health Questionnaire
P.I.E.C.E.S.	Physical, Intellectual, Emotional, Capabilities, Environment, Social

PROSPECT	Prevention of Suicide in Primary Care Elderly: Collaborative Trial
PST	Problem-Solving Therapy
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Controlled Trial
SCID	Structured Clinical Interview for DSM-IV-TR
SMAF	Functional Autonomy Measurement System
SMI	Serious/severe mental illness
3MS	Modified Mini-Mental Status
UBC	University of British Columbia

Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

A series of companion documents to the CCMHI planning and implementation Toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

1. Barriers and strategies
2. A framework
3. Annotated bibliography
4. Better practices
5. Canadian initiatives
6. A policy review
7. International initiatives [unpublished]
8. Health human resources
9. Mental health prevalence and utilization
10. Interprofessional education
11. Aboriginal mental health [unpublished]
12. The state of collaborative mental health care

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