Planning Mental Health Services for an Aging Population

November 2002
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Executive Summary

Effective strategy development and resource coordination for older adults with physical and mental health needs necessitate collaboration of multiple service providers and sectors. Given the lack of resources specific to this population, coordination of services is difficult and is further challenged by the lack of consistent and formal mechanisms between clinical mental health providers and with other service sectors such as long-term care.

To address the needs of this population, the Halton-Peel District Health Council embarked on a planning process to develop a strategy for the coordinated delivery of mental health services for older adults in Halton-Peel. An Advisory Committee was established to guide this project, with membership by geography (Halton and Peel), health care sector (long-term care, mental health, addictions) as well as a blend of community and hospital representatives.

Through this process, four variables were acknowledged as critical in the development of effective mental health services for older adults. The first two variables - clinical processes (functions) and services (components) - that should be available were identified based on a review of relevant research and literature. Having adequate resources (human and financial) is the third variable required to implement and manage these functions and components. The last variable for consideration is that of “organization”, the process and structures necessary for linking these functions and components together in a coordinated manner to ensure effective and collaborative service delivery.

Based on best practice and a review of the literature, the following clinical components should be available to older adults with mental illness:

- Outreach programs
- Outpatient clinics
- Day hospitals / programs
- Inpatient hospital beds
- Hospital consultation liaison teams
- Crisis response

Through these components, the following core functions (processes) should exist:

- Intake and screening
- Assessment
- Case management
- Consultation
- Treatment
- Research
- Education and training

Using a combination of established benchmarks and local planning work, it was found that there are significant gaps between the estimated need for mental health services and the available resources to address these needs. Given that many of the aforementioned clinical components are limited or non-existent in Halton-Peel, this poses significant challenges to service coordination and network development.
Increasing the resource base and guiding future investments towards a network of services is critical. The report outlines the pre-requisites that are necessary to formalize the network of clinical services as well as target areas for further investment. To effectively organize a network of programs and services, two key criteria must be developed or enhanced locally:

1. Mechanisms to formalize and sustain key relationships among individual organizations at the service delivery level
2. Defined roles and accountabilities of individual organizations in terms of functions and components

Given the ongoing work of the provincial Mental Health Task Forces in developing advice and recommendations on local and regional mental health systems, it is anticipated that this report will assist local stakeholders and the Ministry of Health and Long-Term Care in organizing a local network of mental health services for older adults. Additional detailed work will be required to operationalize the concepts contained within this report and to move forward with the work from the provincial Task Forces.
Introduction

Background

Older adults with mental illness often require services and supports from a number of organizations across several health care sectors. There may be difficulty in providing appropriate care to these individuals as there are no consistent mechanisms to ensure that comprehensive mental health services are provided and coordinated with resources from other sectors (Ministry of Health and Long-Term Care (MOHLTC), 1999a). In fact, “the presence of multiple needs can result in the person being ignored by all sectors with the expectation that someone else is responsible to serve him/her” (MOHLTC, 1999a). To address the needs of this population, the Halton-Peel District Health Council (DHC) embarked on a planning process to develop a strategy for a coordinated service delivery continuum for older adults with mental health needs.

Multiple factors influenced the initiation and dissemination of work resulting from this planning process:

- Needs of older adults
- Hospital plans
- Mental Health Implementation Task Forces

Needs of Older Adults

The physical and mental health needs of older adults necessitate collaboration of multiple service providers and sectors. Some of these individuals may require services and support from acute care, long-term care, mental health and addictions (Figure 1). Having a cohesive network of services within a particular sector (i.e. mental health) is as important as strengthening collaboration and client movement between sectors (i.e. mental health and long-term care).

Hospital Plans

In 2001/02, the Halton-Peel DHC was requested to review hospital operating plans for the five hospital corporations in Halton-Peel (Halton-Peel DHC, 2001a). It was noted that all hospitals continue to experience pressures related to population growth and aging. In particular, it was noted that Peel hospital corporations (William Osler Health Centre, The Credit Valley Hospital and Trillium Health Centre) were planning new programs or program expansion in the areas of geriatrics and psychogeriatrics. While the Halton-Peel DHC supports these initiatives, it was recognized that there would be value in working collaboratively with each other and with other stakeholders.
Figure 1 – Building a Network of Services for Older Adults with Mental Illness

- **Acute Care**
  - Tertiary Hospital
  - Inpatient Psychiatrists
  - Outreach Programs
  - Supportive Housing

- **Long Term Care**
  - LTC Facilities
  - Supportive Housing
  - Day Programs

- **Mental Health**
  - Geriatricians
  - Psychiatrists
  - Emergency Departments
  - Community Agencies
  - CCAC
  - Outpatient Clinics

- **Addictions**
  - Concurrent Disorders
  - Outpatient Services
  - Chemical Withdrawal
  - Residential Services

- **Youth**
  - Youth

- **Residential Services**
  - Case Management

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Mental Health Implementation Task Forces

One of the directives that emerged from the Health Services Restructuring Commission was the creation of nine Mental Health Implementation Task Forces. Since their inception in September 2000 and January 2001 respectively, the Central South and Toronto-Peel Mental Health Implementation Task Forces have been working on developing advice and expertise regarding the implementation of restructured local and regional mental health systems in Halton-Peel. From this work, recommendations have been developed from a number of service-related subcommittees, including services for specialized populations such as psychogeriatrics. With the forthcoming recommendations and future operationalization of recommendations from the provincial Task Forces, it was felt that the Halton-Peel planning process could assist in guiding how mental health services for older adults should be organized locally, once direction is received from the Task Forces.

Planning Process

Four variables are critical in the development of effective mental health services for older adults. The first two variables - clinical processes (functions) and services (components) - that should be available were identified based on a review of relevant best practice and policy. Having adequate resources (human and financial) is the third variable required to implement and manage these functions and components. The last variable for consideration is that of “organization”, the process and structures required to link these functions and components in order to ensure that they work collaboratively.

Each of these variables was considered in relation to the other three, as they are interdependent and interactive. For example, having inadequate resources (funding, staffing) or lacking a particular core component will impact the local capacity of other services and programs to collaborate and coordinate mental health services for older adults.

Clinical Resources that should be Available in Halton-Peel

Identifying what services should be available to older adults with mental illness involved: a review of published literature; key stakeholder consultation; and, local discussion on core services and accompanying processes.

The purpose of key stakeholder consultations was four-fold: (1) to expand the number and range of stakeholders involved in the planning process; (2) to provide a venue for confidential and free exchange of information on a one-to-one basis; (3) to provide a qualitative snapshot of the current network of services as defined through resource gaps and challenges in service coordination; and, (4) to solicit ideas for improving the network of services. Themes explored during these meetings included: interagency collaboration, coordination and management of care, training and technical assistance and standards, monitoring and evaluation. Meetings were conducted with a total of 19 organizations in late 2001 / early 2002 (see Appendix A for a listing of participants).

From discussions with key stakeholders, it became evident that there is no shared understanding or terminology regarding the basic services and resources that should be available for older adults with mental illness. Individual expectations and perceptions differed regarding the role and purpose of several functions and components. For example, case
management was described by some as a brokering of services, by others as treatment, with differing levels of intensity and length of follow-up. To consider the key relationships that currently exist among organizations and sectors as well as to identify future investment requirements, local discussion was required regarding core components (services) and functions (processes).

Clinical Resources that are Currently Available in Halton-Peel

Conducting a review of existing resources provides an understanding of what services are currently available to the target population. Future plans of clinical services were also explored.

Organization of Programs and Services

Once an understanding of existing and planned resources was established (through the use of common language and expectations), it became possible to examine the various methods for organizing a network of services.

Advisory Committee

In the fall 2001, the Halton-Peel DHC established the Halton-Peel Advisory Committee on Regional Psychogeriatric Service Planning (Advisory Committee). The purpose of this group was to provide advice on the development of a strategy for the coordinated delivery of mental health services to older adults in Halton-Peel.

In facilitating the establishment of the Advisory Committee, the Halton-Peel DHC sought representation on a geographic basis (Halton and Peel), health care sector (long-term care, mental health, addictions), as well as a blend of community and hospital representatives. The Advisory Committee had seven face-to-face meetings over a 9-month timeframe. Membership on the Advisory Committee was as follows:
**Target Population**

The target population for this planning exercise was defined as:

- Older adults (aged 65 years and older) with a severe, *chronic or late onset* mental illness, behavioural disturbances and / or functional impairments
- Individuals with early or late-onset dementia (e.g. Alzheimer Disease), behavioural disturbances and / or associated mental illness (e.g. depression)
- Older adults with a concurrent disorder (mental illness and substance misuse)
- Families and caregivers who provide care

(Adapted from: Clarke Consulting Group, 1996; MOHLTC, 1995)

Often, older adults with mental illness have complex medical needs and multiple comorbidities that require specialized expertise and services from several sectors. It is these individuals that historically have had difficulty accessing care and coordinated services. Throughout the report, this target population may be referred to as psychogeriatric clients or older adults with mental illness.
Population Growth and Demographic Change

The population growth and demographic changes expected in Halton and Peel over the next 15 years will significantly impact on the number of older adults requiring local services and resources. In 2001, there were approximately 129,000 people 65 years and older living in Halton-Peel (Figure 2). While older adults represent only a small proportion of the population, 9.0% in 2001 and 13.9% by 2016, the absolute number of older adults is expected to increase by 140,000 by 2016.

Figure 2. Population Growth Aged 65 and Older, 2001 - 2016

When considering absolute population growth in Ontario, it is expected that there will be 699,000 additional residents aged 65 and older in 2016 when compared to 2001 (Figure 3). The largest percentage of these additional persons is projected to reside in Halton-Peel.
In addition to an increase in the absolute number of older adults living in Halton-Peel, this “aging” of the older population will further influence the need for service and supports. Of particular concern is the projected increase in certain age cohorts of the older population. For instance, in 2001, there were approximately 50,000 adults 75 years and older in Halton-Peel; by 2016, this number will double to approximately 100,000.

**Translating Population Growth and Aging into Service Need**

**Prevalence of Mental Illness**

Prevalence rates for mental illness vary considerably between research studies, with great disparity in the data provided. Part of the reason for these differences is related to how these rates are defined and categorized. For example, the prevalence rates of many disorders differ depending on the location of residence. Typically, the rate of mental illness is higher in long-term care (LTC) facility populations compared with older adults living in the community (Clarke Consulting Group, 1996). This difference is related to the high level of care and support required by most facility residents, their older ages and increased frailty. Differences in the prevalence of mental illness by residence type have implications on the delivery of services and resources necessary to provide appropriate care and support.

Overall, the prevalence rates of mental illness among older adults has been estimated at 15% for individuals living in the community and 60% of older adults in LTC facilities (Clarke
Consulting Group, 1996). It is estimated that at any given time, 6% of the Ontario population 65 years and older resides in a LTC facility. Applying these estimates to the Halton-Peel population, in 2001, there were 22,045 older adults with mental illness. With population growth and aging, this is expected to increase to 45,763 individuals by 2016. For most of these individuals, appropriate care can be provided by community support or LTC facility staff, family physicians and other providers, with consultation and education support provided by outreach programs as required (Clarke Consulting Group, 1996). However, it is assumed that 2% of these individuals living in the community and 10% of those living in a LTC facility require direct service from an outreach team (Clarke Consulting Group, 1996). This translates into 3,088 clients in 2001; with population growth, this estimate will increase to 6,412 individuals by 2016 (Figure 4).

**Figure 4. Projected Number of Halton-Peel Residents Aged 65 years and Older Requiring Direct Services from an Outreach Program, 2001-2016**

![Figure 4](image)

While the prevalence rates described above reflect a combined estimate of a number of psychiatric conditions, it should be noted that specific disorders do have different implications for service delivery. The most frequent psychiatric disorders displayed in older ages are: dementia, depression and delirium. It should be noted that these conditions are not exclusive to older adults, but their manifestation may be different in the elderly and are more often than not complicated by comorbid and chronic illnesses (i.e. hypertension, diabetes etc). For example, dementia and delirium present more frequently in older adults than in younger cohorts (Canadian Association on Gerontology, 1998), thereby increasing the likelihood that older adults require care and treatment for these conditions. Individuals can also present with two or more of these conditions.

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1 While these benchmarks were designed for psychogeriatric outreach teams, estimates of mental illness were based on a review of Epidemiologic studies, policy and planning documents and expert opinion. The target population, as defined by the Clarke Consulting Group (1996), is identical to the one used for this planning process.

2 Outreach programs need to operate within a system of care that includes inpatient and outpatient resources, physicians and a range of support services (including community support and LTC facilities) (Clarke Consulting Group, 1996). If these additional resources are not available, it becomes difficult to provide a continuum of care.
Dementia

Using data from the Canadian Study of Health and Aging, prevalence projections have been estimated for counties, municipalities and districts within Ontario. It is projected that the number of dementia cases in the aged 65+ population in Halton-Peel will increase from 10,434 in 2001 to 22,742 by 2016; this represents a 118% increase (Hopkins and Hopkins, 2002). The prevalence of dementia is increasing even more rapidly than population aging. This is important because the oldest age cohorts (85-89 years, 90+ years) have extremely high rates of dementia (Hopkins and Hopkins, 2002) and will be increasing significantly relative to their current proportions. Also influencing these rates are earlier diagnosis and treatment of dementia.

Depression

It has been estimated that the prevalence of clinical depression among older adults living in the community is between 2% - 4% (National Advisory Council on Aging, 2002). However, if all individuals with depressive symptoms are considered, this rate increases to between 10% to 15% (National Advisory Council on Aging, 2002). Prevalence rates of depression in LTC facility residents are significantly greater, with some research suggesting that between 15% to 25% have clinical depression, with another 25% experiencing depressive symptoms of a lesser degree (National Advisory Council on Aging, 2002). If these prevalence rates were applied to the Halton-Peel population projections for 2001, it would be expected that 3,586 – 6,786 older adults would be affected by clinical depression. These projections would further increase to 7,490 – 14,171 individuals by 2016. With further education of health care professionals and improved diagnostic precision, these rates are also expected to rise (Elderly Mental Health Care Working Group, 2002). Research also suggests a link between depressive symptoms and Alzheimer Disease, although the specifics of this relationship are unknown (Jankowiak, 2002; Wilson et. al, 2002).

Delirium

Given its clinical presentation, delirium is often misdiagnosed as dementia. However, delirium is frequently due to an acute, reversible underlying medical condition such as infection or drug toxicity (McEwan et. al, 1991). It has been estimated that approximately 13% of all hospitalized older adults develop delirium (McEwan et. al, 1991). In 2000/01, there were 29,113 inpatient discharges for Halton-Peel residents 65 years and older. If a prevalence rate of 13% is applied to local hospital discharge data, it would be expected that 3,785 older adults admitted to hospital would be affected by delirium.

Substance Misuse

Alcohol is the most common substance misused by older adults. It has been estimated that 5.7% to 11.0% of seniors are heavy drinkers (McEwan et. al, 1991). It is uncertain what is the prevalence of concurrent disorders among older age groups.

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3 In 2001, it is estimated that 8.1% of the population aged 65+ in Halton-Peel will have dementia; this proportion will increase to 8.4% by year 2016 (Hopkins and Hopkins, 2002).
4 Source: Provincial Planning Database, 2002
Benchmarks for Service Delivery

Quantifying need for services is possible through an examination of benchmarks. However, although benchmarks for clinical services have been established for outreach programs and inpatient beds, these benchmarks should be applied and considered with caution. Rather than provide an absolute or definitive measure of the minimum level of resources required, benchmarks are more usefully employed as guidelines and relative indicators of scarcity. Also, benchmarks are typically established based on past practice methods, utilization patterns and settings, while service delivery ideas and approaches are constantly evolving. For example, in the Comprehensive Assessment Projects (CAP) conducted in Provincial Psychiatric Hospitals in 1998, the Clarke Group indicated that many older persons utilizing inpatient services could be in LTC facilities “if sufficient support from outreach teams were available to staff in these settings”. The Clarke Group (1998) further identified the need for another level of care (Level 4) using “smaller group home settings especially designed for the elderly”. Accordingly, while the current number of geriatric inpatient mental health beds are below the benchmark, the need for these resources must be considered in relation to other components.

Within the Clarke Consulting Group report (1996), the following benchmark was recommended for outreach programs:

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical staff</td>
<td>5.0 FTE (includes 1.0 FTE physician)</td>
</tr>
<tr>
<td>Non-clinical staff – administration</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>Non-clinical staff – clerical</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>6.5 FTE per 10,000 population 65+</strong></td>
</tr>
</tbody>
</table>

Currently, in Halton-Peel, there are 17.2 FTE devoted to outreach for older adults with mental illness. Given the recommended benchmark, in 2001, Halton-Peel required a total of 81.0 FTE; with population growth and aging, this estimate increases to 101.7 FTE by 2006.

In terms of inpatient beds, a benchmark of 4 to 6 assessment and treatment beds per 10,000 population 65+ (Ministry of Health, 1994) was utilized. Given the recommended benchmark, in 2001, Halton-Peel required a total of **50 – 75 beds**. By 2006, this increases to **63 – 94 beds**.

Currently, in Halton-Peel there are 8 geriatric mental health inpatient beds at Trillium Health Centre.

When considering tertiary level care, the benchmark level of 3 beds per 10,000 population 65+ was applied to the Halton-Peel population (Ministry of Health, 1994). This translates into **37 beds** for 2001, increasing to **47 beds** by 2006. Currently, 10 geriatric inpatient beds at the Centre for Addiction and Mental Health are allocated for Peel and there is a 20-bed secure inpatient unit at Toronto Rehabilitation Institute. There are 19 inpatients beds at St. Joseph’s Health Centre, Hamilton that Halton has access to.

In other areas of mental health services for older adults, no benchmarks have been established. However, local work completed in the areas of outpatient clinics and addiction services, local operating plan reviews and planning reports (Halton-Peel DHC, 1999; Halton-Peel DHC, 2001c; Halton-Peel DHC, 2002) have noted that these services meet or are close to being at capacity. With outpatient clinics functioning at full capacity, there is minimal opportunity for reallocating resources to develop special population programming. While further work is needed to develop appropriate benchmarks, there is a reasonable planning basis to identify the need for future investments in several clinical areas.
Utilization Data

Most programs collect client and utilization data that can provide further estimates of client need and service resource requirements. However, given that many programs serve a broad client base, it becomes difficult to delineate out data that are specific to the target population. Hospital inpatient separation (discharge) data can provide some context and insight into acute care utilization of older adults with mental illness.

As mentioned previously, in 2000/01, there were 29,113 inpatient discharges for Halton-Peel residents 65 years and older. Of these discharges, approximately 2% of cases had a mental illness as the most responsible diagnosis. Affective (mood) disorders such as depression and bipolar disorder accounted for one-quarter (25%) of these discharges. Senile and pre-senile organic (physical) psychotic conditions such as dementia were the second most common diagnosis, accounting for 22% of discharges where mental illness was recorded as the most responsible diagnosis.

Limiting an examination of inpatient hospital discharges to the most responsible diagnosis may underestimate inpatient utilization and mental illness. Often, older adults with mental illness have multiple comorbidities that may be responsible for admission to hospital. When all diagnoses (main, secondary or contributing) were examined, approximately 12% of all Halton-Peel resident discharges (aged 65+) in 2001 had a mental illness. While this data highlights the importance for specialized resources within acute care hospitals (such as consultation liaison teams), the true prevalence of mental illness is most likely underestimated given that mental illness is often under-reported and it was not possible to obtain additional utilization data for community programs and resources.

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5 As defined in Chapter 5 of the International Statistical Classification of Diseases, Injuries and Causes of Death, Ninth Revision (ICD-9).
6 **Most responsible diagnosis** is defined as “the main condition treated or investigated during the relevant episode of hospital or other care” (World Health Organization, 1977, p. XXI).
7 **Contributing diagnoses** (comorbidities) are those conditions, which have a significant influence on the length of stay and / or the patient’s management while in hospital. **Secondary diagnoses** are medical conditions that a patient may or may not have received treatment for while in hospital, but did not significantly contribute to length of stay (World Health Organization, 1977).
Clinical Service Components and Functions: Resources that should be Available in Halton-Peel

Identifying what services should be available to older adults with mental illness involved: a review of published literature; key stakeholder consultation, and; obtaining local consensus on core services and accompanying processes.

Best Practice and Published Literature

The services and supports required by older adults with mental illness vary greatly between individuals and over time (Department of National Health and Welfare, 1988). Despite the limited amount of best practice material published for this target population (Elderly Mental Health Care Working Group, 2002), there are a number of policy papers that document expert opinion regarding what services should be available. Older adults with mental illness have special needs that may not be met through generic long-term care services typically provided to older adults or by adult mental health services (Canadian Association on Gerontology, 2002).

Functions

Functions are core processes or services that are available to a target population. Functions are not dependent upon a specific program or care setting (hospital versus community-based programs) and one program may provide several functions. Likewise, several programs may provide the same function (or variations of it). Based on a review of the literature, the following is an outline of those functions that clinical mental health services for older adults should provide (Central East Region Mental Health Planning Table, 1996; Clarke Consulting Group, 1996; Department of National Health and Welfare, 1988; GTA / 905 Healthcare Alliance, 1999; Ontario Psychogeriatric Association, 1995; Policy Planning Plus, 2000):

- Intake and screening
- Assessment
- Case management
- Consultation
- Treatment
- Research
- Education and training

Intake and Screening

Intake and screening refer to the capacity to receive program inquiry and client referrals. Typically, this process involves collection of client data, including information on client needs, risk factor identification and degree of urgency (client triage) (Ontario Psychogeriatric Association, 1995; Policy Planning Plus, 2000). Program eligibility is often determined at this level and, depending on the program, referrals may be made by families, clients, physicians and other health care providers. While most programs have their own intake and screening process, creating a central, single-entry system that would receive all inquires and referrals for psychogeriatric services is more ideal (Ontario Psychogeriatric Association, 1995). Through the
creation of client consent agreements, this may also facilitate the sharing of client information among service providers.

Assessment

Assessment guides the development of care and treatment plans. “Assessment is necessary for determining priority of needs, for establishing competency, for patient monitoring, for outcome and program evaluation, and hence for resource allocation” (Ontario Psychogeriatric Association, 1995, p. 14). A comprehensive psychogeriatric assessment must be multidimensional in nature and should include a number of domains (Ontario Psychogeriatric Association, 1995):

- Demographic characteristics
- Perceived needs and client preferences
- Risk factors
- Physical health
- Mental health
- Environment (home and immediate surroundings)
- Functional status (activities of daily living)
- Nutritional status
- Social functioning and resources
- Recreational resources
- Financial and legal resources
- Support network

Case Management

Although the term case management has been widely used, there is no standardized method of implementation or definition (Health Systems Research Unit, 1998). Different from the brokerage model which involves the coordination of services (and may result in little or no contact with the client), clinical case management provides more comprehensive support and direct service provision of care to the client (Health Systems Research Unit, 1998). Although multiple programs may offer case management, it may be distinguished based on duration (amount of time) and intensity (degree).

Consultation

Given the specialized and specific expertise of clinical staff working with the target population, consultation and support is often provided on a case-specific basis to community agencies and programs, general hospital units and LTC facilities (Department of National Health and Welfare, 1988). Consultation involves being a resource to other providers (professionals and programs) on an episodic basis when a particular skill and / or knowledge is required (Policy Planning Plus Inc., 2000). This may result in recommendations being made to other health professionals for consideration and implementation.
Treatment

Once a comprehensive assessment has been completed, a care / treatment plan is developed for implementation by the clinical program staff, referring physician or other health care providers. Treatment refers to interventions directed towards assessing, alleviating, reducing or managing the symptoms of an illness or disorder (MOHLTC, 1999a).

Research

Given the dearth of best practice literature in the area of mental health services for older adults, there is a need for basic and applied research. However, few staff working with the target population have special training for this task (Department of National Health and Welfare, 1988), or the time or resources available to conduct research. It was suggested by the Advisory Committee that academic teaching hospitals and Regional Geriatric Programs\(^8\) are best positioned to take the lead in conducting appropriate and relevant research related to this client group. It is also important to strengthen the link to teaching hospitals by providing academic opportunities to medical residents and non-physician students (i.e. nursing).

Education and Training

This refers to training and educational opportunities available to providers delivering mental health services to older adults. It also refers to the capacity of these specialized clinicians to provide education and training resources to other staff working with these clients in support programs. Public education on older adults with mental illness is also necessary. Clinical program staff can contribute to these on a formal or informal basis (Department of National Health and Welfare, 1988). Unlike the other functions, research and education and training are directly related to the capacity of service providers to facilitate appropriate care. Carrying out these functions indirectly impact the client.

Components

Components refer to the actual programs that provide care and support to older adults with mental illness. These programs may provide one or more of the above functions. Based on a review of the literature, the following is an outline of those specific clinical components that need to be available to older adults with mental illness (Central East Region Mental Health Planning Table, 1996; Clarke Consulting Group, 1996; Department of National Health and Welfare, 1988; Elderly Mental Health Care Working Group, 2002; GTA / 905 Healthcare Alliance, 1999; Policy Planning Plus, 2000):

- Outreach programs
- Outpatient clinics
- Day hospital / programs
- Inpatient hospital beds
- Hospital consultation liaison teams
- Crisis response

\(^8\) Regional Geriatric Programs (RGPs) provide a comprehensive network of services which assess and treat functional, medical and psychiatric illness in older adults with multiple complex needs. There are five RGPs in Ontario, established at academic teaching centres in Toronto, Hamilton, London, Kingston and Ottawa.
Outreach Programs

Outreach programs are a central resource in the care continuum for older adults with mental illness (Chronic Care, Mental Health, Long-Term Care Interface Resource Inventory Task Group, 1998; Clarke Consulting Group, 1996; Elderly Mental Health Care Working Group, 2002). These programs bring services and support to the client within their own home (community-based setting) or within a LTC facility. Program staffing is often multidisciplinary in nature, although the exact structure and professional make-up of the team varies depending upon resource availability and community need (Elderly Mental Health Care Working Group, 2002). It has been found that outreach programs make efficient use of scarce resources in a manner responsive to local circumstance and need (Stolee, Kessler and Le Clair, 1996). Liaising with the referring physician and other health providers is crucial to the development of treatment plans for clients under the care of the outreach program. Clients are referred to these programs through multiple sources including physicians, allied health professionals and family members.

Outpatient Clinics

Outpatient clinics are similar in nature and function to an outreach program except that clients come to a clinic for service rather than being served in their own home (Elderly Mental Health Care Working Group, 2002). Typically, these resources are affiliated with a hospital, but are not necessarily co-located. They often provide follow-up for clients discharged from hospital, with enrollment typically being time-limited (Department of National Health and Welfare, 1988; Elderly Mental Health Care Working Group, 2002).

Day Hospital

A day hospital provides an alternative to inpatient hospitalization for clients whose care needs are greater than those served by outpatient clinics or programs (Elderly Mental Health Care Working Group, 2002). Services provided may include psychiatric and other medical care; there is often a component of respite (Department of National Health and Welfare, 1988). Within the Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities report, it is noted that an adult day program9, with additional supports and resources, may provide a similar function if there are not enough local resources to justify a day hospital (Elderly Mental Health Care Working Group, 2002).

Inpatient Hospital Beds

Inpatient mental health hospital programs provide multidisciplinary assessment and treatment for individuals with mental illness. Although only a small number of inpatient hospital beds are needed to serve the target population, the availability of these beds are vital to the overall functioning of the clinical service system (Elderly Mental Health Care Working Group, 2002). Characteristics of these inpatient resources are heavily dependent upon other services available

9 Adult day programs are support services, which provide structured and supervised activities, meals, transportation, personal support, and minor health care services to clients (Source: Revised Adult Day Program Manual, MOHLTC, 1995).
within the community for the target population (Ministry of Health and Ministry Responsible for Seniors, 2000). Rather than integrating with adult mental health beds, it is desirable to have a specialized unit, designed and staffed specific for this client group (Elderly Mental Health Care Working Group, 2002). If critical mass is not obtainable through a specialized unit, mixing these beds with geriatric medicine is more preferable to including this population within adult psychiatry (Ministry of Health and Ministry Responsible for Seniors, 2000). It remains unclear as to whether clients who require inpatient admission could be managed in another environment (such as a LTC facility), with additional staffing and resources (Elderly Mental Health Care Working Group, 2002).

Hospital Consultation Liaison Team

Hospital consultation liaison teams are to be available in acute care settings and provide consultation support for older adults with mental illness who are admitted to an inpatient bed outside of mental health. Most often the client receives psychiatric care and treatment from the consultation liaison team in the inpatient unit (e.g. medical, rehabilitation) where they are receiving medical care (Elderly Mental Health Care Working Group, 2002). Given the interconnected nature of physical and mental health, these teams should also have strong links to (geriatric) medicine.

Crisis Response

The clinical system must have the capacity to respond to urgent referrals (24 – 48 hours) and crises\(^{10}\) (medical and psychiatric emergencies). Existing mental health crisis services should have the capacity to serve older clients as well as other age groups (Elderly Mental Health Care Working Group, 2002). Other components such as outpatient clinics and outreach programs should have adequate capacity to respond to urgent referrals.

Local Discussion on Core Functions and Components

Clinical mental health services and programs for older adults must reflect local circumstances and the potential for innovative responses to need (Stolee, Kessler and Le Clair, 1996). In addition to examining the published literature, it was necessary to have discussion on the core services and processes that should be available locally for the target population. This was to facilitate a common understanding and use of language regarding clinical mental health services for older adults.

From discussions with key stakeholders and the Advisory Committee, the following tables were developed to augment information gleaned from best practice and published literature.

---

\(^{10}\) A mental health crisis has been defined as: “the onset of an emotional disturbance or situational distress (which may be cumulative), involving a sudden breakdown of an individual’s ability to cope. Crisis intervention refers to the active treatment and support offered as soon as possible after an individual has been identified as in acute distress. There is a need to provide immediate relief from symptoms and rapid stabilization so that the condition does not worsen” (MOHLTC, 1999b).
Table 1. Local Discussion on Outreach Programs and Outpatient Clinics

<table>
<thead>
<tr>
<th>Outreach Program</th>
<th>Outpatient Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary functions</strong></td>
<td><strong>Primary Differentiation of Components</strong></td>
</tr>
<tr>
<td>• Assessment (including responsibility for initial / comprehensive assessment)</td>
<td>• Assessment</td>
</tr>
<tr>
<td>• Case management</td>
<td>• Case management</td>
</tr>
<tr>
<td>• Treatment</td>
<td>• Treatment</td>
</tr>
<tr>
<td></td>
<td><strong>Rationale for Component</strong></td>
</tr>
<tr>
<td></td>
<td>• Community-based (including LTC facilities)</td>
</tr>
<tr>
<td></td>
<td>• Transportation and other physical and mental functional barriers limit client mobility</td>
</tr>
<tr>
<td></td>
<td>• Allows for observation of client in “natural” home environment (community, LTC facility)</td>
</tr>
<tr>
<td></td>
<td>• Service accessibility for clients who cannot and / or will not access traditionally-based services</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Consensus</strong></td>
<td></td>
</tr>
<tr>
<td>• Important to incorporate additional resources such as psychogeriatric resource consultants (Alzheimer Strategy) with outreach programs</td>
<td></td>
</tr>
<tr>
<td>• There is potential for incorporating functions and resources of outreach clinic with day programs and LTC facilities (by making this resource mobile on a time-limited basis)</td>
<td></td>
</tr>
<tr>
<td>• While two distinct programs could exist, network development must proceed on the basis of strong linkages, cross-referrals and sharing of expertise and resources. Outreach programs can and often do provide a clinic-based component, while clinics often have an outreach component</td>
<td></td>
</tr>
<tr>
<td>• Network issues that must be addressed include different client “feeder” systems for these programs (e.g. hospital-based flow) as well as different methodologies for accessing multidisciplinary teams (e.g. having an occupational therapist as a member of the team versus CCAC referral for these services)</td>
<td></td>
</tr>
<tr>
<td>• With limited specialized resources, there may be further opportunities for integration of services</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2. Local Discussion on Day Hospitals, Day Programs and Inpatient Resources

<table>
<thead>
<tr>
<th>Day Hospital</th>
<th>Day Program</th>
<th>Inpatient (Beds + Consultation Liaison Team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary functions</td>
<td>• Treatment</td>
<td>• Non-medical support</td>
</tr>
<tr>
<td>• Non-medical support</td>
<td>• Assessment</td>
<td>• Treatment</td>
</tr>
<tr>
<td>Primary Differentiation of Components</td>
<td>• Hospital-based with linkages between psychiatry and medicine</td>
<td>• Community-based</td>
</tr>
<tr>
<td>Rationale for Component</td>
<td>• Alternative to inpatient admission</td>
<td>• Activity and client stimulation</td>
</tr>
<tr>
<td>• Need for longer period of time to monitor medical changes and/or potential side effects</td>
<td>• Respite for caregivers</td>
<td></td>
</tr>
</tbody>
</table>

**General Consensus**
- There is no consensus in the literature regarding day hospitals, although some are moving towards brokering with community support services to provide medical care and support (in addition to psychiatric expertise).
- From a functional perspective, there may be some opportunity to blend day hospitals and day programs, but some caution is required, as there is need to consider issues such as combining acute clients with those who may only require stimulation and recreation. There was also concern regarding the potential medicalization of a social model of care.
- Consultation liaison teams should be familiar with medical issues (to reinforce the link between medicine and psychiatry).
Clinical and Support Services Currently Available in Halton-Peel

As presented in the previous chapter, the published literature and research identifies a range of clinical functions and components that should be available to older adults with mental illness. In addition to having coordinated client access and movement between these clinical services, it is important to examine other support services required by the target population. The current services available to this population are limited and widely dispersed across the local mental health and long-term care sectors. This chapter presents the current clinical and support services available in Halton-Peel. Future plans of clinical services were also explored.

Issues Related to the Current Network of Services

From discussions with key stakeholders and the Advisory Committee, several trends emerged related to the current set of services and resources available for older adults with mental illness.

Scarcity of Resources

In general, many issues that were described by providers as service coordination and networking challenges actually appear to reflect resource inadequacies and how specific programs and organizations respond to the lack of resources. This appears to be most pronounced in terms of outreach programs (i.e. how broad or narrow should their mandate be?) and inpatient resources.

In addition to a lack of specific programs and services (components), local providers also cited a shortage of geriatric psychiatrists, geriatricians and other specialized health professionals. Staff who work with the target population in Halton-Peel are dedicated and have clinical expertise to provide appropriate care; however, it was felt that there are not enough human resources to meet demand for service.

Geography

In both Halton and Peel, there is a perception that the northern areas are not receiving adequate services for community-based clients. Obviously, distance, travel time and critical mass will influence the capacity of organizations to provide service, while balancing a number of other priorities.

Non-comprehensive Program Mandates

Given the shortage of resources, many programs have specifically defined mandates and catchment areas. Having a lack of non-comprehensive programming leads to gaps in service delivery in two ways. Firstly, critical functions and components might not be performed by any local organization or program. Secondly, one or two organizations may perform certain functions, but equitable access may be prevented as a result of client residence or due to the specific referral source.
Differential Access to Programs and Services

Older adults who require mental health services often access resources and move within the health care system according to particular referral sources. There is an apparent lack of equitable and rational access to specialized expertise or services. For example, some LTC facilities refer residents with mental health concerns directly to inpatient programs without accessing or coordinating with outreach programs. This may occur because the facility is unaware of the resources available in the community, or it may be based on past experience.

Ad hoc Connections

Many of the local resources available to older adults with mental illness have evolved through individual organizations willing to address the needs of this client group. This has resulted in the development of special arrangements and relationships between some organizations and programs and not others. There is informal collaboration and communication between local agencies and programs; however, there is also recognition and awareness that more formal relationships and networks are required to address the needs of this client group.

Clinical Mental Health Services Currently Available in Halton-Peel

Outreach Programs

Currently, three distinct outreach programs provide services to psychogeriatric clients in Halton and Peel:

1. Halton Geriatric Mental Health Outreach Program (HGMHOP)

With two offices located in Milton and Burlington, the HGMHOP provides mobile outreach services to clients 65 years of age and over with a mental illness, age-related dementia, concurrent substance abuse and mental health illness, behavioural disturbances, and/or mental illness accompanied by a medical illness or functional needs. The HGMHOP is a collaborative partnership serving all of Halton Region\(^\text{11}\). Clients under 65 years with an age-related severe mental illness are also eligible for HGMHOP services. The range of services and supports offered to clients, family members and service providers include intake/screening, assessment, treatment, consultation, case coordination, secondary crisis intervention, client, family, and professional/ provider education.

\(^{11}\) Five partners contributed resources in order to provide initial support to this regional initiative: CCAC of Halton, Joseph Brant Memorial Hospital, Halton Healthcare Services Corporation, North Halton Mental Health Clinic and St. Joseph’s Healthcare, Hamilton.
2. PACE Peel

The PACE Peel Outreach Team, a program of the Centre for Addiction and Mental Health, provides consultations, case coordination, assessment, crisis, education programs. Access to a day program is also possible through Pace West and Pace Centre. The Team’s catchment area is the Region of Peel north of highway 401.

In 2001/2002, there were 89 referrals to the program.

3. Trillium Health Centre - Geriatric Mental Health Services

The Trillium Health Centre’s Geriatric Mental Health Services is an outreach program operating two teams out of the Queensway and Mississauga hospital sites. The catchment area is aligned with the hospital sites (the Queensway team serves Etobicoke and the Mississauga team serves clients in Mississauga). Services provided include consultation and assessment services. Referral sources include area LTC facilities, family physicians and client/family. In 2001/2002, the Queensway site carried 213 clients while the Mississauga site had 133 clients.

The following table reflects the staffing resources for all outreach programs currently operating in Halton-Peel.

<table>
<thead>
<tr>
<th>Discipline</th>
<th>HGMHOP</th>
<th>PACE Peel</th>
<th>Trillium Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site</td>
<td>Mississauga</td>
<td>Queensway Site</td>
</tr>
<tr>
<td></td>
<td>FTE</td>
<td>Site</td>
<td>Site</td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>4.3</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td></td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>OT</td>
<td>1.0</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>SW</td>
<td>1.0</td>
<td></td>
<td>0.3</td>
</tr>
<tr>
<td>Physician</td>
<td>0.5</td>
<td>0.2</td>
<td>0.25*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.2*</td>
</tr>
<tr>
<td>Non-Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/ Coordinator</td>
<td>1.0**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Program Evaluator</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL FTE</td>
<td>10.1</td>
<td>1.2</td>
<td>2.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.8</td>
</tr>
</tbody>
</table>

*Psychiatrist position is not included in total FTE staffing. Psychiatrist position is paid through a combination of OHIP billing and sessional support
**Coordinator has 30 – 40% clinical responsibilities.
†Accessed as required through First Assessment Clinical Team (FACT) Peel.

Future Planning for Outreach Programs

Within their 2001/2002 Operating Plan, the Credit Valley Hospital identified future plans for an outreach program. The hospital proposes that the program will include a clinical nurse specialist and a physician (both positions will be piloted at 0.5 FTE). The program will partner with the existing day hospital to access social work, occupational and physiotherapy services.
Two geriatricians will support the program at 0.5 days per week initially. It is planned that this initiative will be piloted with one or two area LTC facilities.

**Psychogeriatric Resource Consultants**

Initiated in 1999, Ontario’s Alzheimer Strategy is a ten-point plan to develop and augment Alzheimer-related services, education and research across the province. One of these initiatives identified the need for Psychogeriatric Resource Consultants (PRC). The role of the PRC is to support front-line staff in LTC facilities and community support agencies delivering services to clients with dementia, behavioural problems, and those who are difficult to serve. Two lead agencies have been designated for the 3.5 PRCs serving Halton and Peel: 1.5 FTEs are working with the Halton Geriatric Mental Health Outreach Program and 2.0 FTEs are sponsored by Trillium Health Centre to provide services to Peel.

**Outpatient Clinic**

Currently, there are 2 outpatient clinics in Halton-Peel for older adults with mental illness.

1. **Trillium Health Centre – Senior’s Mental Health Clinic (Ambulatory Clinic)**

   The Seniors Mental Health Clinic is located at the Queensway Site and serves Mississauga and Etobicoke. The Clinic operates two half-days per week with a geriatric psychiatrist and registered nurse. Occupational therapy, social work and physiotherapy support is available as required. Clinic staff provide some in-home follow-up. Referral sources include family physicians and emergency departments. In 2001/2002, there were a total of 688 client visits.

2. **Halton Healthcare Services Corporation – Outpatient Geriatric / Psychogeriatric Assessment Clinic**

   The Outpatient Geriatric / Psychogeriatric Assessment Clinic comprises a multidisciplinary team providing assessment and follow up to outpatients. Approximately 20% of referrals originate from the hospital’s inpatient units. In 2001/2002 there were a total of 1,072 client visits, of which 530 registered to the geriatrician as the attending physician and 542 to a psychiatrist. The hospital has identified a future plan to increase capacity of and accessibility to the clinic.

Table 4 depicts the staffing resources for the two outpatient clinics in Halton-Peel.
Table 4. Current Staffing Resources – Outpatient Clinics

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Halton Healthcare Services Corporation</th>
<th>Trillium Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Time Equivalent (FTE) Resources</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN</td>
<td>.30</td>
<td>1.0</td>
</tr>
<tr>
<td>OT</td>
<td>.22</td>
<td>*</td>
</tr>
<tr>
<td>PT</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>SW</td>
<td>.25</td>
<td>*</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Non-Clinical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management / coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL FTE</strong></td>
<td>.77</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Accessed on a per client basis, as required.

Day Hospital

While Halton-Peel residents do have access to general Day Hospital services at specific hospital sites, there are no day hospitals providing specialized services to older adults with mental illness.

Inpatient Resources

As discussed in the previous section, inpatient clinical resources can be divided into two distinct service delivery forms: inpatient beds and hospital consultation liaison teams.

Inpatient Mental Health Beds

At present in Halton-Peel, there are 8 geriatric mental health inpatient beds at Trillium Health Centre. Older adults with mental illness from Halton and Peel have access to tertiary beds at St. Joseph’s Health Centre in Hamilton and the Centre for Addiction and Mental Health in Toronto. For those clients with behavioural challenges related to dementia, there is a behavioural health program at St. Peter’s Health System in Hamilton (Halton); for Peel residents, there is the geriatric psychiatry service at Toronto Rehabilitation Hospital.

Several Halton-Peel Hospitals are planning to augment existing mental health bed numbers along with the development of new inpatient beds and service resources specifically for the target population. Although geriatric mental health inpatient beds are being developed in these local hospitals, it remains unclear as to whether the population served and patient outcomes differ between these beds and those located in tertiary hospitals.

The following tables provide a synopsis of the numbers and type of beds available to older adults with mental illness residing in Halton-Peel.
Table 5. Current and Planned Inpatient Hospital Beds in Halton-Peel

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Adult Inpatient Mental Health Beds</th>
<th>Geriatric Inpatient Mental Health Beds</th>
<th>Geriatric Bed /Program Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual 2001/02</td>
<td>Planned 2005/06</td>
<td>Actual 2001/02</td>
</tr>
<tr>
<td>Halton Healthcare Services Corporation</td>
<td>22 (Oakville Trafalgar Memorial Hospital site)</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Joseph Brant Memorial Hospital</td>
<td>24</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>The Credit Valley Hospital*</td>
<td>26</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>Trillium Health Centre</td>
<td>42 (M-site)</td>
<td>48</td>
<td>8</td>
</tr>
<tr>
<td>William Osler Health Centre</td>
<td>77 (40 at Brampton campus; 37 at Etobicoke campus)</td>
<td>105 (68 at Brampton campus; 37 at Etobicoke campus)</td>
<td>0</td>
</tr>
</tbody>
</table>

**The CCC beds will be primarily designated for dementia clients with behavioural challenges. It is anticipated that the average length of stay (ALOS) for clients in these beds will be 6 months or more. It is expected that the geriatric mental health inpatient beds will be primarily used for acute management and monitoring of patients with chronic or late onset mental illness. ALOS is anticipated at 12 to 16 weeks.

Table 6. Inpatient Hospital Beds Currently Available Outside of Halton-Peel

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Beds</th>
<th>Bed / Program Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Joseph’s Health Centre, Hamilton</td>
<td>19</td>
<td>Geriatric inpatient psychiatry unit (A1) at Mountain site. These beds are designated for Central South and Halton.</td>
</tr>
<tr>
<td>Centre for Addiction and Mental Health ¹²</td>
<td>54</td>
<td>The Centre has a Geriatric Admission Unit with 28 beds and a Geriatric Continuing Treatment Unit with 26 beds. 10 Geriatric beds have been designated for Peel Region.</td>
</tr>
<tr>
<td>Toronto Rehab Program</td>
<td>20</td>
<td>Rehabilitation hospital Secure behaviour management unit</td>
</tr>
<tr>
<td>St. Peter’s Hospital, Hamilton</td>
<td>68</td>
<td>Chronic care hospital 3 secure units</td>
</tr>
</tbody>
</table>

¹² CAMH is currently undergoing a program review, with plans to integrate the geriatric psychiatry and neuropsychiatry programs. Following integration (anticipated completion date is January 1, 2003), it is anticipated that 10 geriatric beds and 3 neuropsychiatry beds will continue to be designated for Peel clients. Because of the complex and co-occurring medical concerns of the target population, these beds may be co-located within an acute care setting in Peel.
Hospital Consultation Liaison Teams

Trillium Health Centre’s Psychiatric Consultation / Liaison Team is multidisciplinary, providing consultation and limited treatment to adults of all ages admitted to inpatient beds other than mental health. The team performs limited outpatient consultation and treatment. Team resources and structure are outlined in Table 7.

Table 7. Current Staffing Resources – Trillium Health Centre Hospital Consultation Liaison Team

<table>
<thead>
<tr>
<th>Discipline</th>
<th>FTE Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>0.7</td>
</tr>
<tr>
<td>OT</td>
<td>0.5</td>
</tr>
<tr>
<td>SW *</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>0.5**</td>
</tr>
<tr>
<td>Other: Psychologist</td>
<td>1.0</td>
</tr>
<tr>
<td>Other: Psychometrist</td>
<td>0.42</td>
</tr>
<tr>
<td><strong>TOTAL FTE</strong></td>
<td><strong>2.62</strong></td>
</tr>
</tbody>
</table>

* Social Work component is considered part of the role of the unit social worker and is not included in the Consultation Liaison Team costs
** Psychiatrist position is not included in total FTE staffing. Psychiatrist position is paid through a combination of OHIP billing and sessional support

Future Planning for Hospital Consultation Liaison Teams

The Credit Valley Hospital and William Osler Health Centre have identified their intentions to develop hospital consultation liaison team resources within their respective organizations. Their proposed structure is described in Table 8.

Table 8. Proposed Staffing Resources – Hospital Consultation Liaison Teams

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FTE Resources</th>
</tr>
</thead>
</table>
| The Credit Valley Hospital | .5 Registered Nurse  
                           | .5 Physician  
                           | Earliest anticipated date for team to be operational is January 2003. Team will provide consultation and assessment to patients occupying hospital beds outside of mental health unit (medical, rehabilitation, complex continuing care). |
| William Osler Health Centre | Resource currently being developed for the new Brampton hospital campus with an anticipated date of functioning is 2005/2006. The Team FTE resource structure has yet to be determined. |
Crisis Response

All five hospital corporations in Halton-Peel have dedicated resources for hospital-based mental health crisis response. The Community Mental Health Crisis Response Program at Joseph Brant also provides intervention to community settings in Burlington. William Osler is the lead agency for the Peel Integrated Crisis Response Program, a mobile crisis assessment and intervention program serving Peel. Access is coordinated through a 24-hour crisis line managed by the Distress Centre Peel and St. Elizabeth Health Centre provides professional services.

Geriatric Psychiatrists and Geriatricians

It is the role of geriatric psychiatrists and geriatricians to provide medical and psychiatric diagnoses, patient monitoring, consultation and follow-up to clinical and support services. Although there are a few geriatric psychiatrists and geriatricians who have private practices, there are only a small number affiliated with Halton-Peel hospitals (Table 9).

Table 9. Geriatric Psychiatrists and Geriatrician Resources in Halton-Peel*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Geriatric Psychiatrists</th>
<th>Geriatricians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>FTE Resources</td>
</tr>
<tr>
<td>Halton Healthcare Services Corporation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The Credit Valley Hospital</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Trillium Health Centre</td>
<td>2</td>
<td>0.7†</td>
</tr>
<tr>
<td>William Osler Health Centre</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*No information was available for Joseph Brant Memorial Hospital at time of printing.
**Outpatient and inpatient services salaried and committed. Direct service time billable to OHIP
†Positions are paid through a combination of OHIP billings and sessional support.
††No sessional funding associated with this position. Direct service time billable to OHIP.

P.I.E.C.E.S.

In 1997, the MOHLTC initiated a provincial training strategy, Putting the P.I.E.C.E.S. Together, to enhance the ability of LTC facility staff to meet the care needs of residents with complex physical and mental health needs and associated behavioural issues (P.I.E.C.E.S., 2002). Through the Ontario Alzheimer Strategy, this specialized education training continues to be offered to various organizations and staff, including Community Care Access Centres, MOHLTC LTC Facility Compliance Officers and Psychogeriatric Resource Consultants.

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13 Some of these physicians may provide services in Halton-Peel, but are affiliated with hospitals outside Halton-Peel (such as in Toronto and Hamilton).
14 P.I.E.C.E.S. is an acronym that represents Physical, Intellectual, Emotional, Capabilities, Environment and Social, cornerstones of the initiative (P.I.E.C.E.S., 2002).
Support Services

The majority of older adults with mental illness are cared for in the community at home or in a LTC facility, with access to clinical mental health supports as required. While a listing of community-based long-term care and mental health support services is beyond the scope of this report, it is important to highlight these services as they represent various referral sources to the clinical components previously discussed. These support services include, but are not limited to:

- Family Physicians
- Housing
  - Mental Health
  - Long-Term Care
- Community Care Access Centres
- Addiction Services
- Community Support Services
  - Adult Day Programs
  - Meals-on-Wheels
  - Transportation Services
  - Community Information Services
  - Friendly Visiting

Family Physicians

Family physicians are a fundamental resource within the primary care system. These practitioners are frequently the first point of contact and may manage older adults with mental illness without direct consultation from, or with, other specialists. However, to do so effectively, family physicians require specialized training and supports (Elderly Mental Health Care Working Group, 2002), with specialists having an important role to increase the capacity of their colleagues (Allen, 1999). Furthermore, a number of clinical service models operate under the premise of shared care, wherein family physicians work in tandem with specialists and other specialized clinicians (Elderly Mental Health Care Working Group, 2002). Often a family physician is required to ensure continuity of care and appropriate follow-up is provided to the client upon discharge from the clinical program.

Housing

Mental health housing and related supports have traditionally been delivered to a younger population, with the mandate to house older adults with mental illness being the domain of the long-term care sector. Older adults with chronic mental illness who develop physical health conditions at the same time as residing in a mental health supportive environment should continue to remain in these surroundings, with appropriate clinical and long-term care services coming to the place of residence (Elderly Mental Health Care Working Group, 2002). Moving these clients into a LTC facility raises issues of stigma, often coupled with a lack of appropriate skills and knowledge on the part of facility staff (Elderly Mental Health Care Working Group, 2002). On the other hand, clients with Alzheimer’s disease and/or related dementias are typically cared for in the long-term care sector. A wide variety of mental health clinical consultation services need to be available within the community and LTC facilities to assist in
developing the appropriate environment and culture to meet the needs of these clients (Elderly Mental Health Care Working Group, 2002).

Regardless of where the older adult resides, a range of complementary clinical mental health and community support services must exist in order for the client to receive appropriate care and to maintain an optimum level of health given their circumstances. In the case of housing, services should be available within the client’s residence. As such, housing providers need to be informed, highly skilled and coordinated with relevant mental health services. Specifically, LTC facility staff are responsible for the personal support of older adults with a wide range of mental health conditions, but they must intimately relate to the specialty skills of mental health outreach and clinical service providers (Canadian Mental Health Association, Ontario Division, January 1997).

**Community Care Access Centres**

The mandate of Community Care Access Centres (CCAC) is to coordinate community and clinical services with persons requiring LTC services. Given their mandate as the primary point of access for LTC services, it is imperative that CCAC staff be knowledgeable and educated regarding the range of available community-based outreach services and in-hospital clinical services available to older adults with mental illness.

**Addiction Services**

While little data exist on the prevalence of substance misuse among older adults, the ramifications of such related health conditions should not go unnoticed or undiagnosed. Alcohol misuse among older adults is an often hidden and unrecognized problem (Report on Older Adults with Alcohol Misuse, 1994). Misuse of medication is also a concern given prescribing patterns of physicians and the multiple medications required by some older adults. Concurrent disorder is another confounding health problem that, if not detected, could lead to an inability to correctly diagnose an older adult’s mental or physical illness.

Locally, Halton Alcohol, Drug and Gambling Assessment Prevention and Treatment (ADAPT) and Peel Addiction Assessment and Referral Centre (PAARC) have specialized programming for older adults with addictions in their respective regions. Both programs operate in concert with other mental health community service providers to identify, assess and provide services to this population. Due to the relative lack of knowledge regarding substance misuse, mental illness and older adults, continued emphasis on joint and collaborative programming between addiction and mental health service providers is essential.

**Community Support Services**

**Adult Day Programs**

Some adult day programs are specifically designed to meet the health and social needs of persons with dementia and co-occurring physical health conditions. These programs often play a coordinating role of linking clients with clinical and other support services. Currently there are
10 agencies funded by the MOHLTC to provide adult day programs and associated supports to clients and their families in Halton-Peel:

- Region of Halton
- Joseph Brant Memorial Hospital
- The SAM Program in Burlington (Seniors Activation Maintenance Program)
- VON Halton
- Alzheimer Society of Peel
- India Rainbow
- Seniors Life Enhancement Centre
- SENACA Seniors Day Program
- City of Mississauga
- Region of Peel

**Family/caregivers**

At the early to mid stages of dementia, many clients continue to live with their spouse or other family member. The deterioration of a client’s mental and physical health places a tremendous burden on the caregiver to identify and access appropriate clinical and support services. Family and caregivers often depend on the knowledge and existing partnerships between family physicians, CCAC case managers and local chapters of the Alzheimer Society to inform them as to what services are available and appropriate for their loved one. Hence, it is critical to clearly define the various programs and services that families and caregivers may access in order for the client to be appropriately assessed and referred for care. Provision of organized opportunities for caregiver education and support is also critical.

**Other Support Services**

In addition to those support services previously mentioned, there are a number of other programs that serve older adults in general and those with mental illness (e.g. transportation, meals on wheels, friendly visiting). Often these providers are familiar with a client’s overall health and can alert emergency or clinical health service providers when they believe a client’s mental and/or physical health is declining. Given the essential role that support services play in maintaining the target population, it is crucial that strong linkages and collaboration exist between these programs and clinical mental health services.
Organizing Mental Health Services for Older Adults

The challenge of organizing functions and components into services, programs and some type of “system” or “sub-system” is not unique to psychogeriatrics. Finding the best way to organize, coordinate and balance health care, social care and other human services has been a common dilemma since the 1970s (Provan and Milward, 1995). Over the years, there have been a number of models and trends in organizing human service delivery to improve coordination among multiple agencies and organizations (Provan and Milward, 1995).

The Canadian consensus statement of geriatric psychiatry emphasizes the need for a comprehensive approach in terms of target population, method of mental health consultation and location of service delivery. In spite of this recommendation, many existing programs for older adults with mental illness are targeted at one component of the system, such as community caregivers, specialty clinic patients or residents in LTC facilities (Stolee et al, 1990). Given this reality, five key questions guided the planning process of identifying a preferred approach to improving the organization of mental health services for older adults:

1. What are the common approaches to coordinating health and social care services taken from organization science and research?
2. What is the best practice and evidence base describing the strengths and limitations of each organizational approach?
3. What are local stakeholder attitudes, preferences and professional experience regarding each organizational approach?
4. What is the preferred organizational approach based on best practice and local stakeholder input?
5. What strategies are required to support the development of the organizational approach into an operational model?

Common Approaches for Organizing Human Services

There are four common approaches for organizing and coordinating complex human services (including health and social care) that can be identified in organization science and research. These approaches can be distinguished from other approaches such as a mental health authority that is a funding allocation and system management model. Mental health authorities do not provide direct front-line service, while the four organizational approaches discussed in this report are methods of front-line service integration. Accordingly, these four approaches should be considered as complementary rather than a specific alternative to an authority or similar type of models.

The first two approaches can be described as ‘structuralist’ in that they prescribe structures to organize relationships on a hierarchical basis. The latter two approaches are ‘relationship oriented’ by focusing on complex inter-provider and inter-organizational relationships in a non-hierarchical model. Of course, the following is a simple, ideal description to distinguish between these approaches; elements of each approach might actually be used in implemented models.
Organizational Approach #1: The Integrated Delivery System/Program

The integrated delivery system (IDS) is founded on the consolidation of all functions and components within a single organization to have full managerial control from governance to front-line. This approach assumes that it is possible and effective to include all the financial and human resources within a single organization in order to “coordinate” service delivery. The current standard is the IDS as defined by Shortell (1994) for the development of health care systems from primary care through to acute secondary/tertiary to long-term care facility. The ideal IDS would include all resources that are critical for client care and support.

To date, there are no examples of a comprehensive and fully integrated IDS (Hernandez, 2000). A variation on this approach is a small, specialized program established to provide comprehensive, integrated services across the continuum for a small target population. A good example of this approach is the CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) program in Edmonton, Alberta. Modeled after the successful PACE (Program of All-Inclusive Care for the Elderly) program, CHOICE provides comprehensive services to frail older adults including a day centre, health clinic, in-home services, transportation, short-term care beds and 24-hour response service (Tell, 2002). Clients are required to become patients of the program physicians. What distinguishes an integrated program such as CHOICE from the IDS is that the program is a specialized resource for a small and usually specific target population.

Integrated Delivery System/Program
Full ownership and control of all functions and components under a single governance and management structure.

Organizational Approach #2: The Lead Agency

The lead agency model is a variation on the integrated delivery system approach. It has developed due to the practical consideration that it is extremely difficult to locate all critical resources within a single organization, as well as recognizing that expertise is diverse and located throughout any system for logical reasons (Hollander and Prince, 2002). The lead agency is based on the consolidation of funding, while services can be contracted from other organizations and providers (Durbin et al, 2001; Hollander and Prince, 2002; Provan and Milward, 1995). In its developed form, the lead agency serves as the overall client facilitator and centralized authority, but also recognizes that it is difficult for a single organization to be a competent leader in all areas of services and support. The lead agency can organize and contract out for services while continuing to centralize coordinated client entry and movement, as well as control resource planning.
Lead Agency

A centralized disseminator of funds to administer and coordinate service delivery through contracts and service agreements from a number of autonomous organizations.

The model continues to be difficult from an implementation perspective as it requires the consolidation of funding from a variety of sources (Durbin et al, 2001). Also, while the lead agency approach creates a centralized funding flow, the model does not necessarily establish enhanced coordination for the client and movement between organizations unless this is specifically developed, typically provided by the lead agency. An example of the lead agency approach is the Community Care Access Centre model established in Ontario to coordinate long-term care services.

Organizational Approach #3: Managed Network

The World Health Organization (1998) has defined a network as “a grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust”. What distinguishes the network from the previous two organizational approaches is the replacement of a centralized hierarchy and structure with a more decentralized method of diplomacy, negotiation and relationships (Pedler, 2001). Currently, there is strong interest in the network as an organizational approach with the potential to deal with complexity by emphasizing flexibility, responsiveness and innovation (Pedler, 2001; Powell, 1990; Ring and Van de Ven, 1992).

The managed network as an approach can be distinguished from other collaborative approaches because it incorporates a systematic and negotiated balance between diverse types of expertise, resources and organizations (Powell, 1990; Provan and Milward, 2001; Ring and Van de Ven, 1992). The continued autonomy of organizations provides the framework for self-organization and the development of specialized roles and expertise; while negotiation of a coordinated process for client access creates the managed element to what may be previously lacking between services.

Managed Network

A network of services and organizations with a negotiated capacity for one or more organizations to move across inter-organizational boundaries at the service level.
The perceived advantage of the managed network approach is that it can be implemented across multiple system, sector and organizational boundaries. While the problems and limitations of negotiating this order are recognized, there are possible gains by establishing a balance among organizations rather than having one set of values and resources. (Pedler, 2001; Powell, 1992; Ring and Van de Ven, 1992; Snow et al, 1992).

Organizational Approach #4: Decentralized Collaborative Network

The decentralized collaborative network is a loosely associated group of organizations with minimal collaboration in planning or formal coordination in relation to client movement and information exchange (Bolland and Wilson, 1994; Jenkins and Laditka, 2000; Kaluzny et al, 1998). At best, there may be a central group of senior administrative staff who meet to discuss their plans and actions. Typically, this arrangement does not go beyond sharing information, often after individual organizational decisions and changes have taken place (Kaluzny et al, 1998). Beyond this, relationships among various organizations will vary, but usually do not include a larger “system-wide” perspective. Most importantly, relationships at the front-line level will often remain ad hoc and informal (Bolland and Wilson, 1994). In general, this approach best typifies how psychogeriatric services and most health care services are organized and operate (Jenkins and Laditka, 2000).

Collaborative Network

A loose collection of services and organizations in which activities are self-organized and autonomous.

The Evidence Base for Methods of Organization

There is no conclusive research to indicate which organizational approach performs better in relation to standards such as cost, quality, access and coordination, and outcomes. What does exist within the literature is a set of “consensus” benchmarks or standards upon which to assess service organization. These include:

- A single or coordinated entry system
- Standardized entry assessment tools
- Standardized client classification system (who goes where and needs what)
- On-going case management
- Communication with clients and families.

(Hollander and Prince, February 2002)

Table 10 summarizes the potential strengths and possible limitations of all four organizational approaches. The inconclusive nature of the literature on approaches to organizing complex and
diverse services and resources means that a preferred organizational approach cannot be prescribed on the basis of research evidence alone. Therefore, another source of information and expertise is local stakeholders. In presenting the above organizational approaches and best practice analysis, the key question to stakeholder consultation participants in Halton-Peel was “What organizational approach would appear to have the strongest capacity to coordinate services and resources with multiple providers, organizations, sectors and systems for older adults with mental illness?” From this question, stakeholders were presented with a review of the existing research that was considered with their own experiences and expertise.
Table 10. Overview of Four Common Organizational Approaches

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<th>Approach</th>
<th>Method</th>
<th>Potential Strengths</th>
<th>Possible Limitations</th>
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| Integrated Organization/Program | Consolidation of governance, management and front-line staff within a single organization or program | □ Centralizes administrative control of all functions and components (Hollander and Prince, 2002)  
□ Some limited evidence that centralization of resources improves overall coordination (Scott, 1987)  
□ Potential to create single entry point if all resources incorporated under the 'ownership' structure (Hollander and Prince, 2002)  
□ Can lead to standardized entry and referral processes through internal management tools | □ Difficult to include all resources within a single organization (Hernandez, 2000; Hollander and Prince, 2002)  
□ Organization or program might continue to separate functions and components that limit coordination (Scott, 1987)  
□ Creates the potential that one aspect of services and supports are emphasized (e.g., medical care) at the expense of other (e.g., social care) (Scott, 1987; Stolee et al, 1990)  
□ Implementation can take a long period of time during which there can be serious service disruptions and poor staff morale (Durbin et al, 2001; Goddard and Ferguson, 1997; Fulop et al, 2002; Hernandez, 2000; Weil, 2000)  
□ Increasing evidence base questions whether IDS is most is most effective organizational approach (Ferguson and Goddard, 1997; Goddard et al, 1997; Hernandez, 2000)  
□ Difficulties associated with IDS has been attributed to an observed trend away from this approach to initiatives emphasizing collaboration and cooperation (Deloitte and Touche, 2000; Shortell et al, 2001) |
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<th>Approach</th>
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<th>Potential Strengths</th>
<th>Possible Limitations</th>
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<tr>
<td><strong>Lead Agency</strong></td>
<td>Consolidation of funding within a single organization or program with services decentralized through service contracts</td>
<td>- Centralizes administrative control of all functions and components but not service delivery (Hollander and Prince, 2002; Provan and Milward, 1995)&lt;br&gt;- Flexible and allows for multiple organizations or sectors to be involved in service delivery (Hollander and Prince, 2002)&lt;br&gt;- Can create single access point and standardized client assessment and referral tools (Hollander and Prince, 2002; Provan and Milward, 1995)&lt;br&gt;- Some evidence that coordination is equal to, if not superior, to IDS or integrated program (Kaluzny et al, 1995; Waltston, Kimberly and Burns, 1996)</td>
<td>- Difficult to include all funding within a single organization&lt;br&gt;- Continuance of hierarchical structure can lead to dominance of approaches or philosophy at the expense of other services and sectors (Scott, 1987)&lt;br&gt;- Like the integrated program/organization, implementation can be conflictual with negative impact on service and quality (Durbin et al, 2001)</td>
</tr>
<tr>
<td><strong>Managed Network</strong></td>
<td>Systematic approach to collaboration and service delivery between two or more organizations across many sectors and systems</td>
<td>- Emphasizes diversity and acknowledges different service and support competencies (Pedler, 2001; Kwiat et al, 2001; Ring and Van de Ven, 1992; Shortell, 2001)&lt;br&gt;- Capacity to involve multiple organizations, sectors and systems (Pedler, 2001; Ring and Van de Ven, 1992)&lt;br&gt;- Can be relatively easily implemented although dependent on goodwill, trust, leadership and cooperation (Pedler, 2001; Ring and Van de Ven, 1992)</td>
<td>- Dependent on cooperation rather than centralized hierarchy and chain of command (Pedler, 2001; Ring and Van de Ven, 1992)&lt;br&gt;- Subject to influence of local ‘politics’ and personality conflict (Shortell, 2001)&lt;br&gt;- Minimal evidence that network produces superior outcomes or improved coordination</td>
</tr>
<tr>
<td><strong>Decentralized Collaboration</strong></td>
<td>Ad hoc and frequently informal collaboration between two or more organizations across many sectors and systems</td>
<td>- Easy to implement</td>
<td>- No systematic approach to building relationships or centralized process&lt;br&gt;- No evidence that collaboration leads to improved coordination</td>
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*Halton-Peel District Health Council<br>November 2002*
Local Stakeholder Perspectives on the Preferred Method of Organization

In May 2002, two consultations were held in Halton and Peel with approximately 40 representatives from various organizations representing mental health, addictions, geriatric medicine, long-term care, and community support services (see Appendix B for participant list).

The meeting agenda was as follows:

- Overview of planning process
- Demographic snapshot of Halton-Peel populations from the perspective of aging and health care utilization
- Review of ‘best practice’ standards for the functions and components of psychogeriatric treatment and support
- Presentation of four approaches to organizing functions and components followed by open discussion

Overall, there was no unanimous opinion on a preferred approach to organizing mental health services for older adults. Feedback ranged from a preference for informal collaboration to an integrated delivery system/program approach that should be used to eliminate “politics and personality conflicts”. Despite the lack of consensus regarding the organization of services, participants reiterated the lack of resources available to properly treat this client group. Furthermore, it was felt that the integration of services would not generate sufficient resources to meet population need and growth.

In general, many participants felt that a developmental approach be adopted and one example given was dementia networks. As one participant observed, what started in some areas through a decentralized collaborative network approach for dementia care and support is evolving in some areas into a managed network approach.

Some of the critical questions and observations made by participants include:

- What would be the appropriate “sector” in which to integrate services – geriatrics, psychogeriatrics, long-term care or mental health?
- Integrated program and lead agency may lead to a dominant perspective, e.g., may become too medically focused, there must be a balance
- Lead agency and similarly “tightly coupled” models can lead to “system shut-down” or “blockage” when there is instability or insufficient resources
- Informal networks work best because they are based on goodwill
- Other models such as a lead agency can be conflictual and disenfranchise key stakeholders such as physicians
- Lead agency model can re-direct focus from service delivery to inter-organizational conflict over funding and other non-service management issues
- There is merit in consolidating and centralizing the case management function
- There must be a facilitated process, incentives and support to develop and sustain a network – collaboration and management takes time and costs money
- Any approach must be sensitive to diverse populations, e.g., how can a single program or agency accommodate cultural diversity

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15 Dementia networks are part of the Alzheimer Strategy, a 10-point provincial action plan for Alzheimer Disease and related dementias. The purpose of a dementia network is to serve as a vehicle to facilitate individuals and resources coming together locally, regionally and provincially to improve the system of care for persons with dementia, their families and caregivers.
In reviewing the feedback, the following strategic elements and principles were developed:

1) The guiding principle of organizing mental health services for older adults should be that of growth and investment based on a directed and managed change process, balanced with self-organization and individual organizational roles and responsibilities

2) Establish benchmarks and criteria to direct, support and assess coordination

3) Use future resource investments to manage the change process and establish individual organization roles in a systematic collective network

A Strategy for Developing a Managed Network of Services: Key Relationships and Structures

Feedback received at the consultation sessions was brought back to the Advisory Committee for consideration and discussion. Using this local context, along with best practice and research, it was agreed that the preferred approach to organizing mental health services for older adults with mental illness is to move from decentralized collaboration towards a managed network. Future financial investments should be used to encourage and support network development.

In creating a managed network, the critical issue is to establish cross-sector assessment, clinical treatment and specialized support in a range of environments to both clients and other service providers. The network should blend resources to promote mental health and the capacity of clients and caregivers, and should work to assist in maintaining individuals in their place of residence. Place of residence should include, but not be limited to, independent living environments, supportive housing, retirement homes and LTC facilities.

The network should be based on interdependency rather than sole client “ownership” (Jenkins and Laditka, 2000; Kaluzny et. al, 1998). The network should be designed to facilitate, when necessary, inter-organizational teams that work through interdependency and allocating tasks and responsibilities relevant to each organization’s expertise and competency. This might also encourage capacity building within specific organizations.

It is important to stress that providing these services in a balanced network will be contingent on sufficient resources. When resources are overly constrained, the natural response of provider organizations is to favour their own interests and important partner relationships that may disrupt the overall balance, trust-building and cooperation of the collective process (Pfeffer and Salancik, 1978).

To lay the basis for developing a network, two key factors must be developed:

1) Defined roles and accountabilities of individual organizations, defined and resourced by the MOHLTC in terms of functions and components

2) Mechanisms to formalize and sustain key relationships at the service delivery level among individual organizations (i.e., multi-organizational client teams)
Identifying the Core Network Functions and Components by Organization

The network should be founded on three critical areas of competency: assessment, case management, and mental health clinical services. These will form the basis of linking different health and social care organizations by: (1) serving as the entry point for clients from anywhere within the community or an institution; (2) by providing assessment and treatment in a coordinated manner with linkages to the full continuum of care from general practitioners to specialized tertiary hospitals; and (3) organizing a multi-organizational response and shared participation in client care throughout the process. Entry and case management should be linked to ensure continuity.

Core Component #1 Community Outreach

The research literature and recent policy documents emphasize the role of community outreach as the foundation of any system or network of psychogeriatric services (British Columbia, 2002; Stolee et al, 1990). The underlying rationale for this defined role is that community outreach can develop the capacity to provide services in any environment of consumer choice: home, LTC facility, supportive housing or even within an inpatient hospital unit or outpatient clinic.

Three key design features are necessary for community outreach:

Regional and Community Based: The community outreach program should have a regional mandate and be governed through a community board to assist in facilitating the two other design features of balance and front-line team building.

Balanced: As a regional and community organization, the community outreach program will not have an individual accountability that might favour any single organization. For example, a program that is “owned” by another organization will more likely prioritize their organization’s needs and priorities when resources are scarce (Jenkins and Laditka, 2000; Pfeffer and Salancik, 1978). Therefore, setting up a network of interdependency can create balance so that a number of organizations control certain critical functions and resources making cooperation and exchange more intrinsic to their operational interests (Mordock, 1989; Pfeffer and Salancik, 1978). A similar logic applies when considering a regional perspective: a community-wide mandate will more likely result in services being delivered equitably rather than favouring neighbourhood or institutional catchment populations at the expense of other areas.

Front-Line “Coordinator”: The outreach program would be developed as the coordinator for community referrals including linking with entry points in other sectors such as hospitals through collaborative agreement. Historically, efforts to establish a single point of entry have tried to eliminate “client feeder systems”. The service network will adapt to the “natural” existing flow of clients and professionals by linking and coordinating a central assessment function to other clinical programs. As the front-line coordinator, the outreach program and staff would be responsible for providing the key functions of initial assessment, coordinating care plan development with other relevant providers and organizations, and case management. As well, the outreach program would provide client consultation and staff education and learning opportunities across the various organizations.
Core Component #2  Schedule 1 Hospitals

Hospitals have a significant concentration of clinical expertise in both mental and physical health. This includes not only human resources such as physicians and other allied health professionals, but also costly diagnostic technology and inpatient beds. This resource concentration makes the Schedule 1 hospital the natural clinical leader within the network for medical treatment and interventions.

The key role of the hospital will be to advocate for the development of and coordinate treatment resources in partnership with the community outreach program, at a number of levels, including:

- **Tertiary Inpatient Beds:** Responsible for establishing a triage / screening role for the appropriate transfer of patients from one setting or another, or to “gatekeep” and coordinate an admission with the outreach program.
- **Inpatient Beds:** Responsible for providing acute care beds at the local level including admissions from other parts of the region. Responsible for advocating for the development of specialized inpatient resources (i.e. geriatric mental health inpatient beds). Also responsible to advocate and develop consultation liaison services across all hospital departments.
- **Outpatient clinics:** Responsible for linking assessment and treatment access with community outreach as well as coordinating the logical flow and placement of clients among geriatric, psychogeriatric and mental health outpatient clinics, and ensuring treatment capacity is available.

Core Component #3  Addiction Treatment Programs

Within the addiction treatment sector, there are assessment/referral centres with responsibility for coordinating access and movement among programs. Assessment/referral centres should be linked to the network teams, as well as other addiction treatment programs to provide access to specialized chemical withdrawal and residential services, and clinical services in accordance with best practice using outreach home models as well as office-based treatment when appropriate.

The network map is a working framework to identify the key roles, and equally important, the essential relationships that must be developed through a process of negotiation and evolution. What it does not attempt to prescribe a generic set of working relationships as they should develop and adapt at the front-line level. Instead, it sets out is how to structure and manage self-organization and innovation between organizations and sectors to establish a comprehensive and flexible continuum of services and supports.

Mapping the Network

The resources required to provide mental health treatment and supports for older adults come from many different systems and sectors (Jenkins and Laditka, 2000; Kaluzny et al, 1998). The primary function of a managed network is to establish formal, regular channels for communication, cooperation and coordinating activities in front-line service delivery (Powell, 1990; Ring and Van de Ven, 1992). Typical approaches to network development have primarily focused on the use of senior administration from individual organizations in a collective group (Jenkins and Laditka, 2000). However, the focus of a service network means the critical
linkages and relationships are between front-line services workers (Bolland and Wilson, 1994). For the service network, the primary outcome is to establish fluid inter-organizational groups of diverse providers (when necessary) to provide both inter-and intra-disciplinary services to clients (Halton-Peel DHC, 2001b; Jenkins and Laditka, 2000). Service network coordination at the front-line level relies on the exchange of ideas among health providers who offer specific and specialized expertise to produce a coordinated client treatment and support plan (Jenkins and Laditka, 2000).

The role of the front-line service networks would vary on a client-by-client basis. The core linkage would be between the assessment-referral and treatment processes. Other members of the service network would vary by place of residence (e.g., LTC facility) and/or related life skill issues. The network size would expand and contract depending on what sectors and services are at issue in care plan development. Teams would organize through case conferencing whenever a joint client management process is required.

To establish network catchments, the preferred method would be to establish “catchment” by geography and use hospital “catchments” as the approximate service borders. The logic of linking network catchment to hospital primary catchment is to naturally align community-based functions and relationships with the resources of each hospital. Within the network catchment, responsibility would include providing services and specialized expertise to LTC facilities, supportive housing and retirement homes. Over time, the outcome should be the development of key relationships that build interdependency, trust and innovation at the front-line level.

A second level for enhancing coordination in the areas of planning and administration would be a team of senior administrators. The senior level would have responsibility for the accountability of their organization’s participation in the network process, the development of a systematic overview of services, and negotiating changes in the network process as required. In many respects, this network configuration would be the inverse of most current network models in that the managerial group is in place to support the front-line team.

**Future Investments**

A parallel strategy of increasing the resource base for mental health services and using future investments to guide the network development process is necessary. The first stream is to increase existing capacity to move towards established benchmarks and addressing identified gaps. This would involve resource investments in the specific areas of outreach programs, mental health treatment services (inpatient and outpatient) and addiction treatment. The second stream is a list of investment pre-requisites to detail the types of organizational linkages and mechanisms that should be in place to facilitate a process of managed network development (see Table 11).
| **Table 11. A Strategy of Capacity Building and Network Development** |
|-----------------------------|-----------------------------------------------------------------|
| **Stream 1: Component Investments** | **Stream 2: Investment Pre-requisites** |
| Community Outreach Program | ✑ Consolidation of assessment/case management services  |
| | ✑ Consolidation of consultation and education resources  |
| | ✑ Memorandum of agreement with hospitals, LTC facilities, supportive housing units and retirement homes on provision of consultation and education  |
| Outpatient Clinics | ✑ Memorandum of agreement between community outreach program and each Schedule 1 hospital to link and establish joint assessment processes  |
| | ✑ Memorandum of Agreement and protocols between community outreach program, Schedule 1 hospitals, LTC facilities, addiction treatment services, supportive housing units and retirement homes to establish local inter-organizational teams  |
| | ✑ Schedule 1 hospitals to re-organize different clinical programs (i.e., geriatric, psychogeriatric and mental health clinics) to facilitate coordinated care and support  |
| | ✑ Memorandum of Agreement with adult day programs for the provision of psychiatric and medical support  |
| Geriatric Mental Health Inpatient Beds (Schedule 1 Hospitals) | ✑ Access protocols and gatekeeping coordination with community outreach program  |
| | ✑ Transfer agreement with tertiary and other specialized geriatric and psychogeriatric facilities  |
| | ✑ Manage community-based admissions in collaboration with Outreach Program  |
| Geriatric Mental Health Inpatient Beds (Tertiary Hospitals) | ✑ Transfer agreement with Schedule 1  |
| | ✑ Agreement on coordinating clinical roles between community and tertiary services  |
| Addiction Treatment Services | ✑ Development of older adult treatment services including in-home capacity  |
| | ✑ Memorandum of Agreement to participate on local inter-organizational teams  |
| | ✑ Delivery / development of access protocols with specialized chemical withdrawal & residential programs  |
Conclusions

The foregoing planning process was initiated to examine four variables critical to the development of mental health services for older adults in Halton-Peel. The first two variables relate to those clinical services and programs (functions and components) that should be available. Based on best practice literature, the following components were identified as essential to a comprehensive network of clinical mental health services:

- Outreach programs
- Outpatient clinics
- Day hospitals/programs
- Inpatient hospital beds
- Hospital consultation liaison teams
- Crisis response

Of these components, the outreach program was identified in the research literature as the “foundation” of a clinical system. This resource must be comprehensive in terms of the client population served including both community and LTC facility residents. It is also essential that this component be linked and coordinated with other mental health services and older person services (e.g., CCACs, community supports, hospitals, housing).

The third variable of a mental health system for older adults is having adequate resources to manage and implement the identified functions and components. Using a mixture of benchmarks established in research, policy literature and local studies, it was acknowledged that there are significant gaps between the estimated prevalence of mental health illness and available services and resources to address these needs. Concerning existing benchmarks, gaps were identified in the area of outpatient programs and geriatric inpatient mental health beds:

1. Outreach program staffing in Halton-Peel is currently 21 percent of the benchmark of 6.5 FTE per 10,000 population 65 years and older
2. Only 8 geriatric inpatient mental health beds exist in Halton-Peel community hospitals as compared to the recommended benchmark of 4-6 beds per 10,000 population 65 years and older

Using these established benchmarks, significant investments would be required to build adequate capacity.

In other areas of mental health services for older adults, no benchmarks have been established through research. However, in the areas of outpatient mental health treatment services and addiction services, local operating plan reviews and planning reports (Halton-Peel DHC, 1999; Halton-Peel DHC, 2001c; Halton-Peel DHC, 2002) have noted that these types of services meet or are close to being at capacity. With outpatient clinics functioning at full capacity, there is minimal opportunity for reallocating resources to develop special population programming such as mental health and/or addiction treatment services for older adults. While further work is needed, there is a reasonable planning basis to identify a need for future investments in the area of outpatient treatment services.

The final variable, the organization of mental health services, was discussed in the previous section. An approach of developing a “managed” network of services in which outreach programs would facilitate processes of inter-organizational linkages was proposed.
In conclusion, this report provides a strategic framework and strategy for building a comprehensive and coordinated network of mental health services for older adults that encompasses many organizations and transcends sectors, with the flexible capacity to respond to the significant demographic changes that Halton-Peel will experience in the coming years.
### Appendix A. Individual Stakeholder Meetings

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Andersen</td>
<td>The Credit Valley Hospital</td>
</tr>
<tr>
<td>Julia Baxter</td>
<td>Halton Geriatric Mental Health Outreach Program</td>
</tr>
<tr>
<td>Margaret Bickerton</td>
<td>Trillium Health Centre</td>
</tr>
<tr>
<td>Marie Gillespie*</td>
<td></td>
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<tr>
<td>Ted Bober</td>
<td>William Osler Health Centre</td>
</tr>
<tr>
<td>Gertrude Cetinski*</td>
<td>Alzheimer Society for Halton-Wentworth</td>
</tr>
<tr>
<td>Francine Cote</td>
<td>Joseph Brant Memorial Hospital</td>
</tr>
<tr>
<td>Darlene Kindiak*</td>
<td></td>
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<tr>
<td>Carolyn Clubine*</td>
<td>Peel Manor</td>
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<tr>
<td>Maureen Davis</td>
<td>Alzheimer’s Society of Peel</td>
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<tr>
<td>Lynne Edwards</td>
<td>Seniors Activation Maintenance (SAM) Program</td>
</tr>
<tr>
<td>Madeline Edwards</td>
<td>Centre for Addiction and Mental Health</td>
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<tr>
<td>Gabriella Golea</td>
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<tr>
<td>Pam Roberts</td>
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<tr>
<td>Brenda Elias</td>
<td>Supportive Housing in Peel</td>
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<tr>
<td>Sheila Flynn Kingston*</td>
<td>North Halton Mental Health Clinic</td>
</tr>
<tr>
<td>Debby Gaines</td>
<td>Halton Healthcare Services Corporation</td>
</tr>
<tr>
<td>Cathy Heclimovich</td>
<td>Community Care Access Centre of Halton</td>
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<tr>
<td>Marilyn Jerry</td>
<td>Family Representative</td>
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<tr>
<td>Ingrid Johnston</td>
<td>Allendale</td>
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<tr>
<td>Anne Kulpa</td>
<td>Community Care Access Centre of Peel</td>
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<tr>
<td>Karen Parsons*</td>
<td>Peel Addiction Assessment &amp; Referral Centre</td>
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<tr>
<td>Sharron Kusiari*</td>
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</tr>
<tr>
<td>Wendy Shelley*</td>
<td>Chesley Park (Streetsville)</td>
</tr>
<tr>
<td>Ian Stewart*</td>
<td>ADAPT</td>
</tr>
<tr>
<td>Laurence Wolfson</td>
<td>William Osler Health Centre</td>
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</table>

*External to the Advisory Committee
### Appendix B. Participant List - Community Forums (May 31, 2002)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td><strong>Halton Attendees – Town of Milton</strong></td>
<td></td>
</tr>
<tr>
<td>Karen Aikman</td>
<td>Halton Region Supportive Housing &amp; ESAC</td>
</tr>
<tr>
<td>Helga Allan</td>
<td>Oakville Re-Entry Homes Inc.</td>
</tr>
<tr>
<td>Julia Baxter</td>
<td>Halton Geriatric Mental Health Outreach</td>
</tr>
<tr>
<td>Gertrude Cetinski</td>
<td>Alzheimer Society for Halton-Wentworth</td>
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<tr>
<td>Lisa Hudson</td>
<td>Oakville Lifecare Centre</td>
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<td>Allendale Manor</td>
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<tr>
<td>Wendy McBride</td>
<td>S.E.N.A.C.A. Seniors Day Program</td>
</tr>
<tr>
<td>Mary Ellen Morrison</td>
<td>Oakville Seniors Citizens Residence</td>
</tr>
<tr>
<td>Joan Murphy</td>
<td>Halton Region – Supportive Housing</td>
</tr>
<tr>
<td>Marion Penko</td>
<td>Halton Geriatric Mental Health Outreach</td>
</tr>
<tr>
<td>Stephanie Schouten</td>
<td>Halton Region – Supportive Housing</td>
</tr>
<tr>
<td>Linda Shaver</td>
<td>Halton Region – Supportive Housing</td>
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<tr>
<td>Lorena Smith</td>
<td>Allendale</td>
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<tr>
<td>Ian Stewart</td>
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<tr>
<td>Dr. Greg Thomson</td>
<td>Halton Healthcare Services Corporation</td>
</tr>
<tr>
<td>Monica Webber</td>
<td>Region of Halton</td>
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<tr>
<td><strong>Peel Attendees – South Common Community Centre</strong></td>
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<tr>
<td>Helen Andersen</td>
<td>The Credit Valley Hospital</td>
</tr>
<tr>
<td>Barb Ashenhurst</td>
<td>Chelsey Park Streetsville</td>
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<tr>
<td>Kathy Bamford</td>
<td>VON Peel Branch</td>
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<tr>
<td>Wendy Beattie</td>
<td>Vera M. Davis Community Care Centre</td>
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<td>Margaret Bickerton</td>
<td>Trillium Health Centre</td>
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<tr>
<td>Elizabeth Chu</td>
<td>Tullamore Nursing Home</td>
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<tr>
<td>Maureen Davis</td>
<td>Alzheimer Society of Peel</td>
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<tr>
<td>Larisa Drozd</td>
<td>Peel Senior Link</td>
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<tr>
<td>Brenda Elias</td>
<td>Supportive Housing in Peel</td>
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<tr>
<td>Marie Gillespie</td>
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<td>Alice Grzesiak</td>
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<tr>
<td>Maureen Hennessy</td>
<td>Trillium Health Centre</td>
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<tr>
<td>Dr. Erika Lautenschlaeger</td>
<td>The Credit Valley Hospital</td>
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<tr>
<td>Lezlie Leduc</td>
<td>Next Step to Active Living Program</td>
</tr>
<tr>
<td>Inga Mazuryk</td>
<td>Sheridan Villa Long-Term Care Facility</td>
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<td>Anthony Mcevenue</td>
<td>Canadian Mental Health Assoc.-Peel</td>
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<td>Sharon Morrison</td>
<td>Holland Christian Homes Inc.</td>
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<tr>
<td>Fran Mortiboys</td>
<td>Next Step to Active Living Program</td>
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<td>Karen Parsons</td>
<td>PAARC</td>
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<tr>
<td>Priya Rana</td>
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<td>Doris Rice</td>
<td>Peel Manor</td>
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<tr>
<td>Pam Roberts</td>
<td>Centre for Addiction &amp; Mental Health</td>
</tr>
<tr>
<td>Diana Simpson</td>
<td>City of Mississauga – Recreation &amp; Parks</td>
</tr>
<tr>
<td>Mary Lou Werlich</td>
<td>Peel Senior Link</td>
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</table>
Appendix C. References


Canadian Association on Gerontology (1998) *Issues in the Delivery of Mental Health Services to Older Adults*, Ottawa

Canadian Mental Health Association, Ontario Division (1997) *Policy Consultation Document: Respecting Older Persons with Mental Health / Psychogeriatric Issues*, Toronto, January

Central East Region Mental Health Planning Table (1996) *Psychogeriatric Work Group Report*, Toronto

Chronic Care, Mental Health, Long-Term Care Interface Resource Inventory Task Group (1998) *Final Report of the Resource Inventory Task Group to the Provincial Steering Committee Mental Health and Long-Term Care Facility Sector*, Toronto

Clarke Consulting Group (1996) *Establishing Benchmarks for Psychogeriatric Outreach Programs*, Toronto

Clarke Consulting Group (1998), *Comprehensive Assessment Project Lakehead Provincial Psychiatric Hospital*, Centre for Addiction and Mental Health, Toronto


Halton-Peel District Health Council (2001c) 2001/2002 Community Mental Health & Provincial Psychiatric Hospital Operating Plan Review, Mississauga

Halton-Peel District Health Council (1999) The Halton-Peel Addiction Treatment Plan for Integrated Services, Mississauga


Jankowiak, J. (2002) Depression may be another risk for Alzheimer's dementia: Your doctor can help, Neurology, 59


Kaluzny, A., Zuckerman, H. and Rabiner, D. (1998) Interorganizational Factors Affecting the Delivery of Primary Care to Older Americans, Health Services Research, 33


Ministry of Health and Long-Term Care (1999a) *Making it Happen: Implementation Plan for Mental Health Reform*, Toronto

Ministry of Health and Long-Term Care (1999b) *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, Toronto


Stolee, P., Kessler, L. and Le Clair, K. A community development and outreach program in geriatric mental health: Four years’ experience *Journal of the American Geriatrics Society*, 44


