Guidelines for Community-Based Team Interventions for Seniors with Severe and Persistent Mental Health Problems Living in the Community

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Lignes directrices pour le développement et l'amélioration des interventions des équipes communautaires intervenant auprès des personnes âgées atteintes de problèmes de santé mentale sévères et persistants qui vivent dans leur communauté.

Theoritical guidelines for the development and the improvement of community-based team interventions for seniors with severe and persistent mental health problems, living in the community.

***Intervention*, la revue de l'Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec.**
Numéro 133, (2010.2) : 98-109.

The massive demographic aging of baby-boomers compounded by the deinstitutionalization of psychiatric patients in Canada and elsewhere have yielded an unprecedented increase in seniors aged 60 years and over with severe and persistent mental health problems (SPMHP) living in the community. In Quebec, the deinstitutionalization movement initiated in the 1960s was based on a humanistic philosophy focused on individual rights and freedoms and humanizing mental health care, - and on economic and therapeutic (psychiatrists' belief in more efficient care) concerns. This movement was expressed in two forms: phasing out of the asylum as a model of intervention and limited recourse to hospitalization. Thus, a reorganization of the health system was necessary, leading to the creation of new mental health organizations and changes in psychiatric hospitals (Dorvil & Guttman, 2005) for all people, particularly seniors with SPMHP.

Depending on the definition of SPMHP and the age considered to be "an older adult", the prevalence of SPMHP is between about 2% and 3% of the older population and this rate could double by 2030 (Bartels & al., 2004). In this article, SPMHP refers to long-standing and debilitating occurrences of psychopathologies/mental disorders (e.g., schizophrenia, mood or personality disorders), which negatively impact on the individual's daily functioning. Seniors with SPMHP require a disproportionate amount of health care from practitioners, their families and the community (Nour, Dallaire, Regenstreif, Hébert & Moscovitz, 2010).

Mental health problems experienced by seniors are often different from those of a younger person because of: 1) the diversity of physical issues and SPMHP that seniors face, 2) adaptation or coping skills that are more difficult to mobilize in late adulthood, and 3) challenging life transitions and stressful life events (Nour & al., 2010). These seniors may also have less social support and be victims of ageism and social exclusion. Seniors living in the

community with SPMHP experience a " double stigma": being old and living with SPMHP, which can precipitate risk behaviours (Nikolova, Carignan, Moscovitz & Demers, 2004), deficits in social skills and interpersonal problems (Bartels, 2004).

Age-adapted mental health interventions for seniors are lacking and can lead to reduced functional autonomy in the community, negative mental and physical health consequences, premature institutionalization and mortality, and an excessive caregiver burden (Bartels, 2004). Seniors with SPMHP have often received insufficient and inadequate mental health services as a result of numerous barriers: limitations faced by themselves and their families (e.g., reduced mobility interfering with their ability to consult with specialized resources in the community), health practitioners (e.g., age and gender-related bias), and inadequacies in health care systems (e.g., lack of mental health services) (Bartels, 2004). Given the complexity of this problem, community-based interdisciplinary teams have gradually developed in Europe and the U.S. in order to provide integrated psychiatric, medical and psychosocial care to older clients with SPMHP living in the community. These types of teams are also emerging in Canada with the same biopsychosocial approaches and comprehensive health care philosophy. While they seem to differ slightly in terms of their objectives and composition (Tuokko, MacCourt & Milliken, 2008), psychosocial practitioners[1] usually play a prominent role and the impact of these teams on the health and general functioning of clients is promising. However, guidelines required for these teams to appropriately address the needs of seniors with SPMHP living in the community are still unclear.

The objective of this article is to prepare the ground for guidelines aimed at developing community-based team interventions for seniors with SPMHP. Although they will not be exhaustive or definitive, they may help to better address the needs of clients, practitioners and decision-makers. This mandate is not simple as the specific needs of seniors with SPMHP living in the community have been generically included with those of the adult population (Ministère de la Santé et des Services sociaux [MSSS], 2005).

Method for Literature Review

A two-step methodology was used. First, a brief review of the literature on community-based mental health teams for seniors with SPMHP was conducted. Twenty empirical evaluations of community-based team interventions for seniors with SPMHP were examined. These studies were identified from the following databases between 1990 and 2006: Medline, PsycInfo, Current Contents, Ageline and Social Services Abstracts. To be included in this review, a study had to meet three criteria. It had to 1) be a program evaluation of a community-based mental health team; 2) include seniors (aged 60 years or older) with diagnosed mental disorders (other than dementia only); 3) report quantitative results concerning outcomes. Secondly, a group of practitioners specialized in the field of community mental health interventions for seniors (n=7) was consulted. It was composed of researchers, psychosocial practitioners, nurses and a program manager from the Mental Health Department of CSSS Cavendish, one of the only specialized community mental health services in Quebec offering biopsychosocial office-based and homecare services to seniors with SPMHP. This program, now undergoing an implementation and impact assessment, encourages screening and the provision of services to seniors with SPMHP using broadened and inclusive admission criteria (e.g. based on risk behaviour)[2]. This group of experts analyzed the information in the literature in order to determine the guidelines to be retained. In a 90-minute focus group, experts read the proposed guidelines and provided comments and suggestions. Subsequently, information was shared and the group discussed each guideline in light of its importance and implication for practice (presented in this text as Practice). Thus, even though a particular guideline might not be found frequently in the empirical literature, it might be retained if considered to be a key element for effective intervention. This analysis is consistent with the guidelines suggested by the Centre for Addiction and Mental Health (CAMH), 2009 on current evidence-based approaches in the application of mental health promotion concepts and principles for seniors.

Table 1: Characteristics and outcomes of 20 empirical evaluations of community-based team interventions for seniors with SPMHP

Programs and methods *(n & design)*	home care	transition management	case management & monitoring	interdisciplinary teams & comprehensive services	screening system	target population & flexibility	systematic holistic evaluation	partnership & coordination	education & training	implementation phase	program & service evaluation	research & transfer of knowledge	Outcomes
1. Ackerman & al. (2003) UK *(n=86; 2-year follow-up)*	X		X	X		X	X						- ↑ discharged clients to the community - ↑ client satisfaction - ↓ costs related to conventional services
2. Banerjee & al. (1996) UK *(nintr=33 nctrl=36; 6-month RCT)*	X		X	X		X	X						- ↓ costs related to new service - ↓ psychiatric symptoms
3. Bartels & al. (2004) USA *(nintr=12 nctrl=12; 1-year quasi exp.)*	X	X	X			X	X	X					- ↑ client functioning - ↑ interpersonal relations - no- less psychiatric symptoms
4. Bernstein & Hensley (1993) USA *(n=403; 13-year follow-up)*	X	X	X	X		X	X	X	X				- ↓ costs related to conventional services - ↓ hospital readmissions
5. Black & Mindell (1996) USA (*n=275; 4-year follow-up)*	X		X		X	X	X	X	X				- ↓ costs related to conventional services - ↓ costs related to new service - ↓ hospital readmissions - ↑ activity level - efficient training - ↑ interpersonal relations - ↑ emotional well-being
6. Blackmon (1990) USA *(n=24; 1-year follow-up)*	X	X	X	X	X	X	X	X	X	X			- ↓ hospital readmissions - ↓ attrition of clients - ↑ quality of life - ↑ client satisfaction
7. Blanchard & al. (1995) UK (*nintr=47, nctrl=49; 3-month RCT)*	X		X	X		X	X			X			- ↓ psychiatric symptoms
8. Brown & al. (1996) UK *(n=95; 18-month follow-up)*	X		X	X		X	X						- ↓ hospital readmissions - ↓ incidence of mortality - ↓ screening - ↓ psychiatric symptoms

9. Buckwalter & al. (1991) USA *(n=420; 4-month follow-up)*	X		X	X	X	X	X	X	X	X			- ↓ psychiatric symptoms - ↓ costs related to conventional services - successful screening
10. Cohen & al. (1993) USA *(n=41; 3-year follow-up)*	X		X	X		X	X	X	X				- ↑ client functioning - ↑ physical condition
11. Eleazer & al. (1996) USA *(n=35; 6 month follow-up)*			X	X			X	X	X				- ↑ emotional well-being - ↑ interpersonal relations - ↑ quality of life
12. Florio & al. (1998) USA *(nintr=40 nctrl=48; 1-year follow-up)*	X	X	X	X	X	X	X	X	X	X			- successful screening - ↓ attrition of clients - ↓ costs related to conventional services - ↓ of health service use
13. Gupta & al. (1996) UK *(n=97; 2-year follow-up)*	X		X	X	X	X	X						- ↓ health service use - ↑ client satisfaction - ↑ relevant client referral - successful screening
14. Harris & al. (1990) Canada *(n=21; 24-month follow-up)*	X		X	X		X	X	X	X	X			- ↑ client satisfaction - ↓ costs related to conventional services
15. Jenkins & MacDonald (1994) UK *(nintr=39 nctrl=26; 9-month quasi exp.)*	X		X	X		X	X	X					- no- less psychiatric symptoms
16. Kohn & al. (2002) USA *(n=93; 2.5-year follow-up)*	X	X	X	X	X	X	X	X	X				- ↑ client functioning
17. Rabins & al. (2000) USA *(nintr=62 nctrl=69; 26-month RCT)*	X		X		X	X	X	X	X	X			- successful screening - ↓ psychiatric symptoms
18. Robbins & al. (2000) USA *(n=97, 1 month follow-up)*	X		X		X	X	X	X	X	X			- successful screening
19. Stolee & al. (1996) Canada *(n=484; 4-year follow-up)*	X		X	X		X	X	X	X	X		X	- ↓ health service use - ↓ costs related to new service
20. Waterreus & al. (1994) UK *(n=96; 3-month follow-up)*	X		X			X	X	X	X	X			- ↓ psychiatric symptoms - ↑ client satisfaction
Total:	19	4	20	15	6	19	20	15	12	9	0	1	

Results and Discussion

The literature review and group consultation delineated 12 theoretical guidelines for the development of community-based team interventions for seniors with SPMHP.

1-Home care

Psychiatric and medical health services for seniors with SPMHP should usually be offered at home in order to enable them to remain in their natural milieu as long as possible and prevent premature institutionalization (Administration on Aging [AOA], 2001). Home care increases access to mental health services for those with reduced functionality and mobility, while countering stigma. Out of the 20 program evaluations reviewed, 19 provided mental health services at home for seniors with SPMHP.

For Practice: Home care allows for a complete evaluation of the client's health status and functioning at home and for observation and possible intervention to improve factors influencing mental health, such as physical and social environment, habits and living conditions (MSSS, 2010). These aspects cannot be observed from public health facilities or clinical settings. Also, this clientele may be resistant to accessing help in institutions and, in many cases, may suffer from secondary physical and/or cognitive losses of autonomy, which complicate transportation. Home interventions can be tailored to the client's needs, level of functioning and everyday context. However, Parent, Anderson and Neuwelt (2000) pointed out the absence of Canadian policies that stipulate the right for clients with SPMHP as a primary diagnosis (without debilitating physical or cognitive losses) to receive home care services. In Quebec, there is a history of home care services being provided to seniors but very few teams offer first-line interventions for seniors with SPMHP. This is unfortunate, given the issues faced by this clientele (Nour & al., 2010). However, the financial costs generated by workers making home visits and the transportation time involved must also be considered, as these have a direct impact on the number of clients visited (Coyte & McKeever, 2001).

2-Transition management

Community-based mental health services often need to establish a transition plan for older clients with SPMHP prior to their transfer from healthcare institutions to the community. Larivière, Gélinas, Mazer, Tallant & Paquette (2002) argue that seniors with SPMHP who spent most of their adult years in psychiatric institutions can be distressed by their transfer to the community. This can lead to a declining health status, higher readmission rates to hospitals and increases in health care costs. Careful discharge planning, however, can assure efficient transfers (Larivière & al., 2002; 2006). From the 20 program evaluations reviewed, only 4 established a transition plan for older clients with SPMHP.

For Practice: Being discharged from an acute care hospital can be stressful for frail seniors with SPMHP who may have difficulty adjusting and may require effective transition protocols and specialized support during this period. This transition must be understood in light of the psychosocial frailty of this subgroup, an individual characteristic that some mental health workers see as a direct consequence of long-term psychiatric institutionalization (Dallaire, McCubbin & Provost, 2010). Transition management also aims to facilitate communication between services and organizations and ensure the transmission of client information.

3-Case management

Case management services should be provided according to a client's specific needs. These include risk management and monitoring the evolution of the condition of seniors with SPMHP in the community (AOA, 2001). Also, importance is assigned to a client's self-determination and empowerment (empowerment defined as a set of activities and practices that give power and control over one's health; and self-determination as the opportunity to select activities that have meaning; Bear, Sauer & Jentsch, 2000). All 20 program evaluations reviewed included case management for seniors with SPMHP.

For Practice: The designation of one professional as case manager to assess the client's global needs, act as resource manager, and follow

the client's evolution, is necessary for a comprehensive, individualized treatment plan and follow-up (Wallach, Lavoie, Leibing, Regenstreif & Moscovitz, 2010). For seniors with SPMHP, this facilitates access to the public health and social service system and to other resources in the community. Some practical issues related to case management remain unanswered, such as the type of professional to perform this role. In many settings, due to the diversity of needs (e.g. counselling) and problems (e.g. risk behaviours) faced by this clientele, psychosocial practitioners are designated as case managers in front-line mental health services (Burns, Purandare & Craig, 2002). Ideally, the individual's needs should dictate the type of professional to best respond to the client's needs.

4-Interdisciplinary teams

Due to the complexity of their problems, seniors with SPMHP often need interdisciplinary teams (i.e. various professionals discuss clients' needs and service plans) to provide them with comprehensive health services at the same location in the community (AOA, 2001). The diverse skills of community mental health nurses and psychosocial practitioners enable them to play key roles in such teams. The psychiatrist's role is crucial, especially in evaluating the psychiatric and medical condition of clients and providing psychotropic medication as needed. Occupational therapists can also provide an expertise in the evaluation and promotion of functioning in the daily lives of seniors with SPMHP (Larivière & al., 2002). Such interdisciplinary mental health teams are already present in some Canadian communities (Tuokko & al., 2008). Out of the 20 program evaluations reviewed, 15 functioned with an interdisciplinary team.

For Practice: The use of an interdisciplinary approach allows the team to use the strengths of all disciplines involved, and communication among them adds to the comprehensiveness of the evaluation and intervention. This approach also uses a range of strategies (e.g. outreach, home visits) that complements the disciplines in order to achieve a common goal (CAMH, 2009). Yet, interdisciplinary teams may experience challenges, such as differing professional perspectives, role definition and competition, physician dominance in team decisions, and overlapping skills (Leipzig & al., 2002). Although the role of a psychiatrist or psychologist is important, such a contribution is often missing from interdisciplinary teams.

5-Screening system

The implementation of a proactive screening system for seniors in need of mental health services is increasingly regarded as essential (AOA, 2001). Screening sources may include health professionals, clients, families or members of the community. Also, it has been suggested that front-line physicians receive additional training so they can act as screening sources (Bartels, 2004). Among the program evaluations reviewed, only 6 conducted proactive outreach to seniors with SPMHP. Two program evaluations reported a significant short-term impact among those implementing screening activities for seniors with SPMHP living in the community (i.e. programs able to reach adults with SPMHP in the community who were not receiving social and health services, but who needed them). The first promising screening model is the *Gatekeepers Model* (Florio, Jensen, Hendryx, Raschko & Mathieson, 1998) and the second is an outreach component included within a larger program (Rabins & al., 2000).

For Practice: Beyond the basic mandate of responding to requests for help, the CSSS in Quebec have a responsibility to reach out to residents of their territory (some of whom may be vulnerable and isolated) who have not asked for help but are in need of assistance. Innovative screening systems such as the *Sentinels project* (MSSS, 2006) related to suicide and *Project P.I.E.* related to social isolation (Nour, Brown, Moscovitz, Hébert & Regenstreif, 2009) have emerged. However, implementing and maintaining this type of system places time and resource demands on health and social service resources and community organizations.

6-Target population and flexibility

Mental health services for seniors with SPMHP living in the community must adapt to the characteristics of their different communities (AOA, 2001); consequently, the target population should be defined accurately. Such services

need to be adapted according to the demographic, ethnic, cultural, economic, and epidemiological profiles of the communities (Brown, Challis & Von Abebdorff, 1996). Underutilization of mental health services and treatment retention problems are reported with older clients with SPMHP from ethnic minority groups (Choi & Gonzalez, 2005). Of the 20 program evaluations reviewed, 19 documented client characteristics.

For Practice: There is a lack of mental health practitioners with language and cultural competencies (Sadavoy, Meier & Ong, 2004) and a need to improve multicultural training of front-line mental health practitioners in order to best serve older clients with SPMHP. It is of fundamental importance to know their lifestyle, cultural background, and needs in regards to all aspects of their health and aging.

7-Systematic holistic evaluation

A standardized holistic evaluation should be conducted in order to evaluate the biological, psychological, and social strengths and needs of older clients with SPMHP (AOA, 2001; Bartels, 2004). Every program evaluation reviewed offered systematic holistic assessments (partial or total) for older clients with SPMHP.

For Practice: There is a need to consider the person as a whole and take into account the physical, mental, social, and religious factors that affect mental health (CAMH, 2009). The focus of the mental health evaluation is an issue, because a psychiatric diagnosis in seniors can be symptom-oriented and complex (AOA, 2001) while displaying limited appraisal of their psychosocial situation. An interesting adjunct for community-based mental health programs for seniors with SPMHP would be to focus on evaluating risk behaviours (Bartels, 2004; Nikolova & al., 2004). This leads to managing risk factors (e.g., low socioeconomic status), precipitant factors (e.g., stressful events), and protective factors (e.g., client's resources), which go beyond what is usually considered clinically. The use of specific tools is needed for a comprehensive assessment of the client's situation. Currently, the provincially-mandated *Multiclientele Autonomy Assessment Form* is used in the CSSS to assess clients physically, psychologically, socially, and their ability to respond to their daily needs. Although the tool is comprehensive and suitable for older clients, it is limited in regards to an older population with SPMHP: only one broad question on psychological health and a few on mental functions. An adjunct to this form, *Psychogeriatric and Risk Behavior Assessment Scale* (Nikolova & al., 2004), accessible in several CSSS, assesses 10 categories of risk behaviours possibly experienced by seniors living in the community. Several CSSS have undertaken a periodic needs assessment of their clientele, which is recommended.

8-Partnership and coordination

Community mental health services for seniors with SPMHP should be coordinated with other community services in order to provide comprehensive and adequate health care (AOA, 2001). A community-based mental health service can act as the entry point in the reorganization of hospital and community services (by maximizing limited resources through reallocation and liaison between existing resources in the community (e.g., day centres, nutritional services, religious organizations or transportation services). Lastly, Canadian initiatives exist, such as the *Canadian Collaborative Mental Health Initiative* (Canadian Collaborative Mental Health Initiative [CCMHI], 2006), which provides a toolkit for health care providers and planners to establish collaborative initiatives between mental health care and physical health care of seniors. Of the 20 program evaluations reviewed, 15 reported partnerships and coordination in the community.

For Practice: Developing coordinated and formal partnerships among related resources will increase communication among professionals allowing easier access for clients when using more than one service. Partnerships should be promoted between establishments and with community organizations. In this perspective of "community", any partnership with external services used by seniors, such as pharmacies, should be promoted (Wallach & al., 2010). It is crucial to connect different players in the community and to involve members of the care team in planning and decision-making (CAMH, 2009).

9-Education and training

While specialized training in mental health for seniors is crucial, it is lacking or inadequate (AOA, 2001) and should be provided to professionals (Newhill & Korr, 2004). This situation is doubly problematic, given that mental health services should also provide relevant information to clients, their families, and the community. It has been suggested that Canadian universities give supplementary education and training in mental health for seniors (Kirby & Keon, 2004). An example of such an initiative is the *Canadian Academy of Geriatric Psychiatry,* which offers a subspecialty in Geriatric Psychiatry. Of the 20 program evaluations reviewed, 12 provided education (to clients, caregivers and community).

For Practice: The interplay between mental and physical health problems in seniors is complex and requires specialized education and training in order to better respond to their multiple needs. This type of specialized education (on aging, mental health and stigma), especially among front-line professionals, is lacking, not only in terms of university training, but also within health care organizations (Wallach & al., 2010). While several researcher/practitioner groups (e.g. Jewish General Hospital, McGill University Health Centre, CSSS Cavendish) do offer specialized presentations for professionals on specific issues relating to SPMHP and aging, education and training require time, money and qualified professionals.

10-Implementation phase: There are few implementation protocols regarding community-based intervention models for seniors with SPMHP (AOA, 2001), although standardized implementation can probably improve outcome validity and the likelihood of replication. Out of the 20 program evaluations reviewed, 9 had a clear implementation protocol. Three program evaluations used standardized implementation protocols: *Assertive Community Treatment* (Blackmon, 1990); *Gatekeepers Model* (Florio & al., 1998), and a hybrid model combining both of the above models (Rabins & al., 2000). Overall, they were successful at reducing the number of hospitalizations and the impact of SPMHP on functional abilities, while improving screening and permitting earlier interventions.

For Practice: Programs are being increasingly asked to evaluate their effectiveness and efficacy. In Quebec, the accreditation process that all CSSS must pursue permits a partial evaluation of implementation and effects but usually is not performed with these objectives in mind. A clear summary of the implementation phase is needed to clarify the initial model and implementation process upon which the program is based, and current activities must be related to the goals of the program (Wallach & al., 2010).

11-Program and service evaluation

Cost reduction in service provision is frequently prioritized. The major objective concerns the prevention and delay of hospitalizations, because it reduces the number of hospitalization days and the mobilization of health resources (Department of Health and Human Services, [USDHHS-US], 1999). A systematic review by Simmonds, Coid, Joseph, Marriott, and Tyrer (2001) indicated that community mental health team management can reduce costs of care, days of in-patient psychiatric treatment, risk of suicide and treatment drop-outs, while improving client satisfaction. Lastly, new or established programs should regularly evaluate the quality of their interdisciplinary services for seniors with SPMHP. However, none of the 20 program evaluations clearly described such an initiative. In these program evaluations, 18 outcomes were found and 6 global outcomes were identified: 1- better functioning of clients; 2- reduced health care costs; 3- less inappropriate health care service use; 4- improved client screening; 5- reduced psychiatric symptoms; 6- increased client satisfaction. However, the methodological aspects of most studies (e.g. medium-sized samples, less than 24-month post-program follow-up), may limit the validity and generalization of these outcomes.

For Practice: The evaluation of a mental health program or service enables decision-makers to determine the extent to which the initial mandate has been achieved. For practitioners, it also enables them to examine their practice with objectivity. Continual revision of program objectives is needed to ensure progress towards the objectives and ultimate outcomes of the program (CAMH, 2009). However, to the extent that the research evaluates practices/interventions, there may be resistance from personnel for fear that

their work is being judged. Evaluations require the mobilization of resources in terms of time and personnel, but also the involvement of a research team to ensure the continuity of evaluation. Also, performance evaluations of the CSSS mental health departments are conducted based on the number of clients seen and not the number of interventions. These statistics lead practitioners to limit time allowed for each client possibly to the detriment of the quality of the intervention (Wallach et al, 2010). Too often, such evaluations are rationalized (i.e. doing more with less) and are therefore unattractive to practitioners.

12-Research and transfer of knowledge

The outcomes obtained from intervention programs or services should be documented in professional and scientific journals to ensure transfer of knowledge (AOA, 2001). However, peer reviewed publishing can take too long for practitioners in need of urgent evidence-based support for their practice. Among the 20 program evaluations reviewed, only one Canadian program evaluation provided sufficient information regarding ongoing transfer of knowledge to other mental health services (Stolee, Kessler & LeClair, 1996). Nevertheless, other Canadian initiatives exist such as the *National Consensus Process* created to promote research evidence from studies in the aging population (MacCourt, 2008).

For Practice: For the benefit of older adults with SPMHP, resources cannot work in a vacuum. Transferring knowledge about community mental health programs, services and initiatives among those working in the field will improve their professional skills, which will then improve services to users (Wallach & al., 2010). Also, formal evaluation processes that clearly state outcomes and consider process indicators are needed for effective interventions and programs (CAMH, 2009). Yet, few mental health practitioners have the opportunity to initiate and participate in research projects or transfer of knowledge activities. To our knowledge, research centres specialized in the field of seniors with SPMHP are rare, and time, money and resources are required for more practitioner involvement. Their clinical and field expertise is crucial for knowledge transfer to the community.

Conclusion

In Canada, the health care system has often neglected universal coverage of non physician-centred community mental health services and home care services for people with SPMHP living in the community. Yet, the aging of the Canadian population will predictably increase the need for such services. Romanow (2002) suggested that financing of programs be coordinated with the needs of Canadians as they age. However, Kirby and Keon (2004) underlined the insufficient evidence-based literature on best practices in mental health for seniors.

In an effort to rectify this deficiency, this article defined 12 theoretical guidelines that practitioners, program managers, and policy-makers may consider to improve mental health care for Canadian seniors with SPMHP living in the community. The 12 guidelines are similar to the work of Donnelly and MacCourt (2002) who developed 6 principles of mental health care for Canadian seniors (client and family-centred; goal-oriented; accessible-flexible; comprehensive; specific services; accountable) and 9 key elements for the provision of such care (health promotion-early intervention; education; family support-involvement; psychosocial rehabilitation-recovery; environmental milieu; integrated-continuous services; quality improvement-evaluation processes; volunteers-mentors-peer counsellors; advocacy-protection). However, 5 out of the 12 guidelines (transition management; screening system; implementation phase; program-service evaluation; research/transfer of knowledge) were less reported in the 20 studies reviewed, but were still highlighted by practitioners as key elements for community-based mental health teams for seniors.

The outcomes of the 20 studies and the consultation with specialized practitioners suggest that community-based mental health teams for seniors with SPMHP can provide short-term psychosocial and economic benefits. In addition, program evaluations that used standardized implementation protocols seemed to increase the likelihood of successful practice with seniors with SPMHP. These outcomes are encouraging even though most program evaluations reviewed had significant methodological limitations and were not Canadian. Thus,

whether these outcomes can be generalized to Canadian communities remains an open question.

We believe that with the use of more qualitative methodologies, and through the development of intervention strategies and the implementation of services, a participatory approach should be promoted in order to obtain the clientele's viewpoint. This approach combines methods that empower or increase the autonomy of communities, often realized by the development of a committee including clients, managers, workers, etc. It improves understanding and creates a sense of ownership of development projects that result in lasting change. The development of these guidelines should have been made via this approach, which is a limitation of this study. Another limitation is in the methodology used. Only experts from the CSSS Cavendish were part of the focus group and the guidelines retained by these experts might fit with the values and philosophy of an urban and strong community setting. Nonetheless, we consider the 12 guidelines to be promising elements for the development and implementation of community-based teams working with a senior clientele with SPMHP living in the community.

Descripteurs :

Personnes âgées - Santé mentale // Personnes âgées - Soins à domicile // Services de santé mentale // Services aux personnes âgées

Aged - Mental health // Aged - Home care // Mental health services // Aged - Services for

Notes

1 The term psychosocial practitioner refers to practitioners with a degree in social work, whether or not they are a member of the Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec (OTSTCFQ).

2 This program is currently being evaluated. This evaluation will be completed by spring 2011.

References

Ackerman, E., Burnand, J., Horton, C., Jenkins, D., Joomraty, H., Pritchard, D., Raynard, F., Wedatilake, G., & Wilson, R. (2003). Two-year outcomes of a multiagency elderly mentally ill unit providing intermediate care, *International Journal of Geriatric Psychiatry, 18*, 353-361.

Administration on Aging (2001). *Mental Health & Elderlies: Issues & Opportunities.* Rockville: US Department of Health and Human Services.

Banerjee, S., Shamash, K., Macdonald, A., & Mann, A. H. (1996). Randomized controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home**,** *British Medical Journal*, *313*, 1058-1061.

Bartels, S. J. (2004). Caring for the whole person: Integrated health care for elderlies with severe mental illness and medical comorbidity, *Journal of the American Geriatrics Society*, *52*, 249-257.

Bartels, S. J., Forester, B., Mueser, K. T., Miles, K. M., Dums, K. R., Pratt, S. I., Sengupta, A., Littlefield, C., O'Hurley, S., White, P., & Perkins, L. (2004). Enhanced skills training and health care management for older persons with severe mental illness, *Community Mental Health Journal*, *40*, 75-90.

Bear, M., Sauer, M., & Jentsch, F. (2000). Community based use with service coordinators and case managers in a shared cost program, *Journal of Gerontological Social Work*, *33*, 35-49.

Bernstein, M. A., & Hensley, R. (1993). Developing community-based program alternatives for the seriously and persistently mentally ill elderly, *Journal of Mental Health Administration*, *20*, 201-207.

Black, J., & Mindell, M. (1996). A model for community-based mental health services for older adults: Innovative social practice, *Journal of Gerontological Social Work*, *26*, 113-127.

Blackmon, A. A. (1990). South Carolina's Elder Support Program: An alternative to hospital care for elderly persons with chronic mental illness, *Adult Residential Care Journal*, *4*, 119-122.

Blanchard, M. R., Waterreus, A., & Mann, A. H. (1995). The effect of primary care nurse intervention upon older people screened as depressed, *International Journal of Geriatric Psychiatry*, *10*, 289-298.

Brown, P., Challis, D., & Von Abendorff, R. (1996). The work of a community mental health team for the elderly: Referrals, caseloads, contact history and outcomes, *International Journal of Geriatric Psychiatry*, *11*, 29-39.

Buckwalter, K. C., Smith, M., & Zevenbergen, P. (1991). Mental health services of the rural elderly outreach program, *Gerontologist*, *31*, 408-412.

Burns, A., Purandare, N., & Craig, S. (2002). *Mental health in older people in practice*. The Royal Society of Medicine Press.

Canadian Collaborative Mental Health Initiative (2006). *Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners*. www.ccmhi.ca/fr.

Centre Addiction and Mental Health (2009). *Best-practice guidelines for mental health promotion programs: Olders adults 55+*. https://knowledges.camh.net.

Choi, N. G., & Gonzalez, J. M. (2005). Geriatric mental health clinicians' perceptions of barriers and contributors to retention of older minorities in treatment: An exploratory study, *Clinical Gerontologist*, *28*, 3-25.

Cohen, C., Onserud, H., & Monaco, C. (1993). Outcomes for the mentally ill in a program for older homeless persons, *Hospital & Community Psychiatry*, *44*, 650-656.

Coyte, P. C., & McKeever, P. (2001). Home care in Canada: Passing the buck, *Canadian Journal of Nursing Research*, *33 (2)*, 11-25.

Dallaire, B., McCubbin, M., & Provost, M. (2010). Vieillissement et trouble mental grave : questions de représentations, questions d'intervention, dans M. Lagacé (ed.). *L'âgisme. Comprendre et changer le regard social sur le vieillissement* : 175-197. Québec : Les Presses de l'Université Laval.

Donnelly, M., & MacCourt, P. (2002). *Guidelines for Elderly Mental Health Care Planning for Best Practices for Health Authorities*. British Columbia: Ministry of Health Services.

Dorvill, H., et Guttman, H. (2005). Annexe 1. 35 ans de désinstitutionnalisation au Québec, 1961-1996. www.le-pont.ca/Ladésinstitutionnalisation.pdf.

Eleazer, G. P., Bryant, E. S., Crow, S., Ryan, C., Rowen, R., Valleni, D., Hedgepeth, J., & Weinrich, S. (1996). A new geropsychiatric approach: Assertive community-based case management, *Journal of Clinical Geropsychology*, *2*, 129-140.

Florio, E. R., Jensen, J. E., Hendryx, M., Raschko, R., & Mathieson, K. (1998). One year outcomes of elderlies referred for aging and mental health services by community gatekeepers, *Journal of Case Management*, *7*, 74-83.

Gupta, K., Coupland, L., & Fottrell, E. (1996). A two-year review of an "open access" multidisciplinary community psychiatric service for the elderly, *International Journal of Geriatric Psychiatry*, *11*, 795-799.

Harris, A. G., Marriott, M. B., & Robertson, R. N. (1990). Issues in the evaluation of a community psychogeriatric service, *Canadian Journal of Psychiatry*, *35*, 215-222.

Jenkins, D., & MacDonald, A. (1994). Should general practitioners refer more of their elderly depressed patients to psychiatric services, *International Journal of Geriatric Psychiatry*, *9*, 461-465.

Kirby, M. J. L., & Keon, W. J. (2004). *Mental Health, Mental Illness and Addiction: Issues and options for Canada (Report 3)*. Interim report of The Standing Senate Committee on Social Affairs, Science and Technology.

Kohn, R., Goldsmith, E., & Sedgwick, T. W. (2002). Treatment of homebound mentally ill elderly patients: the multidisciplinary psychiatric mobile team, *American Journal of Geriatric Psychiatry*, *10*, 469-475.

Larivière, N., Gélinas, I., Mazer, B., Tallant, B., & Paquette, I. (2002). Discharging elderlies with a severe and chronic mental illness in the community, *The Canadian Journal of Occupational Therapy*, *69*, 71-83.

Larivière, N., Gélinas, I., Mazer, B., Tallant, B., & Paquette, I. (2006). Adjustment to community residential settings over time among elderlies with serious mental illnesses, *Psychiatric Rehabilitation Journal*, *29*, 189-196.

Leipzig, R. M., Hyer, K., Ek, K., Wallenstein, S., Vezina, M. L., Fairchild, S., Cassel, C. K., & Howe, J. L. (2002). Attitudes toward working on interdisciplinary healthcare teams: A comparison by discipline, *Journal of the American Geriatric Society*, *50*, 1141-1148.

MacCourt, P. (2008). *Promoting Seniors' Well-Being: A Seniors Mental Health Policies Lens Toolkit* . Victoria, British Columbia: British Columbia Psychogeriatric Association.

Ministère de la Santé et des Services sociaux (2005). *Mental Health Action Plan 2005-2010*. publications.msss.gouv.qc.ca.

Ministère de la Santé et des Services sociaux (2006). *L'implantation de réseaux de sentinelles en prévention du suicide*. Cadre de réference. publications.msss.gouv.qc.ca.

Ministère de la Santé et des Services sociaux (2010). *Organisation des services de soutien à domicile*. www.msss.gouv.qc.ca.

Newhill, C. E., & Korr, W. S. (2004). Practice with people with severe mental illness: rewards, challenges, burdens, *Health & Social Work*, *29*, 297-305.

Nikolova, R., Carignan, M., Moscovitz, N., & Demers, L. (2004). The psychogeriatric and risk behaviour assessment scale (PARBAS), *Archives of Gerontology and Geriatrics*, *39*, 187-200.

Nour, K., Brown, B., Moscovitz, N., Hébert, M., & Regenstreif, A. (2009). Le projet PIE : une stratégie prometteuse de dépistage des aînés qui présentent des problèmes de santé mentale, *Santé mentale au Québec*, *XXXIV*, *2*, 217-235.

Nour, K., Dallaire, B., Regenstreif, A., Hébert, M., et Moscovitz, N. (2010). Les problèmes de santé mentale chez les aînés : des réalités et répercussions diverses, des services à adapter, dans M. Charpentier, N. Guberman, V. Billette, J.-P. Lavoie, A. Grenier et I. Olazabal. *Vieillir au pluriel.* Montréal : PUQ.

Parent, K., Anderson, M., & Neuwelt, B. (2000). *Home care and people with psychiatric disabilities: Needs & Issues.* Toronto: Canadian Mental Health Association.

Rabins, P. V., Black, B. S., Roca, R., German, P., McGuire, M., Robbins, B., Rye, R., & Brant, L. (2000). Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly, *Journal of the American Medicine Association*, *283*, 2802-2909.

Robbins, B., Rye, R., German, P. S., Tlasek-Wolfson, M., Penrod, J., Rabins, P. V., & Smith Black, B. (2000). The psychogeriatric assessment and treatment in city housing (PATCH) program for elders with mental illness in public housing: getting through the crack in the door, *Archives of Psychiatric Nursing*, *14*, 163-172.

Romanow, R. J. (2002). *Building on Values: The Future of Health Care in Canada*. Ottawa: Health Canada.

Sadavoy, J., Meier, R., & Ong, A.Y. M. (2004). Barriers to access to mental health services for ethnic seniors: The Toronto study, *Canadian Journal of Psychiatry*, *49*, 192-199.

Simmonds, S., Coid, J., Joseph, P., Marriott, S., & Tyrer, P. (2001). Community mental health team management in severe mental illness: a systematic review, *British Journal of Psychiatry*, *178*, 497-502.

Stolee, P., Kessler, L., & LeClair, J. K. (1996). A community development and outreach program in geriatric mental health: Four years' experience, *Journal of the American Geriatrics Society*, *44*, 314-320.

Tuokko, H., MacCourt, P., & Milliken, J. (2008). *Understanding the needs of caregivers of mentally ill elderlies: Hearing their voices to inform services*. Victoria: University of Victoria Centre on Aging.

Department of Health and Human Services (1999). *Mental Health: A report of the surgeon general*. Chapter 5: Elderlies and Mental Health, 335-401. Rockville: U.S. Department of Health and Human Services.

Wallach, I., Lavoie, J.-P., Leibing, A., Regenstreif, A., et Moscovitz, N. (2010). *Naviguer entre deux eaux… Intervenir auprès des personnes âgées avec des troubles graves de santé mentale.* Rapport de recherche. CSSS Cavendish – CAU.

Waterreus, A., Blanchard, M., & Mann, A. (1994). Community psychiatric nurses for the elderly: well tolerated, few side-effects and effective in the treatment of depression, *Journal of Clinical Nursing*, *3*, 299-306.