“I don’t have a problem”: How to engage seniors in their mental health care

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Geriatric Psychiatry Community Services of Ottawa

Introduction

Seniors face overlapping stigma: the stigma of living with a mental illness, as well as the stigma of being older.[1] Seniors will have the highest rate of mental illness in Canada by 2041.[1]

Physical, economic, and social barriers may often prevent older adults from receiving essential psychiatric treatment.[2] The Mental Health Commission of Canada Guidelines recommends in-home clinical case management for seniors.[1]

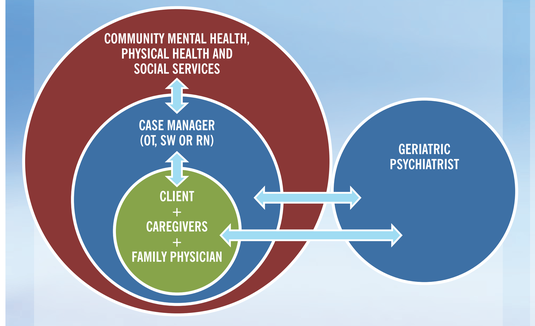
Objectives

1. Recognize barriers limiting access to mental health care for seniors.
2. Learn about a home-based case management service delivery model for hard to reach seniors with serious mental health needs.
3. Appreciate how case managers collaborate with clients, their caregivers and other community health and social service agencies to maintain clients in their homes.

Geriatric Psychiatry Community Services of Ottawa

- 2590 clients served in 2016-2017
- At any one time, an estimated:
  - 18% of our clients are seen in our clinic by a geriatric psychiatrist uniquely
  - 82% of our clients are followed by a case manager (18.5 FTE)
    - 55% intervention by a case manager uniquely
    - 45% joint intervention with a geriatric psychiatrist

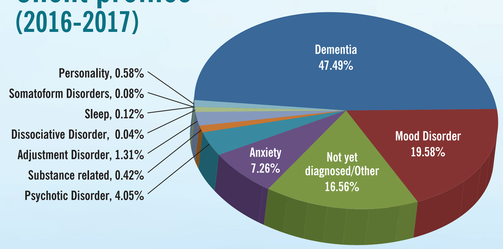
Collaborative Service Delivery Model



Seniors: Multiple health conditions

- 86% of our clients have 1 or more chronic illnesses such as:
  - Diabetes and/or other cardiovascular disease
  - COPD and/or other pulmonary disease
  - Dementia or other cognitive impairment
  - Parkinson’s and/or other neurological disease
  - Arthritis and/or other musculoskeletal disorder

Client profiles (2016-2017)



Clinical Case Management Framework

- Biopsychosocial approach
- Three phases of case management[4]:
  - Assessment
  - Treatment/Care coordination
  - Termination/Linkage
- Services provided in the home/community

Service limitations such as:

- No accompaniment or transportation directly provided (need to collaborate with other partners)
- Limited time frame for intervention
- Long wait time
- Large geographic area to cover

CASE STUDY

History of Presenting Illness

- 75 year old woman hospitalized for 2 months with “failure to thrive” (severe osteoarthritis, refused hip replacement), history of depression but stable mental health during hospitalization
- Discharged from hospital to subsidized retirement home but withdrawn behavior and multiple emergency room visits for anxiety/high blood pressure x 2 months
- Upon last emergency room visit, referred for geriatric psychiatry services

Assessment Summary

BIOPHYSICAL

- Parkinson’s disease (unsteady gait)
- Osteoarthritis with regular hip and knee pain and does not ask staff for PRN pain medication
- Lost 15 lbs/3 months unintentionally
- Anti-depressant medication unchanged from prior to hospitalization

PSYCHOLOGICAL

- “I’m having a nervous breakdown”
- New symptoms of severe depression (little to no spontaneous speech, significant psychomotor retardation, poor sleep and appetite, hopelessness and shame)
- Persecutory delusions (believes she owes lots of money despite finances being in order leading to fear of being punished and evicted)

SOCIAL

- No supports except for a niece 2 hours away whom she has not had contact with in over a year
- Limited income, has subsidy for housing but no simple access to funds, transportation or accompaniment

FUNCTIONAL

- Spends all day in bed, brought to meals otherwise refuses
- Does not participate in personal care other than toilets self, refusing personal care assistance
- High falls risk as poor use of walker/staying in bed all day

Goals

- ↑ psychological well-being (improve mood, sleep, appetite, ↓ panic attacks and delusions)
- ↑ biophysical function (pain control, weight/nutrition, Parkinson’s management)
- ↑ social supports
- ↑ functional participation and assistance available
- Avoid hospitalization as per client’s wishes and she is agreeable to changes in medication

Methods

Home visits	Collaboration tasks
Visits #1 + #2: (over 4 days) • Assessment • Develop therapeutic trusting relationship as client reluctant to talk to anyone • Bank visit with client to assist in paying month-late rent (decrease fear of eviction/ maintain support of housing owner and staff)	Obtain collateral + baseline from supervised living staff, hospital SW, previous senior’s outreach social service worker and GP Case discussion with geriatric psychiatrist and other case managers (interdisciplinary) at team meeting, client put on high priority out-patient geriatric psychiatrist wait list Liaison with GP and nurse at supervised living re: medication for pain + mood as well as nutrition optimization while waiting to see geriatric psychiatrist Liaison with assisted living housing owner re: rent amount due and relocating to room closer to dining room to + meal attendance
Visit #3: (1 week later) • Monitor symptoms and impact of collaboration tasks to date (biopsychosocial treatment) • Coordinate upcoming geriatric psychiatrist out-patient consultation	Obtain collateral from supervised living staff Coordinate wheelchair loan, adapted public transportation and volunteer accompaniment with supervised living staff and local senior’s center
Visit #4: (1 week later) • Monitor symptoms • Assistance to attend geriatric psychiatrist out-patient consultation • Discuss and obtain consent to contact distant niece and homecare services	Ensure up to date symptoms and medication list/effects for geriatric psychiatrist consult Support to supervised living staff and volunteer Referral to homecare to increase personal care support and for mobility and bathroom safety assessments (OT & PT) Liaison with homecare social worker re: roles, agreed SW to focus limited visits on canceling telephone/obtaining credit and income taxes Telephone calls to niece to inform of changes since hospitalization as she had not seen the client/been unaware of changes. Niece offered to visit shortly, bring to bank, do personal errands and organize regular payment of rent/monthly expenses
Visits #5-#9: (over 3 months) • Monitor symptoms, possible side effects and treatment outcomes • Linkages/prepare discharge	Regular contact with supervised living staff, volunteer and niece re: symptoms and treatment outcomes Regular liaison with geriatric psychiatrist and GP in assessing response to treatment and modifications to treatment plan Liaison with social supports re: transportation to medical appointments and finances, gradual transfer of task coordination to niece

Outcomes

- ↑ mood, sleep and appetite
- No further emergency room visits for panic attacks
- Remained distrustful of most people but no longer feels persecuted and accepting help from niece and regular retirement home staff
- ↑ biophysical function (regular pain meds vs. PRN, gained 10 lbs/4 months, Parkinson’s optimized/attended neurology consultation)
- ↑ social supports: niece now main support with regular contact to monitor via retirement home staff
- ↑ function: outings with niece 1x/month, sits in common room/goes to activities by herself vs. lying in bed
- Happily for client, she was not hospitalized!

Conclusion

- Individualized case management within an interdisciplinary team approach in the home improves opportunities for vulnerable seniors that are reluctant to accept help from traditional modes (i.e. an out-patient clinic)[3]
- Mental health case management for seniors involves a biopsychosocial approach; physical health comorbidities are common, can pose barriers and often adds complexity to treatment planning[2]
- Collaborative “shared practice” model to engage patients with mental health issues, family members, allied health professionals working with specialists (geriatric psychiatrists) and primary care (family physicians)
- Linkage and transitions to community health and social services are essential for goal attainment and discharge

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