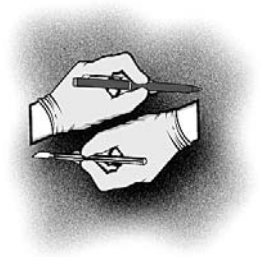

Shared geriatric mental health care in a rural community

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Introduction: A pilot project in shared mental health care was initiated to explore opportunities to increase the capacity of the rural primary care system as a resource for older people with mental health needs. This was done within a framework for the delivery of best practices in geriatric mental health outreach.
Methods: Shared-care strategies combining education and clinical consultation between mentor psychiatrists and family physicians were implemented and then evaluated after one year to identify key factors in the success of approaches to shared mental health care for older people in a rural setting.
Results: Results provided new insights into shared care between primary care and specialty geriatric mental health services, rural geriatric mental health service delivery, developmental phases in service learning approaches, and building knowledge networks to promote continuing best practices.
Conclusion: The results from the project's process evaluation have been integrated into the development of a permanent shared geriatric mental health care service for the rural setting. Preparation for an outcome evaluation that will focus on the impact on patient care has also been initiated.

Introduction : On a lancé un projet pilote de soins de santé mentale partagés afin d'explorer la possibilité d'accroître la capacité du système rural de soins primaires comme ressource pour les personnes âgées ayant besoin de services de santé mentale. Le projet s'est déroulé dans le contexte d'un cadre de pratiques exemplaires pour l'extension des services de santé mentale en gériatrie.
Méthodes : On a mis en œuvre des stratégies de soins partagés conjuguant l'éducation et la consultation clinique entre psychiatres mentors et médecins de famille; on a évalué les stratégies après un an pour déterminer les facteurs clés de la réussite d'une démarche de soins de santé mentale partagés pour personnes âgées en milieu rural.
Résultats : Les résultats ont dégagé de nouvelles perspectives sur les soins partagés entre les soins primaires et les soins spécialisés en santé mentale gériatrique, la prestation de services de santé mentale gériatrique en milieu rural, les stades du développement des méthodes d'apprentissage du service et la création de réseaux de connaissances afin de promouvoir l'implantation suivie des pratiques exemplaires.
Conclusion : On a intégré les résultats de l'évaluation de la démarche du projet dans l'élaboration d'un service permanent de soins de santé mentale gériatriques partagés en milieu rural. On a aussi entrepris de préparer une évaluation des résultats qui portera principalement sur l'incidence sur les soins aux patients.

Introduction

The reform of mental health services in Ontario has been guided by *Putting People First*[1] and the *Policy Framework and Implementation Guidelines for Mental Health/Long Term Care*.[2] Specifications for geriatric mental health services include the requirement for a multi-level response to meet the needs of a diverse older population, as is more recently highlighted in *Specialized Geriatric Mental Health Outreach Teams: Program Policy and Accountability Framework*.[3] The Framework clearly identifies the roles of specialized teams in providing 3 major functions: (i) direct shared care; (ii) education; and (iii) establishing service

linkages. The long-term care and community care sectors at both local and regional levels are also expected to increase their service capacity with specialty outreach teams. These teams target high-risk individuals within the continuum of geriatric services. Although models can vary, they are typically interdisciplinary teams made up of geriatric psychiatry, nursing, social work and occupational therapy. Their work is outreach in that they are working with and working in other sectors of care — primary care, hospital care, nursing home care, community care — but funded by the mental health sector. Team members, other than psychiatrists, are sometimes referred to as case managers. These teams are considered an essential link within the continuum of care, as are clinicians authorized to assume these roles that are aimed at the promotion of effective shared mental health care.[4]

Recent literature on shared mental health care suggests that if care that is focused on the community is to be achieved, then increased collaboration between family physicians (FPs) and psychiatrists is paramount.[3,5,6] Draper[7] suggests the consultation-liaison versus consultation-only model is superior in terms of developing and maintaining shared-care working relationships between psychiatrists and FPs. According to Craven and Bland,[5] who have reviewed models of shared mental health care, consultation-liaison involves regular visits by the psychiatrist to the primary care physician's office, including direct patient assessment and opportunities for case discussions and advice about non-referred patients and other educational opportunities. They identify several advantages, such as enhanced face-to-face communication, skill transfer, collaborative treatment planning, integrated physical and mental health care, and increased continuity of care.[5] Similarly, an emphasis on implementing best practices within mental health care highlights the need for newer service and education delivery models that link FPs with mental health clinicians.[8,9] More recent studies indicate increased effectiveness in the mental health care for older people when specialty case managers, supported by geriatric psychiatrists, are working onsite at the FP's office or in his or her patient's home alongside family practitioners.[10] It can include patient assessment, consultation with FPs or even joint patient assessments.

Older people with mental health problems residing in rural communities pose unique challenges for community-based providers. Although there is a growing body of evidence demonstrating the effectiveness of outreach geriatric mental health services,[11–14] the literature rarely addresses the success of models of delivery in rural or remote communities. It has been identified, however, that the preferred model of geriatric mental health service delivery for underserviced areas is interdisciplinary outreach teams.[15]

Figures suggest that 1 in 5 individuals over the age of 65 have a mental health disorder.[16] In Canada, 8% of individuals aged 65 and older are affected by dementia,[17] and 2%–4% of those living in the community and 15%–20% of those living in institutions experience serious clinical depression.[18] Older people in rural communities are as likely to become mentally ill as their urban counterparts.[19] In rural settings, however, there is a significant gap between need and the utilization of mental health services.[20,21]

In terms of characterizing the rural context, the literature points to a number of issues that have an impact on mental health care. Notably, the social ecology in the rural setting is vastly different from that of the urban. The rural value system has been described as more individualistic or self-reliant.[22] Communities exist with limited access to health and social care or trained professionals.[21] Poverty, inadequate housing, and transportation problems are realities for many inhabitants.[22,23] Therefore, simply replicating an urban model of service delivery would not reflect adequately the rural culture.[21–24]

Methods

The project

A rural pilot project in shared geriatric mental health care was initiated with the aim of supporting and developing the capacity of a rural community health centre as a resource for older people with mental health needs. The pilot project was one arm of a larger initiative focusing on enhancing the capacity of the primary sector in meeting the needs of older people with complex problems, improving the service linkages between primary care and mental health sectors, and discovering new knowledge in shared mental health care for older people.

The model for this initiative was generated from the literature addressing consultation-liaison services, adult learning, and knowledge exchange. Conceptually, the project's development was underpinned by: (i) new information that must be relevant to a learner's values, experience and work context;[25–28] (ii) the effectiveness of using multiple strategies to communicate information;[27] (iii) a lack of knowledge regarding the experiences of special-

ists in a shared-care exchange;[29] (iv) the need for increased collaboration and timely communication between psychiatrists and FPs;[5,6,30,31] and (v) implementing best practices in geriatric mental health outreach as facilitated by a process consisting of (a) an *awareness* of emerging new knowledge, (b) the *accessibility* of effective methods of shared care, (c) education and systems development, (d) *action* based on methods and context, and (e) the *accumulation* of new knowledge through evaluation and dissemination.[4]

The implementation process was aimed to coincide with the development of a new rural specialty geriatric mental health outreach team. It was anticipated that the project would not only act as a vehicle to guide the team's development and inform its members, but also project outcomes could be sustained through new service activities.

The project was initiated during an educational day in geriatric psychiatry held for FPs in a region of southeastern Ontario. FPs who agreed to participate in the project were offered a menu of shared care services that could be tailored to their practice situation. Among the 30 physicians from across the region who participated in the educational day, 4 FPs from a rural community health centre agreed to take part. Their previous experience with regional geriatric psychiatric services was predominately referrals for inpatient assessment and treatment.

Community health centre

The rural Community Health Centre is located in a township covering 897 km^2 in central-eastern Ontario. The closest city (pop.<50 000) is located 35 km from the largest village in the township. According to Statistics Canada,[32] the mainly Canadian-born and English-speaking population is 5612. The median age is 41.9 years, with 1605 individuals over the age of 55. The average household yearly income is $38 432, almost $15 000 less than the average across Ontario. The unemployment rate is 8.8% (6.7% across Ontario).

Mentors

The Community Health Centre was assigned 2 geriatric urban-based psychiatrists who would facilitate the project's implementation and act as mentors. The mentorship program involved linking each primary care physician with a geriatric psychiatrist. The mentor was available via telephone to provide indirect advice, as well as to identify particular resources that could assist the clinician in his or her daily practice. The intention here was to support clinical decision-making, and to enhance accessibility to, and positive interaction with, specialist services.

Critical to enabling the pilot activities to be implemented from the geriatric psychiatrists' point of view was an alternate funding formula provided to them (i.e., salary-based and not a fee-for-service arrangement). The mentors and an experienced specialist geriatric mental health case manager held 2 initial planning meetings at the Centre to further assess readiness to participate in the pilot project, establish learning and service needs, and to explore different approaches to shared mental health care. Links with other stakeholders in the local mental health services and services for older people were established to facilitate the identification of needs, and project implementation. It was eventually agreed that in addition to the mentorship program, monthly educational sessions would be held at the Centre, and FPs could access Timely Information for Primary Care Services (TIPS), shared patient visits between the psychiatrist and the FP, and on-site consultation services between the psychiatrist and the FP.

Evaluation methodology

A process evaluation was completed after 1 year to assess the delivery and efficiency of the project. The purpose of a process evaluation was to identify shared-care activities and other factors that were contributing to the project's aims, rather than looking at the impact or effectiveness more familiar in outcome evaluations. Similar to an outcome evaluation, the process evaluation involved the systematic collection and analysis of data to verify specific evaluation questions.[33] An outcome evaluation examining impact on quality of care was also developed to take place 2 years after the implementation of the project.

Project records were examined to capture concrete indicators of performance. Some of these documents included meeting minutes (e.g., issues discussed), attendance and evaluations for educational sessions, and consultation, TIPS and mentorship records (e.g., number of referrals, presenting problems, response times). Interviews were also conducted with the 2 psychiatrists and the 4 FPs. The aim of the interviews was to collect more in-depth knowledge about various shared care strategies and the complexities and/or successes of implementing shared mental health care. These data were analyzed using thematic content analysis, which is an

articulated method of summarizing and classifying data within a thematic framework.[34]

Results

Consultation

Over an 8-month period, 24 referrals for direct on-site consultation were received. The majority (13) of the patients were female, and the average age 79 (2 <65; 10 >80). The large number of individuals over the age of 80 most likely reflected the growing number of very old people, and the increased likelihood of physical and mental health problems in that age group. The most frequent presenting problem was that of cognitive impairment with behavioural or co-morbid psychiatric disorders. These problems are consistent with the target population for specialty outreach geriatric mental health services as outlined by the Ontario Ministry of Health and Long-term Care.[3,35]

Reports from the specialty and primary care providers reflected, for the most part, the benefits of this model of consultation. The specialists stated that each patient consultation was an opportunity to discuss mental health problems and interventions. It was also reported to be common practice for the consultant to provide literature pertaining to a topic area relevant to a particular care, and to give feedback to the referring physician to reinforce effective clinical practice. The importance of the latter practice has been highlighted in the literature as important for changing long-held patterns of professional behaviour.[36] It also emerged that the nurse practitioner at the Community Health Centre had accompanied the specialists on home visit assessments for learning purposes. This was viewed as positive given the significant clinical role nurse practitioners may assume in underserviced rural areas.

The primary care clinicians concurred with the above statements and indicated they were pleased with these services, particularly because the responses were timely. For example, one individual said *"The psychiatric consultations are accessible; staff are approachable; advice is practical."*

One primary care clinician spoke of the importance of the consultee as the 'situational expert,' thus reinforcing this consultation model as a bilateral exchange of knowledge. This individual spoke of how the 'family practice' in the rural setting *"really knows the patient," "recognizes overall changes"* given their familiarity with them, and knows a patient's *"overall needs."* This clinician also said that it was important for the consultant to ask, for example, *"What do you think? What is your opinion?"* Similarly, he stated that the key to the success of the consultation process was to ensure that the consultee was recognized as an expert in his or her own right.

Mentorship

Project records indicated the average number of times each FP consulted with one of the psychiatrists was once per month. Advice was more frequently sought when the primary care physician was dealing with an older patient with multiple complex problems (e.g., physical, pharmacological, social, and legal). All physicians viewed mentoring as highly valuable and a preferred method to access advice. This direct method of contact was viewed by the primary care physicians as fostering an exchange sufficient in depth and length to allow them to confidently continue their own clinical interventions that they would not be able to support otherwise.

Primary care physicians stated that contact with a mentor only occurred following consultation with an on-site colleague. For example, when further specialist information was required contact would be initiated. This ensured that the mentor's time was spent on complex cases. Another primary care clinician suggested that this service was particularly helpful simply because they were comfortable making contact with their mentor. This same clinician said that this was not the case for many other specialty services, possibly preventing them from managing a patient and necessitating a more complicated process, such as a referral for direct consultation.

A specialist provider indicated that telephone contact was an efficient use of his time — the management of 1 to 2 calls per month was not unreasonable. He also felt that many FPs seemed able to practise more confidently knowing availability was ensured.

Educational sessions

Eight educational sessions were held at the rural practice by one or both of the specialists. Attendance at the sessions included the physicians and the nurse practitioner. On some occasions other local mental health providers were invited to foster service networking (mean attendance, 5). Topics for the sessions were either recommended by the specialist providers from analysis of those cases referred for clinical consultation, or requested from the primary care team. Topics included, for example, cognitive enhancers, depression, alcoholism, competency and

interventions with high-risk patients, driving and dementia. The sessions included a combination of formal lecturing and interactive discussion using case examples. Supplementary educational materials and job aids relevant to the sessions were also developed to ensure on-site literature and practical tools were available for easy reference and use. Periodic evaluations occurred to identify learning needs, preferred learning styles, and ratings to indicate new learning and its relevance to daily practice.

Without exception, primary care participants indicated that participation was contingent on the learning sessions being time that was well spent, given their heavy patient load. A matter such as the day of the week or the time of the day became critical to their success. The approach of presenting a topic area and combining a specific case for discussion was described as effective. The primary care group was particularly satisfied with the convenience of on-site learning, and they commented on the sessions as being both practical and open; the latter feature permitting the introduction of patient problems that might have presented that day or week. Additionally, the *"relaxed atmosphere"* was much appreciated and was indicated as having contributed to learning and sharing. Both a case-based approach to teaching and on-site learning have been highlighted as essential in the adult learning and knowledge exchange literature.

From a specialty perspective, the sessions were effective because the primary care providers were both *"receptive"* and *"interested in learning"*; perhaps confirming the readiness of the primary care group to engage with the project. One specialist remarked the importance of adopting a *"missionary approach — the first teacher is the host."* This not only reinforced the specialist as downplaying the role of expert psychiatrist who would impart knowledge on the less expert FP, but also reinforced a bilateral exchange of knowledge being central within shared care. This specialist also remarked that the sessions were effective and likened them to *"sitting around the kitchen table."* Sitting around the table appeared to capture the open relationship that had evolved between the geriatric mental health specialists and the FPs, and the comfort of learning from one another to improve the care for older people.

Although the expanded group membership in some of these sessions was thought beneficial in terms of community networking, it posed challenges according to both the specialty and primary care providers. The difficulties reported included: (i) tailoring the topic area and level of information to a multidisciplinary team; (ii) ease at which FPs would be open in front of other providers; and (iii) determining how effective a physician-led session for a multidiscipline audience was.

Timely Information for Primary Care Services (TIPS)

TIPS was a service whereby a physician could email or fax a clinical question to a specialist. Within an established period of one week, a response was either emailed or faxed back. The response given was not meant as a substitute for direct consultation, but rather to provide more general information on a topic area (i.e., similar to accessing a textbook reference).

The primary care group suggested they did not use TIPS because they were not prone to use their computers in this fashion. One physician commented that he would much rather access his mentor for advice as this was a quick and easy method of accessing timely information. Notably, these physicians indicated that it was sometimes difficult and time-consuming to write a question that was clear and concise for complex clinical issues. Rather, they wanted direct dialogue to assist in unravelling the patient's situation and in considering the various intervention options.

Shared visits

A shared visit is a service learning approach that involves the FP and psychiatrist jointly assessing a patient with challenging clinical presentations. It provides an opportunity for knowledge exchange and targeted skill development for the FP. It also offers an opportunity for psychiatrists to get 'hands-on' experience consulting in the primary care setting, and learn what is required for relevant and effective consultation.

Shared visits were not implemented despite the fact that they were positively regarded from the outset of the project. For all practitioners the explanation for lack of use was the amount of time spent to successfully complete such a visit.

Two of the primary care physicians said that they viewed this as a good learning opportunity, but not a good use of their time. One physician suggested that when he contacted psychiatry for a consultation he was confident that a skilled specialist was required for a specific aspect of the patient's care. He added that he was not interested in learning specific specialist skills, and commented that *"By the*

time I have referred I have already spent considerable time with the patient and just want a consultation at that point." Further feedback identified a critical difference in need and expectation between the specialist and the FP. The specialist interview with the patient was usually 1 hour in length using a set of skills relevant to that time frame. Family practice realities often dictate a much shorter interaction using another set of interviewing and assessment skills. The skills required, therefore, were not specialist skills but those of a family practice approach.

Discussion

The model of consultation adopted for the project was a multilevel approach permitting shared care, education and systems development.[37] This model is also consistent with the more recent accountability framework for specialized geriatric mental health outreach teams developed by the Ministry of Health and Long-term Care.[3] The significant elements of this non-hierarchal model are that there is both an interactive engagement and bilateral exchange of knowledge between consultant and consultee. This bilateral exchange of knowledge is viewed as central in shared care as it recognizes the primary care physicians as situational experts and the consulting physicians as content experts. Complementing this type of consultation service was the model of geriatric mental health outreach services, which attaches a case manager to a consulting psychiatrist. Thus the case manager contributed to the collection of assessment data, as well as providing follow-up specific to intervention plans including engagement with other local resources.

Five strategies focusing on best practices in geriatric mental health outreach were implemented to achieve the shared-care goal. Each strategy is based on the premise of shared care and a bilateral exchange of knowledge between the psychiatrists and FPs in order to facilitate discussions and to access and use information appropriately.[4]

New insights into the following areas emerged from the process evaluation: (1) shared care and knowledge exchange between primary care and specialty geriatric psychiatry; (2) rural geriatric mental health service delivery; and (3) developmental phases in service learning implementation and building knowledge networks.

The use of multiple learning and development strategies was positively reinforced. Not only were different styles of learning among participants evident, but also the continuous process of knowledge exchange to knowledge utilization seemed to be facilitated by the link between various methods of educational development and direct clinical service. The specific strategies that were commonly highlighted as most pertinent for the FP in a rural setting were mentorship, case-based educational sessions and direct on-site consultation. Notably, the central feature of these strategies was the integration of the day-to-day challenges of physician care with ongoing educational opportunities. Despite broader developments in knowledge exchange that places reliance on computer technology, these physicians did not respond as anticipated with TIPS.

Although it was anticipated that the mentorship would be very popular and potentially time consuming for the specialist, project records indicated that average service use was once per month per doctor. There are little research data detailing mentorship utilization rates, however, Rockman and colleagues reported rates of 2–3 per year.[38] Interviews with participants suggested that the combination of clinical consultation with mentorship contributed to a significantly higher use of the service in the rural project.

For the consulting specialist, the importance of recognizing the primary care physician as a situational expert was strengthened. Indeed, the specialists appeared to begin to more fully understand their role as facilitators of dialogue, knowledge discovery and knowledge application. This strengthened the primary care sector's ability to meet the needs of older people with mental health problems as the agreed upon aim.

The project evaluation also reinforced the rural catchment area as distinct from the urban setting. Three features of the rural setting stood out as key for geriatric mental health service development. The Community Health Centre was a 'hub' within the community, and central to development and coordination among providers within new development initiatives. The primary care physician's relationship with his or her patient and family was also significant in terms of the extent to which the physician knew patients and was part of their lives. Developing supportive working relationships with this sector was critical if geriatric mental health care services were to achieve their aims. Although subtle, there was also a sense that the culture within the rural setting was more informal. This informal nature was thought to contribute to a sense of trust between individuals and services, ultimately benefiting patient care. This also features in the literature, which suggests the helping network and/or gatekeeper system within the rural setting comprises

individuals such as postmen, pharmacists, neighbours, and other non-family members of the community.[20,24,39,40]

The project also offered some reflections regarding the developmental phases in building a geriatric mental health shared care network. Generally speaking, the 5 stages of group development as outlined by Tuckman and Jensen[41] were observed. An awareness of these phases appeared significant in terms of supporting a network's development, maintaining the momentum of project implementation, and maintaining the engagement of participants. In addition, the recognition of these developmental phases can inform project leaders of when to either strategically implement supports to maintain momentum, or when to reframe periods when activities have slowed down as normal group progression. For example, the following phases were identified.

- Early engagement — securing initial commitment to participate, and introducing strategies to implement shared mental health care.
- Maintaining interactive engagement — implementing and tailoring strategies relevant to each physician, developing relationships, and sustaining implementation in response to ongoing feedback.
- Participative evaluation and planning next steps — planning and implementing evaluation approaches to inform next steps in shared care development.
- Modifying and/or expanding shared care strategies — as per evaluation outcomes.

Limitations

The evaluation of this rural shared geriatric mental health care project aimed to provide information about the development of a permanent service for older people with mental health problems. The results are specific to this project only. They are being disseminated to exchange experiences in shared mental health care and service delivery to older people with mental health problems in rural areas, and to demonstrate the role of process evaluation in service development.

Conclusion

Within mental health reform guidelines and with a current emphasis on the delivery of best practices, geriatric shared mental health care services were initiated in a rural setting. Its success thus far has been achieved by the development of a respectful partnership between 2 different cultures of service providers, ease at which specialty services are accessible, the provision of alternative strategies to build capacity to provide geriatric mental health services in the primary care setting, and a continual exchange of knowledge underpinning clinical practice. These elements were developed and implemented within a broader framework to deliver best practices in geriatric mental health outreach. The results also provide important insights into the development of shared care practices and the reform of primary care across Canada and elsewhere.

With the feedback from the process evaluation, the project has now been integrated into the new rural geriatric outreach team's service delivery plan and includes 1 salaried psychiatrist and 5.5 case managers. Further research on rural geriatric shared mental health care is planned for the near future to assess the impact on patient outcomes.

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