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COLLABORATIVE CARE: ADDRESSING SENIORS' MENTAL, PHYSICAL AND SOCIAL HEALTH NEEDS

Overview

This article reports on an interprofessional (multiple health professions) and intersectoral (multiple health sectors) health initiative implemented in Southeastern Ontario to increase the capacity of regional primary care, geriatric psychiatry, and community sector services to collaboratively meet the complex physical and mental health needs of older adults.

Background

Prevalence data support the need to develop sustainable interprofessional/intersectoral processes to benefit the health outcomes of our ever expanding seniors population. Statistics Canada cites seniors as the fastest growing sector of the overall population and the most likely to suffer from chronic health conditions (Health Canada, 2002; Gilmour & Park, 2006). In fact, 33 per cent of seniors suffer from more than one chronic condition; the average number of conditions accruing with advancing age (Gilmour & Park, 2006; Jeste et al, 1996). The presence of multiple chronic conditions is indicative of the frequency of health service use. Thus, it is predicted that a large proportion of future health care dollars will need to be directed toward treating the chronic health conditions of older adults (Mirolla, 2004).

Often the health challenges associated with aging make assessment and management difficult as the health issues

Editor's Note

By Philip Burge, PhD
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In the several months since our last issue readers may have witnessed a significant degree of media attention on the various endeavors surrounding mental health policy reform. Two examples include the developmental work of the still relatively new federal Mental Health Commission and, in Ontario, the five pronged efforts now underway aimed at future mental health policy reform.

No doubt, those who work in the mental health sector, or are consumers, or both, will increasingly learn of opportunities to engage in these reform processes. Future issues of Synergy will seek to report on some of these developments wherever possible.

In this issue we focus on a range of research projects and educational efforts that may especially impact on our region of Ontario.

We hope you enjoy reading this issue of Synergy. As always we look forward to your comments at robertk4@providencecare.ca.

COLLABORATIVE CARE: ADDRESSING SENIORS' MENTAL, PHYSICAL AND SOCIAL HEALTH NEEDS
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necessitate a broad spectrum of health and community partners. Older adults experience a complex integration of physical, mental, and social health needs. Some of the more significant health challenges include some combination of chronic pain (Mirolla, 2004), dementia, depression, anxiety (Unutzer, 2002), bereavement, multiple losses, social isolation (Livingston et al, 1996) and poor nutrition (Curran, 1990). The degree to which seniors make use of formal health care services is likewise impacted by personal and systemic factors which limit their ability to physically access these services (Horgan et al, 2009).

Collaborative initiatives - which integrate mental health, primary care, and pertinent community supports – have the potential to ease the accessibility issues faced by older adults (Horgan et al., 2009) and to foster cross-discipline / cross-sector knowledge transfer to address complex situations (Kates et al, 1997).

Project Description

The Mobile Interprofessional Coaching Team (MICT) initiative was implemented as a means to foster, through various field-based strategies, the clinical and educational interchange between mental health, primary care and community partners at program, organizational, and systems levels. It brings together providers from across disciplines (medicine, nursing, social work), organizations (Family Health Teams, Specialty Geriatric Mental Health Outreach, Alzheimer Society First Link Project) and sectors (mental health, primary care, community and education) to advance a common vision, language and approach to the diagnosis, treatment and referral of older adults with complex mental and physical health needs. Funds to establish the MICT initiative have been provided through a series of HealthForceOntario grants.

MICT is founded upon four fundamental concepts (interprofessional practice and education, shared care, knowledge transfer and exchange, and ecological change theory) which together form a foundational approach for building sustainable field-based interprofessional/intersectoral knowledge exchange. The objectives of the initiative involve: (a) creating effective collaborative processes for post-licensure professionals across healthcare sectors; (b) building the capacity (i.e., knowledge, skills, experience) of post-licensure professionals to engage in and benefit from effective interactions with providers in other key disciplines and sectors; (c) fostering role and responsibility sharing between disciplines, organizations, and sectors; and (d) enhancing access to pertinent materials (toolkits, fact sheets, articles, question and answer forums, etc.) relevant to the care of older adults with complex mental health needs. A variety of knowledge transfer strategies have been implemented which involve cross-disciplinary and cross-sector representation including: collaborative practice coaching sessions; collaborative educational sessions; and interprofessional preceptorships. These activities are indirectly supported by an information management and knowledge exchange repository.

Discussion

Collaborative health care represents a fundamental conceptual and instrumental shift away from traditional silo-based thinking and practice (Ontario Ministry of Health and Long-Term Care, 2006). Invariably, this shift will necessitate a re-alignment of resources, professional responsibilities, and scopes of practice not only between professions but also between primary, secondary, tertiary and community care sectors (Ontario Ministry of Health and Long-Term Care, 2006). It is primarily through real-life engagement with other disciplines and sectors for the purpose of delivering actual health care, that post-licensure professionals will develop a practical understanding and level of comfort engaging in these new modes of role and responsibility sharing (Graham & Logan, 2004). Innovative field-based interventions, such as MICT, that formally support, promote and orchestrate the participation of post-licensure practitioners in integrated knowledge and practice sharing activities are important vehicles for instigating field-based change.

Interprofessional/intersectoral knowledge exchange initiatives physically and conceptually re-shape modes of interaction and collaboration between health professionals and sector groups. These initiatives offer a tangible means for fostering productive partnerships, open dialogue and practice innovation between, not only different disciplines, but importantly, diverse health care sectors (Graham & Logan, 2004; Ontario Ministry of Health and Long-Term Care, 2006). Such exchanges enable individuals, organizations, and health sectors to access and utilize essential information, expertise and resources previously known intrinsically to only one group of practitioners, thereby, enhancing mutual learning and practice capacity across the health care spectrum.

Next Steps

Three key activities will be undertaken to evaluate the MICT initiative. A process evaluation will be implemented to assess

the extent to which collaborative strategies have been implemented as planned and whether expected output has been achieved. A concept analysis will also be performed to identify key concepts, collaborative partnerships, foundational activities, and supporting resources across individual, organizational, and systems levels to support and sustain field-based interprofessional/intersectoral collaboration. Finally the impact of cultural and contextual factors on the process of transferring knowledge between health professions and sectors will be explored through the use of qualitative methods.

For more information about the MICT initiative please contact Shauna Sweeney (MICT Project Coordinator) at: sweeneys@providencecare.ca .

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WEBSITE INFORMATION

Frontenac Community Mental Health Services
www.fcmhs.ca

Hotel Dieu Hospital
www.hoteldieu.com

Kingston General Hospital
www.kgh.on.ca

Ongwanada
www.ongwanada.com

Providence Care
www.providencecare.ca

Queen's University Department of Psychiatry
meds.queensu.ca/psychiatry

Southeastern Ontario Addictions and Mental Health Services & Information
www.recoveryconnections.ca

UNDER A CLOUD OF STIGMA: PARENTS' EXPERIENCE CARING FOR ADULT CHILDREN WITH SPECIAL NEEDS

By Ahana Sarkar, Graduate Student
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Stigma was originally conceptualized as a mark of social disgrace in which society marks a person, discrediting, and thus, rejecting him or her on the basis of attributes such as physical disability, mental disability or ethnicity (Goffman, 1963). As such, the process of stigmatization starts with a negative labeled difference, which can lead to discrimination by society. Once such stigma is internalized by the marked person, the individual can feel devalued and shamed when he or she applies the negative label to themselves (Corrigan, 1998). Stigma may also affect individuals, such as family members, who are closely associated with the stigmatized person (Goffman, 1963). This process whereby an individual is stigmatized due to his or her association with a stigmatized individual is referred to as 'courtesy stigma' (Goffman, 1963), stigma by association (Mehta and Farina, 1988), or 'affiliate stigma' (Mak and Cheung, 2008).

For individuals with developmental disabilities or dual diagnoses (i.e., having both a developmental disability and another mental disorder), social support most often comes from family members who are active participants in their lives (Shilling et al., 1984) and who may themselves become targets for stigma (Shibre et al., 2001). Past family research related to stigma has generally been qualitative and focused on the experiences reported by families caring for someone with a mental illness only. Such families have reported being avoided by others (Phelan et al., 1998) and feeling worried they would be blamed for their relative's mental illness (Shibre et al., 2001). Stigma experiences of family members were also associated with feelings of hardship, psychological suffering, sleep disturbances, relationship disturbances, poor quality of life (Kadri et al., 2004), and low self-esteem (Shibre et al., 2001). Family members have reported strains on extended family relationships, along with distancing of other relatives (Shibre et al., 2001).

Research in the 1970s and 80s reported that parents of individuals with developmental disabilities experienced similar negative impacts including feelings of social exclusion and strains on relationships (Birenbaum, 1970) as well as low self-esteem (Schilling and Schinke, 1984). However, few studies of this group have looked at stigma directly or in a contemporary context.

An important barrier to the study of stigma in families of individuals with developmental disabilities has been the lack of psychometrically tested tools designed specifically for use with them. In a study undertaken by the author, we have focused on a sub-group of family members, parents, because we believe the relationship which exists between parents and their children is likely to mediate stigma by association in unique ways. Research has shown that the impact of stigma on family members may vary; for example, parents may internalize the perception of blame for their child's stigmatizing condition (Sigelman et al., 1991). For our study, our two study groups are parents of adults with (a) developmental disability only, and (b) a dual diagnosis.

Thus, the primary objective of this study is to assess the reliability (internal consistency) of two scales, previously used to measure stigma experienced by families of individuals with mental illnesses (Stuart et al., 2008), when modified for use with parents of individuals with developmental disabilities. We expect that the scales will produce internally consistent data when reworded to apply to our two groups of parents. The secondary objective is to describe the scope and magnitude of stigma reported by the parents recruited for study. Finally, we will compare stigma experiences across the two groups of parents in order to determine whether parents of those with a dual diagnosis report higher levels of stigma.

According to data from the social service agencies

who are partners in the South Eastern Ontario Community-University Research Alliance in Intellectual Disabilities (SEO CURA in ID), there were 2323 adults with a developmental disability in 2006 (1437 had a developmental disability only and 886 had a dual diagnosis). These numbers have remained fairly consistent over time. With the assistance of these service providers and once we have the consent of adults with a developmental disability for whom contact information of a parent is on the agency file, we are inviting these parents to participate in the study. We expect to recruit a total of 110 participants giving 55 parents per group. This will be sufficient to assess the internal consistency of the adapted instruments.

Since so little research has focused on stigma experienced by family members of people with a developmental disability, and no research has examined stigma among family members of those with a dual diagnosis, this study will provide new descriptive data that may be of importance for designing future comparative research. Studying the experiences of parents of adults with a dual diagnosis is particularly important given the high prevalence of mental illness among those with developmental disabilities, estimated to be 38 per cent (Yu and Atkinson, 1993). Finally comparisons across groups with a single versus a double disability will provide insight into the extent to which a layering of stigma occurs with each added disability, thus providing greater insight into the process of stigma itself (Kowalewski, 1988).

For more information about this study please contact the author: 6as34@queensu.ca

Acknowledgements

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COURSE ON MENTAL HEALTH FIRST AID GAINS POPULARITY AMONG QUEEN'S STAFF

By Kay Langmuir

Growing interest and concern in mental-health issues have driven a staff initiative at Queen's University to join an international training program that teaches people how to recognize signs of mental illness and encourage sufferers to seek professional help.

"A lot of us are afraid to intervene because we don't want to say or do the wrong thing," said Mike Condra, director of Health, Counselling and Disability Services at Queen's. "But we want people to not back away…there is something you can do."

But in order to feel empowered to help when a situation arises, people must be well-informed and know what steps to take, he said. Dr. Condra and his colleague Ms. Beth Doxsee have recently been certified as instructors in Mental Health First Aid (MHFA), which was founded in Australia by mental-health researchers. They taught their first two-day course to 50 staff members earlier this month. Over the next year, the goal is to try to train all 300 staff, as well as student staffers, within Student Affairs. The purpose of MHFA is to teach participants how best to assist someone showing signs of a mental health problem or crisis. The program aims to improve mental-health literacy, and give people the skills to help recognize and seek help for developing mental-health problems in themselves or people around them.

Dr. Condra, who has been at Queen's for 16 years, says he's seen a significant increase in the number of students who either come to Queen's with a mental-health issue, or develop one while they're here.

National statistics suggest one in three people will suffer a mental-health disorder during their lifetime. But the thirst for information about mental-health issues has also increased. Dr. Condra and some other mental-health professionals on campus held an information session on depression one evening last March, and were amazed to see 150 people show up for the 90- minute session.

The MHFA program, which first came to Canada via Alberta, was initially brought to the attention of Student Affairs by Mr. Wayne Myles, director of the International Centre. Ms. Roxy Dennison-Stewart, associate dean of Student Affairs, was among 20 staff people who took the course last year, and then decided it was a good fit for Queen's. The course contains broadly based information about many mental-health issues, and focuses on what people can do, she said. "In the same way as regular first aid, if you are faced with a situation, do you know what to do and what steps to take?" she asked. "We were very impressed."

Dr. Condra, who has worked with various campus and student groups for years to raise mental-health awareness, concurs wholeheartedly with the course approach. "There is something you can do. I've been saying this repeatedly…And people are already doing it in frontline offices…all mental health first aid is about, is reaching out and comforting the person and then getting them help."

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RESEARCH CONFERENCE 2009 @ QUEEN'S DEPARTMENT OF PSYCHIATRY

By Philip Burge

The Queen's University Department of Psychiatry held its annual research conference this past May in Kingston. An appreciative audience of about 70 researchers, clinicians, mental health administrators, psychiatry residents and students interacted with the keynote speaker, presenters of 14 research papers, and researchers during a poster session. From the varied presentation topics it was obvious that a wide range of mental health research is occurring in the southeast.

These projects appear to cover much on the continuum of the four pillars of health research outlined by the Canadian Institutes of Health Research: biomedical, clinical, health

systems and services and, population and public health. For example, research now underway at Queen's ranges from genomic approaches for identifying susceptibility for neuropsychiatric disorders, drug studies (e.g., psychotropic drug induced metabolic effects), examining the efficacy of various treatments, the impacts of stigma and discrimination, and the growth of specific treatment services in our health system. As well, Queen's researchers reported on team-based collaborative inter-professional mental health education.

A number of presenters were students or Residents who spoke passionately about the projects in which they participated. The keynote address was delivered by Lt. Col. Rakesh Jetly, a psychiatrist with the Canadian Armed Forces. He spoke about the psychiatric care of soldiers in Afghanistan and the history and theory behind a changing succession of war and post wartime clinical presentations identified variously as shell shock, PTSD, etc.

As is customary at their research day, a number of awards were given out to departmental Residents and faculty members.

For more information: a complete list of the presentation titles and names of presenters can be obtained from Ms. Krista Robertson, robertk4@ providencecare.ca.

IMPROVING COMMUNITY MENTAL HEALTH IN ONTARIO THROUGH COMMON ASSESSMENT

By Susan Maclean
Community Care Information
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With more than 300 community mental health agencies across Ontario using different assessment practices with little or no provincial standards to guide them, there is a significant opportunity to improve the assessment process to make it more effective for both consumers and mental health workers. Community Mental Health Common Assessment Project (CMH CAP) is delivering on the sector's vision of a streamlined assessment process through the Ontario Common Assessment of Need (OCAN) tool.

Last July, Frontenac Community Mental Health Services in Kingston and 15 other organizations completed a three-month pilot of OCAN. The 16 original pilot organizations continue to use this automated common assessment tool and be involved in the project by sharing their OCAN learning and expertise. A Local Health Integration Network (LHIN) pilot of the OCAN implementation approach in the North East LHIN is currently underway with 30 organizations beginning to use OCAN since June 2009, with the tool proving its value as the client-driven common assessment tool that fosters the recovery philosophy in the sector.

OCAN is a standardized, consumer-led decision-making tool that allows key information to be electronically gathered in a secure and efficient manner. It includes key questions that cover 24 life domains and additional questions related to risk, physical health and gambling, and provides consumers with a formal place to voice their hopes and dreams.

OCAN is designed to:

• Enable consumer-led decision making at an individual level
• Reduce repetitive information gathering
• Standardize, streamline and unify assessments
• Provide an aggregate view of the sector to support informed decision making.

OCAN provides consumers with a more active role in their service planning while allowing community mental health agencies to share and re-use consumer-consented information in a way that provides structure and focus for comprehensive assessments. "The greatest benefits of using OCAN have been seen by both sides," comments Susan Marshall, consumer/survivor and team leader for the CAN-Help Program, Community Mental Health Association - Fort Frances Branch. "First, the worker gets to assess a full range of needs for the consumer, many which they might not have thought about or assessed before. The consumer gets to write down what they feel their own needs are in areas that they may have never considered before as well, and it is their own opinion, so I think OCAN has shown to be a huge benefit for both sides."

CMH CAP is one of the initiatives of CCIM to improve the health care system in the community care sector by implementing common assessment and business systems tools. For more information about CMH CAP, visit www.ehealthontario.ca/ccim or email cmhcap@ontario.ca.