



Mental Health Centre Penetanguishene
Le Centre de santé mentale de Penetanguishene

Collaborative Care: Aging & Dual Diagnosis (CCADD)

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Today's Objectives

- Background information
- Subspecialty populations
- Development of work group and model
- Progress and successes
- Future directions



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- 312 bed psychiatric hospital with three distinct divisions:
 - Acute and Community Care
 - Tertiary Care Division
 - Forensic Division



Bayview Dual Diagnosis Program



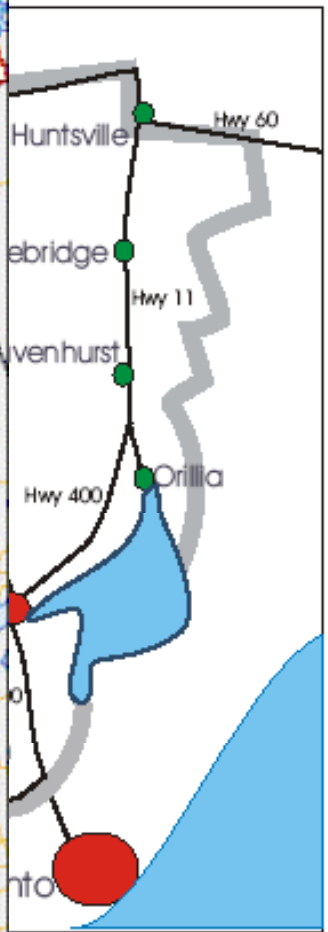
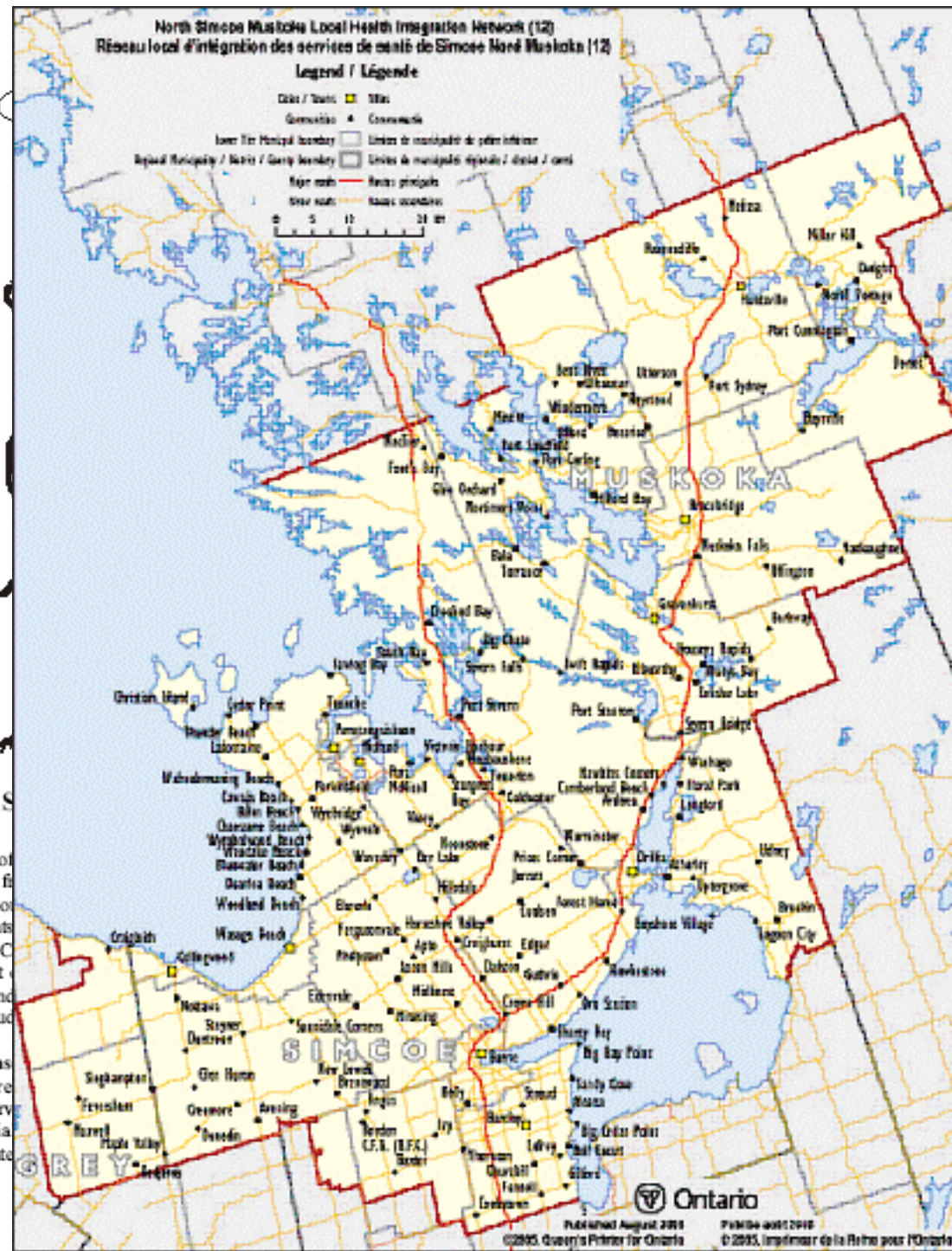
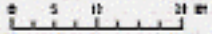
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North Simcoe Muskoka Local Health Integration Network (12)
 Réseau local d'intégration des services de santé de Simcoe Nord Muskoka (12)

Legend / Légende

- City / Ville: Yellow square icon
- Geoweb: Blue square icon
- Lower Tier Municipal boundary: Dashed line icon
- Regional Municipality / Health / County boundary: Solid line icon
- Major road: Red line icon
- Minor road: Orange line icon



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Tertiary Care Division

- Committed to serving those individuals who have been diagnosed with a complex, serious mental illness.
- Continuing multiple and complex needs which cannot be met at the primary and secondary levels of service.
- Our goal is to transition clients into the community.
- Services are provided on four distinct programs.



Bayview Dual Diagnosis Program



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Bayview Dual Diagnosis Program (BDDP)

- Adults with a developmental disability and a mental health need.
- Individuals within MHCP's catchment area and LHIN12
- Full multidisciplinary team providing inpatient and outpatient consultation, assessment, treatment, transitional discharge and community follow-up.



Bayview Dual Diagnosis Program



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Geriatrics Services Program (GSP)

- Inpatient and outpatient psychiatric services to clients 65 years of age or older within North Simcoe Muskoka
- The Program has five main components: a 26 bed inpatient unit; a consultative outreach team; a Day Clinic; and two Nursing Home Clinics
- Full inter-professional team providing assessment, treatment, rehabilitation, transitional discharge and ongoing monitoring via outpatient services



GSP and BDDP: Working Together

- An increase in clients who were aging with developmental disabilities
- The development of a volunteer working group



Methodology

- Searched for clients over age of 50 who had “official” diagnosis of dual diagnosis
- Found 33 individuals from January 1, 2000 to Dec 31, 2005
- Some clients had been admitted to several different units of the hospital
- Diagnostics were all over the “map” – where the client was placed determined the assessment / treatment received



Literature Review

- The longer a client is admitted to an institution, the higher the mortality rate once transferred to community
- Behaviour disorders occur less often in older adults with developmental disabilities as compared to younger groups



Literature Review *Continued*

- Elderly people with developmental disabilities have a greater prevalence of psychiatric morbidity than younger controls
- Rates of anxiety and depression are high and dementia is common
- Psychiatric and behavioural disorders declined with increasing age, at least through 70 years of life
- Elderly people with developmental disabilities had significantly more medical problems than did their non-disabled counterparts of the same age



Findings

- Aims
 - Improve quality of care
 - Prior to collaboration, a dichotomous model of care existed
 - Bridging services
 - Disjointed follow up service
 - Develop specialized knowledge/skills in staff
 - Set a model for other collaborative care partnerships for other “sub-specialty” populations.



Purpose of CCADD

Purpose:

- System Development
- Promote Excellence

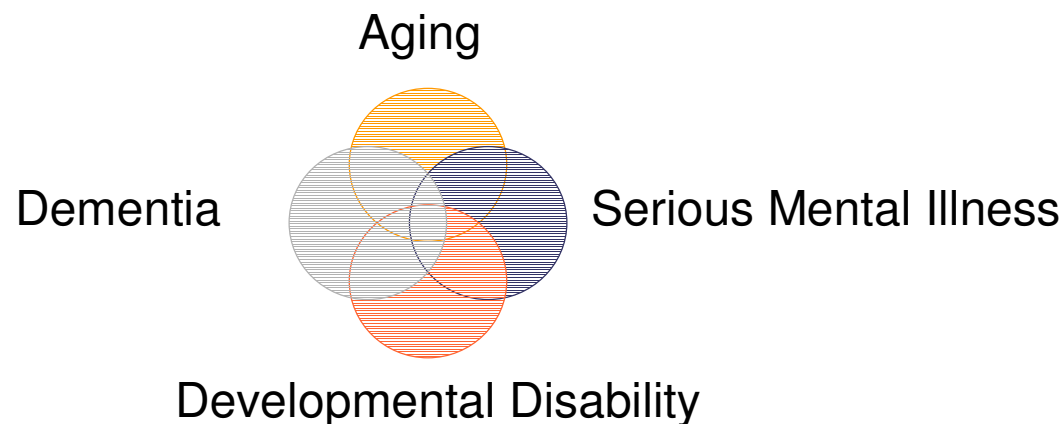
Mandate:

- Research
- Leading Practices
- Recommendations
- Advise

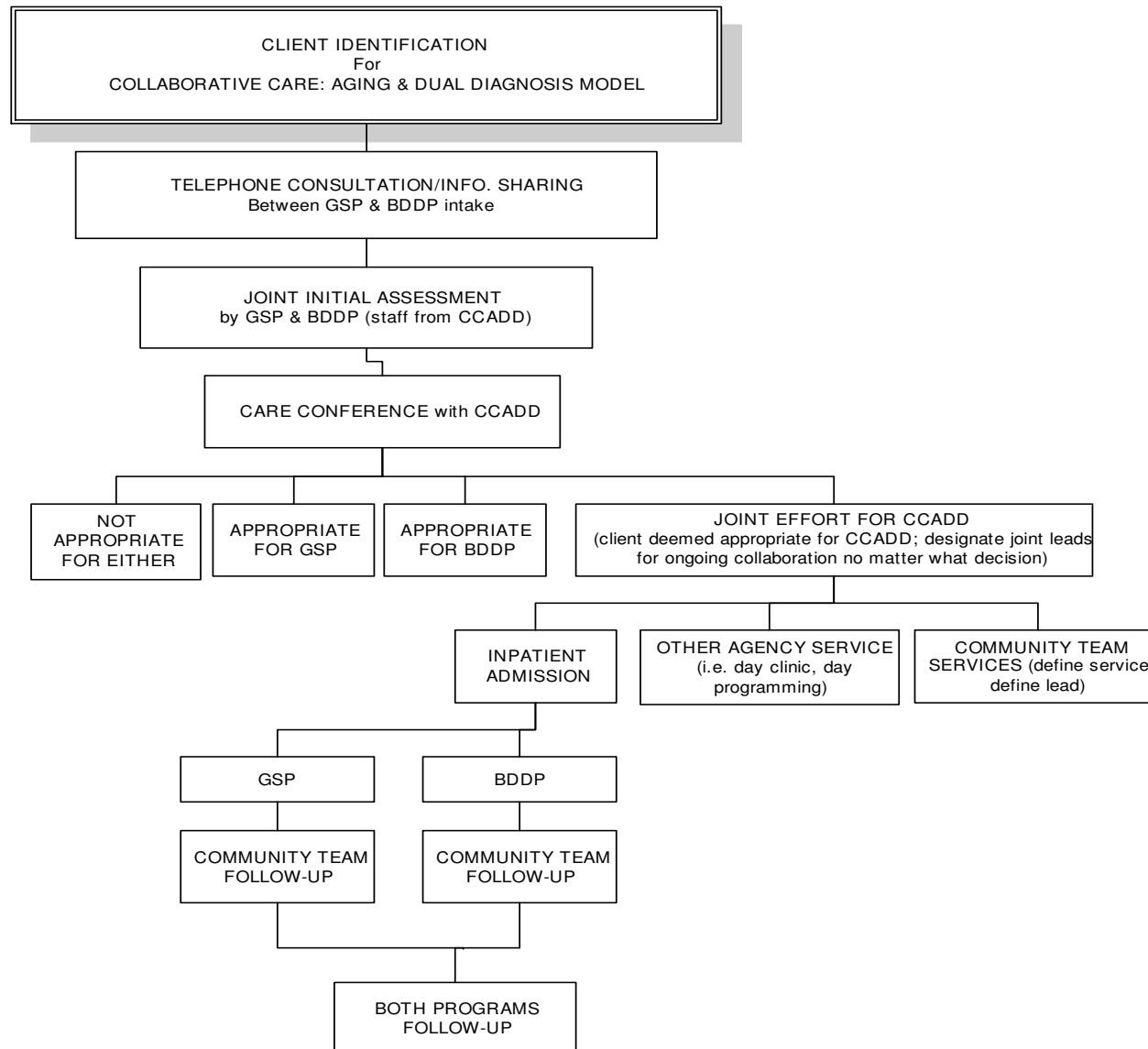


The 'Specialty' of Working with Aging & Dual Diagnosis

- Psychogeriatric Client = Older Adults + Psychiatric Disorders + Cognitive Impairment
- Dually Diagnosed Client = Developmental disability + Psychiatric Disorder
- Both specialty areas must account for other clinical diagnosis: neurological disorders; medical frailty; Axis II; etc.



COLLABORATIVE CARE: AGING & DUAL DIAGNOSIS MODEL



“Mr. A”

- 7 inpatient admissions from 1950 – 2004; 4 outpatient admissions from 1974 – 2005
- Admissions: Acute Care unit and later to GSP.
- On first admission, dx of “mental retardation” and “psychosis”.
- Remained in community for 15 years until he became disoriented, confused, and aggressive.
- 1990, first diagnosis of dementia appeared
- 1990 and 2004 continued to decline resulting in two further admissions during this period
- End result – look to MHCP for crisis placement/respice



Mr. A *Continued*

With CCADD.....

- More responsive service
- Higher potential for avoiding admission
- Admission would be to either GSP/BDDP depending on client need
- Increased community involvement on a consultative basis
- Opportunities to be preventative
- Screening; assessment; and diagnosis would have been more comprehensive
- Ultimately, CCADD would provide a more client driven service as well as decrease the over-reliance on the in-patient psychiatric system



Client Base

- Age range
- Previous diagnosis
- Origin of request

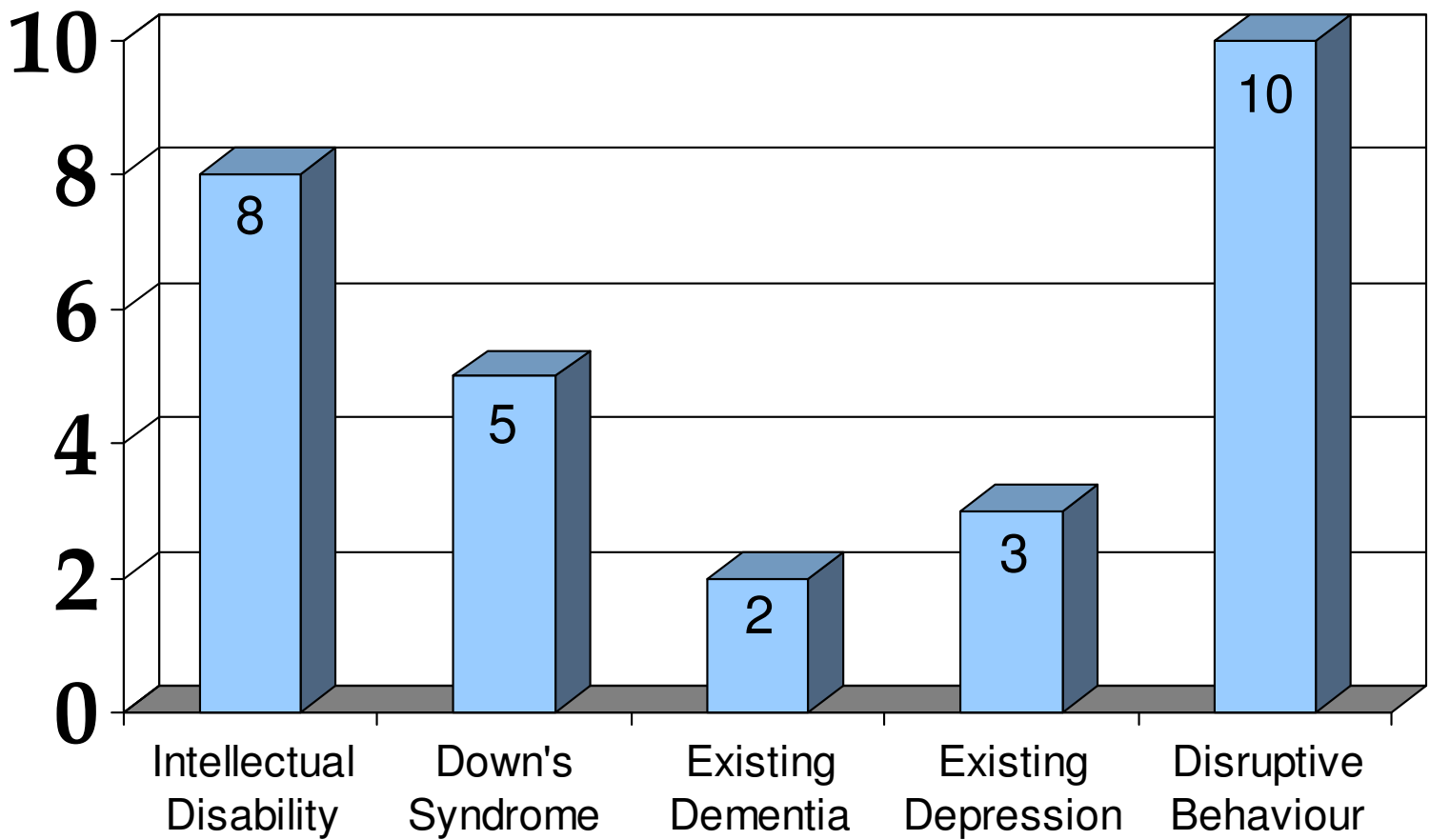


Bayview Dual Diagnosis Program

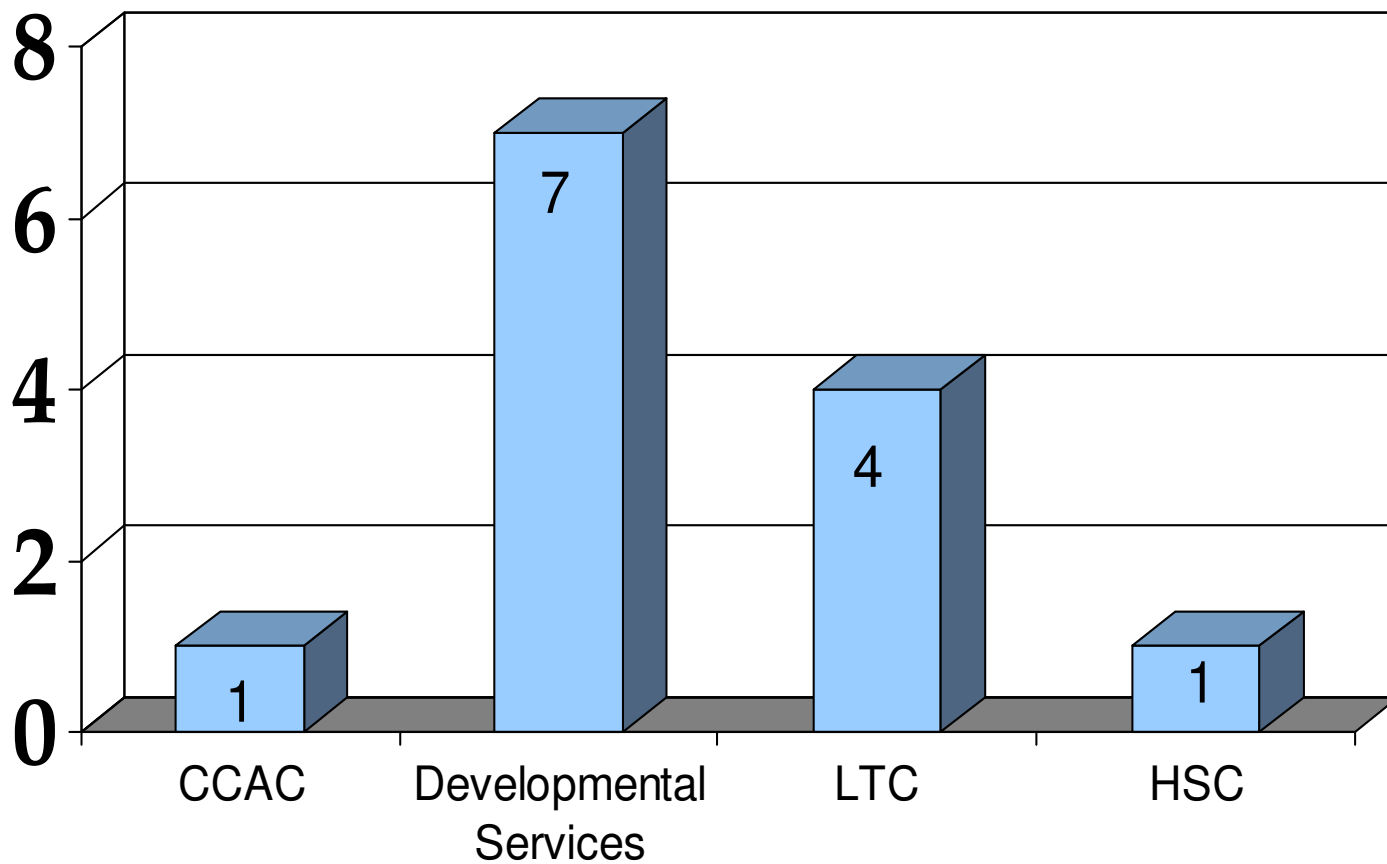


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Diagnoses



Origin of Requests



Client Base

- Nature of referral / presenting problem
- Determination of appropriateness for CCADD



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Assessments

- Where
 - Place of residence
- When
 - Following intake process
- Who attends
 - Client, Caregivers and the CCADD clinicians



Assessment Outcome

- Requests for further medical investigations,
- Follow up by tertiary care, i.e. GSP or BDDP
- Recommendation of referral to other services such as behaviour management
- No need for follow-up based on CCADD's brief intervention



Test Batteries

- Adaptive Behaviour Assessment System (ABAS)
- Multidimensional Observation Scale for the Elderley (MOSES)
- Dementia Scale for Down's Syndrome (DSDS)
- Repeatable Battery for the Assessment of Neuro-Psychological Status (RBANPS)
- Test of Non-Verbal Intelligence (TONI-3)



Progress to Date

- Program evaluation
- Initial impressions
 - Need for specialized services confirmed by clients / caregivers
 - Provision of services more accessible and thus more timely
 - Positive client outcomes
 - Case studies



Case Study - Jane

- 72 year old female
- Diagnoses
 - Axis I
 - History of significant behavioural difficulties
 - Axis II
 - Profound intellectual disability (Etiology: Meningo-encephalitis also resulting in deafness)
 - Axis III
 - Seizure activity
 - Urinary tract infection
 - Hyperopic astigmatism
 - Gait disturbances, osteoporosis
 - Watershed infarct
 - Rectal prolapse



Case Study *Continued*

- Reason for referral
 - Through geriatric service program
 - Presenting problems: aggression, sleep disturbance, and relocation stress
- Assessment
 - Observational assessment only
 - Examined physical status, intellectual, emotional, capabilities, environmental, social and mental status



Case Study *Continued*

- Outcomes/Recommendations
 - Psycho-geriatric consultation; medication review
 - Letter of support to extend 1:1 staffing
 - Baseline cognitive function
 - OT assessment
 - Appropriate levels of staffing
- Appropriateness for CCADD
 - Intellectual disability
 - Aging
 - Serious mental illness



Case Study - Larry

- 81 year old male
- Diagnoses
 - Axis I
 - Depression, OCD
 - Dementia that dates back to 1999
 - Axis II
 - Intellectual disability
 - Axis III
 - Osteo-arthritis
 - Positive for Hepatitis A
 - Shingles



Case Study *Continued*

- Reason for referral
 - Depressive symptoms
 - Change in behaviour
- Assessment
 - Observational assessment
 - Examined physical status, intellectual, emotional, capabilities, environmental, and mental status



Case Study cont'd

- Outcome/Recommendations
 - Geriatric psychiatrist to assess
 - Referral to Alzheimer's society for staff education
 - Me & U First education for staff
 - Behavioural intervention strategies
- Appropriateness for CCADD
 - Intellectual disability
 - Cognitive changes
 - Depression
 - Older adult



Sustainability

- Infrastructure
 - Forms
 - Testing
 - Tracking
 - Commitment from management
- Workload
 - Accountability
- Tools
 - Trial for a year
 - Evaluation



Future Direction

- Develop an assessment framework to use for all clients who meet the CCADD criteria.
- Conduct an evaluation of the selected test battery
- Recruit MHCP doctor
- Engage in partnerships
- Program evaluation





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No wrong door!

Improving direct client care means we must also improve overall service by ensuring access and other processes are customer service friendly!

Key Points

- Specialty approach to meet a uniquely identified need
- Seamless process
- Central access point





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Questions?

Thank You

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