Psychogeriatric Outreach Treatment

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Key Words: psychogeriatric outreach, rural, community, consultation

The last 20 years have seen an increasing but modest number of articles concerned with psychogeriatric outreach treatment initiatives. Canadian programs, usually originating in hospital-based psychogeriatric services, were among the first to be described (1–3). Several papers describe outreach to rural or remote areas (1,4,5).

Although there is empirical support for the effectiveness of community-based, multidisciplinary psychogeriatric teams (6–8), there is insufficient evidence to determine which processes of care are associated with better outcomes (9). Psychogeriatric best-practices reports recommend outreach service as part of a comprehensive approach (9,10).

Catchment

The northern half of Vancouver Island is a largely rural area with a population of 130,000, of whom 13.5 per cent are aged 65 years or over. Most of the elderly and the more specialized medical resources are situated in two small (30,000 to 40,000) urban centres in the south of this area. Travel by car to or from these resources may take up to five hours or more, depending on ferry availability to six smaller islands. The area encompasses many First Nations bands.

Program Description

History
Based on a needs assessment initiated by local community hospital and governmental groups, joint funding was approved, and the Upper Island Geriatric Outreach Program (UIGOP) was established in 1992.

Mission
The purpose of the program is to promote excellence in psychogeriatric care through clinical service and education to the elderly, caregivers, health professionals and agencies.

Service Model
UIGOP activities are based on Gerald Caplan’s mental health consultation model (11). Client-centred, consultee-centred and program-centred consultations are provided on request. With this model, primary responsibility for patient care is retained by front-line catchment resources. UIGOP objectives are to reinforce and enhance existing attitudes and skills as well as to increase collaboration regarding prevention and care.

Team Composition
The UIGOP interdisciplinary team consists of two full-time equivalent (FTE) geriatric psychiatrists; one FTE program coordinator, who is a registered nurse (RN); 1.6 FTE nurse clinicians; 1.75 FTE occupational therapists (OTs); and one FTE secretary–office manager. A one-FTE social work position has just been acquired.

Administration and Setting
Within UIGOP, there is an egalitarian structure based on mutual respect and collaboration. The coordinator has administrative responsibility for nonphysician members. The physicians are consultants to UIGOP as well as active staff members of the Department of Psychiatry of St. Joseph’s General Hospital in Comox, British Columbia; this site houses most of the UIGOP team and the Psychiatry Unit for the catchment area. UIGOP has retained essential autonomy and flexibility, administratively and professionally, thus enabling fulfillment of its regional mandate.

Communication and Coordination
Team members are based in the two urban centres in the south, but most activities are provided in the community. Communication is facilitated by formal and informal meetings and rounds among UIGOP members and by weekly joint rounds with major community partners. Monthly visits to the more remote catchment areas feature joint rounds and are supplemented by telephone consultations and conference calls. Although most initial assessments are done in the home, clinical consultations frequently occur in physician’s offices.

Partnerships
UIGOP has established clinical, educational, research and community partnerships. Among others, these include six local and one provincial hospital, multiple medical clinics and primary physicians, 10 long-term care facilities, various health services (mental health, continuing care and home care), assisted living sites, daycare programs
and seniors’ volunteer and support groups. Educational partnerships exist with the University of British Columbia, the University of Victoria (Centre on Aging), two local colleges and the BC Psychogeriatric Association.

Referral Process
Referrals requiring involvement of a geriatric psychiatrist (> 90 per cent) must be from a primary physician. Those requesting only RN or OT involvement do not. Priority is given to those aged 65 years or over, although younger persons with age-related illnesses (for example, dementia) are accepted on a case-by-case basis. Persons with early onset severe and persistent psychiatric disorders continue to be followed by adult psychiatry services. Fortunately, many referrals have been assessed previously by a single-entry community service provincial agency (continuing care), thus avoiding common pitfalls and enabling collaboration and follow-up care.

Services Provided

Statistics
From April 1, 2002, to March 31, 2003, the team assessed 745 patients, of whom one-half were previously unknown. Of these, 60 per cent were residing at home, and the rest were in facilities. Referral rates were higher for remote areas. Total contacts by all team members included 903 assessments, 6,007 direct patient contacts, 16,088 indirect (case-management) contacts, 1,155 liaison meetings (ongoing services to particular offices or facilities) and 1,413 consultations (patient not seen). The geriatric psychiatrists acted as most-responsible physicians for psychiatry unit admissions from outside the Comox area and as consultants for other hospitalized patients throughout the catchment. The usual active census is four to six patients on the psychiatry unit and 30 to 35 elsewhere. There were 1,725 total active UIGOP cases during the year.

Diagnosis
The primary diagnostic categories included dementia (57 per cent), affective disorders (20 per cent), delirium (10 per cent), mild cognitive impairment (five per cent), alcohol-related disorders (two per cent) and other (six per cent). The absence of local specialists in neurology and geriatric medicine leads to the team’s diagnosing and jointly managing most individuals with early-onset dementias, strokes and neurodegenerative diseases.

Education and Administrative Consultations and Research
In the past year, UIGOP provided 49 formal educational events and seven program-centred administrative consultations. Educational and care manuals were created and distributed. Team members participated in local and provincial committees and helped create two best-practices documents. UIGOP has been involved in university didactic teaching and clinical supervision for nursing, OT and medical students, as well as for family practice and psychiatry residents. Research has been descriptive and concerned with service delivery.

Results and Benefits
UIGOP performance is assessed by self-initiated medical audits and external reviews. Formal feedback is obtained for educational activities. Satisfaction ratings have been favourable. Perceived benefits (by UIGOP and partners) include those associated with home assessments; the availability of catchment-specialized services; appropriate delays in institutionalization; diminished caregiver burden; more equitable and efficient use of community and facility resources; decreased emergency room and inpatient psychiatry unit use; increased health professional skills, referral use and satisfaction; provincial advocacy for services for the elderly; and creation of a best-practice model for care.

Challenges
We have been fortunate with our partners. Many potential problems are averted or quickly resolved because of the small-town setting with frequent face-to-face encounters, early access to administrators and evident impact of interventions. This has been more of a problem in remote areas, largely because of frequent administrative and clinical personnel changes. UIGOP funding has increased with persistent advocacy and documentation of results. Services have been limited to some extent by the absence of allied geriatric medical specialists and by not having a dedicated geriatric assessment unit. Proposals for these necessities are being considered by appropriate government bodies.

We have developed several researchable clinical questions that will be addressed over the coming several years, with help from academically based partners. These questions concern compliance rates and factors determining consultee response to team recommendations, feasibility and effectiveness of telepsychiatry interventions, the impact of a standardized OT functional assessment on physician diagnosis of mild cognitive impairment and the optimal role of the nurse clinician consultant in a long-term care facility. These diverse areas of interest reflect the unique opportunities for collaboration inherent in a multidisciplinary team.

Conclusion
We believe that our team’s approach can be replicated elsewhere, given comparable catchment characteristics, staffing, budget and administrative autonomy. The consultation-liaison model has been extensively described and widely employed in various service settings (11). The community collaborative planning model used in organizing catchment resources already has been disseminated by the team to interested parties in Canada, Ireland and the United States (12).

The team’s activities are strongly influenced by current best-practices guidelines for geriatric mental health care (7,9,10) and by a consensus statement of the World
Health Organization and the World Psychiatric Association (13). Team services embody best-practice principles by providing comprehensive assessment and treatment that is evidence-based, accessible, responsive, individualized, accountable and integrated with other catchment resources. Similarly, team educational programs feature active involvement of participants, integrated case management and implementation toolkits. Teaching priorities are based on epidemiologic considerations, consultee requests and needs assessments.

In our experience, psychogeriatric outreach is an extremely efficient, effective and enjoyable component of elder care that is well suited to rural and remote areas. However, further outcome research is needed to clarify the essential and most effective interventions to be used.

References

Congratulations to Dr. Pushpa Kumara Malaviarachchi of Toronto! Dr. Malaviarachchi was the winner of the DVD player, which was drawn by The Personal Insurance Company as part of the launch of CPA’s Home and Auto Group Insurance Program.

Félicitations au Dr Pushpa Kumara Malaviarachchi de Toronto! Il gagne un lecteur DVD qui a été attribué par la compagnie d’assurances The Personal, dans le cadre du lancement du régime d’assurance-maison et automobile collective.