

HOW TO IMPROVE THE ORGANISATION OF MENTAL HEALTHCARE FOR OLDER ADULTS IN BELGIUM?



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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
A bed	Neuropsychiatric bed for observation and treatment
A1 bed	Neuropsychiatric bed for observation and treatment (day-bed)
A2 bed	Neuropsychiatric bed for observation and treatment night-bed)
ACTE	Assertive Community Treatment for the Elderly
ADL	Activities of Daily Living
ALC	Alternate Level of Care
APA	Activité Physique globale Adaptée
APA	Allocation d'aide aux personnes âgées
APR-DRGs	All Patient. Refined Diagnosis Related Groups
ARS	Agence Régionale de Santé
ASBL	Association Sans But Lucratif
ATC codes	Anatomical Therapeutic Chemical Classification System
AUDIT	Alcohol Use Disorders Identification Test
AVIQ	L'Agence pour une Vie de Qualité
BASDEC	Brief Assessment Schedule for the Elderly
BFM	Budget of Financial Means
BGD	Between group difference
BPSD	Behavioural and psychological symptoms of dementia
CAR – CRA	Centra voor ambulante revalidatie – les centres de rééducation ambulatoire
CARITAS	Comprehensive, Accessible, Responsive, Individualized service, Transdisciplinary approach, Accountable service and Systemic approach
CCGs	Clinical commissioning groups
CCM	Chronic Care Model
CES-D	Center for Epidemiologic Studies Depression Scale
CGG – SSM	Centrum voor Geestelijke Gezondheidszorg – Service de Santé Mentale
CIDI	Composite International Diagnostic Interview
CLIC	Centres Locaux d'Information et de Coordination
CMA	Canadian Medical Association



CMHT	Community mental health teams
CMP	Centres médico-psychologiques
CNK codes	Code national Nationale Kode
CNSA	Caisse Nationale de Solidarité pour l'Autonomie
COCOF	Commission communautaire française
COCOM	Commission communautaire commune de Bruxelles-Capitale
CRHT	Crisis Resolution and Home Treatment
CRRPSA	Centre Ressource Régional de Psychiatrie du Sujet Agé
DALY	Disability-adjusted life year
DBC	Diagnostic related groups
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
ECTS	European Credits Transfer System
EHPAD	Etablissements d'hébergement pour personnes âgées dépendantes
EIU	Economist Intelligence Unit
EMPSA	Equipe mobile de psychiatrie du sujet âgé
EPA	Ernstige Psychische Aandoening
EPSI – UCUP	Eenheid voor Psychiatrische Spoed Interventie – Unité de Crise et d'Urgences Psychiatriques
EQ5D	EuroQol five dimensions questionnaire
ESEMeD	European Study on the Epidemiology of Mental Disorders
FOD – SPF	Federale Overheidsdienst – Service Public Fédéral
FPS	Federal Public Service
FTE	Full Time Equivalent
FU	Follow-up
G bed	Geriatric bed
GDS	Geriatric Depression Scale
GDT	Geïntegreerde dienst voor thuisverzorging
GEM	Geriatric Emergency Medicine
GGC	Gemeenschappelijke Gemeenschapscommissie van Brussel-Hoofdstad



GGZ	Geestelijke GezondheidsZorg
GHQ	General Health Questionnaire
GMSS	Geriatric Mental Health Schedule
GP	General Practitioner
HAM-D	Hamilton Rating Scale for Depression
HGR – CSS	Superior Health Council (Hoge Gezondheidsraad – Conseil Supérieur de la Santé)
HIS	Health Interview Survey
HoNOS65+	Health of the Nation Outcome Scales for Elderly People
HP	Health Practitioner
I bed	Intensive treatment bed for psychiatric patients
IAPT	Improving Access to Psychological Therapies
IBW – IHP	Initiatieven Beschut Wonen – Initiatives d’Habitations Protégées
ICT	Information and communication technology
ILSS	Independent Living Skills Survey
IMA – AIM	InterMutualistisch Agentschap – Agence Intermutualiste
IPREP	Institut de Formation, de Recherche et d’Evaluation des Pratiques médico-sociales
IPSA	Initiatives spécifiques Personnes Agées
IRR	Incidence rate ratio
KCE	Federaal Kenniscentrum voor de Gezondheidszorg – Centre fédéral d’expertise des soins de santé
KNOP	Het Nederlands Kenniscentrum Ouderenpsychiatrie
LDC	Lokale Dienstencentra
LOS	Length of stay
LTC	Long Term Care
MHC	Mental Healthcare
MEMO	Mental health care Monitor Older adults
MHCC	Mental Health Commission of Canada



MHCOA	Mental health care for older adults
MHN	Mental Health nurses
MPG – RPM	Minimale psychiatrische gegevens – Résumé Psychiatrique Minimum
MZG – RHM	Minimale Ziekenhuis Gegevens – Résumé Hospitalier Minimum
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NNT	Number Needed to Treat
NRZV – CNEH	Nationale raad voor ziekenhuisvoorzieningen – Conseil national des établissements hospitaliers
NS	Not significant
OCMW – CPAS	Openbare Centra voor Maatschappelijk Welzijn – Centre Public d'Aide Sociale
OECD	Organisation for economic cooperation and development
OR	Odds Ratio
PAAZ – SPHG	Psychiatric wards in acute general hospitals
PAERPA	Personne Agée en Risque de Perte d'Autonomie
PCH	Prestation de Compensation du Handicap
PHQ-9	Patient Health Questionnaire
PTSD	Post-traumatic stress disorder
PVT – MSP	Psychiatrische verzorgingshuizen - maisons de soins psychiatriques
PZ – HP	Psychiatrisch Ziekenhuis – Hopital Psychiatrique
PZT – SPAD	Psychiatrische zorg in the thuissituatie – Soins Psychiatriques pour personnes séjournant à Domicile
R bed	Geriatrics and revalidation bed
RAID	Rapid, Assessment, Interface and Discharge
RCT	Randomized controlled trial
RIZIV – INAMI	Rijksinstituut voor ziekte- en invaliditeitsverzekering – Institut national d'assurance maladie-invalidité
RN	Registered Nurses
ROB – MRPA	Rustoorden voor bejaarden – maison de repos pour personnes âgées



ROM	Routine Outcome Monitoring
RR	Relative Risk
RVT – MRS	Rust-en verzorgingstehuis - maison de repos et de soins
S bed	Chronic care bed
SCL	Symptom Checklist
SD	Standard Deviation
SEL(GDT) – SISD	Samenwerkingsinitiatieven Eerstelijnsgezondheidszorg (Geïntegreerde dienst voor thuisverzorging) – Services Intégrés de Soins à Domicile
SF-12 MCS	Mental component summary of short-form 12
SHI	Statutory Health Insurance
Sp bed	Treatment and readaption bed
Sp6 bed	Specialised psychogeriatric bed
SSIAD	Service de soins infirmiers à domicile
T bed	Psychiatric bed for treatment
Tf bed	Host family bed (gezinsverpleging – placement familial)
Tg bed	Psychiatric beds for geriatric patients requiring neuro-psychiatric treatment
THAB	Tegemoetkoming voor hulp aan
UCC	Unité cognitivo-comportementale
UHR	Unité d'hébergement renforcé
UK	United Kingdom
USLD	Unité de soins de longue durée
VADA	Age-friendly cities (Villes Amies Des Aînés)
V bed	Long-term care bed
VGC	Vlaamse Gemeenschapscommissie
Vumc	Vrij Universiteit medical center
WHO	World Health Organization
WIV – ISP	Wetenschappelijk Instituut Volksgezondheid – Institut Scientifique de Santé Publique



■ SCIENTIFIC REPORT

How to use this document?

This Scientific Report is not intended to be read as a stand-alone document, but as a complement to the Short Report of this study. It gives a detailed account of the methods and results of each of the scientific building blocks underpinning the messages rendered in the Short Report.

The discussion of the results, and the conclusions are to be found in the Short Report.

The Short Report and the Appendix are published as two separate documents on our website. It can be accessed from the same referral page as the current document.

1 INTRODUCTION

1.1 Background

A key issue highlighted by the WHO (2009) and needed to be taken into account when discussing and implementing mental health policy is that certain sub-populations, such as children and adolescents, older people, and in some cases ethnic groups, may require more focused policies.¹

At European level, one of the conclusion of the thematic Conference on Mental Health and Well-Being in Older People in 2010 was the requirement of more and better policies to ensure good mental health and wellbeing in the growing elderly population.²

The Belgian government has, for the last twenty years, aimed to diversify the mental healthcare offer in order to cover the needs of different groups of persons. The place of older adults in the different reforms is highlighted in the following section.

1.1.1 *Historical overview of the organisation of mental healthcare in Belgium and the place of older adults*

Before 1948, mental healthcare in Belgium was predominantly organized by religious congregations with the main aim to 'isolate mentally ill in care institutions' (afzondering van geesteszieken in opvanginstellingen – traitement et l'internement de «malades mentaux»), as stipulated by a law of 1850. In that period, the organisation of this system was supervised by the Ministry of Justice. In 1948 it was decided by the Federal Government to transfer mental healthcare institutions to the Ministry of Public Health. However, at that moment there was no specific reimbursement system for treatment of mental health disorders. In 1963, RIZIV – INAMI started with specific reimbursement of mental healthcare.

From the early 1960's, psychiatric institutions created 'crisis units' and general hospitals set up 'psychiatric wards' ('Psychiatrische Afdeling van het Algemeen Ziekenhuis'(PAAZ) – 'Services Psychiatriques en Hôpital Général (SPHG)). The need for specific hospital beds for older persons with mental health problems dates back to the late 1970's. At that time, lack of specific norms for these beds led to their recognition under various indexes



(Vp, Tg, Tv).³ Around 1960, the concept of the 'centres for community mental healthcare' were introduced in the Belgian landscape. In 1975, the 'centres for community mental healthcare' (Centrum voor Geestelijke Gezondheidszorg (CGG) – Service de Santé Mentale (SSM)) were recognised.

Reflexions on de-institutionalisation of persons with mental health disorders as well as rise of psychosocial problems in the community called for the emergence of new models of mental healthcare delivery. Moreover, European initiatives promoted the search for alternatives for internment of mentally ill people. It became clear that Belgium needed a radical change of the model of mental healthcare with emphasis on de-institutionalisation of the classic psychiatric wards⁴

Recent reforms of the mental healthcare system

The main aim of the reform of mental healthcare was to adapt the qualitative provision of care to the needs of people with mental health problems by expanding the community mental healthcare system (centres for ambulatory mental healthcare, psychiatric home care) and by creating new care facilities adapted to patients for whom admission to a psychiatric institution or a psychiatric ward in a hospital is not appropriate. This transition towards a higher provision of care in the community is still on-going.⁵

Between 1990 and 2000 there were two big reform phases for mental healthcare in Belgium, based on reconversion of beds and creation of consultation platforms between the different actors involved in the care of persons with a mental problem.⁴ Reconversion is a system where a reduction of psychiatric beds can lead to the creation of other kinds of beds, services or care facilities in the same organisation or institution. *The first reconversion phase (1990)* started with the creation of psychiatric care

homes [psychiatrische verzorgingshuizen (PVT) – maisons de soins psychiatriques (MSP)]^a and initiatives for sheltered living (Initiatieven Beschut Wonen – Initiatives Habitation Protégée) (IBW – IHP)^b. The law of 1991 also formalized the conditions for psychiatric hospital services to organise psychiatric nursing in a home environment (Tf) (places de soins psychiatriques en milieu familial – psychiatrische gezinsverpleging)^c. This means that the person with a mental disorder lives with a foster-family supported by professional services, but at the same time a certain number of hospital beds serve as back-up in case the patient should need hospitalisation.

The laws mentioned above also stipulated the conditions for the creation of 'concertation platforms' ('overlegplatforms geestelijke gezondheidszorg' – 'plateformes de concertation en santé mentale'). The most important goal of these platforms is the regional coordination of the different existing and new forms of medical and psychosocial supply for persons with a mental disorder in a delimited catchment area. In addition, representatives of the home care sector (e.g. Geïntegreerde dienst voor thuisverzorging (GDT) – Services intégrés de soins à domicile (SISD)), the sickness funds among others can also participate in the activities of the platforms.

The second phase (1999) started with new laws that defined clear and precise conversion rates from hospital beds to psychiatric care home^d and sheltered living^e places. This initiated a massive voluntary reconversion of 'classic' psychiatric beds to PVT – MSP and IBW – IHP beds (and partly to psychiatric nursing in a home environment). The main aim was to foster a horizontal structure focused on specific sub-groups of patients with mental health problems (children and adolescents, adults, elderly, drug and alcohol addiction, forensic psychiatry, and mental health for disabled persons with

^a Belgisch Staatsblad/Moniteur Belge M.B./A.M. 10.07.1990

^b Belgisch Staatsblad/Moniteur Belge K.B./A.R. 10.07.1990

^c Belgisch Staatsblad/Moniteur Belge K.B./A.R. 10.04.1991

^d K.B./A.R. 16.04.1999 (MB/AM 29.09.1999) modified by K.B./A.R. 18.02.2000 (MB/AM 16.05.2000), K.B./A.R. 14.04.2001 (MB/AM 26.10.2001) and K.B./A.R. 03.07.2005 (MB/AM 12.08.2005).

^e K.B./A.R. 16.06.1999 (MB/AM 29.09.1999) modified by K.B./A.R. 18.02.2000 (MB/AM 16.03.2000), 05.06.2000 (MB/AM 14.07.2000), 14.09.2001 (MB/AM 26.10.2001) and 10.11.2005 (MB/AM 13.12.2005)



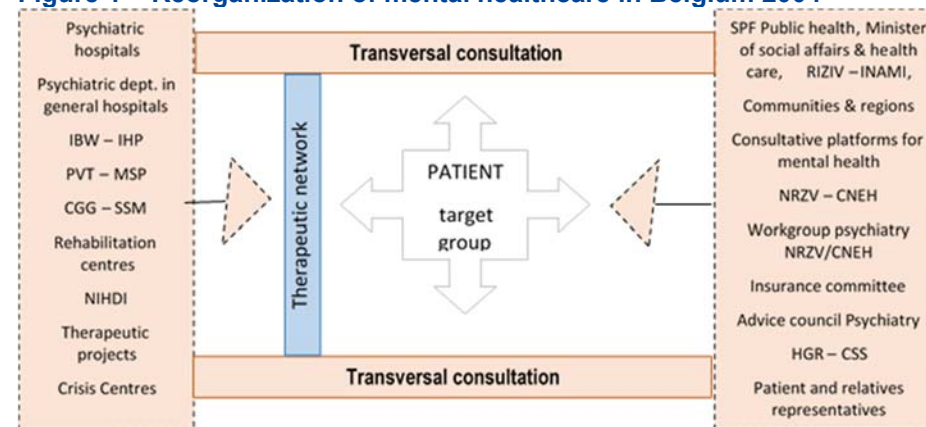
severe psychiatric disorders). The intention was to develop a specific care circuit and care network for each of these groups in order to promote specialization, trans-mural care and to increase the capacity for chronic psychiatric care. Moreover, several semi-ambulatory structures, were set up, such as day centres, day hospitalisation and night hospitals. The numeric result of the reconversion operation was quite successful and led to increase reception/admission capacity, increased specialisation of care professionals, increased therapeutic perspectives and diversification of alternative care plans. However, the residential aspect of the new structures is still dominant and psychiatric hospitals continue to predominate in the Belgian mental healthcare landscape⁴.

The third phase (first decade of the 2000) was marked by the establishment of the framework to develop 'care networks' or 'care circuits' for specific target groups. Between 1997 and 2002, the National council for hospitals (Nationale raad voor ziekenhuisvoorzieningen (NRZV) – Conseil national des établissements hospitaliers (CNEH)) defined a 'care circuit' as a whole of care programs and services depending on the federal authority, organized by a network of care organisations, and dedicated to one 'target group' or a 'sub target-group'. Based on these new concepts, federal and federated Ministers responsible for Health signed a common declaration about the future mental health policy.^{6, 7} It is during these period that consultation platforms⁸ and other mental health providers were pleaded to organise their activities around these three groups of patients.⁹

During the decade of the 2000, two waves of pilot projects were launched.⁹ The first wave (2000) included among other initiatives the psychiatric home care teams (psychiatrische zorg in the thuissituatie (PZT) – Soins Psychiatriques pour personnes séjournant à Domicile (SPAD)), the 'activation' projects to get back to work, the initiatives to provide counselling and the discharge management in psychiatric hospitals. Most of the projects were re-conducted in the second wave via the so-called 'therapeutic projects' that started in 2007.¹⁰⁻¹² Twelve out of the 76 therapeutic projects concerned older persons.⁴

During the Inter-Ministerial Conference on Public Health (2004), it was decided to set up therapeutic networks and transversal consultation.^{7 10-12} All institutions were obliged to organise recurrent network consultations and meetings to facilitate delivery of coordinated care.

Figure 1 – Reorganization of mental healthcare in Belgium 2004



Source: Federal Public Service (SPF) Health, Food Chain Safety and Environment (2011)⁴. CGG – SSM = Centres for community mental healthcare, NRZV – CNEH = National council for hospitals. PVT – MSP = Psychiatric care homes, HGR – CSS = Superior Health Council. INAMI-RIZIV = National Institute for Health and Disability Insurance

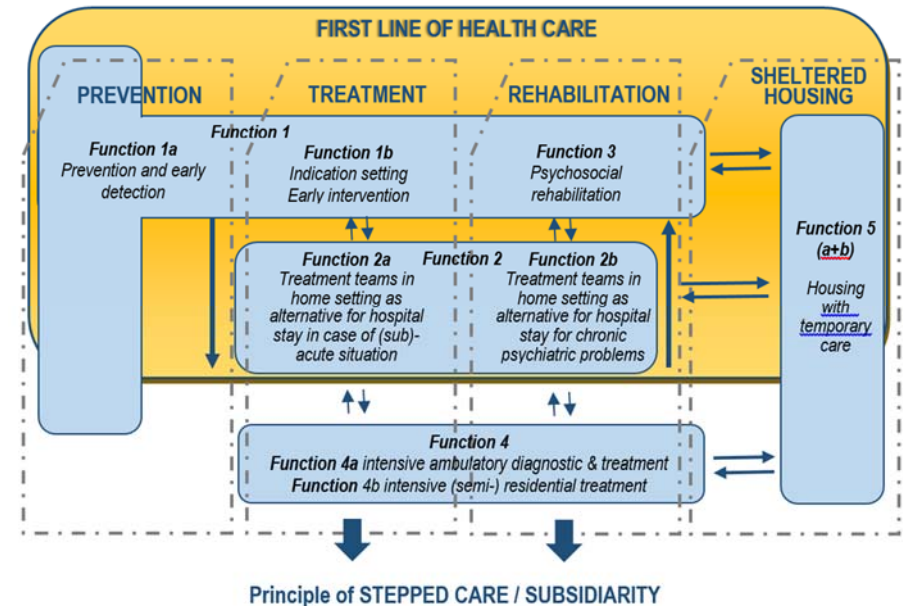
Those previous reforms deeply transformed the mental health landscape and provided new alternatives to inpatient care. Belgium still has, however, the second highest ratio of in-patient psychiatric beds in the OECD (185, 175 and 173/100.000 inhabitants in 2009, 2011 and 2013 respectively).¹³ The fourth phase of the reorganization of mental healthcare in Belgium started in 2010, when the Federal Government launched an extensive project program (Article 107 projects). By means of art. 11 and 107 of the Belgian Hospital law, hospital resources can be used to finance 'care networks', 'care circuits' and innovative projects. The article 107 projects replaced the concept of 'therapeutic projects'. This reform phase targeted adults and adolescents aged 16 years or older, leaving the projects for older persons outside of the scope of the financing coming from the hospital budget.⁴

Starting from a global vision, the projects have to ensure a high qualitative integration of resources from hospitals and (ambulatory) community services. This implies that all actors in a certain region have to be involved in this model. The final aim is to foster care in the community that can be reached according to five core principles:¹⁴

- Restricting residential treatment in healthcare institutions and favouring the setting up of intensive and specialist out-patient treatment solutions as an alternative to hospitalisation, which aim to keep the mental health user in society (desinstitutionalisation).
- Readaptation and rehabilitation in the frame of an essential collaboration with and between other sectors of the social welfare system (e.g. education, social housing, etc.) to the rehabilitation process of persons with mental healthcare problems in order to allow them to participate in the society (inclusion).
- Enhance the collaboration with and between adult healthcare, mental health services, services for people with disabilities and around the patient via health circuits and networks in order to avoid silo management (decategorisation).
- Provide care in hospital settings that focuses on shorter hospitalisation and intensive treatment aiming to allow patients to return as soon as possible to their natural environment (intensification).
- Develop a structural framework for existing pilot projects (fostered by federal and federated entities) in line with the objective of providing, within care networks, a comprehensive service supply; i.e. global treatment offer into a network (consolidation).

This collaborative group has to find solutions that meet the specific regional mental healthcare needs. The model uses a stepped care approach and care is provided from a subsidiarity-viewpoint.⁴ The model is characterised by care delivery divided into five functions:¹⁴

Figure 2 – Reorganization of mental healthcare in Belgium 2010 (article 107)



Function 1: activities regarding prevention and promotion of mental healthcare, early detection, screening and diagnosis. These primary care initiatives apply a multidisciplinary and holistic approach. Based on the established diagnosis, the patient can be referred to an appropriate service (psychiatric nursing home (PVT – MSP), sheltered living initiatives (IBW – IHP), home care, crisis intervention centre, specialized service ...) in the geographical region of the patient.

Function 2: ambulatory intensive treatment teams for acute as well as chronic psychological problems. These treatment teams work in the home environment of the patient, focusing on a (sub)acute situation. However also exacerbation of chronic conditions can be treated by these teams. This function is easily accessible and provides tailored care to people in their home environment (as an alternative for hospitalization).



Function 3: rehabilitation teams working on recovery and social inclusion. Psychosocial inclusion is important in mental healthcare, especially in chronic or less severe conditions. It provides opportunities for reintegration and (re)starting the working life. This function can be preceded by other functions of this model.

Function 4: intensive ambulatory or (semi-) residential treatment units for acute as well as chronic psychological problems. This function is in fact a 'last chance' when other functions have been applied without success. A distinction is made between an ambulatory approach and a (semi-) residential approach. This approach is only used in case of a need for particular acute interventions, lack of resources, the impossibility to treat a patient in his home environment or in case treatment is too time-consuming for a mobile team. Treatment has to be as short as possible and has to be very intensive.

Function 5: development of specific accommodations for housing of persons with stabilised chronic psychiatric problems and less opportunities for integration in the society. Housing is organized in the society as sheltered living, apartments with supervision or a similar arrangement.

At present, 23 projects (art.107) are recognised: 13 in Flanders, 2 in the Brussels Capital region and 8 in the Walloon region.¹⁵ In November 2017, it was decided to proceed with the extension of the reform by restructuring the catching area of the networks and by setting new coverage objectives for the mobile teams. This new phase of the reform does not cover older persons as it targets persons aged between 18 and 65 years.¹⁶

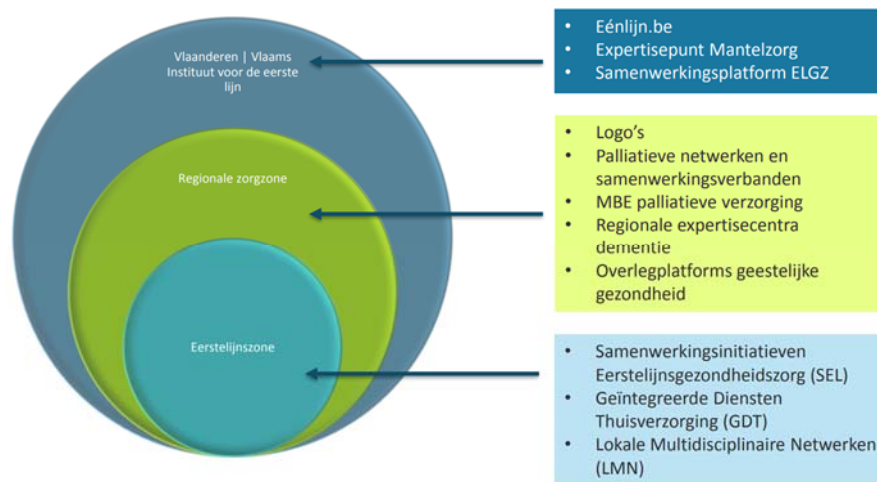
Based on the experiences with the art. 107 projects for adults, a similar approach has been used for the organisation of mental healthcare for children between 0 and 18 years old.¹⁷

The reforms are currently being pursued and lessons from innovative projects have been shared via the called innopsy107.be. Overall the objective remains to further orient mental healthcare towards reduction of residential hospital care in favour of recovery and reintegration treatment in the community. This is a next step in the development of socialisation of mental healthcare [vermaatschappelijking van zorg – soins communautaires] that requires to setup a global, integrated care offer in a structured network in the local living environment close to the social network of the patient.

A look at the future of integrated care in regional entities

The 6th state reform has shifted competences towards the communities. This reform allowed Flanders, to bring the Integrated Services for Home Care (GDT – Geïntegreerde Diensten Thuiszorg – previously under Federal competences), the collaborative initiatives primary care (SEL – Samenwerkingsinitiatieven Eerstelijnszorg) and the Local Multidisciplinary networks (LMN – previously under Federal competences) under the same umbrella. This improves integration of care and allows a more tailored approach for the patient, especially in case of elderly people with chronic conditions, having a mix of physical, mental and social problems. An important step in this process is the approval of the concept note "Een geïntegreerde Zorgverlening in de Eerste Lijn" by the Flemish Government (February 17, 2017), which opened doors for a decentralized, locoregional organisation of care as a collaboration of healthcare, social care, (social) housing, patients and informal carers, and local authorities. This approach is structured in Primary Care Areas (Eerstelijnszones) within Regional Care Areas (Regionale Zorgzones) and covered by the Flemish Institute of Primary Care (Vlaams Instituut voor de Eerste Lijn).^{18, 19}

Figure 3 – Organisation of primary care in Flanders (new model)¹⁸



The Flemish Government opened a call for proposals for regional collaboration (deadline December 31, 2017) and plans a kick-off meeting for the Primary Care Areas in March 2018. Regional Care Areas will however at earliest been financed from 2019.¹⁹ Primary Care Areas allow local authorities, care providers (GPs, home care nurses, physiotherapists, dentists and pharmacists), local community oriented services (e.g. CAW, residential homes for elderly, social services, ...), organisations of patients and informal care givers, and mental healthcare services to collaborate more closely and to align their services. Regarding the organisation of mental healthcare in these Primary Care Areas, (clinical) psychologists, the first line psychological function (if financed by the Government) and mental healthcare partners working under “function 1” of the art. 107 networks will be involved. Although this new organisational approach is not functional to date, it might be of added value to improve mental healthcare for the elderly.

In Wallonia, the primary care remain organised according the SISD (integrated care services - services de soins intégré à domicile). There are 13 SISD in Wallonia. However, as in Flanders, the 6th state reform implies a substantial transformation of care system including care for older adults. We focus here only on initiatives that may benefit to them. Firstly, the Walloon

Government defined the priority for the plan of prevention and health promotion – horizon 2030.²⁰ Based on the SHARE study showing that, in 2011, the half of French speaking Belgians older than 65 years would suffer from mental disorders (mainly depression)²¹, the promotion of mental health is selected as one of the priorities of the plan.

Secondly, another initiative of the Walloon Government is the development of age-friendly cities (villes-amies des aînés - VADA). This concept is based on a holistic approach of older adults' needs as proposed by WHO.^{22, 23} These needs also include mental healthcare. In an age-friendly city, policies, services, settings and structures are designed to enable people to age actively.²² Active ageing depends on a variety of determinants (such material conditions or social factors) that affect how well individuals age (see Figure 4). These determinants must be taken into account when an age-friendly city is promoted.

Figure 4 – Determinants of Active Ageing²²





In 2012, Wallonia launch a call for VADA projects. These projects included the participation of the Public municipal welfare centres (OCMW – CPAS), local associations and local authorities (including municipal advisory council of older peoples (gemeentelijke adviesraad van senioren / conseil consultatif communal des aînés)). Based on the VADA experiences, the WADA project (Wallonie amie des aînés) has been launched in 2016. It includes 6 pilot projects in rural and semi-urban sectors. As early as 2018, l'AViQ will develop the WADA in all the territory of Wallonia.

Thirdly, a dynamic registry of mental health care supply will be developed to allow citizens and health professionals to get the appropriate answer to their specific needs of information. Because of the fragmentation of the supply, the dynamic register will be helpful to care older persons with mental health problem.

Finally, as in the other regions, Wallonia is creating a 'autonomy insurance'²⁴ for 2019 (zorgverzekering, assurance autonomie) to fund services to maintain older adults as long as possible at home or to reduce the nursing home cost for the most vulnerable groups. Disabled persons are also a target of this 'autonomy insurance'. The financial resources of the insurance will stem from a compulsory annual contribution of all Walloons aged of 26 years or older.

Due to the institutional complexity of the Brussels-Capital region and the need for collaboration with other regions for organisation of mental healthcare, Brussels-Capital region bring the different regional players together in a dialogue platform.

1.1.2 Definitions

Mental health:

According to the World Health Organization (WHO), "Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"²⁵.

Mental health problems:

Internationally there is not one single definition for mental health problems. Recurrent themes in definitions are that mental health problems affect the person's personality, ability to deal with different aspects of daily life and social interactions. "Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions".²⁶ Mental health problems comprise psychiatric disorders and psychological distress.

Mental and behavioural disorders:

According to the WHO, "mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others"²⁷. In line with this definition, the American Psychiatric Association (APA) defines mental health disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning"²⁸

Psychological distress:

This concept is not scientifically²⁹ defined but can be simply illustrated as a general term used to describe unpleasant feelings or emotions that impact your level of functioning. In other words, it is psychological discomfort that interferes with your activities of daily living. Psychological distress can result in negative views of the environment, the others, and the self.

Cultural perspectives on mental health problems

Different cultures have different approaches to mental health and mental illness. Most Western countries agree on a similar set of clinical diagnoses and treatments for mental health problems. However, cultures in which there are other traditions or beliefs may not use these terms and might be more familiar with terms like 'poor emotional health'.



1.1.3 Emerging demographic changes

In the last 20 years, the average life expectancy of the world population has grown with six years. European citizens are living longer than ever before. Children born in 2011 have almost one chance out of three to reach their 100th birthday. By 2020, a quarter of the European population will be older than 60 years. This demographic evolution will result in significant changes in the European society, in terms of employability and productivity, but even more in social security and the organisation of healthcare.³⁰

In Belgium, life expectancy at age of 65 was estimated at 16.8, 17.8, 20.0 years in 1990, 2000 and 2015, respectively. There was, however, a small decrease in this indicator between 2014 and 2015 of 0.3 months. Life expectancy at birth is slightly declined in 2015 for 22 European countries.³¹ Population projections show a rapid and continuous increase of the proportion of Belgians aged over 65 from 18.7% in 2018, to 22.3% in 2030 and 24.2% in 2040, after which the trend is expected to level somewhat.³² For those aged 75 and over, the projected increase is from a little over 1 million in 2018 to almost 1.7 million in 2040.

Additionally, a difference is observed in estimations on the absolute growth of the population '65-75' and '75+'. It is estimated that the latter group will keep on growing (at least until 2060) while the former is expected to level at +/- 2030. As every subpopulation has its own characteristics (in terms of prevalence of physical and mental disorders, comorbidity, and healthcare expenses), these demographic population changes will affect on the organisation and financial tenability of healthcare.

1.1.4 Specific concepts attached to older people

Ageing

Ageing is simply growing old but scientifically³³, most evolutionary biologists define ageing as "an age-dependent or age-progressive decline in intrinsic physiological function, leading to an increase in age-specific mortality rate and a decrease in age-specific reproductive rate". Ageing is a heterogeneous process. Some researchers have recommended to focus on biological ageing instead of chronological ageing.³⁴

Older adults

In reference to the official age of retirement, most developed countries have accepted the chronological age of 60 or 65 years as a definition of 'elderly' or 'older adult'.³⁵ However, this social cut-off (in terms of societal roles) does not take into account, in its definition, the cultural (in terms of societal values) and the functional aspects (in terms of self-reliance and independent decision making)³⁶. To define older people only by a certain age range is misleading and poses a risk when setting the access to healthcare services based on a hard age cut-off. In Western countries, a significant part of older adults between their 60s and 70s are still fit, active and able to care well for themselves³⁷ thanks to improvements in health, cognition, and functional abilities. Some experts suggest to increase the age cut-off of the elderly subgroup to 70 or 75 based on biological ageing.³⁴

Recently, Australian researchers attempt to identify how 'elderly' is defined in clinical practical guidelines in pharmacotherapy. The qualitative analysis regarding how 'elderly' was considered within the guidelines highlights the subjective perception of this concept. Indeed, it concludes that themes as *being frail, with altered pharmacology, with multiple comorbidities, limited in the care by less evidence based data and reducing access to treatment* are related to the perceived definition of an 'elderly' persons in the medical world.³⁴

Another conclusion of the above mentioned Conference on Mental Health and Well-Being in Older People referred that older people as a target group for mental health promotion, must be recognised as a widely heterogeneous and diverse group. A definition of older people only by a certain age range is misleading.² They also notice that certain groups with specific burden face a higher risk of poorer mental health (e.g. higher age groups, migrants/ethnic minorities, isolated, depressed and people with dementia).

Wellbeing paradox

In 2010, Charles and Carstensen concluded in a narrative review that in everyday life older adults show social and emotional functioning that is equal to or superior to younger adults and that social relationships and emotional well-being benefit from experience and time perspective.³⁸ These findings were confirmed in a recent study.³⁹ Indeed, when people recognize that their time on Earth is finite, they preferably aim to savour relationships and to



focus on meaningful activities. Another explanation of the wellbeing paradox stem from the physiology of the brain that would be less responsive to stressful images than younger people.⁴⁰ However, when faced with prolonged and unavoidable stress, age-related advantages appear to be compromised. The contrast between findings that clearly demonstrate decreased biological, physiological, and cognitive capacity with those suggesting that people are generally satisfied in old age and experience relatively high levels of emotional wellbeing is seen as a paradox. But aging can also be viewed as an adaptation, shedding light on resilience across adulthood.³⁸

Frailty

Frailty is a syndrome of physiological decline characterized by an increased vulnerability to adverse health events. Frail older persons are less able to adapt to stressors like acute diseases or traumatism than non-frail persons.⁴¹ They have more risk for poor health outcomes including falls, incident disability, hospitalization, and mortality.⁴² It has been defined by Fried et al. as meeting three out of five phenotypic criteria indicating compromised energetics: weakness (low grip strength), exhaustion (low energy), slowness (lower walking speed), low physical activity, and/or unintentional weight loss.⁴³ Others have operationalised frailty as a risk index (Frailty index) counting the number of deficits accumulated over time, including disability, diseases, physical and cognitive impairment, psychological risk factors, and geriatric syndromes such as delirium, falls and urinary incontinence.⁴⁴ One has however to keep in mind that the relationship between age and frailty is not absolute.^{45, 46} Some very old persons remain vigorous while others, younger and without any apparent disease, fail to rebound following illness or hospitalisation.

Geriatric patient

Geriatric patients are described in the law as “patients with an average age ≥ 75 years who need a specific approach for the following reasons: a frailty profile, active multi-pathology, a limited homeostasis, atypical clinical appearances of diseases; disturbed pharmacokinetics, risk for functional decline; risk for malnutrition; trend to be inactive and bedridden, with an

increased risk for institutionalisation and for dependency in activities of daily living; and psychosocial problems.”⁴⁷

Old age psychiatry:

The World Health Organization and World Psychiatric Association have produced (in 1997) a consensus statement on the scope of elderly psychiatry. That consensus statement defines the specialty of elderly psychiatry as a branch of psychiatry that forms part of the multidisciplinary delivery of mental healthcare to older people.⁴⁸ The term “psychogeriatrics” designates the branch of psychiatry concerned with behavioural and emotional disorders among the elderly. Those two terms are often used one for the other. In Belgium, there is no recognition of the old age psychiatry/psychogeriatrics title. Physicians working in psychogeriatric wards get their training by personal experience or through foreign specific training available in the Netherlands, France or Switzerland for example. However, the opportunity exists in Belgium to be trained in psychiatry and in geriatrics and to hold the double title of psychiatrist and geriatrician.⁴⁹ In 2016, in the context of the updating of the Ministerial Decree of the 3rd of January 2002, the superior council of general and specialist physicians gave the priority to the creation of level 2 title in adult psychiatry and in child psychiatry. It suggested that the creation of a level 3 title in old age psychiatry will be examined later.⁵⁰

1.1.5 Mental health problems in older people in Belgium

1.1.5.1 Data from the World Mental Health (WMH) – ESEMED

The WHO World Mental Health (WMH) surveys are general population-based surveys that use structured psychiatric interviews to measure the presence of mental disorders and treatment use.^{51, 52} The data from Belgium was gathered in the European Study on the Epidemiology of Mental Disorders (ESEMED)⁵³ between April 2001 and June 2002. The surveys allow to explore estimation of prevalence of mental health disorders and treatment patterns for non-institutionalised adults. Prevalence were estimated taking into account for the known probability of selection as well as to restore the distribution of the population.⁵⁴



DSM – IV diagnoses were made using the World Health Organization Composite International Diagnostic Interview (CIDI) version 3.0, in a fully structured lay-administered diagnostic interview. An aggregate variable that indicates ‘any mental disorder in the past 12 months’ can be constructed whenever a person was identified as having mental health disorders. Treatment utilisation was assessed by the Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI-3.0) treatment module⁵⁵ regarding past year receipt of treatment from any type of professional, either outpatient or inpatient, for problems with emotion regulation, anxiety, psychological distress, or use of alcohol or drugs. Among those who reported to have used services, follow-up questions were asked about their ages at the moment of the first and most recent contacts, and the number of visits in the past 12 months. Reports of 12-months service use were classified into the following predefined categories following the WHO’s WMH definition.⁵⁶ An aggregate variable that indicates ‘any mental disorder in the past 12 months’ can be constructed whenever a persons was identified as having mental health disorders.

The Belgian study was cross-sectional. The non-institutionalised adult population (aged 18 years or older) were interviewed in person at their homes using computer-assisted interview techniques. In total, 2 419 respondents from Belgium provided data for this study. From these group, 501 participants were aged older than 64 years.

In the early 2000, the 12-month prevalence of any mental disorder was estimated at 5.6% for non-institutionalised older adults in Belgium. From this group, one out of five persons reported having followed a treatment.^f

The prevalence estimate is far below that reported for the general population in Belgium (11%)⁵³ and the estimated 16% of the older people population in the United States.⁵⁷ This is most likely due to the fact that the estimate does not include institutionalised persons and more severe mental disorders such as psychotic disorders or disorders due to a medical condition.

With only 20% of the elderly with mental disorders receiving treatment, the estimated proportion of treated older persons for their mental disorders is much less than comparable estimates for the 18+ population in Belgium.⁵⁸ These estimates should be considered with caution as they reflect the situation at the beginning of the 2000 and rely on a small sample. Some studies showed that in general, the prevalence of mental disorders remains stable whereas the use of services gradually changes by the years⁵⁹. Given the large reform of the mental health landscape in the last 20 years, it is likely that services use have evolved.

1.1.5.2 Health Interview Survey (HIS)

The Belgian National Health Interview Survey (HIS) (Belgische Gezondheidsenquête – Enquête de Santé, 2001, 2004, 2008, 2013) shows^{60,61} that for the age group 65-74, almost one in four persons suffered from psychological distress, three out of ten had sleeping problems, one out of six had symptoms of a depressive disorder, and one out of 12 was found to have an anxiety disorder. Almost 7.5% reported a depression in the past year, from which the majority consulted a health practitioner, took medication and a small part engaged in psychotherapy. Almost 24% of the ‘65-74 group’ took tranquilizers or sleeping tablets and 10% took antidepressants. For the 75+ population, one out of three reported psychological distress, more than one out of three suffered from sleeping problems, one out of ten had an anxiety disorder and almost one out of five suffered from depressive mood. Ten percent of the 75+ group reported to have had a depression in the past year, from which the majority consulted a health practitioner, took medication and a small part engaged in psychotherapy. In the 75+ group, 35% used tranquilizers and 12.5% took antidepressants.

^f Bruffaerts, R. Unpublished work. KULeuven, 31-05-2017.


Table 1 – Crude percentage of the population of mental health indicators from the National Health Survey

Disorder	Age group	2001	2004	2008	2013
Psychological distress (GHQ score 2+)	65-74	24.0	19.9	23.8	23.8
	75+	27.9	25.8	24.4	33.4
	All	24.8	24.5	26	31.8
Depressive feelings (SCL – 90)	65-74	12.1	9.7	14.0	12.9
	75+	13.0	13.0	13.9	18.8
	All	8.6	8	9.5	14.8
Anxiety disorder (SCL – 90)	65-74	8.3	6.2	8.5	8.2
	75+	6.6	8.0	7.7	11.4
	All	6.3	6.1	6.5	10.1
Sleeping disorder (SCL – 90)	65-74	29.1	23.7	26.3	29.4
	75+	30.8	25.4	28.6	36.6
	All	20.2	19.9	21.3	29.6
Suicidal ideation in the past year	65-74			1.7	2.9
	75+			2.7	2.4
	All			3.6	5
Suicide attempt in the past year	65-74		0	0.2	0.5
	75+		0.3	0.2	0.0
	All		0.4	0.4	0.4
Reported major depression in the past year	65-74	8.2	5.7	6.2	7.3
	75+	7	6.7	7.3	9.9
	All	6.3	5.9	6	6.7
<i>Consulted HP for depression in the past year</i>	65-74			94.6*	77.4*
	75+			89.6*	81.2*
	All			88	81.2
<i>Took medication for depression in the past year</i>	65-74	75.4*	80.2*	90.7*	69.2*
	75+	72.0*	85.1*	81.0*	71.8*
	All	75.3	84	81.9	72.1
<i>Got psychotherapy for depression in the past year</i>	65-74		3.7*	45.1*	5.7*
	75+		3.3*	17.1*	7.5*
	All		18.9	40.5	27.8



Used tranquilizers in past two weeks	65-74	23.0	24.7	27.7	23.9
	75+	33.2	38.6	35.8	34.6
	All	11.5	13.2	14.3	13.2
Used antidepressants in past two weeks	65-74	9.0	7.7	7.3	10.1
	75+	5.7	9.6	6.9	12.6
	All	3.9	6	5.7	7.6

Source: Drieskens et al. (2017)⁶⁰ GHQ = General Health Questionnaire, SCL = Symptom Checklist, HP = Health Practitioner (*) N < 150 – due to small sample sizes results have to be interpreted cautiously

1.1.5.3 Dementia in older people in Belgium

Another important topic in mental health in elderly is dementia. Prevalence rates of dementia in Belgium are not exactly known and data often differs significantly according to the source. In the pioneer study of Buntix et al. (2006)⁶², conducted by the KULeuven and ULg, the prevalence of dementia in the 65+ age Belgian population was reported to vary between 6.3% and 9.3%. For older population, the prevalence rates reported are much higher with the 85+ population attaining rates that vary between 22.7% and 33.6%.

Alzheimer Europe (2014)⁶³ reported that in 2012 the estimated number of people with dementia in Belgium is 191.281. This corresponds to approximately 1.73% of the population and is somewhat higher than the European average of 1.55% (year 2012).⁶³

Table 2 – Alzheimer Europe regarding number of people with dementia in Belgium

Age group	Total	
	N ^a	% ^b
< 65 years	9 251	0.10
65 – 69 years	8 251	1.58
70 – 74 years	15 247	3.52
75 – 79 years	29 477	7.43
80 – 84 years	47 929	15.35
85 – 89 years	48 061	26.11
90+ years	33 064	43.42
65+	182 029	9.67
85+	81 125	32.68
Total population	191 281	1.73

Source: ^aAlzheimer Europe (2012)⁶³ ^bStatistics Belgium (2017)⁶⁴. Percentages were calculated using population data from 1 january 2012.

Steyaert (2016)⁶⁵ estimated that in 2015, 201 762 (1.8%) persons in Belgium were affected by dementia (122 161 in Flanders, 62 571 in Wallonia and 17 030 in Brussels). With demographic changes in Belgium a further rise in the prevalence of dementia is expected: +/- 251.000 in 2030 and +/- 350.000 in 2050.⁶⁶



Behavioural and psychological symptoms of dementia (BPSD) is a heterogeneous group of non-cognitive symptoms and behaviours' troubles occurring in persons with dementia. BPSD represent a major component of the dementia syndrome. BPSD include anxiety, agitation, irritability, aberrant motor behaviour, depression, disinhibition, apathy, hallucinations, and appetite or sleep changes. The prevalence of BPSD is estimated to affect up to 90% of all persons with dementia. BPSD is independently associated with poor outcomes like distress of patients and caregivers, long-term hospitalisation, misuse of drugs, and increased cost of healthcare. A high degree of clinical expertise is essential to appropriately recognise and manage BPSD.⁶⁷

1.1.5.4 Suicide and euthanasia

In Belgium, the suicide rate is one of the highest within the European Countries⁶⁸. However, there seems to be a decreasing trend from 1985 up till now.⁶⁹ The Belgian HIS data show that there is a higher rate within the persons of 65 years or older (in 2014 23 suicides per 100 000 residents) compared to the younger persons (15.6 suicides per 100 000 residents).

Table 3 – Number of suicide per 100 000 residents (2008 – 2014)

Age category	Number of suicides		Belgian population		Number of suicide per 100 000 residents	
	0-64	65+	0-64	65+	0-64	65+
2008	1553	447	8 847 140	1 819 726	17.6	24.6
2009	1577	436	8 916 302	1 836 778	17.7	23.7
2010	1547	456	8 979 746	1 860 159	17.2	24.5
2011	1596	488	9 117 456	1 883 182	17.5	25.9
2012	1537	485	9 169 916	1 924 934	16.8	25.2
2013	1436	456	9 201 988	1 959 654	15.6	23.3
2014	1437	459	9 186 665	1 994 175	15.6	23.0

WIV – ISP: Standardised Procedures for Mortality Analysis data.

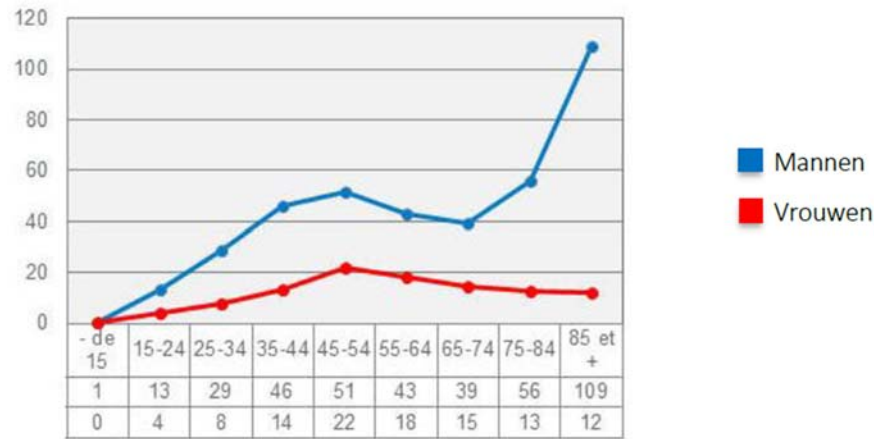
In Flanders, prevalence of death by suicide in older men (above 80) is higher than in the working population. In women, these figures are significantly lower (see Figure 5). In Wallonia, a similar trend over age was found (see Figure 6)

Figure 5 – Number of suicide over age and gender in Flanders (2014)⁶⁹





Figure 6 – Number of suicide over age and gender in Wallonia (2010-2014)⁶⁹



1.1.5.5 Mental health problems in Belgian older adults in comparison with other European countries

The Survey of Health, Ageing and Retirement in Europe (SHARE) is an international survey occurring in 27 European countries and targeting the Europeans aged 50 year or older.⁷⁰ For Belgium, separated results are available for French- and Dutch-speaking Belgium. The survey encompasses modules on health, socio-economics and social networks. In contrast with other European databases in which each member states is the source of information, data of SHARE stem from a questionnaire of which the design and the fieldwork procedures were harmonized through the participating countries allowing clear comparison between countries. The survey was repeated in 7 waves from 2004 to nowadays. The last data collection occurred in 2017 and results will be available in 2019.

Based on the last data available of the 6th wave (2015), we analysed three variables (sadness or depression feeling, trouble in sleeping and loneliness feeling) among Europeans aged 50 years and older. Firstly, we compared Belgium to other European countries included in the 6th wave of SHARE. As shown in Table 4, the proportion of sadness or depression feeling is a little bit higher in Belgium in comparison with other European countries (41,9% vs 40.0%, $p=0.034$). The loneliness feeling is also more present in the Belgian population compared to the other Europeans (8.0% vs 6.6%, $p<0.001$). In contrast, no difference in sleeping trouble was observed between Belgium and the rest of Europe.

In the same database, we also compared French-speaking (FS) and Dutch-speaking (DS) Belgians. We noticed that sadness or depression feeling (FS 41.9% vs DS 40.4%, $p<0.001$), trouble in sleeping (FS 40.2% vs DS 31.1%, $p<0.001$) and loneliness feeling (FS 11.3% vs DS 4.8%, $p<0.001^*$) are more present in the French-speaking regions than in the North of the country.



Table 4 – Comparison of sadness or depression feeling, trouble in sleeping and loneliness feeling among Europeans aged 50 years and older (SHARE – 2015)⁷⁰

	Belgium	Other European countries*	p-value [§]
Sadness or depressed feeling during the last month (n)	5684	57648	
Yes (%)	41.9	40.4	0.034
No (%)	58.1	59.6	
Trouble in sleeping (n)	5684	57667	0.547
Trouble or recent change in pattern (%)	35.5	35.1	
No trouble sleeping (%)	64.5	64.9	
Loneliness feeling (n)	5686	57638	<0.001 [£]
Often (%)	8.0	6.6	
Some of the time (%)	18.9	20.0	
Hardly never or never (%)	73.2	73.4	

* Other European countries: Austria, Germany, Sweden, Spain, Italy, France, Denmark, Greece, Switzerland, Czech Republic, Poland, Luxembourg, Portugal, Slovenia, Estonia, Croatia

[§] *Khi² test*

[£] *p-value for the comparison between often versus some of time and hardly never or never*



1.1.6 *Specific dimensions of mental health in the older people*

Mental health problems seem to differ over age with an increase of (subthreshold) symptoms of psychological distress, depression, dementia, anxiety and sleeping disorders (see section 1.1.5.2). Older people are more likely to experience events such as bereavement, a drop in socioeconomic status with retirement, or disability. All of these factors can result in isolation, loss of independence, loneliness and psychological distress.^{35, 71}

For older persons, a mental health problem may directly affect their quality of life, self-reliance (independent living), co-morbidity and, consequently their level of disability. Moreover, multimorbidity (somatic as well as mental) is an important issue in the older people resulting in increased frailty and psychosomatic instability.^{35, 71, 72} Blom et al. concluded that “Since problems on four domains have an additional effect on health, individuals with combined functional, somatic, mental and social problems could benefit from integrated care”.^{73, 74}

In addition to the burden of mental disease for the patient, the negative effects on relatives and informal carers should also not be underestimated. Physical, emotional and economic pressures can cause great stress to families of older people with e.g. dementia or depression. Therefore the World Health Organisation (WHO) in 2016³⁵ points out that: “Support is needed from the health, social, financial and legal systems for both older people and their caregivers.”

For older persons, there is a strong need to setup detection systems for recognition and adequate treatment of age related mental illness (community care, day care, short stay, long term care, specialised care ...).^{35, 71} Research showed that mental health problems in community dwelling older people are often overlooked and maltreated by healthcare professionals and are often catalogued as ‘normal signs of ageing’ or misdiagnosed because of multimorbidity, polypharmacy, aberrant manifestation of symptoms or stigma.^{71, 75-78} The same issue was raised for mental healthcare in residential settings for older people.⁷⁹

An important point of attention is the link between mental health and physical health. For the general population, mental health has an impact on physical

health and vice versa. This relation is even stronger in older people, due to vulnerability and under-recognition.⁸⁰⁻⁸²

Mental disorders in older people are found to be an independent predictor of poor outcome in somatic health problems, such as increased mortality, longer hospital stays, loss of independent function and higher rates of institutionalisation.^{80, 83} Depression increases the perception of poor health, the utilization of medical services and the healthcare costs.³⁵

Finally, older adults are also vulnerable to physical neglect and maltreatment, which cannot only lead to physical injuries, but also result in severe, sometimes long-lasting psychological consequences, including depression and anxiety disorders.⁸⁴

Box 1 – Terminology used in the report

An older adult or older person refers to people aged 65 years and older. The definition used in this report aims to encompass the population not targeted by the on-going reform of the mental healthcare system (see section 1.1).

A mental health problem is a behavioural or mental pattern that affect the person's personality, ability to deal with different aspects of daily life and social interactions. Mental health problems comprise psychiatric disorders and psychological distress.

A psychiatric disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the mental functioning

A psychological distress is having unpleasant feelings or emotions that impact your level of functioning. Most developed countries accepted the age of 65 years as a definition of older people. But to define older people only by a certain age range is misleading as older people is a widely heterogeneous group. Some very old persons remain vigorous while others, younger and without any apparent disease, fail to rebound following illness or hospitalization. This decrease in functional reserves with higher levels of comorbidities leads to increased vulnerability often described as “Frailty”.



1.2 Objective

In 2002, federal and federated Ministers responsible for Health signed a common declaration about the future mental health policy.^{6, 7} Among other objectives, the intention of the authorities was to construct care networks' or 'care circuits' for specific target groups. Three groups based on aged were identified: children and adolescents, adults and 'older adults'. In 2010, 'care networks' or 'care circuits' for persons aged 16 to 65 years were created.¹⁴ More recently, the principles of this reform were put into practice in order to build networks for children and adolescent.¹⁷ In this context, a program aiming to enhance the mental health of older adults has not been organised yet.

The Federal Public Service for Health, Food Chain Safety and Environment asked KCE whether:

- A specific organisational model that encounters the needs for mental healthcare for older people exists and would be applicable in Belgium, and;
- The current reform of mental healthcare for adults may might be in line with the model identified.

The research questions addressed in this report are:

- What can we learn from the literature regarding models of and elements for the organisation of mental healthcare for older adults?
- What are lessons learned from good practices abroad for the organisation of mental healthcare for older adults?
- What is the supply of mental healthcare services for older adults in Belgium?

Some limitations regarding the scope of the project have to be highlighted. First, specific therapy options and their effectiveness are not taken into consideration. Secondly, the situation of young dependent persons, of older persons with isolated memory problems due to dementia and primary prevention are out-of-scope for this report. Thirdly, this report is not intended to develop practical care pathways for older persons with mental health problems but the orientations of this study can be used in creating them. Information on cost-effectiveness was considered to be out of scope for this review.

1.3 Methods

To answer the previously mentioned research questions, we developed a multimodal approach. A summary of the methods used is presented hereafter:

Chapter 2 of the scientific report includes the overview of the literature on effectiveness of organisational models and specific approaches for mental healthcare for older adults. In line with the request of the commissioning authority for this study, the focus of the literature search was on community and primary care. The models were selected using a two-step procedure. First, a scoping review was conducted to identify potential search terms for the definite literature search. These terms were discussed by KCE experts and the approved list was used to build a search strategy for a definite second search in May 2016 in Medline, Embase, Cinahl and the Cochrane Database of systematic reviews. Publications from 2006 up to May 2016 were included. 45 studies were included in the analysis.

Chapter 3 reports on the results of an online survey that assessed the perception of stakeholders in the mental healthcare sector regarding the congruence of its current organisation with the theoretical requirements found in the literature review, the specific needs of older people in comparison with those of younger adults and the potential improvements that could be introduced into the system

Chapter 4 includes an in-depth analysis of the organisation of mental healthcare for older persons in four countries: England, France, the Netherlands and Canada. The four countries were selected using a prioritisation process which took into account the availability of information regarding mental healthcare for older adults, the similarity to Belgium in the structure of care, and the presence of potential case studies. The data collection method to describe the system of the mental healthcare for the older persons follows three steps: first a scientific literature search in bibliographic databases; second, an additional grey literature top-up searching; and third, a practical analysis of case studies in grey literature. A transversal comparison was then performed according to topics congruent with results from other chapters of the report. National experts with experience in mental health organisation for older persons validated the results of these chapter.



Chapter 5 includes a description of the current supply and use of mental health services for older adults in Belgium. The information for this chapter was gathered from multiple data sources. First, the grey literature was searched in order to create a clear view of the current system. Second, hospital discharge data (Minimal Psychiatric Data (RPM - MPG) and Minimum Hospital Discharge Data (MZG – RHM), billing data for reimbursed health services from the Intermutualist Agency (IMA – AIM) and databases or reports from federated authorities on ambulatory services (e.g. data on community mental healthcare centres (CGG – SSM)) was analysed to assess service use. Finally, a sample of innovative projects that provide mental care services for older adults was contacted via an online questionnaire in order to obtain detailed information on their activities, perceived strengths and weaknesses.

Short report (that can be found on the same webpage) provides a summary of this report with, in addition, discussion of results, conclusions and recommendations. It focuses on the main messages drawn from the scientific research.

2 LITERATURE REVIEW: CONCEPTS & MODELS APPLICABLE FOR MENTAL HEALTHCARE IN THE ELDERLY AND ITS EFFECTIVENESS

The present literature review aims to give an overview of research approaches, models, concepts and criteria to organize mental healthcare for older adults, published in the past 10 years (2006 – 2016), with specific focus on quality of care and effectiveness. As the scope of this research is on organisation of mental/psychiatric care for older adults, dementia is only taken into account in terms of its psychological and behavioural symptoms, as requested by the commissioning authority. Besides the included papers (yielded from the literature research) other literature is used to clarify certain concepts and constructs.

2.1 Methodology

2.1.1 Databases and search terms

In a first stage we conducted a scoping review to identify potential search terms for the definite literature search. These terms, including general models and core elements of care, were discussed with KCE health service research (HSR) experts and a KCE information specialist. A list of terms was compiled following the PICO model.

- P = elderly/older adults with psychic/mental/psychiatric problems/disorders
- I = organisational model of mental health care
- C = /
- O = efficiency and effectiveness of care, quality of care, patient satisfaction, cost effectiveness



In the second and final stage of the search strategy, the search terms were:

- P: elderly, "older adult", "Aged"[Mesh], "Frail Elderly"[Mesh], Aged, "Aged, 80 and over"[Mesh] AND "Mental Disorders"[Mesh], "psychological problem", "psychological disorder", "psychic disorder", "mental illness", "Mental Health"[Mesh]
- I: "Mental Health Services"[Mesh], "mental health care", AND "Health Policy"[Mesh], "organisational model", "organisation of", "integrative care", "collaborative care", "stepped care", "chronic care model"
- C : /
- O: "Outcome Assessment (Health Care)"[Mesh], "Outcome and Process Assessment (Health Care)"[Mesh], efficiency, effectiveness, "cost effectiveness", "quality of care", "Cost-Benefit Analysis"[Mesh], "Quality of Health Care"[Mesh], "Health Care Quality, Access, and Evaluation"[Mesh], "Quality Assurance, Health Care"[Mesh], "Quality Indicators, Health Care"[Mesh]

To identify relevant published evidence it was decided to conduct systematic searches of literature in the following databases:

- The Cochrane Database of systematic reviews (<http://www.cochrane.org>)
- Medline (<http://www.ncbi.nlm.nih.gov/pubmed>)
- Embase (<http://www.embase.com/>)
- Cinahl ([via ebscohost.com](http://www.ebscohost.com))

2.1.2 Search strategy and date limits

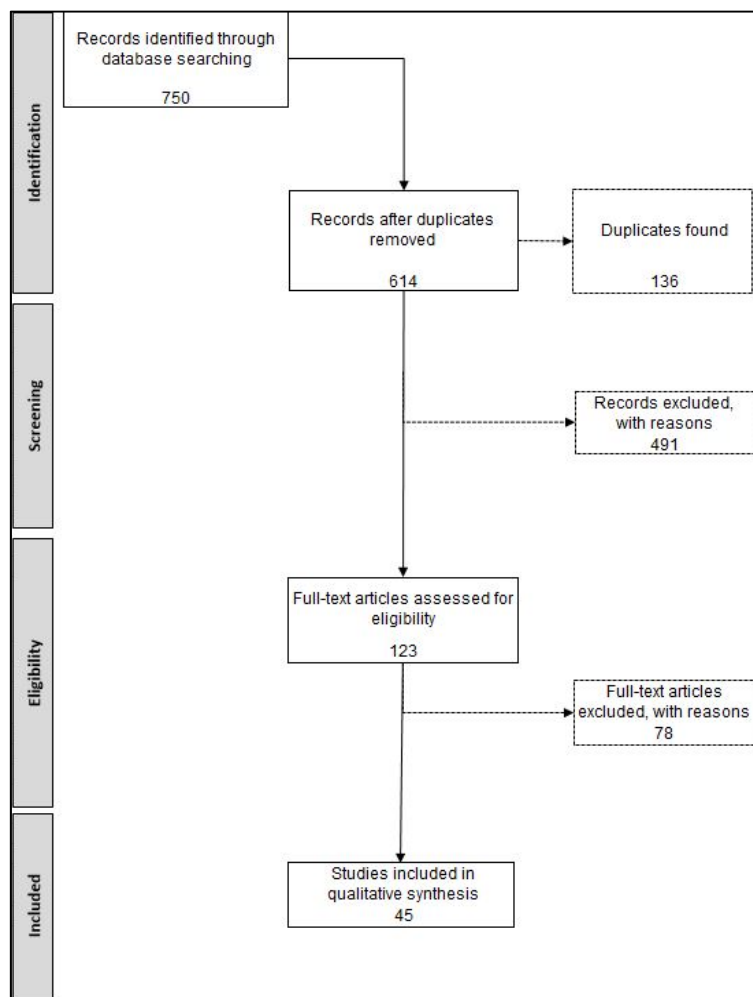
With the gathered information of the first search, a search strategy (see Appendix 1 available in a separated document) was developed to search Medline through the Pubmed interface, taking care that very specific search terms could not hamper the completeness of the search or limit the results. This strategy was adapted to each database.

In a next stage, a literature search was conducted in May 2016 in Medline, Embase, Cinahl and the Cochrane Database of Systematic Reviews. Publications from 2006 up to May 2016 were included with no language restriction. For Embase, conference papers and duplicates from Medline were excluded. Each strategy used a combination of appropriate MeSH terms and free text words. The detail of each strategy with date of the search and number of articles found is provided in Appendix 2 (see separated document). The search results were then imported in Endnote with automatic duplicates removal enabled.



2.1.3 Results of the literature search

Figure 7 – The flowchart details the method of retrieval of relevant articles for this study



Identified publications (N = 1152) from the search in the different databases were merged and duplicates were removed. The remaining 614 records were screened on title and abstract. 491 references were excluded. 123 full-text articles were checked for eligibility and 75 papers were excluded. The final selection of 48 publications consisted of 27 primary research papers, 8 review papers (no systematic reviews), 3 qualitative research papers, 5 expert opinions and 2 research protocols. Research results from one of the protocols (CASPER study) were not published at the time of this literature study but the trial was completed. The first author of the CASPER study was asked to share his results to be included in this literature study, however this request was not granted.

Although some of the included studies provide information on cost-effectiveness of their interventions, it was decided not to include this information in this review as this was not the scope of the literature search (limitations of the study are available in 7.4. of the short report, separate document on the same webpage).

2.2 General models & primary care

2.2.1 The C.A.R.I.T.A.S. principles

In the last decades, specific efforts have been made worldwide to improve care for the elderly with mental health problems. This resulted in the development of models, concepts and criteria. In 1997 the World Health Organization published a technical consensus statement regarding the organization of care in psychiatry for older adults.¹ The purpose of this publication was to define the basic components of care to older people with mental disorders and the coordination of and cooperation between these elements. The final aim was to provide national governments with tools to optimize their mental healthcare systems for older adults, to maximize quality of health and life, to ensure good quality of care and to provide easy access to a range of services that respond to the specific health and social needs of the elderly. The report emphasized that specific efforts were needed to improve prevention, early detection, diagnosis, as well as management and follow up. Although this report was not part of the included papers for this review, it can be useful as a foundation for the approaches of mental healthcare for older adults found in the literature



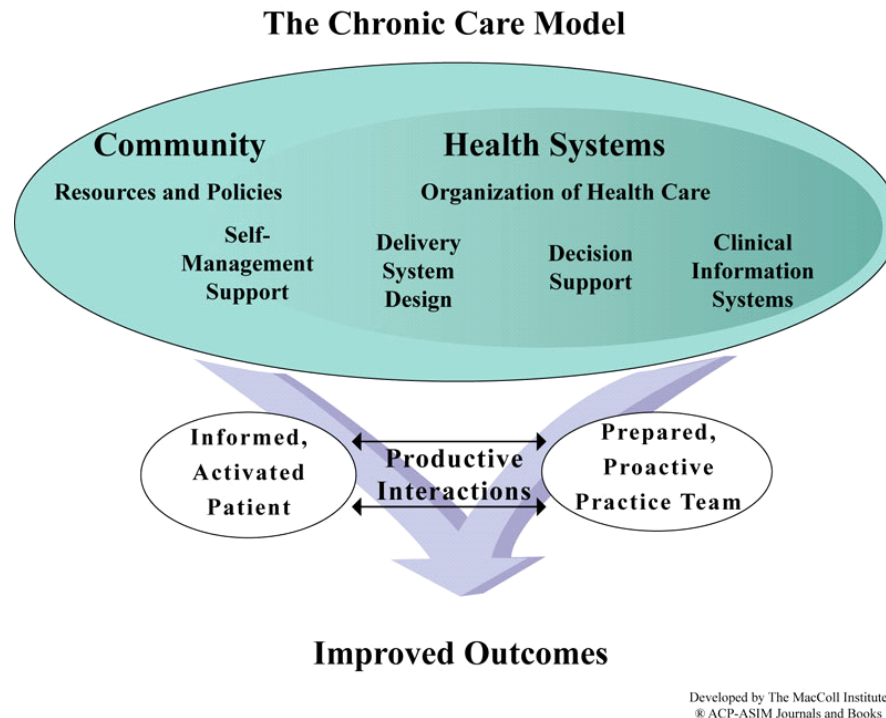
The consensus paper states that good quality of mental healthcare for older adults should consist of a broad set of general principles, which can be applied on every kind of care, but should also take into account 7 specific principles, grouped together in the acronym C.A.R.I.T.A.S.^{85, 86}

1. A Comprehensive service should take into account all aspects of the patient's physical, psychological and social needs and wishes, and be patient-centered.
2. An Accessible service is user friendly and readily available, minimising the geographical, cultural, financial and linguistic obstacles to obtaining care
3. A Responsive service is one that listens to and understands the problems brought to its attention and acts promptly and appropriately.
4. An Individualized service focuses on each person with a mental health problem in her/his family and community context. The planning of care must be tailored for and acceptable to the individual and family, and should aim wherever possible to maintain and support the person within her/his home environment.
5. A Transdisciplinary approach transcends traditional professional boundaries and goes further than multidisciplinary and interdisciplinary collaboration, to optimise the contributions of people (professionals and lay people) with a broad range of personal and professional skills. Such an approach also facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community oriented services.
6. An Accountable service is one that accepts responsibility for assuring the quality of the service. It delivers and monitors this in partnership with patients and their families. Such a service must be ethically and culturally sensitive.
7. A Systemic approach flexibly integrates all available services to ensure continuity of care and coordinates all levels of service providers including local, provincial and national governments and community organisations.

Although the C.A.R.I.T.A.S. concepts were defined almost 20 years ago, these are still relevant for the organization of mental healthcare for older adults.

2.2.2 *The Chronic Care Model (CCM)*

In the same period, Wagner et al. developed the Chronic Care Model (CCM)^{87, 88} in an attempt to improve the American healthcare system, which was at that moment mainly focused on acute care. Their studies revealed that care for chronic illness in the nineties in the US at that moment was suboptimal and was mainly focused on a system of symptom control and complaint handling. In contrast, almost 80% of the financial resources for healthcare was spent on prevention and treatment of chronic diseases. Although this model was not specifically developed for older adults, they are an important target group for the CCM as prevalence of chronic diseases is very high in this population. Wagner advocated for more emphasis on quality of prevention and care and he plead for a shift in responsibility from healthcare professionals towards care recipients (shared responsibility). Next, he revealed gaps in multidisciplinary planning, task delegation and collaboration, resulting in incomplete or fragmented care and late detection of calamities. Another point of concern in his study was the quality of the patients' medical records that were in most cases unstructured, incomplete and therefore difficult to use for data sharing. He also detected a significant lack of knowledge in the patient population regarding their health status, their therapy and their health behaviour, making them unmotivated and passive regarding their self-management and risk-prevention. Finally, he was also concerned about the use of ineffective therapy elements and the neglect of psychosocial stress risk factor and consequences of chronic disease. Based on a broad range of RCTs and Cochrane Reviews in different populations and programs, he developed a comprehensive model, which was further developed in the mid-nineties of the past century at the MacColl Institute for Healthcare Innovation in Seattle. The model was refined in 1997 by the Robert Wood Johnson Foundation. Finally in 2003 the ICIC (Improving Chronic Illness Care) group completed the model with 5 elements.⁸⁹

**Figure 8 – The Chronic Care Model** ⁹⁰

The CCM-model describes delivery of care for chronic diseases in a broad societal and policy context. It consists of four levels ^{89, 91}:

1. community
2. health systems
3. care team or practice
4. patient.

The “community level” covers resources and policies to realize the model in the community. The “Health systems level” covers the creation of a culture, the organization and mechanisms that promote safe, high quality care. This implies that at all levels of the organisation a visible support of improvement efforts (beginning with the senior leader), promotion of effective improvement strategies aimed at comprehensive system change, encouraging open and systematic handling of errors and quality problems to improve care (2003 update), provision of incentives based on quality of care and development of agreements that facilitate care coordination within and across organizations (2003 update) are necessary.

The model also defines four areas which have to be handled in a collaborative and integrated way to deliver high quality care: (1) self-management support, (2) delivery system design, (3) decision support and (4) clinical information systems. Resources, structure and policies for these processes have to be provided by the community (Figure 8).

‘Self-management support’ aims to empower and prepare patients to manage their health and healthcare. The patient with a single or multiple chronic conditions gets a central role in the process of care, has to be informed and empowered adequately and is in fact responsible for his/her health. Self-consultation and self-management of medical information regarding one's disease, provision of tailored information to support the condition of the patient, coaching and interventions to improve self-reliance, provision of tools to localize and mobilize relevant parties in the direct area of the patient, and supportive training to learn patient to interact with their social environment.

‘Delivery system design’ has to ensure careful planning and coordination of safe, effective, timely, efficient and patient centred care and self-management support with emphasis on primary care. This means that role and tasks have to be defined and distributed, evidence based actions have to be promoted, clinical case management for complex patients has to be provided (2003 update), regular follow-up by a care team has to be ensured and care has to be given that fits with the cultural background of and is understandable for the patient (2003 update).



'Decision support' implies the promotion of clinical care that is consistent with scientific evidence and patient preferences, through development of supportive tools to guide practitioners and patients to take the right decisions, such as scientifically sound and effective protocols, guidelines and tools. This point also requests adequate training and (patient) education. The system has to embed evidence-based guidelines into daily clinical practice, share evidence based guidelines an information with patients to encourage their participation, use proven provider education methods and integrate specialist expertise and primary care.

Finally 'clinical information systems' covers the organization of patient and population data to facilitate efficient and effective care. This implies the provision of timely reminders for patients and providers, identification of relevant subpopulations for proactive care, facilitation of individual patient care planning, standardization of information systems (digital patient records), sharing information with patient and providers to coordinate care (2003 update) and monitoring of performance of the practice team and the care system.

The model also emphasizes the need for a smooth and productive interaction between the informed and activated patient and the prepared proactive practice team. Healthcare professionals are not only practitioners/therapists but are also needed to support the patient in the somatic, psychological and social effects of the disease (and the resulting disability and consequences). The therapist has to pay attention to the context and environment of the patient and has to use the available resources (material, personal and financial) to support the specific needs of the patient.

High quality care for chronic conditions (including mental healthcare for the elderly) has to focus on prevention, effectiveness of therapy, shared responsibility (patient & care professional), multidisciplinary and smooth data sharing. There also is a need for a nationwide policy-based comprehensive care model.

2.2.3 Integrated people-centered health services

More recently, to deal with the challenges faced by health systems including ageing population, WHO developed a strategy on integrated people-centered health services ⁹²

This strategy aims to reorient health services, shifting away from fragmented supply-oriented models, towards health services that put people and communities at their centre, and surrounds them with responsive services.

Developing more integrated people-centred care systems may help to transfer the C.A.R.I.T.A.S. principles into practice. Five interdependent strategic goals are defined:

1. Empowering and engaging people : provision of the opportunity, skills and resources to empower users of health services and to reach the underserved and marginalized groups of the population (universal access)
2. Strengthening governance and accountability: improvement of the policy dialogue with citizens, communities and other stakeholders to promote transparency in decision-making and to generate robust systems for the collective accountability of policy-makers, managers, providers and users.
3. Reorienting the model of care: to ensure that efficient and effective healthcare services by making primary and community care services and the coproduction of health a priority. It requires a shifting from inpatient to outpatient and ambulatory care and, investments in holistic and comprehensive care taking into account gender and cultural aspects.
4. Coordinating services: focus on improving the delivery of care through the alignment and harmonizing of the processes of the different services around the needs and preferences of people
5. Creating an enabling environment: to identify the necessary changes to translate the four previous strategies in an operational reality. These changes may occur in legislative frameworks, financial arrangements and incentives, and the reorientation of the workforce and public policymaking.



2.2.4 *Mental healthcare for older adults in primary care settings*

The WHO emphasizes the need for a performant mental health primary care where mental disorders are treated as early as possible, holistically and close to the person's home and community. In addition, primary care offers opportunities for the prevention of mental disorders and mental health promotion, for family and community education, and for collaboration with other sectors.⁹³

The literature search for this report yielded 15 studies that report on primary care settings in mental healthcare delivery for older adults. Foreign research shows that a vast majority of mental health services for older people is provided in primary care.^{94, 95} Most older adults regularly meet their own general practitioner (GP), which implies that these primary care professionals are in fact well-positioned to address mental health problems of their older patients. Moreover, elderly people prefer receiving their (mental) healthcare in primary care settings instead of in specialty mental healthcare institutions.⁹⁶⁻⁹⁸ This also influenced policy makers to decide that their strategies for mental healthcare to older adults have to focus on primary care as locus of intervention.⁹⁹

However, a study from the UK revealed that only a third of the elderly with mental health issues discuss their problems with their GP.¹⁰⁰ In the USA, this underutilisation of mental healthcare was found in rural as well as urban older adult populations.¹⁰¹ Several barriers, such as cultural differences, ideological beliefs, healthcare attitudes, stigma towards mental health and level of education, are reported as a potential cause in literature.¹⁰¹ Besides, the diagnosis of mental health problems (especially depression) is often missed in primary care settings, because elderly consult with atypical complaints. Mental health disorders are frequently comorbid in older adults, occurring with a number of common chronic illnesses.¹⁰² This implies often an overlap of somatic symptoms of mental problems (e.g. depression), such as fatigue and loss of appetite, with symptoms of physical illness or the side effects of medication.

A UK researcher states that mental health problems are often 'normalised' in the presence of a long term health condition.¹⁰³ And even when a mental health condition is diagnosed, it is often attributed to patient's life circumstances, such as bereavement, and considered a 'natural reaction'.⁹⁵ This is in line with a Belgian publication that states that GPs may also

register depressive complaints as part of other psychosocial problems to which the depression is related as they might base their diagnosis on incomplete information from the patient (iceberg phenomenon) or by foreknowledge of the patient's personal problems and by contextual information.¹⁰⁴ This can hamper case finding and screening, and result in substandard or inefficient treatment or care management.⁷²

An American study states that less than half of the elderly population with mental health problems is successfully treated for these disorders in primary care, with a significant impact on general health and functioning and with an increase in medical costs.^{105, 106} Detection, as well as treatment of mental disorders in the elderly population in primary care settings in the USA is often inadequate³⁵, due to insufficient devotion of time of the GP to deal with mental health problems, failure to assess older patients for depression, suboptimal treatment intensity or scope, and a (too) strong preference for psychopharmacologic treatment instead of psychosocial interventions.^{95, 96, 106} Moreover, older patients themselves are in favour of pharmacotherapy (e.g. anti-depressants, sleeping pills) for their mental problems, over psychotherapy.¹⁰⁷ This substandard treatment level might be due to a lack of knowledge, skills and confidence in GPs regarding treatment of geriatric mental health problems, economic aspects of care delivery (fee for service versus time needed to provide adequate mental healthcare or manage care) and lack of access to or communication with mental health specialist services.⁹⁶

Primary care providers might play a significant role in the care for mental health problems in older adults. However, foreign research shows that the quality of detection as well as treatment can be substantially improved. This might be due to lack of knowledge, skills and time available in GPs, lack of collaboration and communication with specialized mental health services, and preferences and beliefs in patients.



2.3 Implementation strategies to organise mental healthcare in older adults

In the next part of this review a description will be given of the operational core elements of mental healthcare models for older adults. These core elements will be applied further on to describe the results of the included comparative studies.

In the last decade, several strategies (operational core elements) have been made to implement models of mental healthcare to older adults, as the Chronic Care Model (CCM). Several studies assessed the effectiveness and feasibility of these strategies. In the next paragraphs, an overview of the core elements will be given.

2.3.1 The stepped Care Model

In a stepped care approach, the least intensive intervention related to the treatment of a disease, that is appropriate for a person, is typically provided first, and people can step up or down the pathway according to changing needs and in response to their treatment. Service users may begin their journey at any step of the pathway, in accordance with their specific needs. Timely referral to higher or lower steps may be appropriate and cost effective.¹⁰⁸ Stepped care aims to meet the need for long term management of the disease and to maximize the effectiveness and efficiency of resource allocation. Progress of the disease conditions of the patient is monitored throughout the entire process in order to decide on stepping up or stepping down in intensity of treatment.¹⁰⁹ The stepped care model is in fact a base-model that can consist of other core elements as described further on.

2.3.2 Indicated prevention

A possible consideration in the approach of mental health problems in the elderly is the use of systematic screening. Systematically searching for cases might be a means to overcome the issues of under-diagnosing and under-treatment of mental disorders in older adults in primary care.⁷² Based on the IOM (Institute of Medicine) classification system of prevention, “indicated prevention” can be defined as measures designed to prevent the onset of mental disorders in elderly who do not meet the medical criteria for these disorders but who are showing early risk signs. The mission of

indicated prevention is to identify individuals who are exhibiting early signs and to involve them in specific treatment programs.¹¹⁰ Several studies suggest indeed that systematic screening for sub-threshold mental disorders (e.g. depression) in elderly might result in better outcomes than selective interventions for “full blown” clinical disorders.¹¹¹⁻¹¹³ However, evidence also shows that when this strategy is not used in a comprehensive approach, no significant effects are seen in adoption of treatment or clinical outcome.¹¹⁴

2.3.3 Watch and Wait strategy

The Watch-and-Wait strategy¹¹⁵, also called “watchful waiting”, starts from the assumption that efforts at human change in elderly are best done from the ‘biopsychosocial model’. Every old aged person has a specific profile of problems, consisting (to a certain extent) of depression, anxiety, cognitive problems, medical-somatic problems, and practical life issues. Every person is unique in his/her status. The belief is that a careful and slow process of care –consisting of assessment, psycho-education, watching and waiting, building trust, weighing options, involving multidisciplinary teams, and then using modules- is most appropriate.¹¹⁵

The Watch and Wait approach often consists of

- Validation of the problem (giving the patient the feeling that his reaction and behaviour is normal and understandable).
- Psycho-education (informing patient and relatives about the disease, symptoms and treatment).
- Align points of view of patient and care practitioner about treatment (Watch & Wait, only striving for small changes, need of monitoring).
- Give direction and leadership to patient (built trust, give support).
- Monitoring & follow up of complaints (return visits, self-monitoring).
- Change emotional climate (active and empathic listening, take time for consultation, provide psycho-education).
- Link problems to achievable reality (give objective perspective to the patient).



- Make haste slowly (emphasize importance of taking time to solve the problem).
- Provide a plan for approaching the disease (introduce steps for change).

Forcing a rapid mainly pharmacological or somatically oriented treatment is expected often not to result in the right outcome. Moreover, watchful waiting, psychological support and empowerment and a slow step-by-step approach, especially in elderly, often results in spontaneous resolution or improvement of the problems.¹¹⁵

2.3.4 Collaborative Care model

Collaborative care, also called “integrated care”,¹¹⁶ is in fact the operationalization of the Chronic Care Model, defined by Wagner et al. (see above). The main aim of this approach is timely access for older adults with specific mental health problems to the expertise of specific specialists, with the use of tailored multi-modal management approaches known to have some efficacy in the specific core group. A collaborative care model often consists of a multi-faceted multiphasic intervention, scheduled patient follow-up, enhanced inter-professional communication, a structured management plan, trained providers, activated patients, cultural competence, patient centered care and reimbursement that rewards quality of care.

Coordination and follow-up of this collaborative care process is done by a case/care manager, often a trained (specialist)-nurse, social worker or

psychologist.^{113, 117} The care manager is the linchpin of the model, as this person screens patients, identifies those for whom intervention may be warranted, supplies patients and their families with educational materials and recovery toolkits, monitors treatment progress, measures outcomes, and provides feedback to the primary care physician. He/she is often also trained to provide certain psychotherapeutic interventions to the older patients. The primary care physician, often a GP, supervises the care process. He/she prescribes all psychoactive medications, but the care manager provides feedback about the effectiveness and identifies when changes in treatment should be considered. The care manager regularly organises (virtual) meetings with mental health specialists, such as psychologists or psychiatrists, and the primary care physician to review cases. The geriatric psychiatrist contributes consultative input, provides oversight, and is available to see patients for whom the first-level collaborative intervention has failed.^{96, 117, 118}

2.4 Studied implementation strategies and their effectiveness

In this chapter an overview will be given of implementation strategies used in the included studies, subdivided on the basis of the mental health disorders the studies focus on (major depression, minor (sub-threshold) depression, suicidal ideation, alcohol abuse, long term or severe psychiatric disorders). Besides, specific points of attention regarding organisation of mental healthcare in older asylum seekers or elderly in minority populations will be described. The next table gives an overview of the included studies for this review.


Table 5 – Overview of the implementation models identified during the literature review

Focus of the study	Year	Trial name	Stepped Care Model	Indicated Prevention	Watch & Wait strategy	Collaborative Care Model	Focus on minorities and asylum seekers	Remark
Impact of collaborative care on suicidal ideation in Primary Care Elderly ⁹⁷	2009	PROSPECT	X			X		
Impact of age on outcomes of collaborative care for major depression ^{119, 120}	2016					X		
Impact of collaborative care for late-life major depression ^{121 111 105 122 123 124 125 126 127 128 129 130 118 107 131}	2002-2011	IMPACT	X			X		
Impact of stepped care on incidence of new depression episode in elderly with previous depression ^{132 133}	2012-2014		X	X	X			
Impact of stepped care on onset of depression and anxiety of people living in elderly homes ^{134 135 136}	2007-2014		X		X			
Impact of collaborative care on behavioural symptoms in Alzheimer patients in primary care ¹³⁷	2006					X		
feasibility of collaborative care for the management of major depression in older people ¹³⁸	2007	PRIDE				X		
Impact of collaborative care on mental problems in elderly with physical illness ¹³⁹	2010	ADAPt-C & MDDP & HOPE-D				X		Pooling of 3 trials different age groups
Impact of collaborative care on mental problems in elderly with memory problems ¹⁴⁰	2014					X		



Focus of the study	Year	Trial name	Stepped Care Model	Indicated Prevention	Watch & Wait strategy	Collaborative Care Model	Focus on minorities and asylum seekers	Remark
Impact of the chronic care model on major depression in elderly care ¹⁴¹	2014					X		
Impact of collaborative care on depression in elderly with cardiac problems ¹⁴²	2011	SUCCEED		X		X		
Impact of collaborative care on depression, anxiety and panic disorder in elderly with acute cardiac problems ¹⁴³	2014	MOSAIC				X		
Impact of collaborative care on elderly with sub-threshold depression ¹⁴⁴	2011	CASPER				X		Protocol published. results not yet available at time of review
Impact of a stepped care intervention for depression in visually impaired elderly ^{109 145 146}	2013 - 2015		X		X			
(cost)-effectiveness of a stepped-care intervention for major depression in elderly ¹⁴⁷	2012	PROMODE	X					
Effectiveness of an indicated stepped-care prevention program for depression and anxiety disorders in the elderly. ¹⁴⁸	2009	PIKO	X	X	X			



2.4.1 *Implementation strategies to organise care for depression in the elderly*

2.4.1.1 *Major depression*

1. **IMPACT STUDY**

The largest treatment trial of collaborative care for depression in elderly worldwide is the IMPACT study (Improving Mood – Promoting Access to Collaborative Treatment).^{105, 107, 111, 118, 121-125, 127-131} This long lasting study, which was set up by Unützer et al. in 1996, comprised 18 primary care clinics from 8 healthcare organizations in 5 American states and included 1801 patients aged 60 years or older with major depression (17%), dysthymic disorder (30%), or both (53%).¹²⁹ In the past two decades, more than 20 papers about this study were published, often focusing on specific subgroups of the IMPACT-study population (e.g. 75+ versus 65 years old, male gender, low income population, PTSD patients ...)

Patients were randomly assigned to the IMPACT intervention (N = 906) or to usual care (N = 895). The intervention-group patients had access for up to 12 months to a depression manager who was supervised by a psychiatrist and a primary care professional, but follow up was longer (until 4 years). The depression manager (a nurse or psychologist) offered supervised case management, education, and support of antidepressant use (prescribed by the patient's GP) or problem solving treatment in primary care (a brief psychotherapeutic intervention for depression). Main outcomes of the study, measured at baseline, at 3, 6 and 12 months and at follow-up, were depression, depression treatment, satisfaction with care, functional impairment, and quality of life.¹²⁹

Regarding the results of the complete sample of elderly, 45% of the intervention patients had (at least) a 50% reduction of depressive symptoms from baseline, compared with 19% of usual care participants (OR: 3.45; 95%CI 2.71-4.38, $p < 0.001$). Intervention patients also had greater rates of depression treatment (OR: 2.98; 95%CI 2.34-3.79, $p < 0.001$), more satisfaction with care (OR: 3.38; 95%CI 2.66-4.30, $p < 0.001$), lower depression severity (range 0-4; between group difference -0.4; 95CI -0.46-0.33, $p < 0.001$), less functional impairment (range 0-10, between group difference 0.56; 95%CI 0.32-0.79, $p < 0.001$) than participants assigned to the usual care group.¹²⁹

A summary of the study results from a review dedicated to the IMPACT trial can be found in Table 6.



Table 6 – Overview of study characteristics and results for the included papers focusing on the IMPACT trial (conducted in USA)

Author(s)	Year	(sub)sample	Sample size		<i>Treatment response for Depression (>50% reduction)</i>	<i>odds for getting any Depression Treatment</i>	<i>Very Satisfaction care</i>	<i>good With</i>	<i>Functional impairment (range 0 – 10)</i>	<i>Quality of life (range 0 – 10)</i>
Unützer et al. ¹²⁹	2002	Whole sample	1801 (906 I + 895 C)		<i>3 months</i> 32% vs 15% OR ¹ 2.73 <i>6 months</i> 49% vs 31% OR ¹ 2.21 <i>12 months</i> 45% vs 19% OR ¹ 3.45	<i>3 months</i> 77% vs 51% OR ¹ 3.33 <i>6 months</i> 78% vs 54% OR ¹ 2.93 <i>12 months</i> 82% vs 61% OR ¹ 2.98	<i>3 months</i> <i>12 months</i> OR ¹ 3.38	<i>3 months</i> <i>12 months</i> BGD ² - 0.94	<i>3 months</i> <i>12 months</i> BGD ² 0.56	
Hunkeler et al. ¹²⁴	2006	Whole sample follow-up 24 months post-intervention)	1801 (906 + 895)		12 months FU ³ 45% vs 18% NNT ⁴ 4.18 18 months FU ² 38% vs 21% NNT ⁴ 6.24 24 months FU ² 34% vs 23% NNT ⁴ 9.00	12 months FU ² 78% vs 53% BGD ² 26 % 18 months FU ² 64% vs 49% BGD ² 15% 24 months FU ² 59% vs 46% BGD ² 14%		<i>12 months</i> <i>24 months</i> n.s. ³	<i>12 months</i> <i>24 months</i> BGD ² 0.26	
Arean et al. ¹¹¹	2007	Poor versus not poor	1801 (576 + 1225)		<i>3 months</i> BGD ¹ Int. vs Ctrl poor -.27 not poor -.30	<i>3 months</i> OR ¹ Int. vs Ctrl poor 4.18 not poor 3.16	<i>3 months</i> OR ¹ Int. vs Ctrl poor 3.00 not poor3.41	<i>3 months</i> BGD ² Int. vs Ctrl poor 1.11 not poor n.s. ⁵		



Author(s)	Year	(sub)sample	Sample size	Treatment response for Depression (>50% reduction)	odds for getting any Depression Treatment	Very Satisfaction care	good With	Functional impairment (range 0 – 10)	Quality of life (range 0 – 10)
				6 months BGD ¹ Int. vs Ctrl poor -.28 not poor -.28	6 months OR ¹ Int. vs Ctrl poor 3.87 not poor 3.29			6 months BGD ² Int. vs Ctrl poor 1.65 not poor n.s ⁵	
				12 months BGD ¹ Int. vs Ctrl poor -.41 not poor -.39	12 months OR ¹ Int. vs Ctrl poor 3.58 not poor 3.80	12 months OR ¹ Int. vs Ctrl poor 3.35 not poor 3.07		12 months BGD ² Int. vs Ctrl poor 1.67 not poor 1.46	
Chan et al. ¹²²	2011	PTSD versus No PTSD	1801 (191P+11601 NP)	6 months BGD ² Int. vs Ctrl PTSD n.s. ⁵ not PTSD -.29 12 months BGD ² Int. vs Ctrl PTSD -.25 not PTSD -.41 18 months BGD ² Int. vs Ctrl PTSD -.30 not PTSD -.28 24 months BGD ² Int. vs Ctrl PTSD -.29 not PTSD -.23					
Fann et al. ¹²³	2009	Cancer patients (sub-sample)	215 (112 + 103)	3 months Interv. vs ctrl 35% vs 15%	3 months Interv. vs ctrl 43% vs 18%	3 months Interv. vs ctrl 76% vs 49%		3 months BGD ¹ Int. vs Ctrl 0.27 – 0.30	3 months BGD ¹ Int. vs Ctrl



Author(s)	Year	(sub)sample	Sample size	Treatment response for Depression (>50% reduction)	odds for getting any Depression Treatment	Very Satisfaction care	good With	Functional impairment (range 0 – 10)	Quality of life (range 0 – 10)
				6 months Interv. vs ctrl 35% vs 15%	6 months Interv. vs ctrl 40% vs 15%	6 months Interv. vs ctrl 93% vs 74%		6 months BGD ¹ Int. vs Ctrl n.s. ⁵	n.s. ⁵ 6 months BGD ¹ Int. vs Ctrl
				12 months Interv. vs ctrl 39% vs 20%	12 months Interv. vs ctrl 42% vs 16%	12 months Interv. vs ctrl n.s. ⁵		12 months BGD ² Int. vs Ctrl 0.28 – 0.31	n.s. ⁵ 12 months BGD ² Int. vs Ctrl
				18 months Interv. vs ctrl 39% vs 18%	18 months Interv. vs ctrl n.s. ⁵	18 months Interv. vs ctrl n.s. ⁵		18 months BGD ² Int. vs Ctrl n.s. ⁵	n.s. ⁵ 18 months BGD ² Int. vs Ctrl
				24 months Interv. vs ctrl n.s. ⁵	24 months Interv. vs ctrl n.s. ⁵	24 months Interv. vs ctrl n.s. ⁵		6 months BGD ² Int. vs Ctrl n.s. ⁵	18 months BGD ² Int. vs Ctrl 6.33 – 5.35. 6 months BGD ² Int. vs Ctrl n.s. ⁵
Van Leeuwen et al. ¹⁰⁷	2009	Young-old (60-74y) vs old-old (+75y)	906 (606 + OO)	3 months n.s. ⁵ 6 months 51% vs 44% 12 months 47% vs 36% 18 months 39% vs 32% 24 months 36% vs 23%					

¹: OR = Odds Ratio, ²: BGD = between group difference, ³: FU. = follow-up, ⁴: NNT: Number Needed to Treat, ⁵: n.s. = not significant



In follow-up studies, the positive effects of the IMPACT-intervention remained: after 24 months, there still was a higher odds for getting depression treatment, depression scores were lower, quality of life was better and patients had more confidence in managing their depression compared to patients in usual care.

Additionally, several sub-group studies explored the relationship of comorbidities (e.g. cancer, diabetes), age (young-old vs old-old) and social status (poverty) on the results of the IMPACT-intervention. In all of these studies, the more positive effect of the IMPACT study compared to usual care remained stable, despite these potential confounding or interacting factors. However, differences in treatment effect, time until treatment effect or duration of the treatment effect were seen.

2. SUCCEED STUDY

The American SUCCEED study (Screening Utilization and Collaborative Care for more Effective and Efficient treatment of Depression)¹⁴² (n=175) in a sample of middle aged and old adults (Mean 62.3, SD 12.5) aimed to determine whether a collaborative care program improves rates of major depression treatment by discharge among patients hospitalized with acute cardiovascular disease, and to assess key clinical characteristics of depression in this cohort. The study compared a collaborative care approach with usual care for depressed cardiac patients in a cardiac unit in an urban setting in the USA. Collaborative care consisted of assessment by a care manager, consultation between care manager and psychiatrist, development of an individualised care plan, contact with patients' primary care physician to discuss proposed treatment, clear recommendations for the inpatient treatment team, depression education to patients, and help to plan patients' post-discharge life. Collaborative care patients were far more likely to receive adequate depression treatment by discharge (71.9% collaborative care vs. 9.5% usual care; $p < 0.001$).

3. MOSAIC STUDY

The Management of Sadness and Anxiety In Cardiology trial by the same authors as the SUCCEED study also focused on comorbidities and depression in middle aged and old adults (Mean age 60.1, SD 12.8).¹⁴³ This American trial (n=183) applied a 24-weeks low intensity telephone based collaborative care approach performed by a social worker, focusing on

support with pharmacotherapy and tailored telephone-call delivered cognitive behavioural therapy interventions in elderly with an acute cardiac illness. Collaborative care was compared to usual care and was found to give greater improvement in mental well-being (estimated mean difference in SF-12 MCS, 5.68 points [95%CI, 2.14-9.22], $p = 0.002$, effect size, 0.61) and level of depression (PHQ-9, effect size 0.45, $p = 0.04$), higher rates of adequate treatment (estimated mean difference 11.4 (5.20 to 24.9), $p < 0.001$) and higher levels of quality of life (EQ5D, effect size 0.34, $p = 0.03$) than the usual care group after 6 months.

4. PRIDE TRIAL

The PRIDE trial (PRimary care Intervention for Depression in Elderly)¹³⁸ is a British study (n=105) that included elderly (Mean age 75, range 60-92) with a clinical depression in a 12-week collaborative care program (6 face-to-face sessions at patients home and 5 telephone sessions) or exposed them randomly to usual care. The program consisted of patient education about depression and medication use, a manualized self-help intervention and sign-posting to other services if needed. A primary care nurse coordinated the process. At 16 weeks, the Odds Ratio (intervention vs usual care) for having a depression was 0.32 [95% CI = 0.11 to 0.93] ($p = 0.04$). The mean level of depression was also lower for the intervention group compared to usual care. Moreover, the study demonstrated that the care program was more acceptable to elderly with depression. No significant changes were found for chronic pain scores or level of disability.

5. COMPARISON OF COLLABORATIVE CARE BETWEEN AGE GROUPS

Angstman et al.¹²⁰ set up a study that focused on differences in outcome of collaborative care for the management of depression. The sample of 574 adult patients with major depression in Minnesota (USA) was split up in 5 age groups <30y (n=148), 30-39y (n=156), 40-49 (n=109), 50-59 (n=94) and >60 (n=67). All patients got a collaborative care program, based on the IMPACT approach (see above) for their depression. The treatment program consisted of a systematic screening and diagnostic approach, development of a patient registry, the introduction of a trained care manager, the utilization of treatment guidelines with standardized monitoring of improvement to ensure adequate therapy, and a consultative relationship with a psychiatrist



and the primary care provider. An evaluation was made at 6 months and 12 months. No differences were found in clinical remission between the age groups.

Another study found a collaborative care delivery model with a stepped care approach to be as effective in elderly as in a younger population.¹³⁹

A stepped care intervention embedded in a collaborative care approach for major depression in elderly appears to have more positive and long lasting intervention effects and is more easily accepted by the core population than usual primary depression care, regardless of comorbidity, age or social status.

6. BRIGHTEN TRIAL

An alternative approach of collaborative care for depression in the elderly was set up in Chicago (US) with the BRIGHTEN trial.¹⁴⁹ In this study (n=150 depressed older patients 65+, later expanded to 60+), a collaborative approach was combined with a virtual team communication process to bring together resources of physically separate services, by use of ICT, email, phone and fax. This approach allowed professionals to discuss and review patient records and care plans and make interdisciplinary recommendations regarding care for physical and mental health. The virtual team consisted of psychologists, social workers, psychiatrists, physical therapists, occupational therapists, dietetics, religious support, and pharmacists together with the patients GP. Screening, assessment, providing team recommendations, and connection to appropriate services were the core elements of the BRIGHTEN intervention. Treatment consisted of physical therapy, occupational therapy, nutritional interventions, psychotherapy, psychiatric medication management, neuropsychological testing and referral to specialized care if needed. After 6 months, significant improvement (pre-post) was found in depression symptoms (Geriatric depression scale, effect size 0.39, $p < 0.001$) and mental well-being (SF-12 MCS scale, effect size 0.19, $p < 0.001$) but no statistical difference was found in physical well-being. Team members were also very satisfied regarding the process of collaboration. In the context of the growing needs for mental healthcare in the elderly, the BRIGHTEN approach was considered as a creative solution to manage care to older adults with complex (mental) health needs.

Virtual communication and data-sharing technology can be considered to be implemented to facilitate the collaborative process and make the approach more time-efficient

2.4.1.2 Minor & sub-threshold depression

Some studies focused on elderly with minor/sub-threshold depression (having depressive symptoms but not exceeding the criteria for a clinical major depression). Indeed, evidence reveals that about a third of these patients will develop a full blown major depression. Lyness et al showed that sub-syndromal depression, functional impairment and past history of depression were the best predictors of major depression in the elderly population (NNT = 5).¹⁵⁰ Moreover, remission of this major disorder is only achieved in one third of this population.¹¹² It can be argued that screening and case finding (indicated prevention) might be an appropriate early detection strategy for mental healthcare in the elderly¹¹⁴, but a treatment should always be embedded within a clear service model.¹¹²

1. PRISM-E STUDY

The American PRISM-E study compared patients with major and subthreshold depression. This study included 1531 older patients (Mean age 74 y) with major and minor depression in a six month trial. Patients were randomly assigned to integrated care (collaboration between co-locating primary care providers and specialised mental healthcare providers, however without a specifically dedicated care coordinator) or to enhanced specialty referral (referral to physically separate, more distant, clearly identified mental health specialty clinics). Mean change over 6 months (CES-D instrument) in depression severity for major depression was -7.5 points (SD 13.1) for integrated care and -10.2 (SD 12.1) for referral to enhanced specialty care. Treatment difference was 2.8 [95%CI 1.0-4.5], $p=.003$. For minor depression change over 6 months was -4.8 (SD 9.5) for integrated care versus 4.0 (SD 10.2) for referral to enhanced specialty care. Treatment difference was -0.8 [95%CI -2.6-1.0], $p=0.38$. However, rates of remission and change in functioning did not differ across models of care for major depression. In conclusion, the authors state that six-month outcomes were comparable for the two models, although severity of depressive symptoms for major depression declined more in the specialty care referral group. This finding suggests that there may be an added value for treatment



or co-treatment in specialty provider clinics for more severe forms of depression. In contrast, comparable results occurred for the integrated care and enhanced specialty referral models for minor depression. This finding suggests that for older patients with less severe forms of depression integrated primary care may be effective. Moreover, integrated care has the advantage that it offers older patients with less severe forms of depression an easy access and convenience to have a “one-stop shopping” with comparable clinical outcomes, compared to (distant) specialty care.¹⁵¹

Involvement of specialty care might be more important for major depression than for minor (subthreshold) depression. Integrated care was found to be as effective as specialty care for minor depression. Integrated care has the advantage for older patient that it has a higher availability, accessibility and proximity compared to specialist care.

2. RELAPSE PREVENTION OF MAJOR DEPRESSION

Apil et al¹³² investigated the effect of a stepped care program versus usual care in 136 patients (aged 55 years or more) who recently had recovered from a major depression and who still experienced sub-threshold symptoms. The stepped care program consisted of 6 weeks of watchful waiting, 6 weeks of bibliotherapy (by use of a self-help booklet), individual cognitive behavioural therapy (a 12 week nurse-led ‘coping with depression’ course) and indicated treatment (by a physician or psychotherapist). Treatment satisfaction was found to be high in the elderly. In the 132 cases available for analysis after 12 months, 30.6% of the persons in the stepped care group and 23.3% in the usual care group had relapsed. Based on the odds ratio, a patient was 1.45 times more likely to relapse if treated with stepped care than treated with usual care. The authors suggest that the watchful waiting element in the stepped care strategy might not be appropriate or even can be a harmful delay in people with a history of a previous major depression. The follow-up study after 24 months (N=123) confirmed the findings of the first study. Of the 123 included patients, 27 out of 68 patients (39.7%) in the stepped care group and 11 out of 55 patients (20%) in the care as usual had a relapse.¹³³

Study results suggest that watchful waiting might not be appropriate to be used in a stepped care approach in elderly with a history of previous major depression.

3. THE PEARLS STUDY

The PEARLS study (Program to Encourage Active and Rewarding Lives for Seniors) was described by two included papers.^{103, 112} This American study compared a community based collaborative stepped care program, led by a care manager (nurse) for 72 medically ill, house-bound older adults (age ≥ 60) (Mean age 73) with minor depression or dysthymia, with 66 elderly randomly assigned to usual care. The program consisted of problem-solving therapy (8 sessions over a period of 19 weeks), patient care review between primary care physician and psychiatrist to optimize treatment, prescription of antidepressant medication, and management of co-morbid medical problems or substance abuse. The study resulted in a 50% greater reduction of depressive symptoms (study response collaborative care 43% after 12 months versus 15% in usual care), higher rates of achievement of remission (33% in collaborative care versus 12% in usual care), improvement in functional and emotional well-being and a decrease in hospitalisation in the stepped care group, compared to usual care.

Study results show that collaborative care for minor depression might be more effective than usual care.

4. THE PROMODE STUDY

The PROMODE trial (Proactive Management of Depression in the Elderly) (N=239) compared the use of a stepped care intervention (consisting of individual counselling, “Coping with Depression”-course, and –if indicated- referral back to the GP) with usual care in older adults (75+) with previously undetected minor depression (screening by means of interviewer-administered questionnaire). No differences were found in effectiveness between age groups (75-79y vs >80y). The vast majority of the intervention group accepted a stepped care approach but only a small part of them accepted the “Coping with Depression”-course. At 12 months, the stepped care approach did not show better effects regarding severity of depressive symptoms compared to usual care. The authors of the study argue that this might be due to the fact that the patients were included only by screening at home by use of an instrument instead of the more explorative screening during a consultation with the GP.



Study results show that a stepped care approach following a screening process for depression by an interviewer was not more effective compared to usual care. This might be related to the role of the GP in the screening process for depression in elderly

5. DEPRESSION IN VISUALLY IMPAIRED ELDERLY

Van der Aa et al (2015) compared a stepped care approach with usual care in preventing the onset of major depressive, dysthymic and anxiety disorders in 265 older people (Mean age 74y) with age related visual impairment and subthreshold depressive symptoms. 265 older people (> 50 years old) were randomly assigned to the intervention (n=131) or usual care group (n=134). After two years, 46% of usual care and 29% of stepped care developed a major depression disorder (RR = 0.63, 95%CI 0.45 – 0.87). The calculated Number Needed to Treat (NNT) was 5.8.¹⁴⁵ The stepped care approach started with 3 months of watchful waiting. After these 3 months, depression and anxiety decreased significantly ($p < 0.001$). 34.1% of the sample recovered from sub-threshold depression of anxiety and 18.3% developed a depressive and/or anxiety disorder. Female gender (OR 2.04), more severe visual impairment (OR 1.02), more depression symptoms (OR 1.06) and having a history of depression, anxiety or dysthymic disorder (OR 2.28) were related to higher odds for developing a major disorder. The authors conclude that watchful waiting might be an efficient, effective strategy for certain subgroups of the depressed elderly population while it may be not appropriate for others. This should be taken into account in choosing the right approach.¹⁴⁶

A stepped care approach, including a period of watchful waiting, seems to be more effective in preventing development of major depression in visually impaired elderly with a minor depression.

6. THE CASPER TRIAL (ongoing)

The CASPER trial¹⁴⁴ (Collaborative care and Active surveillance for Screen-Positive Elderly with sub-threshold depression) is a promising study, set up in the UK. This randomised controlled multi-centre trial aims to evaluate the effectiveness of collaborative care in elderly with sub-threshold depression, compared to usual care. This trial, coordinated by a case manager, runs over 24 months, from which 12 months definitive trial, and consist of screening to identify eligible elderly, a 8 to 10 weeks low intensity

behavioural activation intervention and referral to a GP in case of deterioration. Symptom monitoring, telephone support, and active surveillance and electronic follow up complete the approach. However, the final results were not published at the time of this review and could not be retrieved from the authors.

7. DEPRESSION IN ELDERLY IN RESIDENTIAL CARE HOMES

The Australian review paper of Snowdon et al (2007)¹⁵² states that subthreshold and major depression in elderly in residential homes is often under-diagnosed. The authors describe an American study by Teresi et al (2001) that found a prevalence of 14.4% for major depression and 16.8% for minor depression in elderly homes, diagnosed by a psychiatrist. Less than half of the residents with depression were however recognized as depressed by nursing home staff. The paper also mentions the study by Davidson et al (2006) that pleads for short educational training sessions for GPs on late-life depression to improve recognition of depression in long term care facilities.

A Dutch study by Dozeman et al.^{135, 153} attempted to prevent the onset of depression and anxiety disorders in 185 elderly people living in residential homes, predominantly women with a mean age of 84.3 years (SD 6.5) and poor daily functioning. A stepped care strategy, consisting of watchful waiting (one month), a self-help intervention (an activity scheduling self-help module and coaching by the nursing home staff), life review (brief structured personal intervention by a mental health nurse), and a consultation with a general practitioner for additional treatment, was compared to usual care. The intervention after one year was not found to be effective in reducing the incidence of anxiety disorders in elderly living in residential homes, but was superior to usual care in reducing the risk of developing a major depression (Incidence rate ratio (IRR) = 0.26 [95%CI 0.12-0.80]). The follow-up study one year after the completion of the trial did however not find any significant long term effect (IRR = 0.98 [95%CI 0.54 – 1.81, $p = 0.97$]).¹³⁶

The PIKO study (Preventieve Interventie Kwetsbare Ouderen [Preventive Intervention Frail Elderly])¹⁵⁴ took place between 2003 and 2006, in the Northwestern part of The Netherlands and aimed to offer extra community oriented primary care to 2850 old-old aged patients (≥ 75 years of age), living independently. The main aim of the PIKO-study was to test the feasibility of



a postal multidimensional frailty instrument. Van 't Veer et al. used a subset of this data to analyse symptoms of depression in elderly. The study included 170 participants (aged 75+) in 33 primary care practices with sub-threshold depression or anxiety disorder, who were randomly assigned to an intervention group or routine care. The intervention used an indicated prevention and stepped care strategy, consisting of watchful waiting (3 months), a cognitive behavioural therapeutic intervention (bibliotherapy) (3 months), a brief problem solving treatment (3 months) and finally antidepressant medication.¹⁴⁸ The intervention halved the 12-month incidence of depressive and anxiety disorders, from 0.24 (20 of 84) in the usual care group to 0.12 (10 of 86) in the intervention group (RR 0.49; 95%CI 0.24-0.98).¹⁴⁸

Research suggests that active screening of elderly in residential care homes for depressive symptoms is necessary, as these syndromes are frequently overlooked and remain undertreated, what often results in a major disorder. An indicated prevention strategy in these elderly with minor/subthreshold depression and a stepped care approach, starting with watchful waiting, shows to be effective to prevent development of full-blown depression.

2.4.2 Implementation strategies to organise care for suicidal ideation in the elderly

THE PROSPECT STUDY

The American study 'Prevention of Suicide in Primary Care Elderly: Collaborative Trial' (PROSPECT), which focused on treatment of suicidal ideation in elderly, was setup in 20 primary care practices in New-York, Westchester County, Philadelphia and Pittsburgh.^{155 97} The study consisted of 598 elderly (320 intervention and 279 control) with stratification for age 60-74 and 75+; 396 with major depression and 202 with subthreshold depression. The trial consisted of a composite intervention by 15 care managers (nurses, social workers and psychologists) who assisted primary care physicians to recognize depression and provided recommendations, monitored symptoms and medication side effects and gave follow-up over 24 months. A treatment algorithm for geriatric depression in the primary care setting was provided to primary care physicians. The usual care group got

no assistance and got treatment as usual but they received a video and printed materials on geriatric depression. Psychiatrists supervised the trial.

Almost 85 to 89% of patients in the intervention group got treatment versus 49 to 62% in the usual care group at 4, 8, 12, 18 and 24 months (all $p < 0.001$).⁹⁷

Depression severity declined more in the intervention group (HAM-D instrument, group difference = -3.5 [95%CI -4.7- -2.3], $p = < 0.001$) and this difference remained significant until 24 months (HAM-D instrument, group difference = -1.9 [95%CI -3.2- -0.5], $p = 0.007$). By month 24 decline in the intervention group was 2.2 times greater than in the control group. Decrease of depressive symptoms was significantly greater in the intervention group for patients with major depression.⁹⁷ Participants in the intervention group with major depression were more likely to achieve remission compared to the usual care group at months 4 (26.6 vs. 15.2%), 8 (36% vs. 22.5%), and 24 (45.4% vs. 31.5%). No advantages were seen in individuals with minor depression in the intervention group.¹¹³

At baseline, more patients in the intervention group reported suicidal ideation compared to the control group (29.7% vs 20.4%, $p < 0.001$). By month 4 overall suicidal ideation declined more in the intervention group and by month 24 decline in the intervention group was 2.2 times greater than in the control group.⁹⁷ In the major depression group the treatment response was even higher (NNT = 4). No difference was found for minor depression. The remission rate was also higher in the intervention group than in the control group, with NNT 7 for major depression and no effect for minor depression. Over the 24 month period, almost 50% on the intervention group reached remission status.⁹⁷ Moreover, study participants with major depression were 24% less likely to die, compared with usual care.^{96, 112, 156}

A stepped care intervention embedded in a collaborative care approach, in elderly with suicidal ideation proved to be effective for major depression but did not show significant differences for minor depression. However, for minor depression results were also positive but did not differ from usual care.



2.4.3 Implementation strategies to organise care for alcohol abuse in the older adults

THE AESOPS STUDY

Watson et al (2013) published the results of the 'Alcohol: Evaluating Stepped care in Older Populations Study' (AESOPS).^{157, 158} This multicentre two-armed randomised controlled trial, setup in the UK included 529 older patients (age ≥ 55 y) with abusive alcohol use (AUDIT scale ≥ 8). Participants were randomly assigned to minimal intervention care (a five-minute brief intervention) or a stepped care approach, consisting of (1) a 20-minute session of behavioural change counselling, (2) motivational enhancement therapy and (3) local specialist alcohol services.

At 6 and 12 months, no significant differences were found in average drinks per day, the Drinking Problem Index and health-related quality of life. The difference between groups in log-transformed average drinks per day at 12 months was very small, at 0.025 [95%CI -0.060 to 0.119], and not statistically significant. At month 6 the stepped care group had a lower average drinks per day, but not statistically significant. At months 6 and 12, the stepped care group had a lower score on the drinking problem index scale, but this difference was not statistically significant. The stepped care group had a lower SF-12 mental well-being component score and lower physical component score at month 6 and month 12, but again these differences were not statistically significant at the 5% level.

However, although they seemed to be an economical advantage, keeping in mind the effectiveness results, the stepped care approach did not prove to be an advantage over minimal intervention care. Nevertheless, taking into account the growth of the ageing population and the affordability and availability of alcohol in the Western society, there is a strong need for screening (detection) and treatment of alcohol addiction in the elderly population.^{159, 160} Further research has to reveal whether a specific approach, focusing on the elderly, is needed.

The present review provides insufficient evidence for the effectiveness of a stepped care approach for the treatment of alcohol abuse in the elderly.

2.4.4 Implementation strategies to organise care for older long-term or severe psychiatric patients

Included studies in this review on approaches for care of chronic or severe mental illnesses are sparse. O'Connor et al (2011) mentions the 12-month HOPES (Helping Older People Experience Success) study in the UK that focused on well-being and social functioning in elderly with severe mental illness, by comparing a combined approach of psychosocial skills training and health management to improve health and functioning versus usual care. The trial included 183 older adults (age > 50 y, mean age 60y, 53% female) with severe mental illness (schizophrenia, schizo-affective disorder, bipolar disorder and major depression). The study reported on a one, two and three year follow-up. The intervention was associated with improved community living skills (ILSS instrument, effect size 0.25, $p = 0.03$) and functioning (Multnomah Community Ability Scale, effect size 0.26, $p = 0.02$), greater self-efficacy (Revised Self-efficacy Scale, effect size 0.33, $p = 0.01$), lower overall psychiatric symptoms (Brief Psychiatric Rating scale, effect size -0.17, $p < 0.05$) and negative symptoms (Scale for the Assessment of Negative Symptoms, effect size -0.27, $p = 0.01$), and greater acquisition of preventive healthcare.^{161, 162}

McInerney (2010) followed 87 long-stay Irish psychiatric patients who expressed to continue to live in the community, over a period 1 and 5 years after discharge into the community.¹⁶³ Patients were more satisfied with their living arrangements 1 year post-discharge and also more satisfied than when in-hospital (Basic Everyday Living Skills scale, effect size 0.23, $p < .001$). This level of satisfaction reduced however after 5 years. There was no improvement in domestic skills, community skills, activity and social relations over this period. Weekly occupation level increased after 5 years.

Studies on severe psychiatric disorders in elderly were sparse. The included studies provide some evidence for the (temporary) effectiveness of treating chronic mental illnesses in the community.



2.4.5 *Implementation strategies to organise care for mental health problems in older persons with Alzheimer disease*

One included study reported on the effectiveness of a collaborative care model to improve the quality of care for patients with Alzheimer disease.¹³⁷ A sample of 153 older adults (Mean age 77.5, SD 5.7) with Alzheimer disease were randomized to receive collaborative care management and augmented usual care at primary care practices over a period of one year. Intervention group patients had significantly fewer behavioural and psychological symptoms of dementia at 12 months ($p=.01$) and at 18 months ($p=0.01$). Intervention caregivers were also more satisfied about the treatment and reported significant improvements in distress at 12 months. At 18 months, caregivers showed improvement in depression. These improvements were achieved without significantly increasing the use of antipsychotics or sedative-hypnotics.

The included paper showed that collaborative care for the treatment of Alzheimer disease resulted in significant improvement in the quality of care and in behavioural and psychological symptoms of dementia among primary care patients and their caregivers.

2.4.6 *Implementation strategies to organise care for mental health problems in older minority populations*

The included journal articles did not report on specific models of mental healthcare for elderly people in minority populations or groups of asylum seekers. However, several points of attention are reported in the selected papers. Taking into account these points of attention is important as the migrant and minority elderly are increasing rapidly.¹⁶⁴ The prevalence of mental disorders in older people from ethnic minority groups is either similar to or even higher than that in the indigenous population.^{165, 166} When effective treatments are made available to older men in ethnic minority groups, the treatment will be as beneficial as for other populations.^{113, 121} The mental health needs of older people from minorities and asylum seekers are less often recognized by both families and services than those of the white population, due to lack of knowledge in the population, lack of understanding mental illness, stigma, caste status, gender differences, educational level and respect for elders.¹⁶⁴ Once diagnosed, there are again barriers:

communication difficulties, taboo and stigma attached to mental illness, bias and prejudice of clinicians, institutional racism, unfamiliarity of symptoms of dementia to patients and relatives, and paucity of diagnostic and screening instruments. There even can be differences in presentation of symptoms of mental disorders.¹⁶⁶ Some patients might prefer to consult a traditional healer.^{165, 166} Specific attention is needed towards raising awareness, to share expertise, to facilitate early intervention, to overcome language and culture barriers, to improve access, to improve user experiences.¹⁶⁴ Actions that can be taken towards patient and family are: (1) reaching out to the community of the minority (service tailored to cultural differences, language, family context), (2) provision of information in a range of relevant languages, (3) ways to remove language barriers, (4) working closer to families, (5) working on beliefs and myths in communities. Specific attention has to be given to the service model: 1) employment of bilingual healthcare workers, (2) availability of interpreters, (3) close collaboration with local volunteers, (4) it might be considered to set up separate services in certain regions, (5) ethnic multidisciplinary staff, with involvement of GP and other key professionals.¹⁶⁴ Language and cultural barriers are indeed important obstacles to provide efficient and effective mental healthcare to minority groups as it may lead to under-screening, under-diagnoses and under-treatment.⁷²

The included papers did not mention a specific care model for mental healthcare for older people from minorities or refugee populations. It is however important to optimize communication between these populations and healthcare professionals, to identify misconceptions and wrong health beliefs and finally to reach out to the community to treat these patients in their own environment.



2.5 Additional remarks on implementation

Several authors of the included studies mention implementation related topics that might facilitate or hamper the setup of a specific healthcare system for mental healthcare to older adults. Some of these are related to health policy and labour force issues (especially a lack of psychologists), some are associated with organizational matters, some are influenced by the patient-physician interaction and some are related to the expertise of healthcare professionals.^{105, 121, 141, 167}

Studies on mental health in older adults report a significant fragmentation and inflexibility of the healthcare system.¹²¹ Fragmentation of care and lack of communication (data sharing) are found to be important barriers. As a result, GPs often perceive a lack of access to geriatric mental health specialists for consultation and referral, but also for support from these specialist services. Several authors also report a lack of knowledge, skills and confidence in GPs regarding geriatric mental healthcare (screening, diagnosis as well as treatment) and emphasize the need for specific education and training programs.

The reimbursement system is identified as a potential barrier and might have to be rethought. Research reveals that a significant part of the elderly have 'their own' primary care physician. GPs are very important in the setup of a specific mental healthcare program for the elderly. They are well-positioned in the detection (screening, case finding) as well as the supervision of therapy.

Another point of concern mentioned in the selected papers is that detection and treatment of mental health problems in elderly in primary care is not always efficient because of delivery of incomplete care. When problems are identified, treatment often is too limited of scope and intensity, not in accordance with practice guidelines and hampered by therapeutic nihilism and medical complexity when depression co-exists with other problems.¹²¹ It is also stated that mental health interventions provided by primary care physicians are characterized by overreliance on psychopharmacologic treatments and underutilization of psychosocial interventions.^{96, 147} On the other hand, GPs reported that medicalisation of depression in elderly might reduce stigma in patients and family, as it shifts the disease towards a more

'legitimate' organic problem. This approach was found to be quite successful, especially in 'refusing' patients.¹²¹

Another element that hampers treatment of mental health problems is reaching older people, as they often live alone, have a very limited social life and are not very mobile.¹³² Poor elderly also can be compromised by their financial problems what leads to a decrease in healthcare use.¹¹¹ This has to be taken into account when designing a healthcare program (e.g. home visits, outreaching, supportive reimbursement systems, systematic screening ...). Another point of concern is that drop-out is found to be rather high in mental healthcare programs for the elderly. Introduction of a relapse program in the healthcare system¹³² and more emphasis on self-reliance and self-management¹⁴¹ might be helpful.

Enlisting family for the treatment of depression in elderly was found to be a successful approach. Family members are described as crucial in the treatment of depression and anxiety disorders. Involving family was found to facilitate discussions on disease, monitoring of patients and supporting people in their treatment. However, GPs state that family might also be a source of stigma.¹²¹

And finally, specific attention has to be given to ethnic and minority groups as they also have an ageing population with even more frailty. Specific barriers and incentives can be identified regarding this group. Mental healthcare needs in these subgroups are often neglected or not recognised by patient or relatives due to lack of knowledge, lack of understanding mental illness, stigma, caste status, gender differences, educational level, differences in presentation of symptoms, lack of specific assessments for minority groups, and respect for elders. Once diagnosed there are again barriers, such as intercultural and communication difficulties, taboo and stigma attached to mental illness, bias and prejudice of clinicians, institutional racism, unfamiliarity of symptoms of dementia to patients and relatives, and paucity of diagnostic and screening instruments.^{164, 166}



These remarks are in line with views expressed in Belgian publications. The general practitioner remains an important gatekeeper for mental health in Belgium. However, several hurdles must be taken to ensure good mental healthcare for the older adult in the community: (1) the patient has to consult his/her GP, (2) the GP has to recognize the present psychopathology, (3) the GP has to start up the right treatment, and (4) the GP needs to refer the patient to specialised care if necessary.¹⁶⁸

Literature reveals several barriers and incentives regarding implementation of mental healthcare systems for the elderly such as health policy issues, labour force problems and reimbursement issues, but also a lack of knowledge, skills and confidence in patients as well as healthcare providers. Reaching patients, diagnosing mental health problems and therapy adherence also need special attention. And finally, specific attention is needed regarding mental health problems in elderly in ethnic or minority groups. All of these topics have to be taken into account when implementing mental healthcare systems for the elderly.

3 PERCEPTION OF THE SERVICE SUPPLY FOR MENTAL HEALTHCARE IN OLDER ADULTS IN BELGIUM

3.1 Objectives and methods

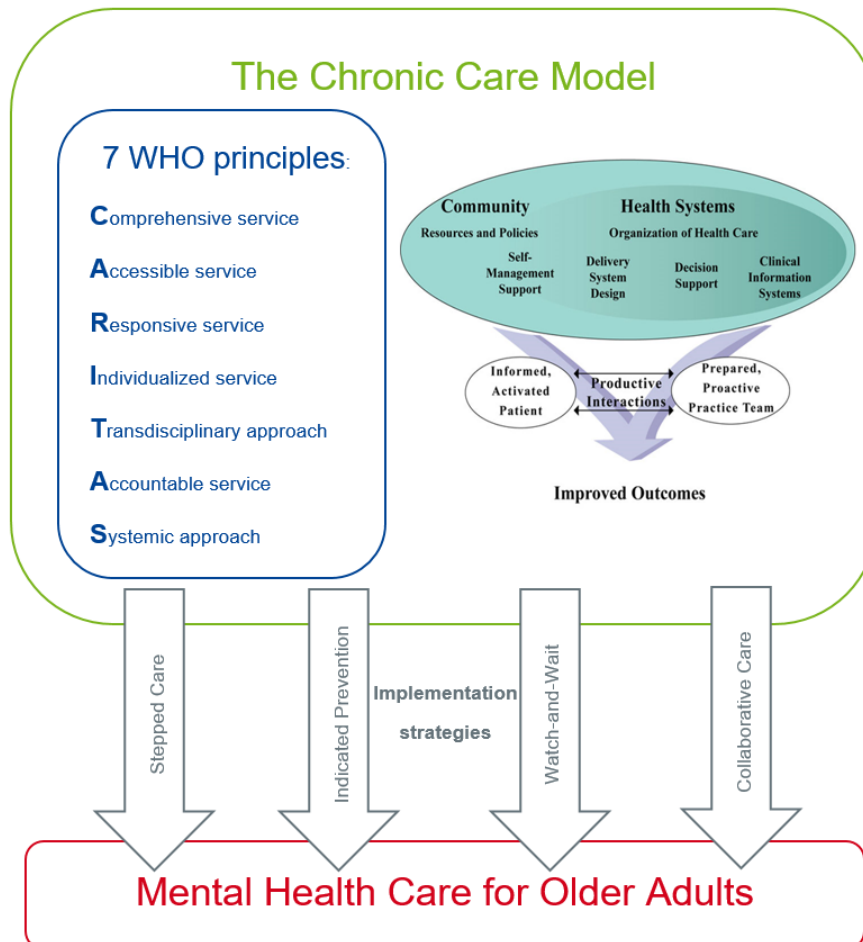
In order to identify the strengths and weaknesses of the current system of care for older adults with mental health problems, we carried out an online survey among a purposive sample including all the representatives of the stakeholders we have identified during the project.

About 60 persons were personally invited to complete a questionnaire using an online platform between 17th of January and 19th of February 2017. Stakeholders involved were professionals working in residential (general hospital, psychiatric hospital, home for the elderly or nursing home) and non-residential settings (ambulatory services), patients associations and healthcare authorities.

The questionnaire is presented in appendix 3 and 4 (see separated document) and was submitted to participants in French or in Dutch. It was based on the results of the literature review (see section 2 in page 32). In brief, WHO defined principles for quality mental healthcare in older adults (the CARITAS principles). The Chronic Care Model (CCM) is an overarching general organisational model that aims to provide comprehensive care while reaching these CARITAS principles. To implement this theoretical model in the field, four core approaches were identified in the literature: the Stepped Care Strategy, the Indicated Prevention strategy, the Watch-and-Wait strategy and the Collaborative Care strategy. These strategies can be used alone or in combination (see Figure 9). The survey gauged to what extent these theoretical requirements are met in the Belgian Mental Healthcare sector for older adults.



Figure 9 – CARITAS principles, Chronic Care Model and implementation strategies



After a series of identification questions, participants were invited to answer general questions regarding the MHC system for older adults in Belgium. They received several groups of close-ended questions and were invited to explain or to comment their position for each block. Afterwards, they were invited to share their perception on residential care (psychiatric hospitals, psychiatric departments in non-psychiatric hospitals, rest homes, nursing homes, psychiatric care homes or initiatives for sheltered accommodations), non-residential care (home, private practice or community mental healthcare centres) or both. Both modules had the same questions (labelling was simply adapted to the type of care).

At the end of the survey, two questions focused on the need for a specific MHC system for older people and respondents were invited to give eventual additional comments.

Before putting the questionnaire online, it was reviewed by 3 experts in the field. They also suggested additional questions or items.

The online version was tested by 4 persons in order to check the layout, the readability, the typography and the technical aspects (including the navigation through the groups of questions).

In this section, we will present the results of the survey as well as a synthesis of the comments and suggestions made by the respondents.



3.2 Results

The results of these section are based on the opinion of few stakeholders. Appraisal of barriers, gaps and solution elements were proposed to stakeholders in open questions included in the questionnaires. As such, it reflects the views and opinions of the respondents and not factual data. The sample size is small but include stakeholders in healthcare sector from very different domains, aiming to provide a board spectrum of view points.

Among the 62 stakeholders contacted to generate our purposive sample, 43 stakeholders completed the questionnaire. In the sample, 16 participants were health professionals in mental health. Overall, 13 respondents worked in institutions (general hospital, psychiatric hospital, rest home, nursing home) and 15 worked outside institutions (at home or ambulatory). More than an half (25/43) participants had more than 10 years of experience in mental health. More details are provided in Table 7 and Table 8.

However, it should be noted that only 19 participants answered all the questions. The remaining 24 only answered to the questions related to residential care or to the questions related to non-residential care.

Table 7 – Type of stakeholders involved in the online survey

Type of stakeholder (representative of)	n
Patient organisation	2
Professional or scientific association of psychologists	1
Professional or scientific association of psychiatrists	1
Professional or scientific association of general practitioners	1
Professional or scientific association of nurses	1
Group of ambulatory care institution	5
Group of residential care or hospital institutions	7
Public administration	1
Ministerial cabinet	0
Research centre / university	2
Sickness fund	2
Other	8
Not specified	11

**Table 8 – Characteristics of respondents**

Characteristics of respondents		n
Healthcare profession (if apply) – more answers were possible		
	General practitioner	1
	Psychiatrist	6
	Geriatrician	1
	Nurse	1
	Psychologist	7
	Psychotherapist	4
	Social worker	1
Specialisation in mental health		16
Type of work place		
	At home	7
	Ambulatory	8
	General hospital	4
	Psychiatric hospital	5
	Rest home	2
	Rest and rest and nursing home	2
	Psychiatric rest and nursing home	0
Years of experience in mental health		
	< 5	2
	5-10	4
	11-20	11
	>20	14



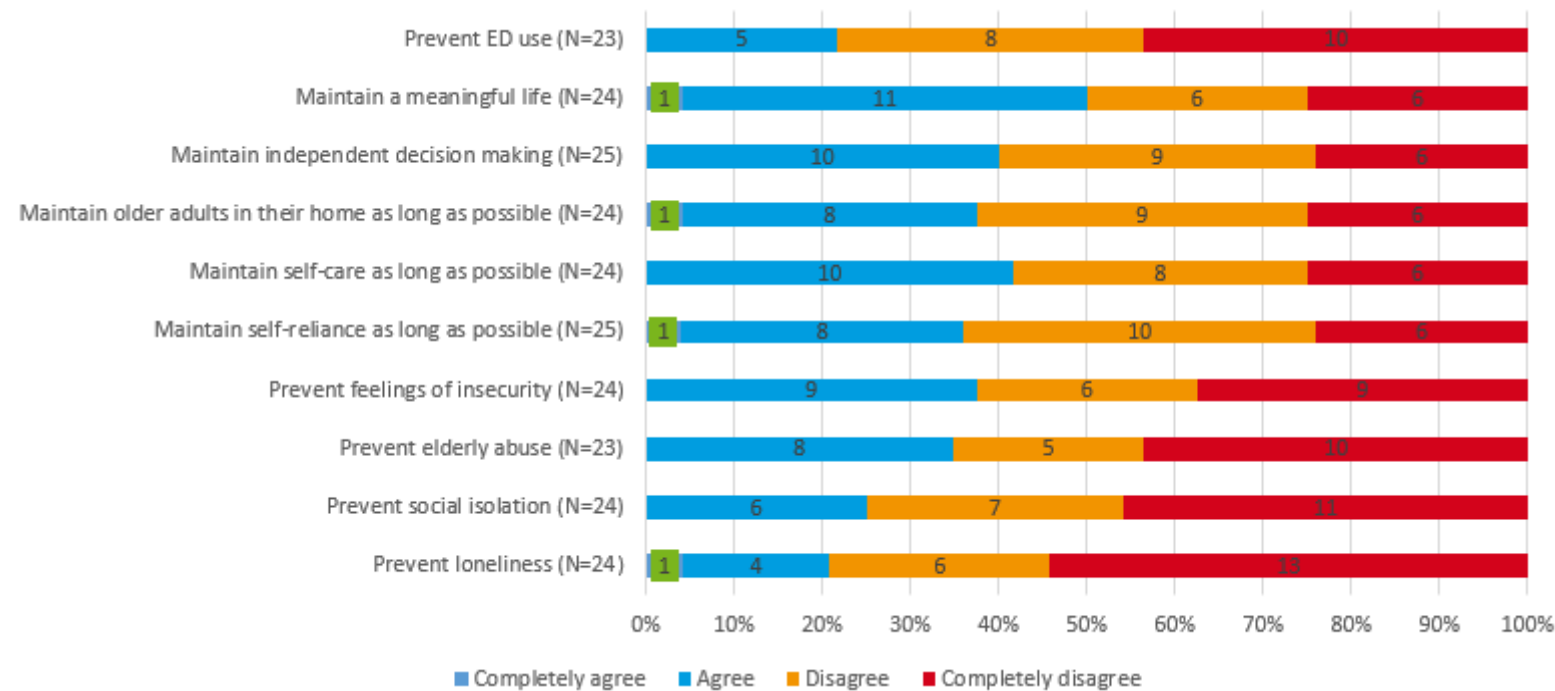
3.2.1 Perceptions of the current MHC system

3.2.1.1 Objectives of a MHC system answering needs of the older people

The older adults' needs

A selection of ten older adults' needs were built and we asked participants whether the current mental healthcare system in Belgium tackles these specific needs (Figure 10).

Figure 10 – Perception of the respondents on whether the current MHC system tackles 10 of older adults' needs





It appears that, for all the proposals, less than the half of the respondents agree that the mental healthcare system do not tackle the needs of older adults, except for 'maintaining a meaningful life'. Additional explanations could be provided in case that respondents did not agree that the needs were met. The respondents criticised the current system regarding the organisation of care, the treatment and the human resources.

Firstly at organisational level, there is a need to enhance access to (first line) ambulatory psychology, including at home by mobile teams with coordination by skilled professional. Currently, GP, or home nurses or family helpers take this role without specific training. Multidisciplinary approach of the older adults is thus needed. In addition, the choice of prevention intervention and delivering stepped care must consider the presence or absence of frailty in the older adults. Placing older adults with mental health disorders in nursing home is still common, leading to less autonomy due to the organisation of care in nursing homes and the lack of available human resources. The use of emergency department is often observed when older adults/resident has not define his/her life plan. Moreover, the meaning and the quality of life do not appear for a respondent as main preoccupations for the system.

Secondly, pharmacological treatment is often the first intervention. Some respondents considered that prevention and support is lacking in MHC for older adults impairing the patient's autonomy.

Finally, according some respondents, the human resources in nursing homes are too low and insufficiently trained continued trained and supervised.

Detection and treatment of mental health problems in older adults

The ability of the current healthcare system to detect and to treat a mental health problem in older adults was then challenged among the participants (see Figure 11)

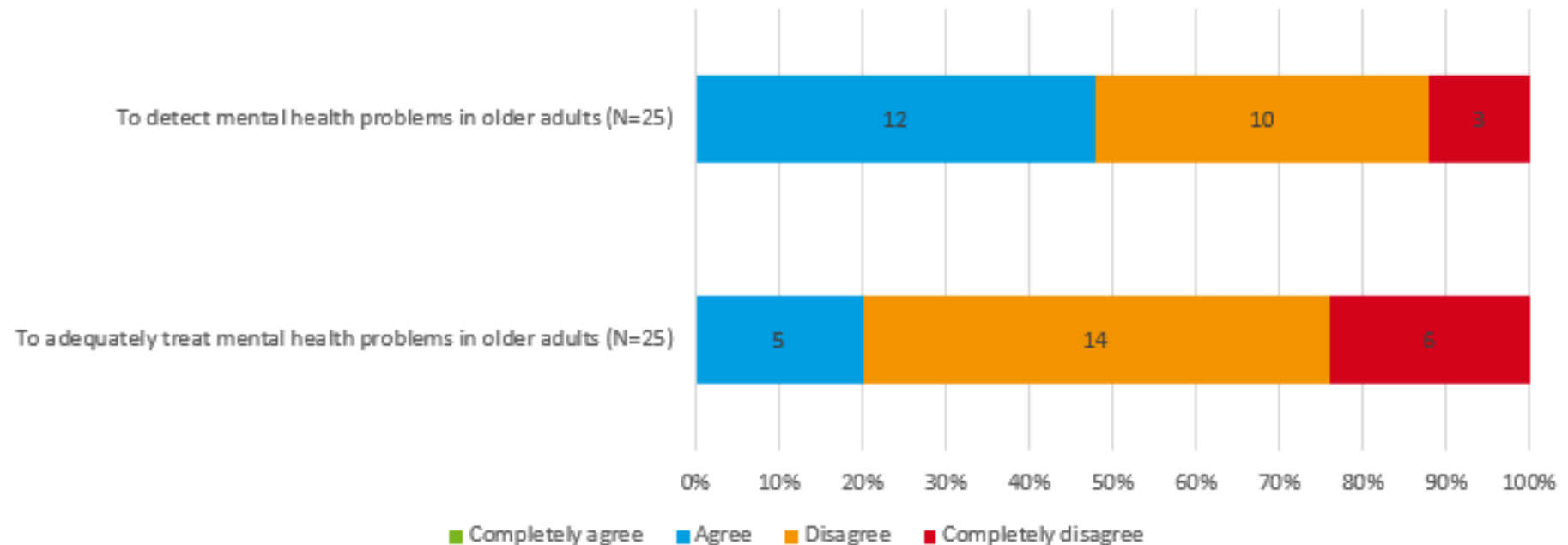
Opinions were split on ability of the Belgian healthcare system to detect mental health problems in older adults. However, a large majority agreed that the current healthcare system did not allow to treat adequately these problems. One respondent pointed out that the system may adequately treat mental health problems in older adults when care providers are correctly sensitised to early detection.

Respondents considered that depression is not always detected or treated because it is considered as inherent of the aging process. According to them, detection and treatment are impaired the underused of psychologists due to the reimbursement system, the lack of referral by (overloaded) GPs that often focus on medication.

Regarding the supply, respondents estimated that ambulatory care, specialized consultations in general hospital and specialised services integrated in the general hospital are missing in Belgium for older adults with mental health problems. Despite older adults require a very specific approach, health professionals are considered by the respondents as insufficiently trained to manage older adults with mental health problem(s) whatever the level of care (general hospital, nursing home or home). Therefore, they pointed out the need of psycho geriatricians and the need of a better communication from specialized care providers to GPs when the latest try to detect and pre diagnose a problem.

**Figure 11 – Perception of the respondents regarding detection and treatment of age-related mental illness**

The current health care system allows...



3.2.1.2 The features of the current Belgian MHC system

The C.A.R.I.T.A.S. principles

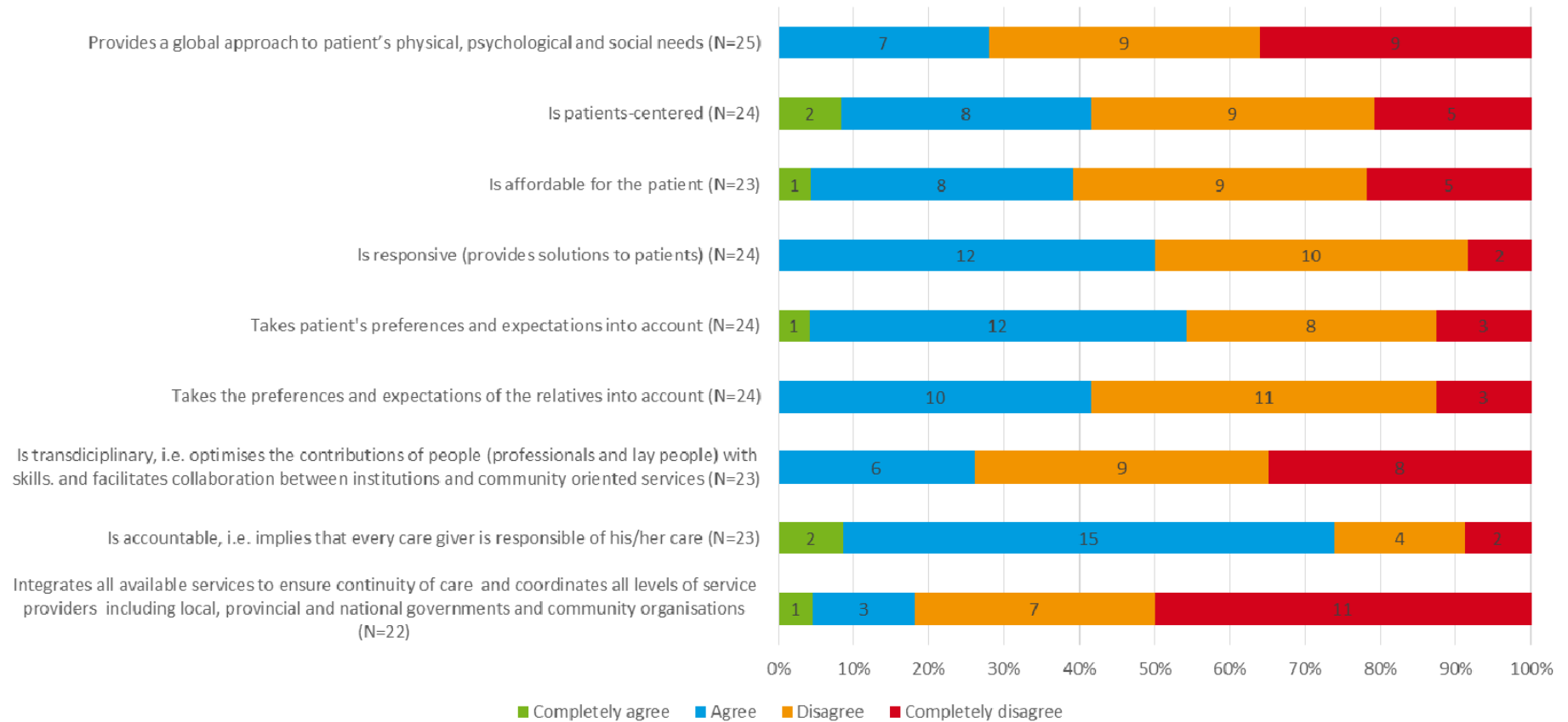
We proposed to respondents several C.A.R.I.T.A.S principles (see section 2.2.1) to characterize the current MHC system and ask them if they agree that these are present in the current MHC system in general.

Only the accountability of the MHC system is recognized by more than seven out ten respondents. A slight majority of them acknowledges that the system takes preferences of the patient into account and the half of them perceived that the system is responsive. Other principles are met for less than the half of the participants (see Figure 10).



Figure 12 – Perception the respondents regarding the features of the Belgian current MHC system, according to the C.A.R.I.T.A.S principles

Overall, the mental health system for older adults





The respondents did not perceive the MCH system for older adults as patient-centered. The reasons are multiple: the decision are too often made according to the care providers' or family's perceptions instead of older adult's perception or needs, the free choice of therapy is impaired by reimbursement system (e.g. psychotherapy) and organisational constraints of residential care predominate the patients' need (e.g. the meals are served according to the time schedule of the cookers, the medications are given according to the availability of the nurses and to limit the demand of attention during the night, etc.).

According to the respondents, the current organisation of MHC for older adults is characterised by a lack of collaboration, coordination and concertation. They also estimated that, in MHC for older adults, the role of the GP and the psychologist / psychiatrist is unclear leading to information flow breaks between the different actors in MHC, relatives and informal caregivers. The supply is judged as not enough spread in the country. The (SP) beds in hospital units dedicated to older adults or geriatric patients with mental health problems are too sparse and understaffed. The need to develop psycho-geriatrics/ cognitivo-behavioural geriatrics wards in general hospital is highlighted by one respondent.

Funding is also an issue of concern for the respondents. Overall, the funding system does not currently support the collaboration between care providers or initiatives aiming to meet psychological needs of older adults (such as coaching by a MH professionals). In addition, the funding of nursing home does not take properly into account the mental health problems in older adults.

Finally, it has been underlined that the mental health remains a 'taboo'.

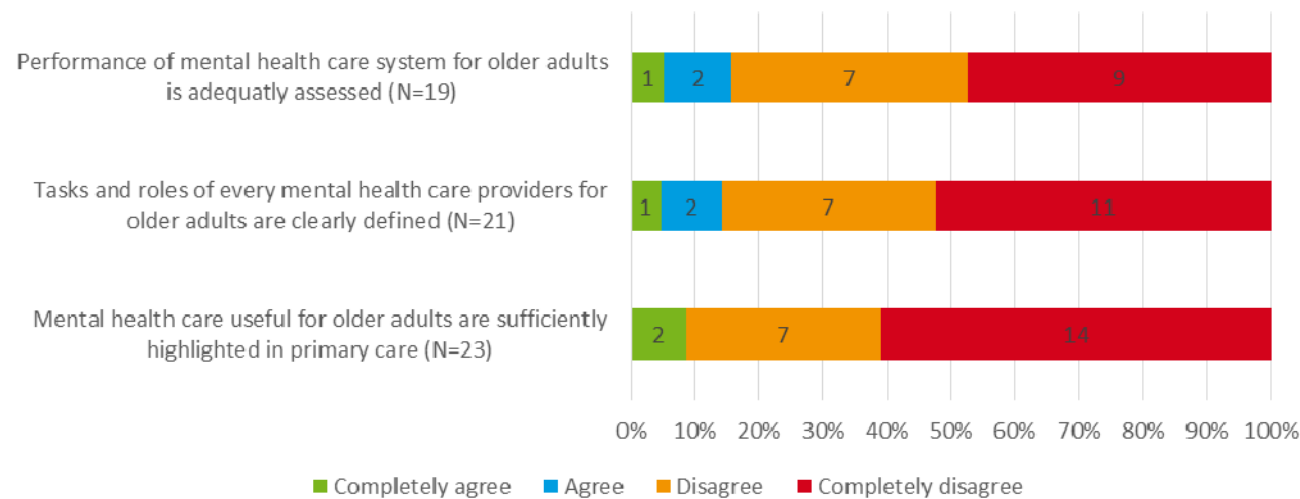
Organisation and performance of mental healthcare system for older adults

Beside the C.A.R.I.T.A.S. principles, the participants were asked to give their opinion about three additional aspects of the current Belgian MHC system, i.e. regarding the definition of the tasks and roles of mental healthcare providers, the place of MHC in primary care, and the assessment of the performance of the system (see Figure 13).

Definition of the tasks and roles of mental healthcare providers, place of MHC in primary care, and assessment of the performance are very low supported by respondents. And one of them regrets the absence of quality indicators or outcome measures, except in psychiatric hospital.

**Figure 13 – Perception of the respondents regarding the features of the Belgian current MHC system – additional aspects**

In general, ...



3.2.1.3 Usefulness of services offered by the current MHC for older adults

In order to be able to care for older adults with mental health problems, a healthcare system should, according to the CCM, offers support to patients and informal caregivers, offers programmes in the community and should reach vulnerable groups. We asked to the stakeholders to what extend the Belgian HC system achieves these requirements.

It is clear that for respondents, there is a lack of support programmes in the environment of patient's residence (also called community development programmes). Almost half of them agrees with the existence of programmes for vulnerable group. They are a few more to recognize the social support to older adults.

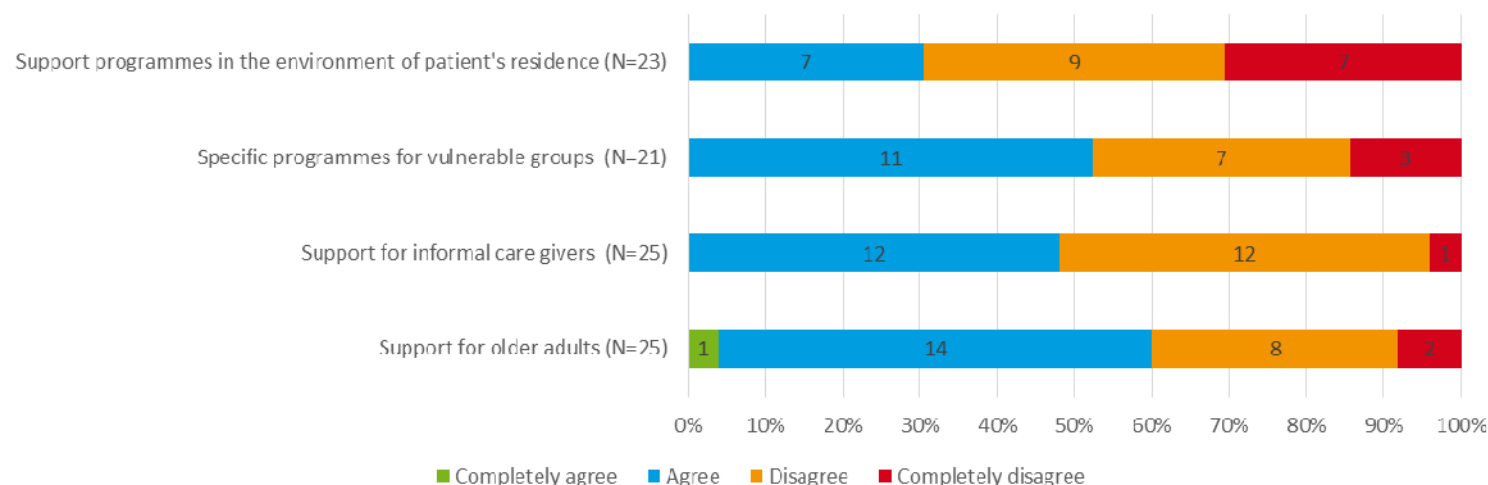
They justify their unsatisfactory points of view by:

- The existence of a cleavage between healthcare and animation in rest homes.
- The absence of intervention at home. Patient has to move to receive care.
- The absence of structured programme to support older adults with mental health problem, to support their relatives or to support first line health professionals. When the programmes are set-up, they are not sufficient in term of quantity and quality because of a lack of training and skills of the professionals.



Figure 14 – Perception of the respondents regarding the support programmes of the current MHC system in general

The current MHC system offers...



3.2.1.4 Perception about the functioning of residential mental healthcare for older adults

We defined *residential mental healthcare* for older adults as care provided in psychiatric hospitals, in psychiatric departments in non-psychiatric hospitals, in rest homes, in nursing homes, in psychiatric care homes or in initiatives for sheltered accommodations.

We investigated to what extent the residential care offered in Belgium correspond to the features including in the CCM and in a model used to operationalise the CCM (e.g. the collaborative care model).^{87, 88} (see section 2.2.)

We partly explored 3 of the 4 areas of the CCM that have to act in a collaborative and integrated way to deliver high quality care: (1) self-management support, (2) delivery system design, (3) decision support. The fourth area, i.e. clinical information systems, was not investigated through this questionnaire because it is more practical and less related to perceptions.



The chronic care model

- Self-management support

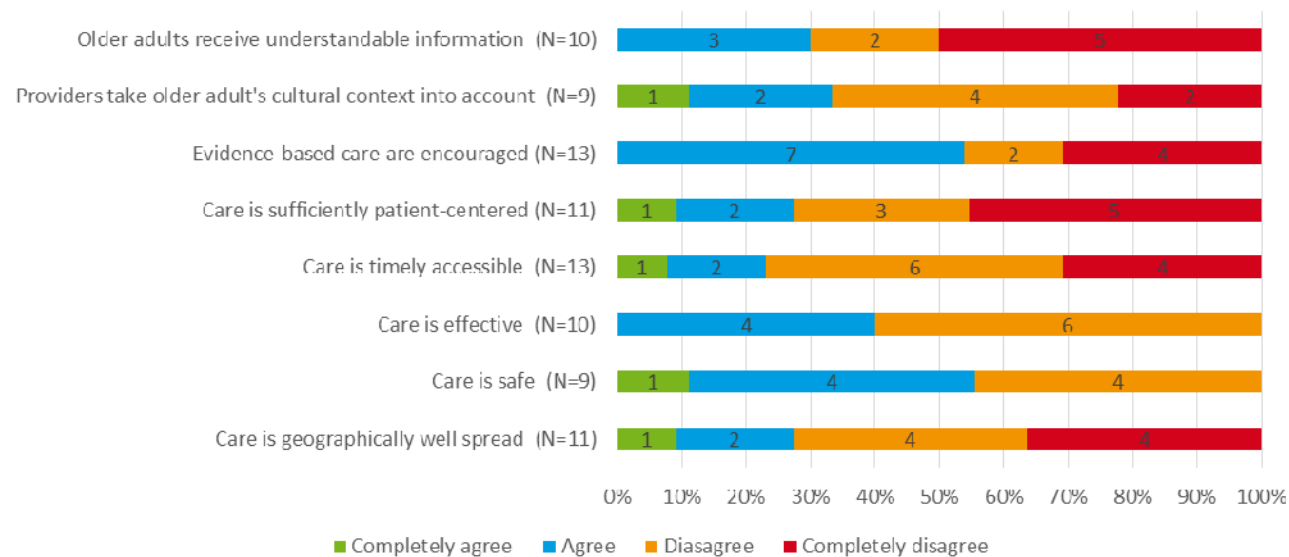
The older adult involvement in the decisions related to their treatment was used to test the self-management support area of the CCM. In residential mental healthcare, 5 respondents completely disagree with the statement of sufficient involvement of older adults in the decisions related to their treatment. Four respondents disagree with this statement while 1 respondent completely agree and 1 respondent agree with this statement.

- Delivery system design

The agreement on core elements of delivery system design was tested among participants. Unclear opinion is found regarding elements such as stimulation to use evidence-based care, or safety and efficiency of the system. Understandable information for older adults, taking the older people's cultural context into account, accessibility on time, patient centeredness and geographical repartition of settings are rejected by the majority of the respondents (see Figure 15)

Figure 15 – Perception of elements of the delivery system design area of the CCM for the older adults in residential care

In residential mental health care...





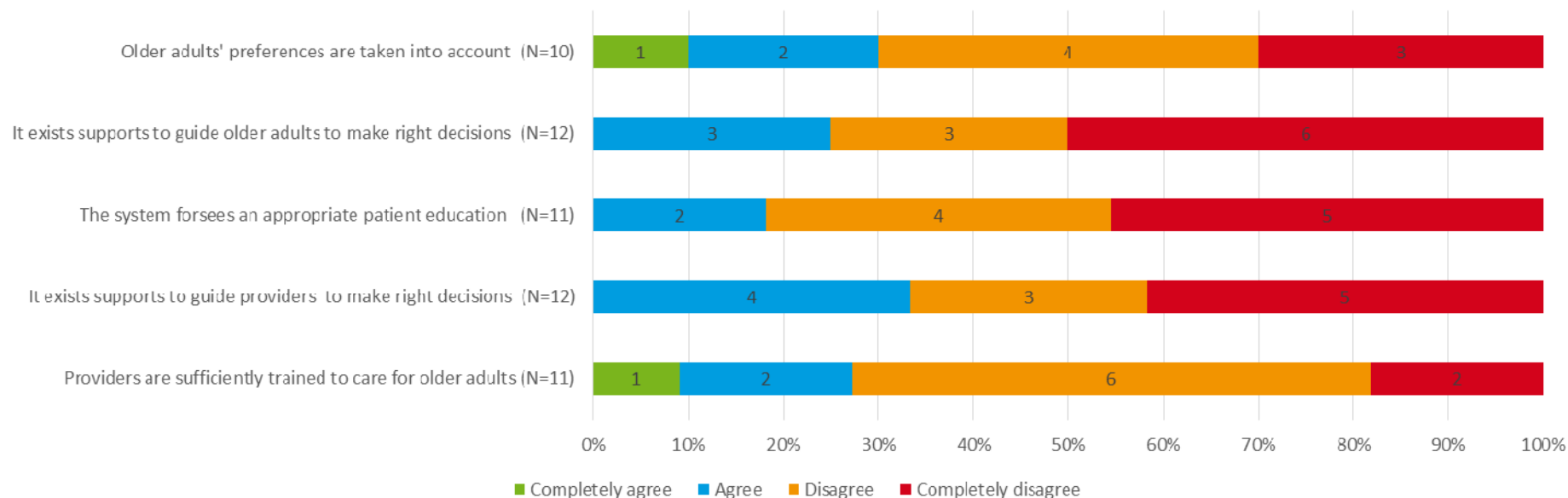
- Decision support

Taking patients preferences into account, guides to support patients' and care providers' decision and appropriate education of older people were dimensions used to test the decision support area.

The presence of these dimensions in MHC for older adults were not supported by all the respondents. In addition, they judged that care providers are insufficient trained to care older people (see Figure 16).

Figure 16 – Perception of elements of the decision support area of the CCM for the older adults in residential care

In residential mental health care...





The collaborative care model

The collaborative care model consists of a multi-faceted care intervention, a scheduled patient follow-up, an enhanced inter-professional communication, a structured management plan, trained providers, activated patients, cultural competences, patient centred care and reimbursements rewarding quality of care. Coordination and follow-up of this collaborative care process is done by a case/care manager.

All features of the collaborative care model were challenged among participants.

As Figure 17 shows, the MHC for older adults in residential care are considered by the majority of the respondents as multi-faceted and as foreseeing a regular follow up of the patients.

For the other features, the majority of the respondents seems to consider that the care are not stepped and do not follow a structured management plan. Also, they also considered inter-professional communication as lacking.

The CCM model, and its operational aspects such those included in the collaborative care model, do not correspond to what stakeholders perceived of the MHC in residential care.

We summarize their comments on these features here after:

Firstly, organisation of care is an issue of concern:

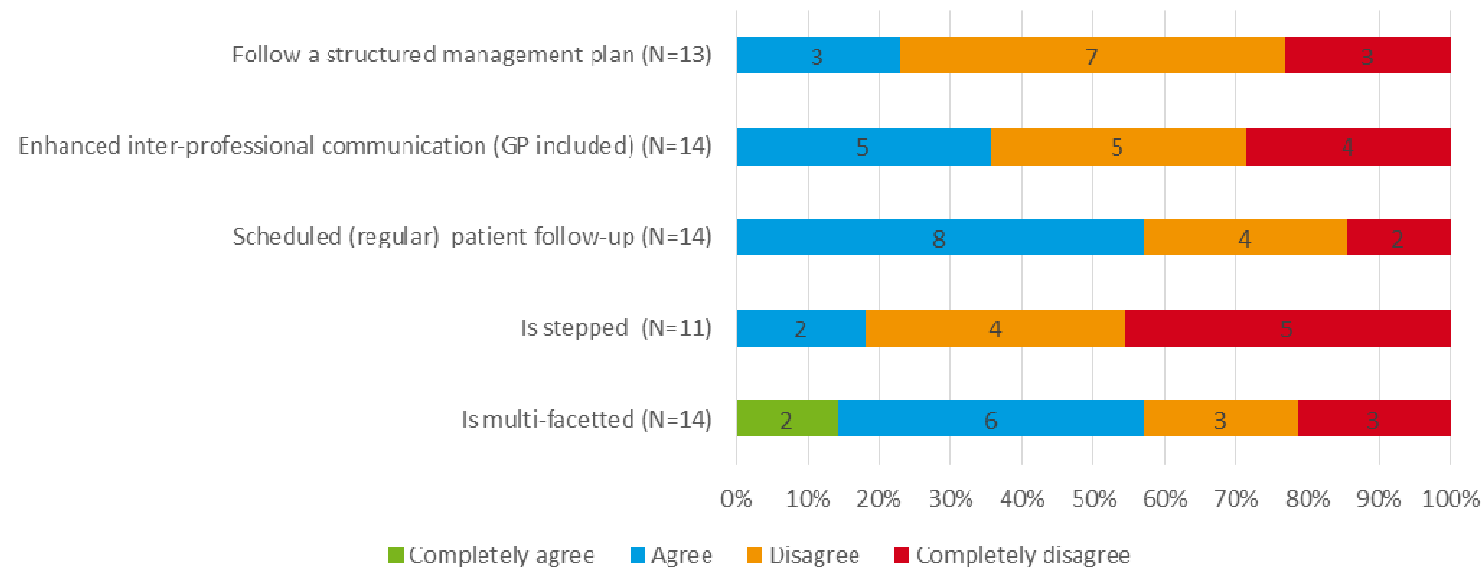
- The *access to rest and nursing homes* are impaired by long waiting list leading to delay in admission even in face of emergency and to increase the length of stay in acute units. The creation of 'Middle term' stay should solve partially this problem in reducing the waiting time between home and admission in rest or nursing homes or in allowing a return at home after recovery. In addition, there is no financing for psychological care for older adults in rest and nursing home. However, CGG SMM may arrange agreement with rest and nursing homes for psychological care but it is seldom in the practice.
- *Multidisciplinary work* is lacking because of geographical separations, competition, lack of time and low level of communication despite technological means to centralize information (e.g. Réseau Santé Wallon).
- One respondent pointed out *the low quality of psychiatric care* for older adults in non-specialised institutions.

Secondly, a respondent pointed that sometimes the safety is guaranteed by the immobilization of the patient (contention) to decrease the risk to fall. The respondent stated that it is not the objective of care that are supposed to help the patient to get more autonomy.

Finally, the availability of staff is evoked, as well as in terms of number as in terms of skills. Here also the communication problems between the providers are stated, and particularly, the communication between the GP and the specialists that is qualified as one way. This impairs the follow up of the patient, especially when there is no family.

**Figure 17 – Perception of the elements of a collaborative care model in MHC for older adults in residential care**

Mental health care in older adults in residential care...



3.2.1.5 Perception about the functioning of non-residential mental healthcare for older adults

We defined *non-residential mental healthcare* for older adults as care provided in the community at home, in private practice or in community mental healthcare centres.

The same features of the CCM model and of the collaborative care model were also challenged for non-residential care.

The chronic care model

- Self-management support

As for the residential care, the participants reported in a large majority (12/17) that the patients using non-residential MHC settings are not sufficiently involved in the decisions (8 completely disagree, 4 disagree, 5 agree with the statement of involvement of older adults in the decisions related to their treatment).



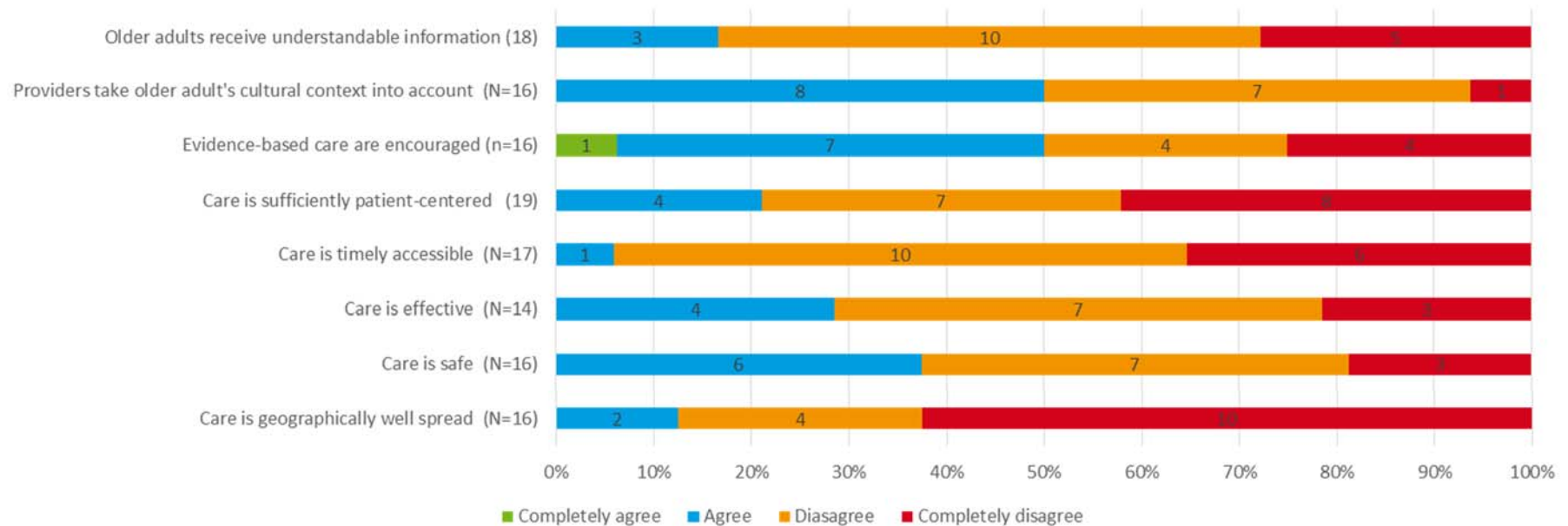
- Delivery system design

The delivery system design used in the CCM is not well supported by our respondents, as it is in the residential care.

Unclear opinion is found regarding elements such as taking the older people's cultural context into account and stimulation to use evidence-based care. Understandable information for older adults, patient centeredness, accessibility on time, efficiency of the system, safety geographical repartition of settings are rejected by the majority of the respondents (see Figure 18).

Figure 18 – Perception of elements of the delivery system design area of the CCM for older adults in non-residential care

Non-residential mental health care...





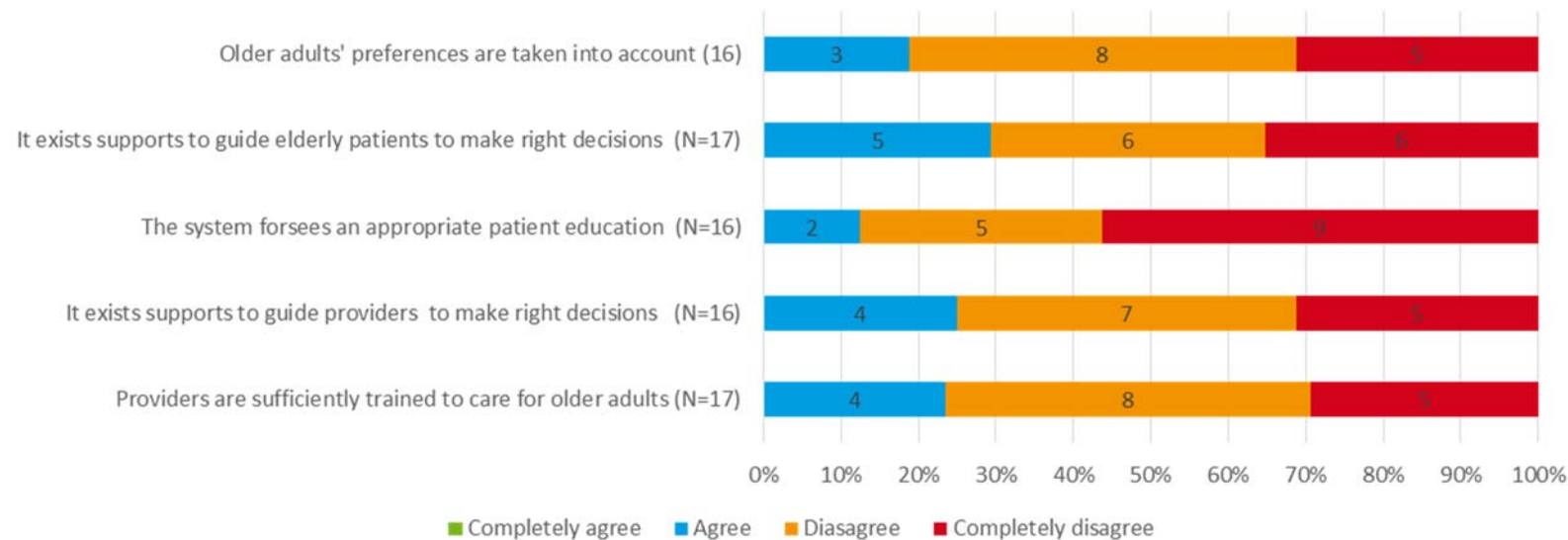
- Decision support

Compared to residential care, the decision support area of the CCM model is not present in current Belgium non-residential sector (see Figure 19).

According to respondents, older adults' preferences seem not to be taken into account, supporting guides for patients or professionals are lacking, appropriate patient education is missing and, care providers are insufficiently trained to care older adults with mental health problems.

Figure 19 – Perception of elements of the decision support area of the CCM for older adults in non-residential care

Non-residential mental health care...



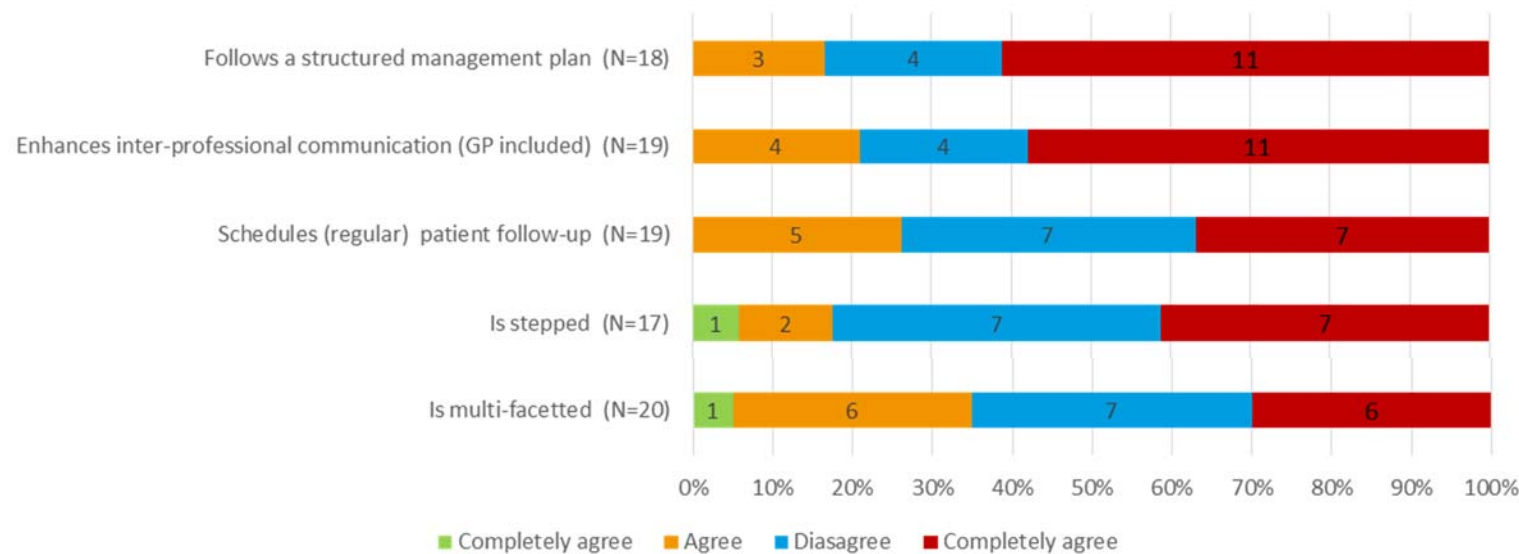
The collaborative care model

All features of the collaborative care model were also challenged in the context of non-residential care among participants. The different elements of the collaborative care model are here again perceived as not present for

the large majority of the respondents: no structured management plan, low inter-professional communication, defaults in patient follow-up and care seems not be stepped or multi-faceted.

**Figure 20 – Perception of the elements of a collaborative care model in MHC for the older adults in non-residential care**

Mental health care in older adults in non-residential care...



According to the respondents, the features of CCM model and of the collaborative care model were perceived as absent in the MHC in non-residential care.

Following comments regarding the features retrieved:

Firstly, organisation of care is a main reported issue.

While one respondent deplored the non-existence of MHC for older adults in non-residential care, another one stated that the offer in general and the *geographical spreading* in particular are clearly insufficient.

Network care around the patient is impaired by the lack of communication between professionals (e.g. between the GP/ the psychologist and

hospitals), the lack of inclusion of mental health professionals in the care plan established by the care coordinators and the lack of multi-disciplinary work by the private psychologists.

According to another respondent, the *multifaceted approach* is mainly assured by the GPs that have to integrate the various aspects of care and to insure the patient's follow up.

Few people acknowledged that informal caregivers are actually often not considered in stepped approach developed in the non-residential MHC for older adults.



Secondly, safety is also an issue of concern because of the length of period during which the patient is alone at home. In this context, the risk of drug misused, especially psychotropic drugs, is high.

Finally, provision of care is impaired by the dominant pharmacological approach and the lack of evidence-based and up to date guidelines.

3.2.1.6 *Perception about the main problems of the current organisation*

To conclude the first part of the survey, we asked respondents to explain, in their opinion, what are the main problems of the current system in Belgium.

We have organised and synthetised their responses here under.

Firstly, the current system suffers from a lack of global and integrated approach in the overall healthcare system. Networking around 'frail' older adults needs a multidisciplinary approach including all health professionals (geriatric / psychiatrist / psychologist / other providers from the first line of care), informal caregivers and relatives. To reach this goal, financial and logistic support must be foreseen (e.g. in nursing homes, in MH centres for outreach work, etc.). In addition, networking requires that MHC professionals know each other properly and frequently communicate about the patients' psychological needs. The respondents claim for an integrated and stepped approach starting with prevention and early detection of mental health problems remembering older adults' needs (e.g. outreach teams to avoid mobility problems, affordable adapted housing, day centres with activities, older psychiatric patients with somatic disorders that cannot be treated properly because of the mental health problem, etc.). However, the division of competences between federal level and federated entities makes this global and integrated approach more difficult than ever.

Secondly, the current system suffers from lack of trained and specialised human resources to ensure the global and integrated approach. The multidisciplinary approach and communication with patient and his/her relatives (needed patient centered care) require time. The lack of psychiatrists, the understaffed psychiatric care for older adults, the absence of training in psycho-gerontology and the unawareness of MHC in older adults (from diagnose to support) by the first line providers, lead to the low

time availability. The GP is often the only caregiver and therefore treatments are mainly pharmaceutical.

Thirdly, the respondents beg the question of accessibility. The current supply does not cover enough rural areas and is overloaded (e.g. in CGG SSM, the capacity of teams for older adults is clearly insufficient and cannot deal with the demographic evolution). Financial accessibility of MHC for older adults remains a concern.

Finally, MHC remains a taboo sphere in our society. In addition, our society no longer values the vulnerability proper to the end of life, the disability, etc.

3.2.2 *Perception of the need for a specific system for older adults, compared to other patients*

Specific healthcare system for older adults with mental health problems

Among 19 respondents, sixteen indicated that there is a need for a specific healthcare system for older adults with mental health problems, and 3 don't know. Opinions expressed by the respondents are summarised hereafter.

We have summarised the respondents' comments here under.

There is a need to develop specific care for older adults with mental health problems in PVT - MSP and nursing homes. Nevertheless it is also needed to take care of younger patients who have mental health disorder and somatic problems. Eligibility criteria to access the system should not include the age of the patient. It is necessary to differentiate the problematics related to the age from psychiatric patients who become aged.

For older patients, it is important to combine individualised and collective approaches, and to differentiate these from social approaches. The integration of primary and secondary care is important for this population, but not only for mental health.

Taking care of older adults requires specific skills. They are a specific group because they are in another life stage, have other life perspectives than adults and deserve other type of management (calm tempo, focus more on the quality of life than healing of the patient). Moreover they combine



cognitive, physical and psychic problems and often suffer from isolation. The health professionals have to be motivated and pleased to work, nevertheless that is not always the case.

As it is logical to have a specific 'pathway' for the somatic care, i.e. geriatric, it should be also the case for the mental health. Such specificities already exist for children and adolescents.

The required specific knowledge on the MHC have anyway to be included in the general basic knowledge of the geriatric medicine. This implies that it require enough staff and a proximity with the geriatric units.

Better integration to the MHC for older adults in the MHC for adults

A better integration to the MHC for older adults in the MHC for adults is supported by the 10 out of 19 respondents while 6 do not support it. Three respondents do not know if a better integration of MHCOA in the overall MHC for adults is needed.

The respondents who do not consider integration of MHC for older adults within the system for adults argued that, firstly, the specificity of the MHC for older adults is scientifically based and underlined by the WHO and, secondly, MHC for older adults requires other care providers than adults or children (the two latter are besides not integrated in one system).

Specific healthcare system for adults aged 75 years or older with mental health problems in comparison with younger older adults

A little more than the half of the respondents acknowledged that there is a need for a specific system for people aged 75 years or older. Indeed, 11 out of 19 respondents stated that patients aged 75 year older and plus need specific MHC. Only 4 do not think that this patient population has specific needs and 4 have no opinion.

Some respondents supported a specific approach for adults aged 75 years or older with mental health problems because of the specificities (psychiatric or not) of this age group: dementia, delirium and cognitive disorders, behavioural and psychological symptoms in dementia, psychiatric aspects of somatic disorders in the older adults, neuropsychiatric disorders (NAH, Parkinson Psychosis / Depression, HD, ...), mood disorders, life-style

disorders of older adults, diagnostics including older adults brain imaging research and neuropsychological research, biology and developmental psychology of aging, elderly psychology (focusing on family therapy / guidance), psycho-social problems, numerous comorbidities, polypharmacy and psychopharmacology of older adults, specific ethical issues in older adults (end of life, euthanasia, etc.)

3.2.3 Suggested improvements

We have summarised and organised all the suggestions that respondents have made through the questionnaire.

At the organisational level

- Integration /coordination and collaborations:
 - Better structuration of the care
 - Embed more welfare, social services and other facilities.
 - De-compartmentalise mental health and somatic health.
 - Promote local multidisciplinary group practices.
 - Make clear what cured and cared are and how they are related to each other.
 - Go towards more integration in the general healthcare, without cutting by age groups, even if there are specific interventions.
 - Empower the first line of care.
 - Coordinate and integrate of the different approaches provided inside and outside hospital or institution.
 - Associate the GP to the process of hospitalization.
 - Competition between care providers:
 - Set a coordination structure to avoid duplicate initiatives and competition.
 - Favour collaboration between care providers or levels of care to decrease competition.



- Communication between health and social care professionals:
 - Improve the communication between providers (e.g. between psychologists and GPs).
 - Create financial and logistical conditions to enhance concertation and dialogue between services.
 - Supply:
 - Improve the knowledge of the supply:
 - Create medium-stay facilities with sufficient amount of beds, appropriate funding for the care of older adults / geriatric patients with cognitive and / or behavioural disorders. These medium-stay facilities should allow a reasonable duration stay to avoid readmission.
 - The multidisciplinary approach needs cartography, networking of the providers and care planning.
 - Initiate Art 107 for the older adults and mobile team:
 - Develop and reinforce MHC mobile teams (based on Art 107) specialized in the older adults with mental health problem(s) and living at home.
 - A mobile team could also visit the nursing home to assess the patient and support the nursing home team. It should be contactable by phone for punctual advice in not complex situation.
 - Associate a community approach of MHC for older adults with the clinical approach.
 - Develop axes specific for the older adults in the current MHC services.
 - Increase healthcare in the community, even at home.
 - Mental healthcare centre should also meet severe mental health problems, to avoid inappropriate referral to the GPs.
 - Better staffing:
 - In quantitative terms (e.g. review the norms for the staffing in psychiatry ward).
 - In skill terms (e.g. occupational therapists and psychologists in nursing home to facilitate the psychological well-being of older adults with MH problem(s)).
 - Financial:
 - Finance and/or reimburse psychological care, including private providers. By reimbursing psychotherapy, it will become less taboo and give credit to this practice.
 - Take into account mental healthcare in the RIZIV/INAMI codes for primary care providers including home nurses.
- ### Management of the patients
- Acknowledge the specificity of MHC for the older adults.
 - Approach of the patient:
 - Pay attention to mental health in combination with somatic problems, e.g. to the mobility and somatic complains.
 - Make the empowerment of the patients and relative obvious (e.g. by using specific methods such as Montessori or by focusing more on the strong sides of the patients to support them in the care).
 - Clarify with the person his/her life project allowing him/her to put his/her own limits on the type of care they judge acceptable. Generalise the technic of 'story telling' that allowed to know the position of the patient and to fix his/her projects.
 - More efforts on prevention and early detection of problems by GPs, home care services... Ability to recognise problems and to provide an appropriate response is still lacking.



- Treatment
 - Make alternatives to medication available, e.g. psychological interventions accessible and affordable for older adults.
 - Use psycho-education of the patient and the relatives in routine.
 - Collaborate with a psychiatrist specialised in older adults, particularly for the pharmacological treatment. He/she should concert with the GP for medication and with the patient (if possible), the team and the relatives for the psychological treatment.
- Accessibility:
 - Improve logistic support to help the patient to go to ambulatory consultations.
 - Improve the free choice of treatments.

Training of the healthcare professionals

- Define and recognise a training in psychogeriatrics or psychogerontology, i.e. as an interface between intern geriatric medicine, neurology and psychiatry instead of gerontopsychiatry as isolate.
- Train psychologists to care for older people.
- Improve training of all the health professionals and search for homogeneity, also in the practices with integrate evidence-based approaches in all settings.

Efficacy / quality

- Empowerment of the community care actors to improve the quality of their care.
- Measure outcomes and quality indicators. Conduct a reflexion on quality criteria in residential care, including relational quality¹⁶⁹.
- Support the older adults, caregivers and care providers to target a good alignment to real needs.

- Make data centralisation compulsory, including the treatments and examinations performed.

At the societal level

- Organisation of the necessary social environment factors that avoid loneliness and enhance a meaningful live (affordable social living environments, meeting points, support from an independent ombudsman, etc.).
- Rethinking the social and urbanistic organisation: develop group housing and transgenerational housing.
- Change societal representations on aging by approaching older adults by their strengths instead by their impairment.

3.3 Key messages

This chapter of the report provides the results of an online survey filled by a purposive sample (n=43) of key stakeholders. The stakeholders were selected based on their experience in the field of mental healthcare organisation for older adults (MHCOA). The stakeholders were surveyed regarding their perception of the current MHCOA system, the specific needs of older people in comparison with adults and potential improvements of MHCOA system. As such, results allow to generate assumptions about the gaps and how to improve the current system but does not rely on statistical significant analysis of quantitative data. Therefore, these findings must be considered as qualitative input.

- A selection of ten older adults' needs were built. We then tested among participants whether the current mental healthcare system in Belgium tackles these specific needs. Not all respondents perceived the entirety of these needs to be reached by the Belgian MHC system. Therefore, a holistic approach of the patients' needs (physical, psychological and social) seems to be lacking.



- The C.A.R.I.T.A.S principles, the Chronic Care Model and the implementation strategies are not perceived as sufficient by all respondents. Following elements were pointed out:
 1. In both residential and non-residential care, points of concern related to delivery system were evidence-based approach, safety, accessibility in time, geographical spreading and patient centeredness of care. Non-residential care was characterised by the existence of programmes for vulnerable group and social support for the older adults but also by a lack of community development programmes. Organisation of residential care for older adults (mainly rest and nursing homes) did not meet the specific need of older adults with mental health problems.
 2. In a purpose of global and integrated approach, a multidisciplinary approach must be promoted with clear definition of tasks and roles. Before, the problem of inter-professional communication and shortage of adequately trained care providers must be solved.
 3. The lack of evidence based guidance for MHCOA and the lack of patients' involvement impeded the decision making process.
 4. Multi-facetted approach (see collaborative model) seemed to be more used in residential care than in non-residential. However, the stepped care strategies did not seem to be implemented to both residential and non-residential care.
- An integrated mental healthcare system must take into account the specificities of older adults.
- A lot of avenues for improvement were suggested by the respondents:
 1. Organisation of care

Firstly, a better structuration of care between primary and secondary care, a better communication among professionals and avoiding competition between care providers were suggested.

Secondly, the MHCOA supply is still not well known by the community and should be expanded to Article 107. The availability of mobile team, care in the community or at home and support services for GP must be increased.

Thirdly, a better staffing is needed both in terms of number, specific skills and training.

Finally, an adequate funding of MHCOA is required in residential and non-residential setting (psychological, nursing care and primary care in overall).

2. Management of the patients

The management of patients must be tailored for older adults (i.e. screening and detection of mental healthcare problems). In addition, treatment must be adapted to avoid medication as much as possible. When avoiding medication, collaboration with GP and psychiatrist has to be strengthened. Finally, availability of services must be enhanced.

3. Training of the health professionals and mental health professionals

Training of physicians, psychologists and the overall health professionals must be adapted to older adults. Evidence-based approaches have to be promoted to align all practices.

4. Efficacy and quality

Quality of home care and assessment of older adults' needs must be promoted. There is a need to collect data for measurement of efficacy and quality of care.

5. Society

Reconsider the social paradigm is essential to reduce loneliness, to support older adults' strengths and to adapt the social and urbanistic organisation (i.e. transgenerational or group housing).



4 INTERNATIONAL COMPARISON: ANALYSIS OF MENTAL HEALTHCARE ORGANIZATION FOR THE OLDER PEOPLE

4.1 Introduction

This chapter provides an international overview of mental healthcare organisation for older people allowing to compare Belgium with foreign experiences. It results from an initial research work done by the Economist Intelligence Unit – EIU (see EIU report in the appendix 4, available in a separated document on the same webpage) which has served as a basis for an additional research done by a KCE researcher (CR).

4.2 Method

4.2.1 Selection of countries

Initial scoping searches were carried out by EIU to identify possible countries for inclusion. Countries were chosen using a prioritisation process that ranked countries by their ability to demonstrate coordination between providers, their integration with health sectors, funding similarities between community health and social care, and additional information regarding elderly mental healthcare. Countries that were reasonably similar to Belgium in the structure of care and that were identified as having potential case studies were selected for inclusion. Five countries were chosen: England, France, the Netherlands, Spain and Canada. Detail results are provided in a report “Comparative study of five country’s approaches to the implementation of mental healthcare for the elderly” commissioned to the EIU (see appendix 4 available in a separated document on the same webpage). In this chapter, we focus on a transversal analysis of the countries from the above selection: England, France, the Netherlands and Canada.

4.2.2 Methodology of data collection

Firstly, a data collection was performed by the EIU team using a literature review carried out in two steps:

- A literature search in bibliographic databases (MEDLINE, EMBASE, CRD (HTA, NHS EED, DARE), PubMed Cochrane search, PubMed guideline search) using the search terms ‘geriatric’ or ‘later life’ and ‘Mental Health Services’ or ‘mental AND community’.
- Additional grey literature top-up searching was performed using reference harvesting and citation tracking.

Secondly, one KCE researcher (CR) deepened the description of the four selected countries by checking the key words “elderly”, “older” and “aging” in the full text of the references selected by EIU.

Thirdly, additional data on case studies and official documentation through a grey literature review were added between April and June 2017 to better encounter the practical reality of the organization of mental healthcare for the older adults (MHCOA).

Fourthly, for the transversal comparison, the following topics were selected by two KCE researchers, according to their common presence among EIU’s transversal analysis, the online survey preliminary results and the enlarged countries description:

1. Specific elderly mental healthcare services.
2. Stigma.
3. Assessment means.
4. Type of care.
5. Type of services.
6. Services availability.
7. Data flow and inter-professional communication.
8. Training (geriatric, psychiatric...).
9. Skills in psychogeriatric of healthcare professionals.



10. Funding of specific elderly mental healthcare.
11. Influence of the age on the system of mental healthcare.
12. State priorities, specific laws, program of mental healthcare elderly.
13. Networks.
14. Balance between community and residential care.
15. Care manager or self-empowerment.
16. Role of each caregiver.
17. Available allocations.
18. Care plan.
19. First line.
20. Position of neuro-degenerative diseases.

As almost all the data used in the transversal comparison were extracted from the countries description, the references are reported in the first part of this chapter (countries description).

Finally, in order to validate the findings of the transversal analysis, two experts in the delivery of mental healthcare for older people reviewed the draft of this chapter.

4.3 England

4.3.1 Healthcare system in general

National Health Service (NHS) is available to all UK residents and is generally free at the point of care. It is designed to cover all of individual's health needs, including antenatal screening, routine screenings, treatments for long-term conditions, transplants, emergency treatment and end-of-life care. However there are some exceptions, such as subsidised charges for prescriptions, optical services and dental services¹⁷⁰

The provision and commissioning of NHS healthcare services in local areas is the remit of General Practice (GP) led clinical commissioning groups (CCGs)¹⁷¹. CCGs are charged with ensuring effective and integrated care.

CCGs are informed by commissioning guides and NICE guidelines. Though as each group is responsible for the configuration of local services according to local need, there is some variation across the country.

4.3.2 Organisation of mental healthcare

Reforms

Over the years there has been a move from psychiatric institutions to a community based approach. Due to political shifts with a growing emphasis on human rights, as well as increased understanding of mental health problems and improvements in treatments, deinstitutionalisation was considered an issue of public and moral necessity since the 1950s and 60s¹⁷².

In recent years, there has been a renewed focus on mental health. In 2011 the “*No health without mental health*” strategy was launched by the NHS England. This set out six objectives, including improvement in outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma¹⁷³

The strategy was well received in 2011 but according to a 2016 report by an independent taskforce to NHS England, there were implementation challenges, inadequate provision and worsening outcomes in recent years. While the plan spoke of achieving “an additional one million people receiving high-quality care by 2020/21”, many of the specific investments are currently focused on children, young people and maternal mental health^{174, 175}. Mental health has still not received the same priority that physical health has in the UK, and services have often been short of qualified staff and received relatively less funding. Campaigns continue to promote the idea that there must be 1) equal status to mental and physical health, 2) equal status to mental health staff and 3) equal funding for mental health services¹⁷⁵. Numerous campaigns have sought to address stigmatizing public attitudes towards mental health for everyone including older people,



notably the Time to Change campaign⁹. This was a collaboration between MIND and Rethink Mental Illness, two major voluntary sector providers of mental health support services in England. Attitudes are reported to be changing, with an increased understanding of the need to improve experiences of people with mental health problems, both within and beyond the NHS¹⁷⁵.

Delivery of mental healthcare

Provision of mental healthcare in general takes place in a number of settings including primary care, the patient's own home (including "sheltered" or "warden-controlled accommodation", in which the person can summon assistance, usually by pulling a cord in the flat), acute general hospitals, psychiatric hospitals, and, more specifically for older people, in residential/nursing homes and hospices.¹⁷⁶

In the primary care setting, GP's can offer advice and treatment, or a referral to secondary mental healthcare or psychology services through the Improving Access to Psychological Therapies (IAPT) system¹⁷¹. Patients referred to secondary services will be assessed and may be referred back to the GP with advice on management, referred to IAPT, or offered ongoing follow-up by a community team.¹⁷⁷

Whilst receiving treatment within secondary care, adult patients have access to specialist mental health services such as psychiatric hospitals, crisis resolution teams, assertive outreach teams, and psychotherapy. These services involve extensive assessment, monitoring and treatment and tend to be run by a multidisciplinary team who are able to provide psychiatric, nursing, psychological and occupational therapy, and social work expertise, according to need¹⁷⁷. Those who are more unwell may be offered frequent (up to four visits daily) mental health treatment and monitoring at home by a home treatment or crisis resolution service; or inpatient care in a mental health unit. Due to differing local priorities, the structure and eligibility criteria of these services vary slightly across the country.

The treatment may be provided on a one-to-one basis or in a group with others with similar difficulties, and therapy sometimes also involves partners and families. The patient has the legal right to choose which provider and clinical team he is referred to by his GP. There are some mental health services that will allow people to refer themselves. This commonly includes services for drug problems and alcohol problems, as well as some psychological therapies (IAPT). In case of urgent talking need, several charities offer mental health helplines for immediate assistance. These are helplines with specially trained volunteers who will listen to the patient, understand what is going on, and help through the immediate crisis.¹⁷⁸ Acute psychiatric assessments and admissions can be arranged through the emergency departments.

Patient information needs to flow between services in order to provide good continuity of care. Electronic health records have been introduced over the last decade in most areas.¹⁷⁹ Hospital staff directly involved in care and organizations such as social services have access to these records, although often social care, mental healthcare, acute care and primary care use different electronic systems (because they are separate organisations) making interfaces challenging.¹⁷⁹

4.3.3 Demographics on elderly population

The proportion of older people in England's population has grown in recent years. In 1974, 13.8% of people were aged over 65, however this grew to nearly 18% by mid- 2014. Projections suggest that this will grow to 24.3% in 2039.¹⁸⁰ By 2035, the number of people aged 85 and over is projected to be almost 2.5 times larger than in 2010.¹⁷⁶

⁹ <http://www.time-to-change.org.uk>



4.3.4 Burden of mental health in older people from UK

The burden of mental health in older people is large. It reduces quality of life and increases use of health and social care services. In the UK, depression affects 22% of men and 28% of women aged 65 or over, and 40% of older people in care homes. The Royal College of Psychiatrists has estimated in 2009, that 85% of older people with depression were not treated for it. The main risk factors for older people's mental health are loneliness, financial insecurity and dealing with major life changes.¹⁷⁴

On an average day in a 500 beds general hospital, 330 of the beds will be occupied by older people, of whom 220 will have a mental disorder.¹⁸¹ Breaking these figures down further, 100 will have dementia, 100 will have depression and 66 will have delirium. It is also estimated that out of every 1,000 people over the age of 65, 250 will have a mental health problem, 135 will have depression, of whom 115 will be receiving no treatment.¹⁸¹

Detention of older people (aged 65 and over) under the Mental Health Act 1983 by the police in the UK happened more than 600 times in the 2010-2015 period. Over 90 of these detentions of older people were held in a police cell because hospital has no available place of safety. The majority of those elderly detained due to a mental health problem were living with dementia.¹⁷⁴

4.3.5 Mental Healthcare system for the older people

Reform

In 1999 a National Service Framework in England set out a ten year programme of action and reform to deliver higher quality services for older people. The report included a standard for mental health to promote good care and support those with dementia and depression.¹⁸² It further suggested that older people with mental health problems should have access to integrated mental health services provided by the NHS. The framework put a responsibility on councils to ensure effective diagnosis, treatment and support for patients and their carers, and described how the NHS and local councils should work with care home providers in their areas to develop a range of services to meet the needs of older people with mental health problems.¹⁸²

The 2011 “No health without mental health” plan focuses on three points concerning the elderly: the fight against age-related stigma, the depression screening and treatment, and the care for demented patients and their carers. The following commitments support these objectives.¹⁷³

- To protect key benefits for older people.
- To work with the Fitness Industry Association to explore ways of utilizing spare capacity in their facilities for older people.
- To extend psychological therapies to children and young people, those with serious mental illness, older people and those with medically unexplained symptoms.
- To help elderly people to live at home for longer, through solutions such as home adaptations and community support programs.

Delivery of mental healthcare for older people

The mental well-being of older people is largely the responsibility of primary care teams, which have direct access to psychological services. Specialist support is provided through community mental health teams, including community psychiatric nurses and old-age psychiatry expertise.¹⁷¹

Since the late 1950s, secondary mental healthcare for older people in England has been provided by specialised old age psychiatry units, home treatment teams and crisis resolution services. Due to differing local priorities, these services vary slightly across the country. In recent years there has been a move to create “ageless” services¹⁸³ but authoritative voices have expressed concern that an ageless service might cause even more discrimination for elderly people as it is not designed to meet their specific needs. Accordingly, a recent English publication has revealed that older people with mental health problems using general adult psychiatric services had twice as many unmet needs after treatment compared to those using old age services.¹⁸⁴ The Mental Health Taskforce has recently pointed out that older people should be able to access services that meet their needs, the reason that older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care. The Mental Health Taskforce also recommended that older people being supported by specialist physical healthcare services



should have access to liaison mental health support, incentivized by new payments for these services.¹⁷⁴

A number of specific mental health programmes are available to older people in England, though there is some regional variation. Services include elderly-focused Community Mental Health Teams, Memory Services, Psychology Services and Specialist Dementia Services. The Pennine care NHS foundation trust is an example of it¹⁸⁵.

The Joint Commissioning Panel for Mental Health has given ten key messages for commissioners in charge of older people's mental health services organization¹⁷⁶, including:

1. the importance of multidisciplinary team encompassing social, physical and mental carers.
2. the inclusion of patients with dementia and functional illness selected not on their age but on their need.
3. the necessity of coordination with GPs and hospital services
4. the wide access for older people with mental health to crisis teams, psychotherapy and home treatment.

In addition to inpatient and outpatient teams, other key actors involved in the provision of mental healthcare include social workers and occupational therapists. Local councils provide social workers who play a role in ensuring people are receiving any benefits they are entitled to, helping with any accommodation issues as well as planning management and follow-up. Occupational therapists are involved in risk assessment such as for falls, potential fire hazards, wandering and road safety, assessing the person's environment and need for aids, and developing their care programme to help maximize their independence and activities of daily living. They are also involved in planning discharge, where applicable.¹⁷⁶

A range of local organisations also offer help.¹⁷⁸ The Rethink Mental health problems support groups cater to the needs of patients or their carers of all ages.¹⁸⁶ The activities they provide vary but can include self-help, information, peer support and fundraising. Age UK is another prominent third sector organization providing support to older people with and without mental health problems.

To assess care, a number of elderly specific outcome measures are in use including the Geriatric Depression Scale and the Cornell Scale for Depression in Dementia. Some Trusts in England also use the elderly specific HoNOS65+ (Health of the Nation Outcome Scale for older people) measure.¹⁸⁷ At a minimum, IAPT services record pre- and post-intervention outcomes for each person. Clinicians are being asked to use outcomes measures routinely, as a standard part of all therapeutic work. The ambition for 2020/21 is that services will provide clear data about access and waiting times and, so, payment will be linked to the interventions delivered and the outcomes achieved.¹⁸⁵

4.3.6 Funding

The Department of Health funds mental health services, relying on a system of assurance around the commissioning, provision and regulation of healthcare¹⁸⁸. The funding that NHS England allocates to CCGs is a combined amount for acute hospital care, community health services and mental health services. Funding is not allocated for particular services and decisions about how to use the funding are with the individual CCGs.¹⁸⁸ Mental health services are provided free at the point of delivery by the NHS in England, although a small number of people prefer to pay for private care. Patients do not face out of pocket payments for mental health services, and people over 60 years of age are entitled to free prescriptions.

An alternative model to the activity-based payment is a payment linked to achievement of agreed quality and outcomes measures. The Oxfordshire CCG has developed a successful outcomes-based commissioning model. Their aim is to "deliver better outcomes for service users while maintaining financial stability for the local health economy". Within this model "the success of healthcare provision is measured by the outcomes that are most meaningful to service users, rather than by activity". S-Selected outcomes include: people living longer, people improving their level of functioning, people receiving timely access to assessment and support, carers feeling supported in their caring role, people maintaining a role that is meaningful to them, people continuing to live in stable accommodation, and people having fewer physical health problems related to their mental health.¹⁸⁹



Spending on social care for the elderly has decreased over the past decade. In 2005/06 local authorities were spending a total of £8.26 billion but this has fallen to just £6.31 billion in 2015/16¹⁹⁰ Home care and community based services were mostly affected by the spending reductions as local authorities focussed on those most in need. Service cuts especially likely to impact on mental health are support for independent living and support for informal carers.¹⁹⁰ However, supporting older people to stay mentally and physically well for longer makes good economic sense if it enables people to stay in work for longer and reduces demand on services for caring for family and volunteering.¹⁷⁴

4.3.7 Description of some case studies

4.3.7.1 Pennine Care NHS foundation Trust

Pennine care NHS foundation trust (Pennine Trust) is one of the UK providers of mental health services, providing care across six boroughs of Greater Manchester. All of the boroughs have at their disposal a large panel of mental healthcare services and five of them have specific services for older people with mental health problems¹⁹¹.

The different older people services of Pennine Trust are listed below and their specificity is described.¹⁹¹

1. Wards for elderly with mental health problems: nine different wards are located in the Pennine Trust area. They are composed of 10 to 20 beds dedicated to the assessment and/or treatment of patients 65 year or older with organic or functional mental illness which cannot be cared in the community. In two boroughs, patients with functional illness (depression, bi-polar disorder, severe anxiety) are treated in a separate ward to patients with organic illness (primarily dementia). In contrary, one of the wards located in Stockport provides care specifically to patients suffering only from delirium, dementia and depression. Selected patients under the Mental Health Act 1983 (see above) are allowed in some of the Pennine Trust wards.
2. Older people's RAID (Rapid, Assessment, Interface and Discharge) services: several hospitals in the Pennine trust area have access to RAID services, who are able to address the mental health needs of elderly patients suffering from physical health problems and hospitalized in medical wards. The RAID team appraises their mental status during the hospitalization and offer support to nurses. In Stockport, the service operates 7 days a week 364 days a year. Training on mental health issues is also provided to hospital staff.
3. Older people's community mental health services: these teams offer multi-disciplinary assessment, treatment, intervention and care for older people who may be experiencing moderate to severe mental health problems. That may include depression, bi-polar disorder & psychosis. The teams also offer a service to people with a diagnosis of dementia. A wider description of this type of service is given below.
4. Memory assessment and treatment services: these services allow assessment and diagnosis of memory conditions, initiation and monitoring of anti-dementia medication, post diagnostic information and support, helping people to live well with their dementia.
5. Older people's Day Hospitals: these two services offer specialist multi-disciplinary assessment and intervention/treatments for older adults with mental health problems preventing them from being able to carry out their normal everyday activities and hobbies.
6. Older people 's Intensive Home Treatment Services: these services, also called crisis teams, are dedicated to people over 65 experiencing either functional or organic acute mental health problems and who are in crisis. These intensive home support and treatment teams enable people to avoid admission in an acute hospital bed and to stay within a community setting. The team also facilitates timely and safe discharge and follow-up from older people's mental health inpatient wards.
7. Mental health liaison service for older people: This team supports the mental healthcare of older people and ensures that their needs are being met appropriately by joint working between health and social care professionals. In the last 12 months of life, a palliative care liaison service ensures that the mental health needs of older people with dementia are assessed and supported.



8. Older people's secondary care psychological therapies service: Psychological assessment, detailed neuropsychological assessment and psychological interventions are provided in both one-to-one and group formats. Formal and informal training are also delivered to multidisciplinary colleagues.

4.3.7.2 Community Mental Health Teams (England)

The service

Community mental health teams (CMHTs) are multidisciplinary. Those teams offer specialist assessment, treatment and care to adults with mental health problems, both in their own homes and in the community. They work with people often described as having complex needs – for example, in relation to housing and homelessness, benefits, unemployment, use of drugs or alcohol, or those who have had contact with the criminal justice system. CMHTs aim to provide the day-to-day support needed to allow a person to live in the community. Teams may provide a whole range of community-based services themselves, or be complemented by one or more teams providing specialist functions.¹⁹² Multidisciplinary CMHTs usually consist of psychiatrists, community psychiatric nurses, social workers, clinical psychologists, occupational therapists and support staff. They are the focal point of the interface between primary care and specialist mental healthcare.¹⁹³

Commissioning guides describe the services that should be available to people with mental health problems. Whether an older people's caregivers' service or an integrated service delivers these, and how the services are configured, is decided by local regions. In most regions, older people with severe and enduring mental health problems will be offered a service via CMHTs¹⁹². The teams could include old age psychiatrists and nurses.^{194;195} Regional variation determines whether people with suspected dementia are referred to a memory service (organisationally separated from the services for those with psychosis, depression and other mental health problems) or to one integrated service; and whether separate teams manage those with mental health problems in residential or nursing care homes, general hospitals and the community.¹⁹⁶

Access to CMHT services is made by a single point of access, usually a GP. The team will then discuss the most appropriate range of assessments and treatments and offer these services and support to people who have functional mental health illnesses, or cognitive decline including dementia. Within the CMHT system there is an allocated worker who delivers care and can consult other team members. This person is involved in monitoring health, adherence to medication, risks, and supporting social needs. This worker is likely to refer to psychology specialists for specific, evidence-based talking therapies where appropriate, rather than offering these themselves. A benefit of CMHTs is that they provide continuity and coordination between other services within mental health, such as inpatient wards, hospital liaison, memory services, and also services beyond, including acute geriatric medicine. In summary, CMHTs aim to provide support that allows a person to live in the community, who may otherwise have to live in an institution. Teams may provide the services on their own or together with other specialist teams.

In 2007, Chew-Graham et al described some limitations of CMHTs as a lack of clarity over the referral criteria to the CMHT by the GP, and the decision-making about what constitutes an "appropriate" referral. Within the teams, the psychiatrists saw themselves as "experts" and GPs describe a wish for access to this "expert knowledge" but the team structure (requiring referrals to be made to the team, not the individual psychiatrist) prevented this. The creation of crisis resolution teams may resolve some of the tension between referral of patients in crisis and the request for assessment or care for patients for whom some additional input is requested, but CMHTs will still have to contend with referrals that they may feel are "inappropriate" with GPs feeling they are at the limit of their capacity to manage an individual patient.¹⁹³

Models of care used

CMHTs follow the 'stepped care' model, incorporating the collaborative care model for more severe cases.¹⁹³ The 'stepped care' approach involves delivering and monitoring treatments so that the least intensive appropriate treatment is offered first, stepping up or down the pathway according to response.¹⁰⁸



4.3.7.3 Improving Access to Psychological Therapies (England)

The service

The Improving Access to Psychological Therapies (IAPT) programme was fully introduced in 2008 with the goal of improving the utilisation of cognitive behavioural therapy (sometimes referred to as “talking therapies”) for depression and anxiety disorders as recommended by the NICE guidelines.¹⁹⁷ Before the programme began, psychological therapy services were often not evidence-based and were inconsistent in both quality and geographical provision.¹⁹⁸ IAPT is fundamental to the implementation and success of the Government’s mental health strategy, “*No health without mental health*”.¹⁹⁹ The programme recognised the large and growing prevalence of mental health conditions in the adult population and the significant impact they have on mental and physical wellbeing and a person’s ability to function day to day.¹⁷⁴

It set out to increase the number of therapists and the availability of services to treat depression and anxiety. Initially focused on adults under the age 65, it was later expanded to include older people.¹⁷⁴ Talking therapies can be highly effective in older people and often better than for those aged below 65.²⁰⁰

Take up of the programme has increased each year. In 2015 to 2016 there were^{200,197}:

- 1,399,088 new referrals.
- 88,519 adults over the age of 65 were referred, 59,761 women and 28,758 men.
- Treatment was more successful for adults over the age of 65, with 60% recovering.
- Once referred, a greater proportion of older adults (56%) complete treatment than their working age counterparts (42%).²⁰¹

Since 2008/09, the first year of operation of IAPT across England, to 2015/16, national reporting shows the total proportion of patients aged over 64 had only increased from 4% to 6.1%. This is still well below the expected rate of 12% set out in the ‘Talking Therapies: four year plan of action’ in 2011. There also seems to be variation with age, as the vast majority of older people (roughly two-thirds) who access IAPT services are under the age of 75, with very few people over the age of 90 accessing these services. The rate of increase has been slow, and at the current rate of growth it would take until 2031 before the 12% target of referrals is met.¹⁷⁴

Four main barriers interfere with older people’s access to IAPT services²⁰¹:

- The perception: Some older people believe that psychological therapies are not relevant or helpful for their problems. This view may be shared by health and social care professionals.
- Practical barriers: Mobility and sensory problems that are common in older people may require special consideration by IAPT services about the venue, timing and format of service delivery.
- The confidence: IAPT staff are often less confident in working with older people.
- The exclusions: IAPT was initially established to focus on working age adults. In some services, the needs of older people are not actively considered.

From 2014, Age UK has worked with NHS England on a campaign to improve older people’s access to talking treatments with the aim of fighting stigma and misconceptions. Bespoke materials and films in which older people shared their experiences of talking therapies were made in order to raise awareness of the effect that life events such as bereavement, living with a long-term medical condition and retirement, can have on an older person’s thoughts and feelings and demonstrate how talking treatments can help.¹⁷⁴

In order to promote compliance in IAPT services and to improve access by older people or ethnic minorities a payment approach has been developed that rewards providers for delivering outcomes. Measured outcomes were developed taking into account what matters to people and their daily activities.¹⁹⁸



The IAPT programme was allocated funding of £33 million in the first year and £70 million each year for a further two years under the 2007 Spending Review. The funding was subject to a public service agreement between the Department of Health and the Treasury. IAPT was made a priority in the NHS Operating Framework 2008/9.¹⁹⁸ In the 2010 Spending Review, the government agreed an additional £400 million to be spent over the next four years as the success of the initial phase of the program in the provision of services to the adult population has dramatically increased referrals to such an extent that significant waiting lists have built up in a number of areas as the limited number of service providers struggle to keep pace with demand.¹⁹⁹

Within the programme, services are able to offer care to complex cases but also be able to offer lower levels of support according to needs. Services available include a choice of therapies, practitioners and locations, and focus on prompt access to services for harder to reach groups.¹⁹⁸ Older people's caregivers may also be part of the team. In some foundations, IAPT services have assistant psychologists delivering START (STrategies for RelaTives), which is a manualized intervention shown to reduce anxiety and depression in carers of people with dementia, at least half of whom are also older people.²⁰²

National resources have also been developed to promote IAPT, including resources to help IAPT practitioners develop basic competences and skills to work with older people. Many of these resources are fairly recent, so the impact on increasing referral rates for older people or improving the level of mental healthcare offered to older people are not yet apparent.¹⁷⁴

Some strategies taken by CCGs to improve access to IAPT programs for those aged 65 and over include posters, promotional items, and, question and answer stands. One example is "Older People's Champions" looking at identifying barriers to referrals and any difficulties with engagement once referrals take place. Linking IAPT services to GPs, carers' services and memory assessment teams can improve access, as can offering interventions designed to target the older age group such as anxiety management, behavioural activation and living well with aches and pains.¹⁷⁴

Models of care used

The IAPT programme has brought in evidence-based therapies using an integrated and stepped model of care. The stepped care approach involves using the least intrusive and intensive form of therapy first, progressing to more specialized therapies. The IAPT service provides a number of interventions which includes guided self-help, psycho-education, group and individual therapies including cognitive behavioural therapy, counselling and interpersonal therapy.¹⁹⁸ Lower intensity IAPT therapies include computerised cognitive behaviour therapy and self-directed learning. Higher intensity therapies are conducted face to face with a therapist.

4.3.7.4 Crisis Teams (England)

The service

Crisis teams, also known as Crisis Resolution and Home Treatment teams (CRHT), are multidisciplinary and operate all day, every day on a mobile basis.¹⁷⁶ They were implemented in England following the NHS Plan of 2000²⁰³ They visit the homes of people with acute mental health problems to assess and provide care which would otherwise have required hospital admission. If felt appropriate, the team facilitates inpatient admissions and early supported discharge.¹⁷⁶ Staff members are normally mental healthcare professionals. Psychiatrists assess, diagnose, prescribe medication and manage treatment, whilst community psychiatric nurses ensure that care plans are implemented and offer support. In some areas highly trained nurses, including nurse prescribers, are taking on roles traditionally allocated to doctors. Mental health social workers give practical help for social care needs.²⁰⁴ A crisis team can also provide support when a patient is discharged from a short stay in hospital with home visits to ensure the patient is keeping well.²⁰⁴ Crisis teams are trained to recognise any physical health needs that could be better treated in hospital. GPs have to be contacted within 24 hours when someone is acutely seen by a crisis team and they are again informed within 24 hours when someone is discharged with a current diagnosis and list of their current medication.¹⁷⁶ In severe situations, the team can visit the patients four times a day every day of the week.



The teams were originally introduced throughout England for adults, but dedicated teams are now being set up for older adults.^{205,206} CRHT teams for older adults provide crisis assessment and intensive treatment pathways for older people. This includes integrated services to promote recovery from mental illness, early intervention, intensive home treatment, therapy and support on preventing avoidable admission to hospital and facilitating earlier discharge from mental health hospital beds. CRHT is a time-limited intervention (initially up to six weeks) and, depending upon clinical need, it may be necessary to refer patients to other teams within Older People's Mental Health Services to ensure patients receive long-term treatment and therapy as appropriate²⁰⁵. Older people's crisis teams are often able to undertake urine or blood tests to screen for physical illness, as delirium (confusion resulting from physical illness) is a common cause of mental health crisis in older people, especially those with dementia. In the South London and Maudsley NHS Foundation trust, in 2011-2012, 40% of referrals to the crisis team for older adults were for non-psychotic problems like severe depression, 28% for psychotic problems and 22% for dementia.²⁰⁶

In some areas, crisis services are provided by CMHTs during working hours and only by specialized crisis teams during out-of-hours. In other areas, crisis teams have a broader remit and look after every crisis 24 hours a day. In all areas, crisis teams should be the gateway to inpatient beds, and patients should not be admitted except through the CRHT.¹⁷⁶

A systematic review of crisis resolution teams found limited evidence that they can reduce hospital admissions and increase service user satisfaction in some circumstances, but there is no robust evidence on which to base conclusions about the specific characteristics of crisis teams which influence their effectiveness. There is some empirical support for the inclusion of a psychiatrist within the crisis team and provision of a 24-hour service rather than reduced operating hours.²⁰³ In the West Suffolk county in 2006, a study on the impact of crisis resolution and home treatment teams has shown reduction of hospital admissions for older people by 31%, 6 months after its implementation.²⁰⁷ In contrast, a review by the Care Quality Commission in 2015 found that only 14% of adults surveyed felt they were provided with the right response when in crisis, and that only about half of community teams were able to offer an adequate 24/7 crisis service.²⁰⁸ However, this was not focused on elderly CRHTs.

Models of care used

There are a number of models within crisis teams. A large proportion of people seen are on a pre-emptive basis, these are people who appear to be at high risk of hospital admission in the near future unless they receive an intensive intervention.²⁰⁹

Stepped care applies to crisis teams, where only those who need this resource intensive treatment are treated by the team, and those whose needs are less are referred back to other lower intensity services.

4.4 France

4.4.1 Healthcare system in general

The French healthcare system provides universal acute and chronic healthcare mostly financed by governmental Statutory Health Insurance (SHI, *assurance maladie*). The general philosophy in France is the reduction of central control over policy and finance with the creation of the ARSs (Agence Régionale de Santé) in 2010.²¹⁰ The ARSs monitor the regional health status of the population, ensure that hygiene rules are respected, participate in prevention and patient health education and assess health professionals' education. They coordinate ambulatory and hospital care on the regional level through a regional strategic health plan (Plan stratégique régional de santé²¹⁰).

In France, registration by a GP is not compulsory, although there are financial incentives available to those that register. GP's act as gatekeepers to specialist care.²¹¹ If a patient is referred by a GP to specialist care then they can choose the specialist they see. For gynaecology, ophthalmology, psychiatry, and dental medicine, the patient does not need a referral from a GP. Approximately 36% of outpatient specialist care providers are self-employed and paid on a fee-for-service basis; the rest are either fully salaried by hospitals or have a mix of incomes.²¹¹

The role of informal carers is not officially recognized in France despite their crucial role in the management of frail people.²¹² In 2003, about 75% of dependent older people received care from a family member.²¹³ The majority of caregivers are women (62%, average age 58 years²¹³). The legal support



obligation (*obligation alimentaire*) stipulates that basic support for daily living is expected between members of a couple and for all ascendants and descendants. Eligibility for financial assistance in order to pay a salary to the informal carers of dependent people depends on his/her relationship with the person in need²¹⁰. Financial assistance cannot be used to pay a carer who is the spouse of the elderly person in receipt of personal autonomy allowance (*Allocation Personnalisée d'Autonomie*, APA) or disability compensation allowance (*Prestation de Compensation du Handicap*, PCH).

4.4.2 Demographics on elderly population

In 2011, the French aged population was near the European Union average, with about 16.9% of the population aged 65 and older, 8% of people over 75²¹⁰ and 5.5% over 80.²¹³ Over the next few decades, the share of the French population aged 65 and older is predicted to increase steadily, to reach about 25% in 2030 and nearly 30% in 2050.²¹⁴ The population aged over 75 years is expected to nearly double by 2050, representing 15.6% of the population.²¹⁰ The demographic weight of people aged 85 and older will rise even faster, increasing from about 1 million people in the mid-2000s to about 2.5 million in 2030.²¹⁴ However, in France, older people remain in better health than in many other countries.²¹⁰

4.4.3 Healthcare system for the older people

Reform specific for older people

The shock of the 2003 heat-wave combined with the reality of an ageing population has made care for vulnerable and frail elderly people a major concern for policy-makers in France. Two types of measures have been proposed: developing more services and improving coordination of health and social care services in light of this population's complex care needs, particularly for those with chronic diseases.²¹⁰

Since the mid 2000s, the plan "Solidarité grand âge" has been put in place with the aim of developing capacity in residential care but also in the home care setting in order to support the policy objective of "ageing in place" (*maintien à domicile*).²¹⁰

A project on the adaptation of the society to an ageing population called PAERPA (Personne Agée en Risque de Perte d'Autonomie) was introduced in 2014 as part of a two-step approach²¹⁰: a program of regional pilot projects which were aimed at improving care coordination between the sanitary, the social and the medico-social sectors through preventive and curative support²¹⁵ for frail people aged 75 and over and a plan for financing long-term care for frail elderly persons.²¹⁰ Financial incentives to improve care coordination by GPs are also being tested as part of regional pilot projects.²¹⁰ A more adapted use of drugs, scheduling of hospitalization, closer follow-up after hospital discharge and the avoidance of emergency admission are several examples of actions targeted by the PAERPA project.²¹⁶ The final objective is to maintain older people at home with an increasing quality of life for the elderly and their relatives, and to fight against the loss of autonomy through an adaptation of the professional practices.

Delivery of care for older people

Residential care for elderly people is provided by many types of institutions offering different levels of service.²¹⁰ These include collective housing facilities (foyers logements), nursing homes (EHPAD: établissements d'hébergement pour personnes âgées dépendantes), long-term care units (USLD: unite de soins de longue durée) which can be psychogeriatric wards, reinforced stay unit (UHR: Unité d'hébergement renforcée), specifically dedicated to people with neuro-cognitive disorders, and cognitive behavioural unit (UCC: unite cognitive-comportementale). There are important disparities in the distribution of these institutions. Some departments are also far better equipped than others, where capacity does not always match population needs.

In the early 2000s, intermediary services were created to provide short term accommodation for frail elderly people not living in residential services. Care is provided on a daily basis (*accueil de jour*) or on a temporary basis (*accueil temporaire*), with the main goals of offering respite care for families and day care for patients with Alzheimer's disease and other dementias.



Since 1981, SSIAD (service de soins infirmiers à domicile) units have been developed in the health and social care sector for disabled and frail elderly people. They are mainly staffed by salaried nursing auxiliaries, with nurses participating in the delivery of care to a lesser extent. Substantial geographical inequities of access to nursing care exist. Home nursing care includes support for ADLs (Activity of Daily Living) such as personal hygiene and eating. Prescribed home nursing care is fully covered by SHI.²¹³ First line medico-social practitioners are organised in gerontologic networks. There are more than 100 in France. Each of these includes GPs, SSIAD nurses, social workers, proximity hospital and paramedical workers.²¹⁷

The CLIC (Centres Locaux d'Information et de Coordination) welcome all people aged 60 and older, their relatives and their carers. They orient and help them through a personalized and free service in the aim of maintaining autonomy at home and giving advice on adapted structure for living.²¹⁷ The MAIA (méthode d'action pour l'intégration des services d'aide et de soins dans le champ de l'autonomie) group all the actors involved in the support of older people (60+) with a lack of autonomy. The MAIA aim to integrate services dedicated to care and social help. They are funded by CNSA.

4.4.4 Burden of mental health disorders in French older people

The number of people over 65 that died in France as a result of mental and behavioural disorders was 148.7 per 100,000 inhabitants in 2013.²¹⁸ Among those, 24.3 per 100,000 self-harm intentionally.²¹⁸ According to Eurostat, the proportion of people aged over 65 years with depressive symptoms is 12.2%. Among those 5.4% have major depressive symptoms. When focusing on the 75 years and over population, the proportion of people with depressive symptoms grows to 18.2%, of whom 8.3% have major depressive symptoms.²¹⁹ A study published in 2010, using data collected between 1999 and 2003 through the Mini International Neuropsychiatric Interview (MINI) tool to assess the prevalence of depression, anxiety, addiction and psychiatric disorders, concludes that the prevalence of elderly people in France with at least one disorder was 23.2% for those aged 65 to 74 years, and 22.9% for those 75 years old and above.²²⁰

Table 9 – Proportion of French population with mental health problem in 90's

	18-64 years	65-74 years	75+ years
detected disorder by the MINI	34.4%	23.2%	22.9%
Depression	11%	9%	11.3%
Suicide risk	9.5%	7.9%	14.2%
Anxiety	23.4%	15.9%	12.7%
Alcohol addiction	2.7%	1.1%	0.4%
Psychosis syndrome	3.1%	1.5%	1.1%

source: Giordana et al²²⁰

In 2003, the ESPRIT study has shown that, among 1,863 non-institutionalized people aged 65 or more, 14.2% had anxiety and 3.1% had major depression. In institutional care, the prevalence was more dramatic.²²¹ The DREES study (2006) showed that 85% of EHPAD residents were suffering from psychiatric conditions, highlighting the very common use of psychotropic drugs in this subpopulation.²²²

4.4.5 Organisation of mental healthcare

Reform of mental healthcare system

Similar to many other European countries, there has been a shift away from the institutionalised approach of mental healthcare. Community based services are now generally preferred.²¹⁰ Due to the deinstitutionalization policy that started in the 80s, most of the psychiatric care is in the community, with 77%²¹⁰ of patients in 2011 treated exclusively on an outpatient basis.



In 2011 and 2013, the official rules concerning the compulsory admission in psychiatric hospital were profoundly modified, allowing, amongst others, ambulatory not consented care instead of full time compulsory hospitalization. The observation period is now limited to 72 hours and a specific judge (juge des libertés et de la détention) controls the conditions and the reasons of not consented care.²²³ This procedure occurs when a patient presents mental health disorder without the ability to consent to care and with the need of immediate and close medical monitoring.

Delivery of mental healthcare

In France, the services for adult mentally ill people are provided by self-employed health professionals, private psychiatric hospitals or public mental healthcare areas (secteurs de soins de santé mentale). Public and private mental healthcare are funded by the SHI while the medico-social sector co-finances long-term care for the disabled and the elderly. The mental healthcare areas are each coordinated by a public hospital (in 90% of the cases²¹⁰) to provide both in-patient and out-patient services. Care is organized separately for adults and children.²¹⁰ In 2010, there were 857 adult mental healthcare areas throughout the country.²¹⁰ The size and resources of mental healthcare areas are quite heterogeneous.

Short-term services include, on the one hand for in-patient care, psychiatric hospitals and psychiatric beds in general hospital and, on the other hand for out-patient care, psychiatry care centres and face-to-face consultations. Mental healthcare areas (public sector) account for the major part of psychiatric beds.²²⁴ With 20 000 hospital beds in 2014, the private for-profit sector accounts also of a large part of the hospitalization capacity and is, therefore, an important actor in the field of mental healthcare.²²⁴ They accept patients with psychiatric disorders on the same basis as public hospitals.²¹⁰

Out-patients psychiatric ambulatory care centres (*centres médico-psychologiques, CMP*) are present in almost every mental healthcare area, providing primary ambulatory mental healthcare, including home visits, and directing patients towards appropriate services. CMPs include nurses, psychiatrists, psychologists and social workers.²¹⁷ Private for-profit hospitals are only marginally involved in outpatient treatment.²¹⁰ Day hospitals can also offer specialized assessment and care to older people with mental health problems.

A large number of psychological disorders are dealt with on an outpatient basis by GPs or private psychiatrists or psychologists, some of them practicing psychotherapy. In 2012, there were 12,400 psychiatrists in employment, the majority of whom (57%) were salaried doctors in hospitals; the rest were based in private and mixed practices. It is estimated that about 35 000 psychologists work in France, either as salaried employees or in private practice²¹⁰. People with mental disabilities also receive care and services from the health and social care sector for the disabled.²¹⁰

In France, national data on mental healthcare services include data on use, treatment, procedures, staff and structure. The indicators dealing with treatment of depression seem to be the most challenging in terms of data availability because these indicators require the ability to follow-up individual patients along a time period and this information is hardly recorded unless the patient can be individually identified.²²⁵ Mental morbidity aggregate and individual data are available for people who are followed in health centres. An elderly specific measure is also in use, the Health of the Nation Outcome Scales for Elderly People (HoNOS65+).¹⁸⁷ A new information system named “summary of medical information for psychiatry” (recueil d’informations médicalisées en psychiatrie) has been implemented, but the payment mechanism (valorisation de l’activité en psychiatrie) to support the data collection is not still implemented.²¹⁰

4.4.6 Mental healthcare system for older people

Reform specific for mental healthcare to older people

In 2004, the regional care organization bureau of the health and social affairs minister has written a decree which define the care to the elderly as a national priority. The integration of medical and social care, and an improvement of the mental healthcare provision for the elderly, in particular at home or in EHPAD were explained in details in the decree.²²⁶

The 2005-2008 Mental Health Plan dedicated 2 billion euros to old age psychiatry with the objective of meeting the needs of mental healthcare to older people in the aim of coordinating medico-social and sanitary cares. The plan focused on several domains of care: the establishment of good clinical practices and staff training in geriatric psychiatry, the EHPAD adaptation to better handle people with intellectual defect and the availability



of mental healthcare services adapted to the older people, at home, in general hospitals, in EHPAD or in psychiatric hospitals.²²⁷

Delivery of mental healthcare to older people

Older people with mental health conditions could be treated through two different channels: the geriatrics channel and the psychiatric channel but no rule exists to direct older people to one or the other type of service. Older people with mental health problems develop frailty status earlier than others of the same age without mental health problems, leading to a recent issue on the limit of age to enter a psychogeriatric ward²²⁸. The advantage of care in a psychogeriatric ward is the management of the very frequently associated organic health events. In contrary the disadvantage is the lack of care continuity after discharge from the hospital. A better coordination between the community mental health services and the geriatric sector would be a clear added-value to avoid re-admission.²²⁸ According to Prof. Limosin (old age psychiatrist), a psychogeriatric ward is an ambiguous term as it designates either a geriatric unit where the geriatricians delivers directly care to older people with psycho-behavioural disorders related to dementia, or old age psychiatry units where psychiatrists delivers care to older people with psychiatric disorders. Since the end of the 20th century, old age psychiatry was defined as the part of psychiatry which aims to detect, assess and manage all types of elderly psychiatric pathologies, including organic conditions and their consequences. But the official subspecialty of old age psychiatry in France is only recognized since 2017 with one year of additional training of the internship in psychiatry.²²⁹ The creation of this subspecialty aims to improve the care offer. And to increase the attractiveness for this domain of care in an attempt of a better viability of the services involved in older people mental healthcare. The function to supply by the new subspecialist in old age psychiatry are in mobile team, in therapeutic day hospital, in conventional wards and as referent adviser of hospital psychiatrists teams. A postgraduate training in geriatric was available for psychiatrists till 2017 but was now abolished since the creation of a full specialty in Geriatrics.²³⁰

Recently, specific teams and wards for older patients with mental health problems were developed. In example, at the "Centre Hospitalier Alpes-Isère (Grenoble), a psychiatry multidisciplinary team for older patients is set-up".²³¹ The old age team is set within a broader team including in-patient and out-patients centres, and adult and child psychiatry.

According to Cohen et al, the care provision in old age psychiatry suffers from important territorial disparities although the care should be based on three levels: the proximity level, the district level and the regional reference level. The proximity level should aim to improve the screening of mental health problems and the access of mental health structure through GP and medico-social teams. The district level should aim to coordinate the data and the procedure and should include psychiatrists, day hospital, mobile teams and beds in psychiatry units specifically dedicated to older people. The regional level should be a reference centre for training and teaching. The first regional reference centre was created in 2013 in Ile-de-France. In 2014, this above described global organisational scheme was not yet broadly implemented in France.²²²

4.4.7 Funding

Budgets corresponding to the targets for health and social care for the older people and disabled are under the control of the Caisse Nationale de Solidarité pour l'Autonomie (CNSA)/National Solidarity Fund for Autonomy²¹⁰ It is responsible for financial aid for older people, frail and disabled people. The fund is generated from the revenue of an unpaid working day of the French working population, and an additional solidarity and autonomy contribution which is 0.3% tax applied to retirement and disability pension income.²¹⁰

The CNSA funds a universal financial benefit called the Personal Allocation of Autonomy/Allocation Personnalisée d'Autonomie (APA)²¹⁰ and allocated budgets to ARSs (Agence Régionale de Santé). The ARSs allocate budgets to services depending on service capacities in their geographical areas²¹⁰ and provide the APA to people aged over 60 to finance long-term care such as domiciliary staff, home care devices or residential care. The APA is received whether the person is in a home or an institution.²¹² The amount given will depend on the income of the person and the degree of dependency as assessed by a joint health and social care team.²¹⁰ There



are other benefits which are determined based on income, such as help for cleaning or meals on wheels. Finally, people with low income may be entitled to a benefit from the local department (l'aide sociale à l'hébergement) to help them afford a nursing home, although there is no specific funding available to older people.²¹²

Funding of nursing homes (*EHPAD*) is currently obtained by three main sources: the SHI, which covers the cost of medical care (health cost); the APA, which covers the cost of personal care related to loss of autonomy (dependence cost); and the users, who mostly cover the cost of housing and feeding (hotel cost).^{210,212} On the household level, the out-of-pocket payment for care in residential care services is currently €1500 per month on average. The constant increase of this figure is a major concern for the government.²¹⁰

Usual fee is applied to care provided for mental illness by GPs and psychiatrists in private practice. The SHI finances it as it does for public mental health areas. People presenting with long term psychiatric conditions are fully covered.²¹⁰

Only about 10% of informal caregivers are paid in the context of APA. For combining care and work activities, employed family caregivers can take 3 months of unpaid leave to care for a dependent person. Lastly, specific tax reductions are also available to individuals who care for a dependent person.²¹³

In total, the estimated expenditure on mental health services in France was €16.6 billion in 2007.²¹⁰ Of this, €13.4 billion was associated with healthcare services and the remaining €3.2 billion for the health and social healthcare sector for the elderly and disabled.²¹⁰ In 2014, the budget was €8.6 billion for elderly care out of a total healthcare budget of €178.3 billion.²¹⁰ However, all patients in France, including older people, face some out of pocket costs as access to psychological therapy is paid for by the patient. Access is therefore affected by the patient's ability to pay.^{213;210}

4.4.8 Description of some case studies

4.4.8.1 Regional Resource Centre of Psychiatry for older People in Ile-de-France

The Regional Resource Centre of Psychiatry of Older People (Centre Ressource Régional de Psychiatrie du Sujet Agé, CRRPSA) takes place in the Corentin-Celton hospital area in west-Paris, under the direction of Pr. F. Limosin.²³² This new care pathway for the older people was created by the regional health agency (ARS) of Ile-de-France and constitutes a resource place for practical knowledge of old age psychiatry, a meeting point for first and second line caregivers and a centre of learning and improving competency in old age psychiatry. Their action is reinforced by a collaboration with psychiatric institutions and medico-social services working in Ile-de-France for older people.²³³

Their missions are:

- To assess complex cases through multidisciplinary consultations with staff including psychiatrists, psychologists, neuropsychologists, geriatricians and neurologists.
- To inform and communicate about old age psychiatric care provision in Ile-de-France, in particular for GPs and medico-social actors.
- To specifically analyse ethical questions like elderly care adherence and consent.
- To address elderly abuse.
- To lead epidemiological, clinical and basic science research in the field of old age psychiatry.
- To teach and train students and professionals in the framework of the Paris-Descartes University.

The care provision includes expert consultations for very complex psychiatric situations with behavioural, neuropsychological and personality check-ups and hospital wards for emergencies such as suicidal attempts, behavioural decompensation and elderly abuse; and telemedicine through two interactive web programs set up in 2016, TélPsyGé and TélGéria.²³⁴



TéléPsyGé allows EHPAD which are equipped by the appropriate device to get psychiatric advice for their residents and also allows healthcare professionals to hold multidisciplinary meetings. Talking therapies specially adapted for the older people are also provided in the in-patient and out-patient settings. In addition, the CCRPSA offers a mobile unit service called EMPSA 92 Sud (équipe mobile de psychiatrie du sujet âgé) which operates in 7 psychiatric sectors in the south of Hauts de Seine.

4.4.8.2 Geronto-psychiatric mobile team

Geronto-psychiatric mobile teams are a second line service for older people at home or in EHPAD. The main aim of this service is to maintain older people at home and avoid hospitalization. Their main function is the coordination of mental healthcare between GPs, relatives and psychiatric services in accordance with an active participation in direct care and a deep knowledge of the geronto-psychiatric domain. It does not aim to substitute first line services but to bring support for specific problems. A specialized nurse is the corner stone of the care, keeping the links with the patient and all the participants while a psychiatrist is always part of the team. The mobile teams are also deeply involved in training and teaching of the speciality in mental healthcare for the older people to social and medical professionals. As 70 to 80% of the patients present with somatic conditions in parallel with their mental health problem, the mobile team is often associated with a geriatrician. So, the psychiatric, socio-affective and somatic dimensions of the patient are all taking into account. The home becomes the place where the solutions are found and implemented. The number of interventions is usually limited, favouring a reorientation to the right in- or out-patient service instead of long-term interventions. The adherence of the patient, the relatives and the proximal caregiver is crucial. The mobile team is the most often requested at the demand of a medico-social professionals.

4.4.8.3 Therapeutic host families (France)

The service

Therapeutic host families (Accueil Familial Thérapeutique-AFT) services offer a way for patients with mental health to readapt to real life in a non-medicalized environment and to acquire new social skills through

spontaneous social and affective care provided by a selected host family. It is an alternative to psychiatric hospitalisation for mental healthcare.²³⁵ This is not specific for older people. According to Prof. Limosin, expert in old age psychiatry in Ile-de-France, older people with mental health problems are not the usual target population of AFT care. The therapeutic flat are also an alternative to therapeutic host families.²³⁶

The ATF service can be commissioned by any public hospital involved in mental healthcare, inside the psychiatric sector. A therapeutic care plan is made and can propose full- or part-time care in the host family. The specific needs of the patient are identified and filled through the family with the help of an external care team related to the hospital. This multidisciplinary team provides therapeutic support and controls host family according to the legal rules. The coordinating psychiatrist is responsible for the medical and technical care. People under forced hospitalization are not eligible for therapeutic host family care. People with paranoiac pathology, perverted functioning, instability or non-compliance are also excluded from this service.

The targeted patients are those for whom care in a stable familial environment could improve their capacity for human relationships and autonomy. The therapeutic host family service is well adapted either for patients with long lasting hospitalization (10 to 20 years) or for acute situations. There is an improvement in quality of life for the patient in comparison to long-term hospitalization.²³⁷

East Lille is one of the towns that has been experimenting with this approach. Referred patients are often in an acute situation and are sent to the host family either directly after a consultation, to avoid hospitalization, or secondarily after a hospitalisation to shorten it. Host families are instructed to just host the patient - their role is not to try to cure them,²³⁸ but the main hosted member of the family is trained to manage people with mental health problems. They work like salaried employees for a mental health institution²³⁵. A nurse and the social and medical team support the patient during home visits. These visits involve the management of any treatments, therapeutic activities and psychiatric consultations. Support is similar to that offered within the full-time hospitalisation unit located in hospital: medication



and therapeutic activities are carried out in the city in consultation centres and the towns' activity centres.^{235,238} In Lille, families are paid up to €1,036 per patient per month and are considered a key part of the psychiatry sector "team". They provide attention and support, both of which are considered important for patients. The host family in this way is considered therapeutic. The patient is helped through having the opportunity to embed themselves in the family's dynamics, complemented by the professional team. The average length of stay is 21 days.²³⁸

During the study days in Paris on the "AFT" in 2012^h, it was underlined that this effective service is not developed enough. Only 1000 to 2500 therapeutic host families exist in France. Currently the psychiatric sector have a decreased interest for this type of care service, except in the specialized centre of Ainay-le-Château which includes 200 host-families. Among the hosted patients in this large centre, one of them is aged 88 years and has been hosted for more than 40 years. But the actual tendency is to host younger people (18-30). A direct contact with the IPREP (Institut de Formation, de Recherche et d'Evaluation des Pratiques médico-sociales) confirms the 2012 tendency that AFT has been going downhill for several years.²³⁷

Models of care used

The use of therapeutic host families follows the indicated prevention model of care. The patients are considered high risk following hospitalisation for a mental health event. This service targets those who are identified as having detectable signs or symptoms foreshadowing mental disorder.

4.4.8.4 *Medico-psychological care centre for the elderly of Fleury-les-Aubrais (Loiret)*

The hospital centre Georges Daumezon has developed a specific provision of care for older people with psychological trouble called the medico-psychological care centre for the older people in Fleury-les-Aubrais. They offer support and consultation to the older people and their relatives through a multidisciplinary team including psychiatrists, nurses, administrative and

logistic support, psychologists, social workers and physiotherapists. The care provision is double, consisting of the medico-psychological centre activity with intervention at home or through medical consultation at the centre, and a day hospital where therapeutic activities are proposed. The objectives of the team is to respect the rights of the older people, to maintain them as long as possible at home, to help them to be as informed as possible so they can consent to their care plan, and to adapt the care, according to the expectation of the person, during ethical discussions within the multidisciplinary context.²³⁹

The team is mainly contacted by relatives. The older person often presents with one of three types of problems: psychological problems related to age such as mood disorders, anxiety, alcohol abuse, sleeping or food disorders which could be secondary to bereavement, loss of autonomy or other causes; psychiatric conditions such as psychosis or personality disturbance in people already known by psychiatric services who are getting older; and memory problems, mostly secondary to dementia. A real support and training is offered to institutional care team.²³⁹

The proposed care starts with phone contact with the older person and aims to collect all the information about the person's situation and clarify the request. If the older person consents to be helped, a visit is organized to their place of living. This is a time of observation, listening and getting the right tempo with the patient. After a multidisciplinary team clinical meeting, a personalized care plan is established. The interventions include medical consultations, nurse follow-up, social support, home care coordination and therapeutic activities in the day-hospital aiming for physical and mental stimulation to improve self-esteem, give some respite to relatives and break the social isolation.²³⁹

The medico-psychological care centre of Fleury-les-Aubrais is also widely involved in gerontologic networks with the goal of spreading its action in the geronto-psychiatric domain in particular inside the George Daumezon hospital, in EHPAD and with all services working to maintain the older people at home.²³⁹

^h <http://grefpa.fr/fr-article-103-168-302-0>



4.4.8.5 Old age psychiatric hospitals: example

The private geronto-psychiatric hospital of Rochebrune offers global care to people aged 60 and over, in collaboration with patients, professionals, carers and relatives with the objective of a return at home. Five psychiatrists, a neurologist and four geriatricians group their competencies to improve the treatment of the older people with mental health problems. The Rochebrune hospital includes a day hospital for follow-up and re-integration, a consultation service, a geriatric revalidation ward of 60 beds, and a short-stay geronto-psychiatric ward of 60 beds. The multidisciplinary staff include medical doctors, nurses, psychologists, neuropsychologists, pharmacists, an occupational therapist, speech therapist, dietician, social workers, physical therapist and coordinating nurse who can see people at home for follow-up.²⁴⁰ The statutory health insurance (SHI) covers the care in Rochebrune hospital in part or totally depending on each patient's social status.²⁴⁰

The private hospital centre Le Vinatier offers an in-patient and out-patient service for people aged 65 and older, presenting with mental health problems. A large panel of services are available: three hospital wards, a part-time therapeutic centre in the hospital, a day-hospital, an ambulatory centre of guidance, a geronto-psychiatric centre for families and a mobile team to evaluate the older people at home and orient them to the most appropriate service.²⁴¹

Besides private clinics, public hospitals also offer conventional old age psychiatry wards. In academic hospital, recourse can be found near experts about complex cases.

4.5 The Netherlands

4.5.1 Healthcare system in general

Since 2006, all Dutch citizens are compulsorily insured for curative healthcare under the Health Insurance Act providing a basic benefit package, including all GP-care, maternity care, hospital care, some allied healthcare, mental care and home nursing care.²⁴²

The Long-Term Care Act is strictly intended for the most vulnerable categories of people who require permanent supervision or 24-hour home care.

The Social Support Act and the Youth Act are implemented under the responsibility of the local authorities. They provide support, assistance or care services for those unable to secure it themselves. But people are encouraged to firstly draw on their own network and resources for support.²⁴³

The healthcare system is publicly funded. The insurance companies are obliged to offer a policy to any citizen, regardless of their current health status or known major health risks (e.g. AIDS, cancer or dementia). Insurance companies are compensated for excessive costs for these patients out of a national fund.

In the Netherlands, there is a shift of care to lower levels of specialization: from hospital care to GP care to practice nurse to self-care.²⁴² The GP is the central figure in Dutch primary care, in a gatekeeping position. Although registration with a GP is not formally required, most citizens are registered with one they have chosen, and patients can switch GPs without formal restriction. In the Netherlands there were over 11,300 GPs in 2014. Nearly 72% of practicing GPs worked in group practices. Many GPs employ nurses and primary care psychologists on salary. Reimbursement for the nurse is received by the GP, so any productivity gains that result from substituting a nurse for a doctor accrue to the GP. Almost 100% of the population can reach a GP within 15 minutes from their home. Given their key role in the healthcare system, quick and easy access to a GP is generally seen as very important.²⁴²



Referrals from a GP are required for hospital and specialist care. The doctor making the referral and the patient determine together the need for care and the necessity of treatment. The next step is to select a service from the available supply of health services. The healthcare provider selected by the patient discusses treatment options with the patient and provides the care required.²⁴³ In July 2014, there were 131 hospitals and 112 outpatient specialty clinics spread among 85 organizations, including eight university medical centres. Practically all organizations were private and non-profit.

Substitution and transfer of tasks from medical to nursing professionals is a relevant trend. In the mental healthcare sector this change has specifically been fed by the general de-institutionalization of mental care services, which requires more independently working nurses. In home care settings, this change is related to the fact that registered nurses (RN)s have additional tasks, for example regarding needs assessment, disease prevention and self-management support.²⁴²

The trend of increasing decentralization of healthcare and social services, especially those for older people and patients with chronic conditions, has created a more prominent role for the municipalities which partly transfer their charge of social support on the families and relatives. In 2012 approximately 1.5 million people (12% of the population) provided informal care to ill or disabled people. Although recent reforms envisage a more central role for informal carers in caring for the sick and disabled, financial compensation and facilities for carers are limited and have recently been reduced. Care duties are expected to be performed by family members and will not be covered by social insurance.²⁴⁴ The Netherlands bent on the self-reliance among citizens, in particular older people and their partners and relatives but a cultural change including a shift of values from government-centred to more family- and neighbourhood-centred is still required.²⁴²

4.5.2 Demographics on elderly population

The Netherlands has an ageing population and there are currently around 2.1 million people aged over 65 years (around 17.7% of the population in 2014²⁴²), with 5% aged over 80 years. It is expected that by 2050 the proportion of adults over the age of 80 in the Netherlands will increase to 10.2% of the total population.²⁴⁵

4.5.3 Healthcare system for the older people

Reform specific for older people

The decentralizing process of long-term care began with the introduction of the Social Support Act 2007. Part of domestic care and psychosocial support were transferred to the municipalities.²⁴²

In 2015, the long-term care reform fundamentally reorganized and definitely decentralized the major parts of long-term care. It was driven by sustainability. Home nursing, most personal care and mid-term mental healthcare are now also covered by the Health Insurance Act, while all support care and day care services have been delegated to the municipalities according to the Social Support Act extended in 2015. Municipalities must support people to live in their home situation for as long as possible. The basic principle of this decentralization is “local as far as possible; regional where necessary”. Only intensive care for vulnerable older people and disabled people is provided under the new Long-term Care Act which covers the care for persons who need 24 hours per day supervision (physically, medically or mentally). This care can be provided in residential/nursing homes, but also in the home of the patient (via the complete care package at home: *Volledig Pakket Thuis*). Home nursing is now included under the Health Insurance Act, moving closer to other types of primary care, such as general practitioner care. Health insurers become responsible for the whole medical domain, from home nursing care to specialist hospital care. Ideally, this would foster a better integration of care.

To improve integrated care for older people with complex care needs, the National Care for the Elderly programme was set up in 2007, allowing regional networks to experiment with models of integrated care delivery.²⁴² For example, developing regional programs for healthcare of older people, organizing care for specific needs of each individual in a cost-effective way, coordinating what the different providers in the healthcare system can offer to older people in a coherent way, boosting research into prevention and improving diagnostic tools for health problems in the elderly.²⁴⁶

Between 2008 and 2016, a total of 125 innovative approaches have been implemented. An example is U-CARE, which aims to improve the identification and monitoring of general practice patients aged 60 years and



older at high risk of developing frailty. It makes use of a software application to detect potentially frail patients. A multicomponent care programme integrating medical, social and home care is delivered by trained practice nurses. The programme has proven to result in less functional decline.

Delivery of care to older people

The long-term residential care sector for older people consists of nursing homes and residential homes. In 2009, there were 479 nursing homes, 1131 residential homes and 290 institutions combining both types. Residential homes provide housing care and support for those who cannot live independently, even with home care support. Nursing homes provide nursing and rehabilitation care to admitted patients, for example, psychogeriatric problems or after a stroke.²⁴²

Long-term care at home for patients who do not need 24-hour supervision is assessed and coordinated by district nurses who play a key role in keeping people in their homes. They will visit home nursing recipients and assess whether it is possible for them to be more self-reliant. District nurses assess the needs of their clients and coordinate the care between client, informal carers, GP, other healthcare professionals and social care professionals involved in the care for the client. They provide nursing care and personal care, such as dressing and bathing. Since 2015, nursing care is provided under the Health Insurance Act.²⁴²

Domestic care and social support are provided by home care organizations. Social support means that people with a (mental or physical) disability receive help in participating in society and in organizing their lives as well as the provision of medical aids (for example, wheelchairs) and home adjustments. Assessments of needs for domestic care and social support are mostly carried out by employees of the municipality. These assessments (frequently called “kitchen table dialogue”, *keukentafelgesprek*) first explore the options for support from the patients’ social network. Since the 2015 Social Support Act, domestic care funding has been under pressure. Some municipalities drastically reduced the hours of provided care, while others completely abolished domestic care.²⁴²

Rehabilitation and long term care are provided by nursing home physicians in the Dutch nursing homes. These physicians are actually the “GPs” for the nursing home residents providing mainly chronic care. Geriatricians provide consultation in nursing homes, but mainly work in acute hospital services.²⁴⁶

4.5.4 Burden of mental health disorders in the Netherlands

In the Netherlands, mental disorders represent the greatest burden of disease and one of the only groups of conditions with rising mortality rates in recent decades. In 2011 mental disorders (22%) contributed most to the burden of disease expressed in DALYs in the Netherlands, together with cardiovascular diseases (20%) and cancer (13%). The “top three” mental disorders are anxiety disorders, mood disorders and dementia.²⁴²

4.5.5 Organisation of mental healthcare

Reform of mental healthcare system

As early as 1998 the wish was formulated to integrate curative mental healthcare with medical specialist care and thus transfer its financing to the predecessor of the Health Insurance Act.²⁴² In 2008 the financing structure was fundamentally reformed. The first 365 days of mental health treatment became part of basic health insurance and are thus financed under the Health Insurance Act. The funding of preventive mental healthcare was transferred to the Social Support Act, which means that the responsibility for organizing this care was shifted to municipalities.

After significant overspending occurred in the mental healthcare sector, the Minister of Health introduced several measures to curb the growth. The National Agreement of the Future of Mental Healthcare in 2013/14 listed a number of actions to shift the provision of mental healthcare to a sustainable, acceptable and more community based approach.²⁴⁷ Priority axis were:

- Strengthening primary mental healthcare for common mental health disorders, including additional finance to general practice in order to reduce the number of patients in specialist mental healthcare by 20%.



- A shift from institutionalized care to community based care for those with severe mental health problems, reducing the number of beds by 30% by 2020.
- A programme to reduce stigma and facilitate social inclusion of people with mental disorders.
- A reduction of coercive measures.

Following this agreement, a reform of the mental healthcare sector in 2014 shifted mental healthcare out of secondary care into primary care and the community, and gave GPs and mental healthcare practice nurses a central role in providing mental healthcare. So far, this shift from specialist to generalist mental healthcare seems to have been successful, but has not resulted in lower costs. In addition, the Health Insurance Act will now cover the first three years of inpatient mental healthcare, before the Long-term Care Act takes over. Previously, it covered only the first year.²⁴²

The Long-Term Care Act applies to the vulnerable people in the society, such as older people in the serious stages of dementia, people with physical or intellectual disabilities, and people with long-term psychiatric disorders.²⁴²

Delivery of mental healthcare

The Dutch government has set up a system of frontline support by GPs, and primary and secondary mental healthcare. Outpatient treatment is always preferred for people with serious mental health problems. Admission – including involuntary admission – to a mental health institution must be a last resort.²⁴⁸

Since 2014 mental healthcare is organised in three segments²⁴²:

1. Patients first have to visit their GP with mental complaints. If feasible and no DSM-IV disorders are diagnosed, the GP will treat the patient with the help of a mental health practice nurse. In 2014 about 80% of GP practices employed a mental healthcare practice nurse. Efforts are made to resolve issues in general practice. It is estimated that 90% of mental health issues are dealt with in primary care.²⁴⁸

2. If the GP suspects a DSM-IV disorder, the patient is referred to the basic mental healthcare sector, which provides outpatient care for non-complex DSM-IV disorders. The basic mental care (level 2) is covered by the Health Insurance Act. No out-of-pocket payments are required for this care. Some treatment and disorders are not part of the basic benefits package and thus have to be wholly paid out-of-pocket. Mental healthcare provided in primary care includes counselling from a psychologist, psychotherapist, or geriatric specialist; online mental health support or a combination of these.
3. For complex disorders, patients are referred to specialized mental care, preferably in ambulatory care and if necessary in inpatient care. Whenever possible, the patient is referred back to the GP. Secondary mental healthcare, is given by a psychiatrist or a clinical psychologist working in a mental health institution.

Provision of mental healthcare in the Netherlands comes in many forms. Counselling, treatment and support is offered to people with mental health problems or psychiatric disorders, such as anxiety disorders, depression, addiction, aggression or schizophrenia. Some providers specialize in specific disorders whilst other large-scale institutions provide a variety of services in care pathways, usually offering prevention, primary mental healthcare, ambulatory care, acute hospital facilities and long-stay residential care.²⁴⁹

In 2013, the cabinet of Health, Welfare and Sport agreed to long-term funding of anonymous e-mental health. E-mental health is considered a cost-effective form of treatment. Online mental health support (e-health) may help in cases of mild mental or social problems such as depressed or anxious feelings, or problems in relationships at work or school. The online support can be anonymous since many people have difficulty admitting to their mental health problems.²⁴⁸

If a patient is in crisis, crisis services are available, although access to these is through a GP.²⁵⁰ In cases of acute depression, delusions, panic attacks, suicidal behaviour or acts of violence towards others, the GP has to be contacted immediately. If necessary, the GP will contact the local crisis intervention team (available 24/7).²⁴⁸ Each area has a crisis team available to patients during open hours and to GPs 24/7.²⁵¹



Regional mental healthcare (GGZ instellingen) centres were built between 1998 and 2000 in the Netherlands. Regional mental healthcare centre catchment area sizes vary from 80,000 to 400,000 inhabitants, and their capacities vary from 34 to 150 treatment spaces. As a starting point, regional mental healthcare centres have 'basic psychiatric functions', which means generalised, non-specialised outpatient treatment for adult and older patients with mental disorders (basis-GGZ), and a small part of the regional mental healthcare centres offer help to children, adolescents or patients with addictions (gespecialiseerde-GGZ). Eighty-seven percent of the regional mental healthcare centres have a mobile team and 24-hour care and three-quarters offer home-based care. Most regional mental healthcare centres are not situated near a general hospital.²⁵²

Treatment of serious and complex psychiatric disorders sometimes requires a patient to be admitted to a mental health institution. In 2014 the mental healthcare sector consisted of 114 institutions, 30 of which providing both inpatient and ambulatory mental healthcare. In 2012 the number of inpatient beds in the curative mental care sector (mental care covered by the Health Insurance Act) was 12,373. An admission to a mental health institution usually takes place voluntarily in close consultation with everyone concerned. A person who is a danger to himself or those around him can be admitted involuntarily (committed).^{242;248}

According to the Social Support Act 2015, the local authority is responsible for facilitating short stays, consisting only of board and lodging, in a mental health institution. These types of short stay may not exceed three days a week.

Some people with mental disorders or psychosocial problems in need of a safe and stable environment, live in supported accommodation (the GGZ-C package) to help them manage on a day-to-day basis.²⁴⁸

National level data collected to assess care includes mental morbidity aggregate and individual data, services utilisation data and treatment and procedures data.²²⁵ The Foundation for Benchmarking of Mental Healthcare (Stichting Benchmark GGZ) is involved in monitoring quality in mental healthcare. The foundation specifically aims at developing benchmark practices and helping health insurance companies to evaluate the quality of care. The foundation uses Routine Outcome Monitoring (ROM) data that is

either self-reported or observer assessed as well as data on coercive practices. Data collection is mandatory. ROM assessments are collected in one database from all mental health institutions nationwide. ROM is used to regularly measure the condition of people for the purpose of evaluation and possible adjustment of treatment.^{253, 254}

A first evaluation of the new mental healthcare system revealed that substitution from specialist to generalist care seems to have been successful. Fewer patients use specialist care, while the number of patients treated in GP practice or basic mental healthcare has increased.²⁴²

Improving performance is only possible if reliable and comparable information is available on both costs and quality of care. In the Netherlands, data is collected individually, analysed and reported nationally. For example, patient-reported outcomes facilitate shared decision-making during treatment and thus empower clients. A national benchmark institute (Trimbos institute) collects the anonymized data and publishes reports for stakeholders. Transparency on outcomes will act as change driver for motivated professionals and the market will drive innovation by rewarding organisations that perform better.²⁴⁷

The average expenditure on treatment for mental healthcare has increased now that it is provided as part of GP care. This is mainly explained by the fact that more GPs use the service of a mental healthcare practice nurse and charge a capitation fee for this care. Average treatment costs have also increased in basic and specialized mental healthcare. This may be explained by downward substitution (in other words, more severe cases have been treated compared to the former situation). The authors of the evaluation stress that conclusions have to be interpreted with caution, because of the short time since the introduction of the reform.²⁴²

4.5.6 Burden of mental health disorders in older people

In 2008, 15% of the older people had clinically relevant depressive symptoms in the Netherlands²⁵⁵. In a sample of 5,686 older people (55 years and over) attending GP practices in the Netherlands in 2005, major depression was found in 13.7% of patients and minor depression in 10.2%.²⁵⁶ There were 2% of men and 5.2% of women in the 65 to 75 years age group found to have generalised anxiety disorder, this slightly increased



for men in the 75 to 85 year age group (2.1%), and decreased for women (4.1%).²⁵⁷ The number of people over 65 that died in the Netherlands as a result of mental and behavioural disorders was 396.1 per 100,000 inhabitants in 2013.²¹⁸ The epidemic of Alzheimer's disease among older people is also a great challenge to both informal and professional care providers.²⁴² Between 2009 and 2012, 10% of the mental health treatments were delivered to the older people. Between 2008 and 2010, use of mental health service were under the population average for men and woman aged from 60 to 80 years.²⁵⁸

4.5.7 *Mental healthcare system for the older people*

Delivery of mental healthcare

Mental health (GGZ) institutions/regional centres may be specific to the older people. People aged 65 years and over with psychological and psychiatric problems are seen for diagnosis, treatment and counselling in GGZ centres. In some of those, care is separated for people between 60-80 years and 80+ years.²⁵⁹ Within the elderly psychiatry program, treatments are offered in the area of geriatric psychiatry, cognitive disorders and psycho-organic disorders. The mental disorders usually cared for in mental health institutions for the older people are dementia and memory problems; depression, manic depression and anxiety; psychosis; and personality disorder.²⁶⁰⁻²⁶¹ In mental health centres, care can be given at home, in day-care, in hospital, in out-patient clinics or in nursing homes, always after referral by a GP or another doctor. The first appointment is an intake call in which complaints and treatments are discussed. Afterwards, in one day, investigations are done by different professionals with the aim to establish a diagnosis. If people are not able to go to the hospital or outpatient clinic, the investigations can also be done at home. A treatment plan will be next decided in accordance with the patient wishes. This plan sets out the goals of treatment and how to achieve these goals. If there is a suspicion of memory problems (e.g. dementia or cognitive disorder), an intake procedure with other organisations will be agreed. Family or relatives, if possible, can be closely involved in the interview and the treatment plan.²⁶¹

Day-care is provided to older people with psychological problems to gain social contacts and to promote/maintain well-being. For example, in Bergen op Zoom, a meaningful structured day programme is offered in a safe environment, through various activities (internally and externally) in the areas of recreation, sports and games, education and relaxation.²⁶¹

For the recent training in old age psychiatry, a wide range of internships have been arranged for psychiatrist in collaboration with internal medicine and neurology practitioners.²⁶² In the same way of thinking for the future of mental healthcare of the older people, the training to become a geriatrician comprises a year of internship in old age psychiatry.²⁴⁶

Physicians who are trained in the "social management" of geriatric patients living in the community can assist the GPs. These physicians are employed by regional organisations for psychiatric treatment outside hospitals called community mental healthcare services. They treat problems of old age psychiatry and dementia of older people living in the community.

If older patients present with multiple issues (physical and psychological), they tend to be referred to general hospitals. In the Netherlands, they are assessed in the hospital but they are only admitted if they have mobility problems, inadequate support at home or specific nursing requirements. This reflects the focus that the Netherlands places on care in the community. If the patient is admitted, treatment is under the supervision of a clinical geriatrician.

Information on which older adults attend mental healthcare centres and whether they benefit from the care they receive is important for policy-makers. To assess this information in daily practice, the "Mental healthcare Monitor Older adults" (MEMO) was developed in the Netherlands for all patients referred to the division of old age psychiatry of participating mental healthcare organisations. Primary outcomes are mental and social functioning, consumer satisfaction, and type of treatment provided (MEMO Basic). Over the years, MEMO Basic is repeated. In each cycle, additional information on specific patient groups is added (e.g. mood disorders). Data collection is supported by a web-based system for clinicians, including direct feedback to monitor patients throughout treatment. First results at baseline showed that the majority of patients that entered the division of old age psychiatry were female (69%), had low education (83%), lived alone (53%),



were depressed (42%) and had a comorbid condition (82%). It seemed that older immigrants were not sufficiently reached²⁶³. The Geriatric Depression Scale (GDS-15) is used for older people assessment in the Netherlands.

4.5.8 Funding

Under the Health Insurance Act:

Under the Health Insurance Act, all insured persons together contribute to the total costs of all care. There are two major financial flows: *on the one hand*, all insured persons aged 18 and over, including the older people, pay a mandatory 'nominal' premium to their health insurer. These premiums average around EUR 1,200 a year. In addition, all individuals aged 18 and over also pay a mandatory policy excess of EUR 385 (amount for 2016). *On the other hand*, there is an income-dependent contribution, which is paid by the employer. This income dependent contribution ends up in the Health Insurance Fund along with the central government contribution for children and adolescents under the age of 18.²⁴³ The Health Insurance Act provides coverage for the first three years of mental health inpatient treatment²⁴², as well as for specialized mental healthcare for complex cases.

The payment for mental care providers for complex mental healthcare is based on the same system as curative hospital care. Treatment of the patient is categorized by the type of activity and the time spent on this activity and/or in days of stay for inpatient care in combination with the care intensity, varying from light to very intensive. The care is financed based on diagnosis and time spent in ranges. There are currently 140 DBCs (diagnostic related groups) for treatment and seven for accommodation. This provides strong incentives to treat patients for longer, without better treatment outcomes. Prices are calculated by the Dutch Healthcare Authority, based on cost data of a sample of providers.

Many lower-income people are entitled to a health insurance allowance, which is provided by the Tax and Customs Administration (i.e. the Dutch tax authorities). This can be used to cover a substantial portion of the premium, along with the policy excess.²⁴³

Under the Long-Term care Act:

The Long-Term Care Act is a statutory social insurance for which people pay an income-dependent premium through their payroll tax. The amount of the premium is based on a fixed percentage (9.65%) of the income tax. In addition, adults who wish to take advantage of healthcare services under the Long-Term Care Act pay a personal contribution which is also income-dependent. In this case, it matters whether the client lives at home or in a care facility, is younger or older than 65, and is single, married or has a domestic partner.²⁴³ The Long-Term Care Act provides funding for more vulnerable groups in society, including older people with more advanced stages of dementia.²⁴³

Health expenditure in 2014 for mental health, according to System of Health Accounts, is 1.1% of public expenditure on health, and 6.9% of total expenditure of health.²⁴²

4.5.9 Description of some case studies

Assertive Community Treatment for Older People

Assertive community treatment (ACT) was developed as an integrated model to meet the needs of difficult-to-engage patients with complex problems. Those patients are often high users of involuntary inpatient hospital services and unwilling to use mental health services. One group of patients who might benefit from ACT are older patients with severe mental illness because they are difficult to engage, have heterogeneous care needs, such as psychiatric as well as somatic problems, and have problems with activities of daily living, housing and social support.²⁶⁴ Compared to usual service, ACT offers assertive engagement, a small caseload (maximum of 10 patients per clinician); shared caseload (i.e. all clinicians collaborate closely for each patient using one treatment plan); and services on a time unlimited basis (24/7).²⁶⁴

The Assertive Community Treatment for the Elderly (ACTE) team described by Stobbe et al. is staffed by a substance-abuse specialist, a rehabilitation worker, a social worker, a psychiatric nurse, a nurse specialized in somatic care, a community mental health nurse and a psychiatrist (preferably with training in treating older people). A psychologist is included where possible.



The cut-off lower limit of age to receive ACTE care is not well defined but approximates to 60-65 years old. The avoidance of patients with moderate to severe cognitive impairment is recommended but this rule can be difficult to follow. The care manager is involved in the care at home as in usual treatment. The drop-out is often related to patients' refusal to open the door. In the study of Stobbe et al, ACTE succeeded better than usual care (classical in and out patient care) in engaging patients into care and in preventing dropout from treatment but ACTE did not produce better psychosocial functioning according to HoNOS65+, did not better met needs or did not decrease classical mental healthcare use. These results are in line with ACT for the working age population.²⁶⁴

Mental health nurses in General Practice

General practice in the Netherlands is responsible for providing many mental healthcare services. Over time there has been a shift towards care from GPs to Mental Health nurses (MHN). GPs usually work together with MHN and an average sized practice will have a MHN for approximately one day a week.²⁶⁵ MHNs are available to see adults of any age including the older people but some older people might not want to be treated by the MHN themselves.²⁶⁵ Larger group practices with multiple GPs might be able to collaborate with several MHNs with varying expertise, for example, in elderly mental healthcare.

Mental Health nurses are trained in nursing and receive some mental health specialist training. They will normally work on diagnosis to improve the quality of the referral to other mental health services. They may also deliver short-term care, such as counselling to patients with psychological symptoms or social problems.²⁶⁵ MHNs work under the supervision of the GP. Access to MHNs is through a GP, who will decide what the most appropriate care route for the patient might be. The GPs can also decide to treat patients themselves, or refer patients to specialized mental healthcare.

A study assessing the shift of management from GPs to MHNs found that increasing numbers of GPs collaborate with an MHN; between 2010 and 2014, the percentage of Dutch general practices with an MHN increased considerably from 20% to 83%.²⁶⁵ GPs working in practices with an MHN record as many consultations per patient as GPs without an MHN, but they record slightly more patients with psychological or social problems. MHNs

most often treat adult female patients with common psychological symptoms, such as depressive feelings.

The shift of care to nurses appears to have reduced the workload of GPs, improved the accessibility of care and reduced the number of patients who need referral to specialized care. Patients are generally satisfied when they receive care from nurses instead of from doctors. Nurses working in general practice is not more cost-effective than GPs as the patients visiting the MHN still need treatment in specialized care.²⁶⁵

The use of MHN within general practice uses a stepped care model.

In recent years, the functioning of MHC nurses in GP practices is extended with the function of practice-assistant (praktijkondersteuner - POH).²⁶⁶ This POH focuses specifically at the follow-up of people with chronic diseases (supervised by the GP). A distinction is made between follow up of somatic disorders (POH-S) and mental disorders (POH-GGZ).²⁶⁷ The role of POH-GGZ consists of screening and detection, development of individual care plans, psycho-education, promotion of self-management, short-running psychological interventions, indicated prevention activities and relapse prevention. Nurses, social assistants, social pedagogists, psychologists and orthopedagogists are allowed to take up this role (after a short training). Although the integration of the quite new function of the POH is successful in the Netherlands (partly due to the governmental financial incentives), there still remain some concerns and additional study is needed.

Het Nederlands Kenniscentrum Ouderenpsychiatrie (NKOP):

The Dutch knowledge centre of old age psychiatry is the central core of knowledge and questions exchange about psychological/psychiatric problems, between professionals involved in mental healthcare and aging including psychiatrists, psychologists, geriatricians, nurses, prevention workers, social workers, GPs and nursing auxiliaries. This institution aims to improve care quality of older people with mental health conditions through knowledge dissemination, transfer and exchange, development of new knowledge through practical research and integration of knowledge in practice through further training activities. It is a part of the Trimbos Institute program for the older people. Trimbos is the scientific institute of mental health and addiction in the Netherlands.²⁶⁸ This institute brings together



relevant organisations and works on improved collaboration, standards of care, and financial and political aspects of mental healthcare.²⁵⁴

Integrating Mental Healthcare into Residential Homes for older people

Integrating mental healthcare into residential homes for older people is a potentially effective model to address the complex care needs of older chronically mentally ill people. Depla et al analysed in 2003 six programs already operating in the Netherlands. At the administrative level, three types of cooperative arrangements existed: a psychiatric hospital renting a unit in a residential home for the older people, a psychiatric hospital stationing mental health professionals in a residential home on a permanent basis, and a residential home employing its own psychiatrically trained staff. At the operational level, contrasting views emerged on the relationship between physical and mental healthcare; these were delivered separately or in an integrated form. In either case, the employees trained as elder care workers or as psychiatric care workers had difficulties understanding each other because they held different ideas about good-quality of care. These care visions can be characterized as a care-giving approach (elder care workers) versus a problem-oriented and rehabilitation approaches (psychiatric care workers). At the housing level, two models existed: mentally ill patients having apartments in a separate unit (concentrated housing) or located throughout the facility (dispersed housing). Finally, the study concludes that the most promising model appears to be the one in which a psychiatric hospital assigns mental health professionals to work in a residential home, where they remain administratively and operationally distinct from the standard residential services. Whether or not the psychiatric residents should be housed in separate units could not be decided based on the study of Depla et al.²⁶⁹

Follow-up study shows that this kind of supported living in residential homes for older persons with chronic mental disorders does not automatically guarantee a better quality of life than in psychiatric hospital, particularly for patients with psychotic disorders.²⁶⁹

The centre for older people and neuropsychiatry of GGZ INGEEST

Within GGZ INGEEST, a mental health (GGZ) regional centre located in Amsterdam, special attention is paid to the vulnerable older people. Its main

aim is to overcome fears and depression in older age. Multiple physical and psychological complaints are taking into account and links to each other if appropriate. For example, many people with dementia suffer from depressive complaints, but not all people with depression have dementia. Importance is given to loneliness, boredom, financial difficulties and housing problems. The outpatient clinic is accessible for older people with complex needs including severe depression, severe anxiety, bipolar disorder, psychosis/schizophrenia, personality disorders and dementia in combination with behavioural problems.²⁷⁰

The service is available to people aged 60 and over but age is only an indication because admission is more about the ability of the team to help with patients' complaints. At GGZ INGEEST, the patient is involved in the treatment process. For example, the therapist will evaluate with them what kind of treatment is the best.²⁷⁰

The Centre offers innovative e-mental healthcare for the older people with severe psychiatric disorders in the community. They use a tablet as communication channel for support for medication, day care and remote treatment contacts with the effect of better and more effective forms of counselling and treatment.

GGZ INGEEST's Senior Psychiatry Division collaborates with the Department of Psychiatry, the Alzheimer Centre and the Internal Medicine Department of the Vrij Universiteit Medical Centre (VUmc).²⁶²

The projects are embedded at the scientific institutes of the VUmc. These departments have a tradition in the field of education and training of all disciplines focusing on the diagnosis and treatment of psychopathology in the elderly.

The network of hospital psychiatry VUmc has been awarded the TOPGGZ mark. It is the first time that the hallmark has been given to a network of psychiatric and somatic care, a collaboration between GGZ INGEEST and VUmc professionals.²⁷¹



4.6 Canada

4.6.1 Healthcare system in general

Canadian citizens are covered by health insurance that provides care regardless of medical history, personal income, or standard of living.²⁷² The healthcare system is publicly funded and the 13 provinces each have their own health insurance plans and systems, following guidelines set by the government.²⁷² Canada's Medicare system, established 50 years ago, deals largely with acute, episodic care.²⁷³ The Canada Health Act states that physician and hospital care deemed as medically necessary is to be provided to citizens without any out of pocket costs for those services. However each province or territory is able to decide what they feel to be essential and how services should be provided. This results in variation across the country. For example, payment for prescription drugs differs by province.²⁷⁴

There is no pan-Canadian standards of coverage for non-medicare health services but there are at least convergence on the funding for long-term care, provided by the provinces and territories; on pharmaceutical coverage for the older people and the very poor; and on the absence of public coverage for dental care and vision or for complementary and alternative medicine and therapies.²⁷⁴ Home care may not be covered under provincial health insurance. In this case, private insurance plan offsets such expense.²⁷²

Preventative care and medical treatments are provided through primary care services, hospitals, dental surgery and additional medical services. If a patient would be better treated by a specialized service then he is referred from his primary care provider.²⁷²

Roles and responsibilities for all general healthcare services are shared between provincial and territorial governments and the federal government.²⁷² The provincial and territorial governments manage, organise and deliver healthcare services, whilst the federal government sets national standards, provides funding and supports the delivery of services to specific groups such as inmates, eligible veterans and serving members of the Canadian forces.²⁷²

4.6.2 Demographics on elderly population

Canada has an aging population.²⁷⁵ The number of seniors in 2011 was 4.9 million, up from 4.3 million in 2006. For the first time, in 2014, there are more people aged 65 and older than there are children aged 0-14 year²⁷³. At present, 15% of Canadians are aged 65 or over, and this is expected to be nearly 25% by 2036.²⁷³ 89% of Canadian seniors were affected, in 2009, by at least one chronic condition.²⁷⁵ 24% of Canadians aged 65 and older had unmet home care needs in 2012.²⁷⁵ 7.9% of Canadian older people lived in collective dwellings in 2011.²⁷⁵

4.6.3 Healthcare system for older people

Reform specific for older people

No pan-Canadian strategy exists in Canada. But since 2015, the Canadian Medical Association (CMA) reports that the health of Canada's growing senior population needs a pan-Canadian strategy.²⁷³ It suggests that this strategy includes agreement on how seniors care is measured and delivered across the country, a focus on healthy aging, an improved integration of health and social services, and a support for family and other caregivers. The CMA insists that seniors care has to be a top public policy priority for governments in Canada. This call was supported by nearly 40,000 Canadians through a campaign.²⁷³

Some of CMA recommendations are²⁷³:

- improving seniors care.
- including increased support for home care and caregivers.
- increasing provincial and territorial governments' capacity to respond effectively to the needs of an aging population.

Those recommendations take place in parallel to initiatives at the national level like the "report on the State of Public Health in Canada 2010: Growing Older – Adding Life to Years" or the "National Seniors Council". But a broad pan-Canadian seniors' strategy is still missing in 2016.²⁷³



Delivery of care for older people

There is a patchwork of seniors care strategies across Canada encompassing healthy lifestyles, improving access to primary and home care, creating age-friendly communities and environments, and better palliative care²⁷³. Many strategies outlined the importance of home care in the aim to remain at home as long as possible (for example the PRISMA program in Québec). It also emphasized the access to home and community services, and support to informal caregivers through education and resources.²⁷³

Long Term Care can be provided in facility-based institutions or in the community and mainly targets older frail Canadians.²⁷⁴ A Statistics Canada study found that in 2012, 10% of the seniors aged 65 to 74 received help or care at home, 21% of those 75 to 84 and 45% of those 85 and older²⁷³. The providers of the LTC services can be provincial ministries of health or private services and accommodations.²⁷⁴ The variety of facility-based long-term care in Canada ranges from residential care with some assisted living services (usually under private funding) to chronic care facilities – which used to be called nursing homes – with 24-hour a day nursing supervision (usually publicly funded).²⁷⁴ Some indicators of the quality and the equity in access of LTC facilities show a need of improvement.²⁷³ Since long-term care is not insured under the Canada Health Act, long-term care beds can be in profit-making facilities or in not-for-profit facilities.²⁷⁴ “Currently in Canada, the majority of residents in these facilities have at least one psychiatric or cognitive disorder and, more often, a combination of both in addition to their medical problems. With reductions in the number of geriatric inpatient resources and, in some jurisdiction the closure of provincial psychiatric hospitals, residential facilities have become, de facto, longer-term mental health facilities.”²⁷⁶

Home care services provide assistance with Activities of Daily Living and with Instrumental Activities of Daily Living.²⁷⁶ An urban–rural divide exists in terms of the quality of home-support services with many more programmes in place for people living in large cities.²⁷⁴

In addition to home health services, many seniors need social supports: housing, meals, transportation, and activities to prevent isolation. The significance of these supports must not be minimized because their impact on overall health and wellbeing is important.²⁷³

Statistics Canada study found that, in 2012, 5.4 million Canadians provided care to a senior family member or friend.²⁷³ Caregivers provide more than 80% of care to seniors, and contribute more than \$5 billion of unpaid labour to the healthcare system^{277,276}. Each province and territory has its own policies for informal caregivers generally as part of the package of home care services. An urban–rural divide also exists in the support of informal caregivers with many more programmes in place for urban caregivers.²⁷⁴ Provincially, Nova Scotia is the only province to support financially for family caregivers with low-income while Manitoba is the only province to have legislation recognizing caregivers' role and to develop a framework for caregiver recognition and caregiver supports²⁷³. At the federal level, since 2002, some financial supports exist like the Family Caregiver Tax Credit, the Caregiver Tax Credit and the Compassionate Care Benefit.²⁷³⁻²⁷⁴

Primary healthcare providers, including GPs and hospital primary care clinics, provide preventive, diagnostic and therapeutic services.²⁷⁶ Ninety-eight percent of Canadian seniors have a regular GP. However, their ability to get a same-day or next-day appointment is low in comparison to other western countries. Canadian seniors are also more likely to use the emergency department.²⁷³

Geriatrics services serve elderly patients with complex medical, functional, and psychosocial needs. Canada counts 276 geriatricians²⁷³ but in-hospital seniors' services led by seniors care specialists are not sufficient.²⁷³ The CMA report suggest that “more care must be provided in the community to prevent avoidable emergency department use and avoidable admissions to hospital (often leading to long lengths of stay and ALC).”²⁷³

Alternate Level of Care (ALC) beds are often used in acute care hospitals to accommodate seniors, waiting for a place in home care, a rehabilitation facility, or a residential facility.²⁷³ 63% of the patients hospitalized in ALC beds had been diagnosed with dementia and have an average length of hospital stay of 380 days.²⁷³ “The Canadian system fails to prevent inappropriate hospitalizations because of a lack of appropriate home or



residential care in stable medical condition. Long hospital stays can lead to hospital-acquired delirium and hospital-acquired deconditioning²⁷³. The CMA report concludes that “effective strategies for reducing ALC rates will require an integrated approach across the spectrum of health and social services”²⁷³.

Medically necessary pharmaceuticals outside of hospital care is not covered under the Canada Health Act. However all provinces and territories set varying plan to support some level of drug coverage to Canadian seniors. After an income-test, the level of charges that are paid is determined and seniors pay for a small portion of the cost of their drugs while the province or the insurer pays the remainder.²⁷³ Even though, 9% of Canadian seniors report experiencing cost-related barriers to access medication.²⁷³

4.6.4 Burden of mental health disorders in Canada

In Canada 20% of Canadians suffer from mental health issues in any given year.²⁷⁸ In 2009-2010, 14.4% of Canadians received health services for a mental illness. The age-standardized prevalence rate of the use of health services for mental illness remained relatively stable since 1996/97²⁷⁸. In 2010, the Global Burden of Disease Study showed that mental and behavioural disorders account for 23% of years of life lost due to disability in Canada.²⁷⁸

4.6.5 Organisation of mental healthcare

Reform of mental healthcare system

Since 50 years, mental healthcare for patients with severe and chronic mental illness has moved from large psychiatric hospitals, in which patients resided for very long periods of time, to more episodic treatment in in- and out-patient psychiatric services. The “deinstitutionalization” that occurred in the sixties-seventies was triggered by the introduction of new pharmaceutical therapies.²⁷⁴

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology recommended in its report called “*Out of the Shadow at last: transforming mental health, mental illness and addiction services in Canada*” that a national commission develops a cross province policy for mental

health in Canada. This Mental Health Commission of Canada (MHCC) endorsed by all provinces and territories except Quebec.^{274,279} The report described a mental healthcare system characterized by fragmentation, lack of availability, and stigmatization.²⁷⁶

In 2009, after a broad consultation with Canadians who have lived experience of mental health problems and illnesses, their families and caregivers, service providers and planners, the MHCC published its goals in a document called “*Towards Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada*”.²⁸⁰ Those are:

- People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
- Mental health is promoted and mental problems and illness are prevented wherever possible.
- The mental health system responds to the diverse needs of all people in Canada.
- The role of families in promoting well-being and providing care is recognized, and their needs are supported.
- People have equitable and timely access to appropriate and effective programs, treatments, services, and supports that are seamlessly integrated around their needs.
- Actions are informed by best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
- People living with mental health problems and illness are fully included as valued members of society.

In 2012, the Mental Health Strategy for Canada called *Changing Directions, Changing Lives* reports that “the approach to recovery has been broadened to include the concept of well-being, so that, with some adaptations to the different stages of life, the principles of recovery can apply to everyone.”²⁷⁹



Delivery of mental healthcare

Treatment and supports for mental illness to Canadians are provided in GPs' and psychiatrists' offices, in psychiatric or general hospitals, in outpatient programs and clinics, and in community agencies.²⁷⁸ An emphasis on hospital-based treatment and a privileged position for doctors over other mental healthcare providers exists. The services provided by psychologists are paid out-of-pocket or through private insurance, or under salary in publicly funded organizations.^{211, 274}

GPs provide the majority of primary mental healthcare in Canada. The results of a recent study on GPs²⁸¹ revealed that 80% of them saw a least six patients a week with mental health problems. They were often frustrated with the quality of the care they gave to their patients. 60% of these GPs collaborate with other professions to manage their patients' mental health problems. The co-management with psychiatrists were particularly dissatisfied.²⁷⁴

The provinces and territories all provide a range of community mental health and addiction services. Crisis services are required in emergency situations and available 24 hours a day, 7 days a week. They offer screening for immediate needs through risk assessments and determine next steps for support.²⁷⁶ Outpatient clinics provide individual support, ongoing consultation, assessment, and treatment for people who lives with persistent mental illnesses, by appointment.²⁷⁶ Community Mental Health teams provide in a multidisciplinary practice, treatment, support and follow-up services. They also ensure the coordination between mental health, health and social services.²⁷⁶ Intensive community treatment and support multidisciplinary teams offer the same service but to people living with severe and persistent mental illnesses.²⁷⁶ Day hospital services offer more intensive levels of support than outpatient clinics. They are staffed by multidisciplinary teams and offer individualized and group support. They help to prevent or shorten psychiatric hospital admissions.²⁷⁶

Inpatient mental health settings are needed when detailed assessment, diagnostic workups, or acute treatment and medication management are required to minimize imminent risk for the safety of the patient or of others. In large acute care settings, consultation liaison services provide consultation in inpatient services (e.g. cardiology, orthopedics), to patients

who may have concurrent mental health problems that complicate their medical care.²⁷⁶

It is thought that only a third of people in Canada will look for treatment for their conditions due to the stigma of seeking mental healthcare.²⁷⁴ Sometimes the issue is not with stigma, but is with accessing effective services. According to Statistics Canada, in 2012 almost a third of Canadians who sought mental healthcare reported that their needs were not met or only partially met. A reported lack of access to GPs, psychiatrists and other healthcare providers contributes to this deficit. The Canadian Medical Association and the Canadian Psychiatric Association stated that much therefore still needs to be done to translate heightened awareness into improvements in service provision.²⁷⁴

4.6.6 Burden of mental health disorders in older people

6.6% of Canadian seniors reported in 2013 a mood disorder such as depression, bipolar disorder, mania or dysthymia.²⁷⁵ Substantial depressive symptoms affect an estimated 15% of seniors living in the community. Rates of depression are higher in long term care homes (up to 44%). Bipolar disorder likely affects less than 1% of older adults. Currently, men aged 80 and older are the group with the highest suicide rates in Canada.²⁷⁶

Anxiety affects at least 5-10 % of the group aged 65 and older, and induces the highest rate of hospitalizations for anxiety disorders comparing to the other age groups.²⁷⁶ Alcohol, illicit drugs and overuse of medications are common in later life with, for example, 6 to 10 percent of older adults have problems with alcohol.²⁷⁶

At the age of 60, the risk for dementia rates at 7%. At age 85, this rate increases to 33% for men and 46% for women. The behavioural and psychological symptoms of dementia (BPSD) affects up to 90% of persons with dementia during their illness.²⁷⁶ Delirium, a life-threatening disorder, affects nearly half of seniors admitted to hospitals for acute care. Mental health professionals assist in the management of the agitation and behavioural symptoms associated with delirium.²⁷⁶

The overall prevalence of persistent psychotic disorders in older people is 1-2 %. A small percentage of seniors could also experience psychotic disorders for the first time.²⁷⁶



4.6.7 Mental healthcare system for older people

Reform of mental healthcare system

In 2006, the “*Out of the shadow*” report from the Standing Senate Committee on Social Affairs, Science and Technology’s²⁸² investigates the state of mental health and mental illness in Canada. It highlighted the effect of ageism in Canadian society through, for example, the stigma of being older in addition to the stigma of mental illness. It also noticed the complex interactions between mental health problems, cognitive difficulties, and chronic physical illnesses.

In 2011, the MHCC Seniors Advisory Committee developed guidelines, presenting a model for a comprehensive, integrated mental health service system for older people, and a service benchmarks based on current evidence, guiding values and principles important to Canadian seniors (e.g., respect and dignity, self-determination, independence and choice for consumers), concepts of recovery, mental health promotion, and mental illness prevention.²⁷⁶ The MHCC identified several facilitators of a comprehensive mental health services: the academic centres through education; the cultural safety skill and awareness of the professionals for a complete communication with the minorities; diversity of seniors’ needs knowledge; the recognition of caregivers as vital partners in care; support for service providers in terms of means and competencies; intersectoral partnerships through collaborative or shared care; use of technology through electronic charts, telenursing and telepsychiatry; and, application of knowledge and evidence.²⁷⁶

The overarching key recommendations to transform a mental health service system for the older people in a comprehensive integrated one, are the followings:²⁷⁶

- Understand the diversity amongst seniors, the local context and resources, and consider the need to modify existing practices and relationships.
- Assess policies, programs and services that affect seniors with the Seniors Mental Health Policy Lens.²⁸³

- Embed mental health promotion in all policies, programs, and services for all older adults (with or without mental illness) and their caregivers, and encompass anti stigma strategies, public awareness, education, and training.
- Inform about the importance of early identification of symptoms of mental illness, prevention strategies and the hope for recovery and well-being.
- Oriented your system to recovery (hope, choice, empowerment) and to well-being for older adults living with mental illnesses.
- Provide access to community-based support services, primary care services, general mental health services and specialized seniors mental health services including specialized community and outreach services to residential care facilities as well as specialized geriatric psychiatry inpatient services.
- Use benchmarks to review existing services and staffing levels and to guide future allocation and deployment of resources.
- Embed cultural safety and diversity in structures, programs, policies and services.
- Consider caregivers as active partners in the journey towards recovery and well-being.
- Include training, education and support for caregivers and healthcare providers.

In 2012, the MHCC released its first major report setting out a mental health strategy, including specific measures for the elderly.²⁷⁴ Their elderly-specific recommendations were²⁷⁹:

- to counter the impact of age discrimination.
- to help older adults maintain good physical health and participate in activities and good relationships.
- to increase awareness of mental illnesses, dementia, elder abuse, and risk of suicide, and intervene when problems first appear.



Delivery of mental healthcare

In Canada, specific services for the elderly with mental health problems in Canada target the adults aged 65 and older. Exceptions to this age cut-off exist: some individuals in their 50s or early 60s age prematurely due to multiple and chronic health problems, developmental delay or early onset Alzheimer disease. Only 3% of older adults needs to access to clinical specialized geriatric mental health services. The guidelines developed in 2011 precise that the scope of mental illnesses cared in the specific services include Alzheimer's disease and age-related dementias.²⁷⁶ Even if a higher percentage of elderly consult for mental health problems compared to the younger population, none of the mental illnesses should be viewed as a consequence of ageing.²⁷⁶

Twenty-three types of services aiming to care older people with mental health problems were identified in Canada and listed in the guidelines report of 2011.²⁷⁶ There are organized in 4 categories. In the community based services and programs are grouped initiatives driven by senior with peer support, caregiver support, community support and supportive housing. In the primary care/front line services for seniors, there are the primary care providers (GPs), home care, adult day centres, counselling services and emergency care. The category of general mental health services includes crisis service, inpatient mental health services, outpatient clinics, community mental health teams, day hospital services, intensive community treatment and support, and consultation liaison services. The specialized seniors' mental health services involve geriatric mental health community and outreach services, geriatric psychiatry inpatient services, geriatric psychiatry day hospital, inpatient geriatric psychiatry consultation and liaison, residential or Long-Term Care facilities, behavioural support systems, specialized support emergency response and crisis services. All of those services are described in the guidelines report from the page 50 to the page 63.²⁷⁶

In Canada a number of elderly specific performance indicators are in use. These include the Geriatric Depression scale (GDS), Brief Assessment Schedule for the Elderly (BASDEC) and the Geriatric Mental State Schedule (GMSS).²²⁵

In 2011, Canada has 166 geriatric psychiatrists.²⁷³ Specialty advanced training program in geriatric psychiatry were developed and approved by the Canadian academy of geriatric psychiatry in 1994.²⁸⁴ In 2009, the Royal College of Physicians and Surgeons of Canada approved geriatric psychiatry as one of the few sub-specialities in psychiatry.²⁸⁴ A 2-year Royal College accredited program in geriatric psychiatry has to be successfully completed after the certification in psychiatry to be recognized as a geriatric Psychiatrist.²⁸⁵ In 2013, the Royal College began to provide a practical examination for sub-speciality designation in this area.²⁸⁴

4.6.8 Funding

The impact of mental health problems on Canada's healthcare system and economy is large. It is estimated that mental health problems cost Canada over \$50 billion per year, including healthcare costs, lost productivity and reductions in health-related quality of life.²⁷⁴ 9% of Canadian seniors spent \$2,000 or more out-of-pocket on services in a year compared to 0% in France and 2% in the UK.²⁷³

A recent publication of the C.D. Howe institute projects that, over the next 40 years, the annual total cost of long-term care will triple.²⁷³ In a highly integrated health systems, home-based care can be a cost-effective alternative to facility-based care.²⁷⁴ A better publicly funding of home care in Canada have shown to reduce the use of hospital services, to reduce reliance on informal caregivers and to increase self-perceived levels of health status.²⁷⁴

Private Health Insurance constitutes an important source of coverage of prescription drugs.²⁷⁴ Some coverage for mental healthcare and substance abuse treatment is also available under specific provincial programs.²⁷²



4.6.9 Description of some case studies

4.6.9.1 Geriatric Mental Health Outreach

The service

Geriatric Mental Health teams have a consultation, non-emergency treatment and follow-up function. They have specialized training in mental health and geriatric issues. They provide education and support to social community agencies, GPs, long-term and residential care homes, general mental health services, and family members, through mental health promotion and illness prevention. They offer a treatment in a time-limited frame for those who have severe, complex and/or persistent illnesses.²⁷⁶ They serve people 65 years and older.²⁸⁶

The service offers a comprehensive psychogeriatric assessment, psychoeducation, counselling and psychiatric treatment. The care are also available to patients with behavioural and psychological symptoms of dementia. Patients can be seen for most interventions at home.²⁸⁶

Geriatric Mental Health Outreach teams aim to enhance the mental health and well-being of individuals and reduce the need for psychiatric admissions and visits to hospital Emergency Departments. Physician referral is required for accessing the programme.²⁸⁶

In Long-Term Care homes, outcome evaluation of geriatric mental health outreach teams starts to show the cost-effectiveness of these services and the potential to reduce hospital admissions²⁸⁷.

Teams can vary from a two-person liaison team to multidisciplinary teams with up to 5 disciplines. In remote areas, the geriatric mental health team may be composed by a physician and a community nurse, in liaison with specialized geriatric mental health services through tele-health technology.²⁷⁶ Other health professionals needed for occasional consultation (pharmacists, neurologists, geriatricians, dieticians, lawyers and ethics consultants) should be available. GPs and community health service professionals are always involved.²⁷⁶

The report of the MHCC summarized in its 2012 report "Changing directions, Changing lives" the results of a study led in southwestern Alberta, in 2008-2009: "the most common reasons for referral to the geriatric mental health service were depression, bipolar disorder, schizophrenia, behavioural issues and anxiety. Referrals come from GPs, hospitals, psychiatrists, community mental health centres, home care services, palliative care teams, family members, police and self-referral. Within a year, 80 per cent of people referred were being contacted by the receiving agency within 72 hours, and 100 per cent were contacted within seven days. During a six-month period, 326 people participated in 16 formal education sessions and 311 people received informal education sessions".²⁷⁹

Models of care used

Similar to the outreach teams in England, the Geriatric Mental Health Outreach teams follow the stepped care model where care is delivered in increasing complexity, starting with the most effective yet least resource intensive and stepping up to more specialized services. According to the 2011 guidelines authors, they also use a shared-care or collaborative care model for their treatment and follow-up functions.

4.6.9.2 Geriatric Emergency Management Nurses

The service

Geriatric Emergency Medicine (GEM) is a specialized frailty focused nursing service based within Emergency departments. This service differs from the traditional nursing found in emergency units as the staff have a greater understanding of aging, geriatric symptoms and the most appropriate intervention and prevention strategies. GEM nurses help emergency departments to manage frail patients.²⁸⁸

GEM nurses focus their attention on elderly patients with complex medical, functional and/or psychosocial problems who are frail and most at risk of losing independence. Patients are usually aged 75 years or older with issues such as delirium, dementia or depression.²⁸⁸



Patients attending the emergency department are assessed using a risk screen. The score is intended to automatically trigger a referral to the GEM nurse. In the meantime, paramedic and emergency department staff can also ask GEM nurses to see older adults if they feel there is a need. Older patients and their family members might also ask for the GEM nurse to become involved.

A GEM assessment is a clinical conversation. The GEM nurse talks with the patient and sometimes their family or support persons, and conducts a geriatric assessment focussing on issues such as falls, delirium, dementia, depression, elder abuse, pressure ulcers, incontinence, malnutrition and functional decline. They also ask about how the patient's life has been over the weeks before their visit to the emergency department, any difficulties they are facing in maintaining their independence and any additional support they might need to maintain their health and well-being. There may also be physical assessments, based on the findings from the initial interview. Following the consultation the GEM nurse will prepare a list of recommendations and talk about the list with the patient and family. With their approval the GEM nurse will work towards the implementation of the recommendations, which may include further assessments by emergency department staff, referrals to other in-patient or out-patient services (such as specialized geriatric services), telephone liaison with home care or residential care providers, and finally communication with the patient's GP.²⁸⁸

Models of care used

Geriatric Emergency Medicine is a nursing service based within emergency departments following an indicated prevention model of care. GEM nurses help emergency departments to manage patients by performing assessments to focussing on geriatric issues and find out about difficulties in maintaining their independence. The patient may then be sent on to other services if specialized care is required.

4.6.9.3 Senior mental health behavioural inpatient program

Longer-term stabilization treatment unit are special units designed for behavioural support to care of older adults living with persistent mental illnesses or Behavioural and Psychological Symptoms of Dementia (BPSD).

There will be a growing need for this type of service. An ideal system of care would provide access to such behavioural support units in at least one of the local or regional residential care home, close to or in the patient's own community, allowing families and friends to participate appropriately in the care of their loved ones. These special units function to treat and stabilize residents with aggressive behaviours. These units offer acute or more intensive intervention with a flexible lengths of stays depending on progress on the behavioural goals. The aim of those specific unit is to give the opportunities to improve resident and staff safety and to reduce emergency department use.²⁷⁶

In Saint-Joseph healthcare in Hamilton (Ontario), the program includes formalized assessment and multidisciplinary care to promote and enhance the capabilities of the patient, in partnership with the caregivers. Depending of the care plan, therapies can be delivered every day to the patient. The clinical team also provides educational tools and emotional support to families. At discharge, the patient is referred to supportive outpatient programs such as Behavioural Supports of Ontario, Psychogeriatric Resource Consultants, or the Outreach Geriatrics Mental Health Team.²⁸⁹

4.6.9.4 Geriatric Psychiatry Day Hospital

In some academic centres, geriatric psychiatry day hospitals are an alternative to specialized inpatient care. Geriatric Psychiatry Day Hospital offer an ambulatory rehabilitation service providing the full interdisciplinary staffing. They also help recently discharged inpatients in their journey toward a full recovery, allowing to shorten the average length of stay in specialized units. The development of a specialized geriatric mental health component within an already existing geriatric day hospital may be considered.²⁷⁶

The Royal mental healthcare and research centre in Ottawa (Ontario) offers, among a large panel of services, the access to a Geriatric Psychiatry Day Hospital which provides day treatment and crisis intervention for seniors who require urgent and intensive treatment. But the condition is that the patient can live safely in the community. It provides assessment and individual and group treatment. The average length of stay for patients is approximately 12 to 16 weeks.²⁹⁰



4.6.9.5 The Canadian Academy of Geriatric Psychiatry

The Canadian academy of geriatric psychiatry promotes mental health in the Canadian population through the clinical, educational and research activities of its members. Its aims are: to promote and develop excellence in the practice of geriatric psychiatry; to maintain full association with general psychiatry; to promote and participate in educational programs; to support dissemination of scientific and clinical information in geriatric psychiatry; to promote research in geriatric psychiatry; and to collaborate with relevant organizations and governmental bodies in the development of mental healthcare resources for the Canadian elderly population.²⁸⁴ This academy supports and delivered education of students, residents and fellows in the field of older adults' mental health. It also develop curriculum guidelines for general training in geriatric psychiatry. It also rewarded specialist in Geriatric Psychiatry through 8 different distinctions; informed the population about through newsletters and website, and organized an annual scientific meeting.²⁸⁴

4.7 International comparison and transversal analysis of mental healthcare organization for the elderly between four foreign countries: England, France, The Netherlands and Canada:

4.7.1 Official priorities:

Official state priorities are rarely focused on mental healthcare for the older adults. More often it concerns either all the older people or all adults with mental health problems. England and Canada are more precise in their laws or programs for older people with mental health problems.

Table 10 – Official priorities about mental healthcare for the older adults in the twenty previous years

England	France	Canada
1999, 10 years program action to deliver higher quality services to older people including a standard for mental health.	2004, decree of the regional care organisation bureau of the health and social affairs minister set that the care to the elderly belongs to the national priority axis with a focus on the integration of medical and social care, and on an improvement of the mental healthcare provision for the older people, in particular at home or in EHPAD.	In 2006, the “ <i>Out of the shadow</i> ” report from the Standing Senate Committee on Social Affairs, Science and Technology’s led to the creation of the Mental Health Commission of Canada (MHCC) and highlighted the effect of ageism in Canadian society through, for example, the stigma of being older in addition to the stigma of mental illness. It also noticed the complex interactions between mental health problems, cognitive difficulties, and chronic physical illnesses.
The 2011 “No health without mental health” plan focuses on three points concerning the older people: the fight against age-related stigma, the depression screening and treatment, and the care for persons with dementia and their carers.	The 2005-2008 Mental Health Plan dedicated 2 billion euros to old age psychiatry with the objective of meeting the needs in mental health of the older people in the scope of coordinated medico-social and sanitary cares. The plan focused on several domains of care: the establishment of good clinical practice and staff training in old age psychiatry; the EHPAD adaptation to better handle people with intellectual defect; and the availability of mental healthcare services adapted to the older	In 2009, the MHCC published its goals in a document called “ <i>Towards Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada</i> ”. Example of one goal: “People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being”



	people, at home, in general hospitals, in EHPAD or in psychiatric hospitals.	
In 2013, the Joint Commissioning Panel for Mental Health has given ten key messages for commissioners in charge of older people's mental health services organisation (details below).	In 2017, the subspecialty in old age psychiatry is officially recognized.	In 2011, the Mental Health Commission of Canada (MHCC) Seniors Advisory Committee developed guidelines, presenting a model for a comprehensive, integrated mental health service system for older people, supported by 10 key recommendations (details below).
The Mental Health Taskforce recommended in 2016 that older people hospitalized in somatic healthcare services should have access to liaison mental health support, incentivized by new payments for these services.		<p>In 2012, the Mental Health Strategy for Canada called <i>Changing Directions, Changing Lives</i> reports that "the approach to recovery has been broadened to include the concept of well-being, so that, with some adaptations to the different stages of life, the principles of recovery can apply to everyone". It includes specific measures for the elderly:</p> <ul style="list-style-type: none"> • to counter the impact of age discrimination. • to help older adults maintain good physical health and participate in activities and good relationships. • to increase awareness of mental illnesses, dementia, elder abuse, and risk of suicide, and intervene when problems first appear.

According to the identified priorities, example of actions implemented by the countries are given here under.

- England NHS, with the help of Age UK, have led several campaigns to fight stigma and increase the number of older people treated in IAPT (Improving Access to Psychological Therapies) services.
- The ARS of Ile-de-France has recently implemented a regional old age psychiatric knowledge centre as requested in the mental health plan of 2005-2008.



4.7.2 Comparison of key recommendations for older adults' mental health services organisation:

Official guidelines were elaborated in England and Canada. They are addressed to commissioners in charge of older people's mental health services organisation in UK and to guide systems planners, government, policy makers, and program managers in Canada.

Table 11 – Key recommendations of official guidelines in England and Canada

England	Canada
Older people will form a larger proportion of the population.	The diversity amongst seniors, the local context and resources, and the need to modify existing practices and relationships must be understood to achieve a transformed system.
Older people's mental health services in particular benefit from an integrated approach with social care services.	Use the Seniors Mental Health Policy Lens ⁱ (MacCourt, 2008) to assess policies, programs and services that affect seniors.
Older people's mental health services need to work closely with primary care community services.	Mental health promotion for all older adults and their caregivers encompass anti stigma strategies, public awareness, education, and training.
Services must be commissioned on the basis of need and not age alone.	Be aware of the importance of early identification of symptoms of mental illness, prevention strategies and the hope for recovery and well-being.
Older people's mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia.	A transformed mental health system for older people is recovery oriented, supports caregivers and provides information to the public and service providers about the journey towards recovery (hope, choice, empowerment) and well-being.
Older people often have a combination of mental and physical health problems.	Provide access to the following range of services for the entire senior population: community-based support services, primary care services, general mental health services and specialized seniors mental health services (including specialized community and outreach services to residential care facilities, and specialized geriatric psychiatry inpatient services), with clear mechanisms in place to facilitate collaboration and access between services.
Older people's mental health services must be multidisciplinary.	Benchmarks should be used to review existing services and staffing levels and guide future allocation and deployment of resources, taking into account the size of the population, existing gaps in services and bottlenecks, as well as the priorities of the community.
Older people with mental health needs should have access to community crisis or home treatment services.	Cultural safety and diversity must be embedded in structures, programs, policies and services.

ⁱ The Seniors Mental Health Policy Lens, informed by evidence, is an analytical framework for determining the degree to which planned and current policies promote and support the mental health of seniors.



England	Canada
Older people with mental health needs respond well to psychological input.	Caregivers must be considered active partners, and their roles must be supported and valued in programs, policies and services.
Older people should have dedicated liaison services in acute hospitals.	Include training, education and support for caregivers and healthcare providers to increase their capacity to respond to the mental health needs of seniors.

4.7.3 Approaches to mental healthcare and mental health services for older people

All of the included countries have moved away from an institutionalized approach for mental healthcare in older people in favour of providing care in the community. Regarding older people, the shift to community is mainly used to avoid hospitalization (CRHT in England, mobile team in France, strict criteria for hospital admission in the Netherlands, geriatric mental health community and outreach teams in Canada). While in the Netherlands the shift of mental healthcare is quite recent, even for adults, in France and UK, a large part (77% in France) of the mental health problems is managed in the community. In Canada, despite a lot of provincial initiatives, the organization of the care is still centred on physicians and hospitals because of the Canada Health Act system.

Characteristics of care

Among the different countries analysed, the following mental healthcare characteristics have been identified in case studies. Some examples are given:

- *Models of care*: the following theoretical models of care are present in case studies: stepped care, intended prevention and collaborative care.
- *Role of psychotherapy* (not only psychotropic drugs as treatment): psychotherapies are an important part of mental healthcare in England and the Netherlands.
- *Patient and relatives empowerment*: this practice is well developed in the Netherlands and is highlighted in National Canadian guidelines on mental healthcare organization for seniors.
- *Care plan at home*: It is very common in all the countries.
- *Physical care aside mental healthcare*: this represents a major concern in the four countries. A lot of services take it into account: in England, the crisis team and elderly psychiatric outpatient and inpatient units; in the Netherlands, the day care and the GGZ centre; and in France, the mobile team, the day hospital and old age psychiatry wards. It is also an official priority for England and Canada. Mobility and sensory problems, frequent in older people, are also taking into account in IAPT services (England). Acute somatic conditions can be managed by psychiatric mobile teams for the older people such as in cases of delirium (England) and by geriatric emergency nurses in Canada. The CRRPSA's old age psychiatrists are trained to identify somatic problems among their patients.
- *E-healthcare*: It exists in England, France, the Netherlands and Canada at different steps of the care plan: screening (the Netherlands), treatment (all three), support for nursing homes (France), multidisciplinary meeting (France) or liaison with geriatric mental health mobile team (Canada).
- *Guided self-help*: It is reported in England (IAPT) and in the Netherlands (supervised by nurses).
- *Social rehabilitation*: It is present in the Netherlands (GGZ centre and day care), in England (day care), in France (AFT) and in Canada (geriatric psychiatric day hospital in academic centre).



- *Prevention*: It is under the responsibility of municipalities in the Netherlands. It is focused on older people but not specifically with mental health in France. It takes the form of campaigns run by charities in England to raise awareness and promote physical activity for prevention of mental illness. It is highlighted in the national guidelines for mental health services organization for seniors in Canada.
- *Multidisciplinary care*: multidisciplinary care is systematically evoked in almost all the services described in England and France. In the Netherlands, the GGZ centre regroups several disciplines around the older people but do not insist precisely on the term "multidisciplinary". In Canada, it is present in recommendations (strong evidence of effectiveness for community multidisciplinary teams) and in services (community and day hospital's geriatric mental health teams).
- *Care based on patient's needs*: Official authorities ask to fill this objective in England among IAPT and psychiatric wards. In the Netherlands, patients' needs are assessed by district nurse for social helps and by GPs for psycho-medical care. In France, AFT bases its care on patient needs to create a therapeutic plan with the host family. In Canada, the MHCC guidelines insists on a good knowledge in the diversity of seniors' needs.
- *Integrated care*: this type of care is very prominent in the Netherlands with the integration of psychiatric care in nursing homes, assertive community teams for the older people and even in the national program for the older people in 2007. It is expressed to a lesser extent in France, Canada and England.

Types of services

Many different types of services for older people with mental health problems exist among the analysed countries, sometimes in a unique representation. The services can be present in primary and secondary cares, in acute and long-term sectors, at home, in in- and out-hospital settings as well as in dementia and social domains. The table 1 shows different types of services: mental healthcare services for the older people are highlighted in bold, and global healthcare services related to ageing are in italic.


Table 12 – Type of services for older adults with mental health problems

	England	France	Netherlands	Canada
Primary care:	<ul style="list-style-type: none"> General Practitioner IAPT 	<ul style="list-style-type: none"> General Practitioner SSIAD Medico-psychological care centre (CMP) 	<ul style="list-style-type: none"> GP with help of mental health nurse or psychologist District nurse 	<ul style="list-style-type: none"> GPs hospital primary care clinics home care adult day centres counselling services
Secondary care:	<ul style="list-style-type: none"> Private face-to-face consultation with old-age psychiatrists Old age psychiatry inpatient and outpatient units Home treatment teams Crisis resolution services Community psychiatric nurses Community Mental Health Teams 	<ul style="list-style-type: none"> Expertise consultations for older adults with complex psychiatric conditions in in- and out-settings Psychiatry care centres Private face-to-face consultations with a <i>geriatrician</i> or a psychiatrist Geriatric-psychiatric mobile teams Hospital mental health centre offers specifically to elderly medical consultations, nurses follow-up, social support, home care coordination and therapeutic activities in the day-hospital 	<ul style="list-style-type: none"> Mental care centre based on the DSM-IV and under GP referral (Basic GGZ) Elderly outpatient clinic, accessible for the older people with complex, severe mental health problems (Secondary GGZ) Regional specialised mental healthcare centres including mobile team and 24-hour care Face-to-face consultation with old age psychiatrist or geriatrician 	<ul style="list-style-type: none"> outpatient mental health clinics community mental health teams geriatric mental health community services psychiatrists offices
Acute care:	<ul style="list-style-type: none"> Crisis Resolution and Home Treatment (CRHT) Older people's intensive home treatment service t Helplines for immediate assistance Emergency department 	<ul style="list-style-type: none"> Accueil Familial Thérapeutique Elderly mental health mobile team in collaboration with adult crisis team Emergency department Hospital wards for emergencies on old age psychiatry (CRRPSA) Cognitivo-behavioural units (UCC) 	<ul style="list-style-type: none"> Crisis services through GP referral 24-hour care in regional mental healthcare centres <i>Geriatric Emergency Management Nurses</i> 	<ul style="list-style-type: none"> <i>geriatric emergency nurses</i> Crisis services intensive community treatment and support teams behavioural support systems for elderly with mental disease, dementia or other neurological diseases



	England	France	Netherlands	Canada
Residential/long term sector:	<ul style="list-style-type: none"> Sheltered and supported accommodations Nursing homes 	<ul style="list-style-type: none"> Nursing home (EHPAD), Long-term care units (USLD), Reinforced stay unit (UHR). 	<ul style="list-style-type: none"> Residential homes (housing care and support) Nursing homes (nursing and rehabilitation care) Supported accommodation 	<ul style="list-style-type: none"> Nursing home Residential facilities with assisted living services Behavioural support units
Community Mental Health Care:	<ul style="list-style-type: none"> Older people's community mental health services Community Mental Health teams 	<ul style="list-style-type: none"> Medico-psychological care centre (CMP) 	<ul style="list-style-type: none"> Old-age GGZ centres for 65+ with psychological and/or psychiatric problems (secondary care always after referral by a GP or another doctor) GGZ centres with 'basic psychiatric functions' (basis-GGZ) Assertive Community Treatment for the Elderly (ACTE) 	<ul style="list-style-type: none"> Community mental health teams Geriatric mental health community and outreach services
Liaison at home/mobile team:	<ul style="list-style-type: none"> Mental health liaison service for older people (Pennine trust) Crisis Resolution and Home Treatment (CRHT) 	<ul style="list-style-type: none"> Old age psychiatric mobile teams Coordinating nurse from old age private psychiatric hospital Home care coordination from hospital mental health centre 	<ul style="list-style-type: none"> District nurse for long-term care at home for patients who do not need 24-hour supervision Three-quarters of GGZ centre offer home-based care The care manager of ACTE (Assertive Community Treatment for the Elderly) 	<ul style="list-style-type: none"> Geriatric mental health outreach services Intensive community treatment and support
Hospitalization:	<ul style="list-style-type: none"> Psychiatric hospital Acute general hospital Older adult psychiatric services should be the preferred model 	<ul style="list-style-type: none"> Psychiatric wards for older patients Hospital wards for emergencies in old age psychiatry Private old age psychiatric hospital 	<ul style="list-style-type: none"> Mental health institution including hospitalisation wards specific for the elderly General hospitals under the supervision of a clinical geriatrician 	<ul style="list-style-type: none"> Inpatient mental health services in psychiatric or general hospitals Psychiatric consultation liaison services Geriatric psychiatry inpatient services: acute (<1 month), medium-stay (<90days) and Long-stay (>90 days)



England	France	Netherlands	Canada
			<ul style="list-style-type: none"> Inpatient geriatric psychiatry consultation and liaison <i>Geriatrics wards in general hospitals</i>
Day hospital: <ul style="list-style-type: none"> Older people's Hospitals. 	Day <ul style="list-style-type: none"> Psychiatric day hospital in general or psychiatric hospitals. Therapeutic activities in the day-hospital of hospital mental health centre specifically to older people 	<ul style="list-style-type: none"> Day-care are provided to elderly people with psychological problems 	<ul style="list-style-type: none"> Day hospital mental health services Geriatric psychiatry day hospital in academic centre
Intermediary service:	<ul style="list-style-type: none"> In relation with dementia On a daily basis 	<ul style="list-style-type: none"> Facilitate short stays in mental health institution May not exceed three days a week 	<ul style="list-style-type: none"> <i>Alternate Level of Care</i> <i>Rehabilitation facilities</i>
Social care sector:	<ul style="list-style-type: none"> Take part in CRHTs, psychiatric hospital multidisciplinary teams, crisis resolution teams, assertive outreach teams and CMHT. 	<ul style="list-style-type: none"> Collaborate with psychiatric institution and with regional centre Hospital mental health centre" offers specifically to older people social support 	<ul style="list-style-type: none"> Social support are provided by home care organizations People with mental disability receive help in participating in society and in organizing their lives <i>Among the older people above the age of 80 years 23.5% received home care or social support</i>
Dementia services:	<ul style="list-style-type: none"> <i>Memory elderly-focused services</i> (Pennine Trust) 	<ul style="list-style-type: none"> Exist but more in a separate care pathway 	<ul style="list-style-type: none"> In GGZ centre Behavioural support systems for elderly with mental disease, dementia or other neurological diseases

In bold: services specific to mental healthcare to older people; in italic: services specific to elderly people, in normal: services of mental healthcare to adults including the older people. IAPT: Improving Access to Psychological Therapies; SSIAD: Service de soins infirmiers à domicile; CMP: Centres médico-psychologiques; GP: General Practitioner; DSMIV: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; GGZ: Geestelijk Gezondheid Zorg; CMHT: Community mental health teams; AFT: Accueil Familial Thérapeutique; EHPAD: Etablissements d'hébergement pour personnes âgées dépendantes; USLD: Unité de soins de longue durée; UHR: Unité d'hébergement renforcé; ACTE: Assertive Community Treatment for the Elderly; CRHT: Crisis Resolution and Home Treatment.



- Primary care:

In all countries, GPs are involved in first line management of mental healthcare to older people. *In the Netherlands*, mental healthcare shifted from secondary care into primary care. GPs, assisted by a mental health nurse or a psychologist, have a central role in providing mental healthcare and deal with 90% of the mental health issues in the all population. If a GP suspects a DSMIV disorder, the patient is referred to basic mental health services (basic GGZ). For people who needs at home supervision but not 24h long, district nurses in each municipality organized long-term care at home. *In England*, GPs look after the majority of older people with mental illness. Psychotherapy can be accessed first line through IAPT services which are not specific for older people even though they aim to increase the care of hard to reach groups like older people. *In France*, some CMP offer psychotherapy as part of first line care to older people but talking therapies specific to the older people are more common in third line centres (CRRPSA). *In Canada*, GPs provide the majority of primary mental health services but the co-management with psychiatrists is particularly dissatisfied.

- Secondary care:

Secondary mental healthcare are quite similar in all analysed countries. *In the Netherlands*, patients referred by their GPs to basic mental health service received care from psychologist, psychotherapist or, geriatrician including online mental health support. Basic GGZ centres offer generalised, non-specialised outpatient treatment for adult and older patients with mental disorders (level 2). The next level services called regional secondary mental healthcare, also based on the DSM-IV, is given by a psychiatrist or a clinical psychologist preferably in ambulatory care and if necessary in inpatient care (level 3). Elderly mental health clinics exist and are accessible for older people with complex, severe depression; complex, severe anxiety; bipolar disorder; psychosis/schizophrenia; personality disorders; and dementia in combination with behavioural problems. *In England*, second line care includes old age psychiatry expertise in in- and out-patient settings although an “ageless” wave is currently followed by the government. *In France*, psychiatry care centres can offer expertise consultations for older people with complex psychiatric situations. Geriatrician sector and psychiatric sector collaborate in the care of mental health problems to older people, for

example in old age-psychiatric mobile team. *In Canada*, the specialized seniors’ mental health services involve in-, out-, community and mobile geriatric mental health teams.

- Acute care:

Crisis teams exist in the four countries but teams specifically dedicated to older adults with acute mental health problems are quite rare. Acute care is well developed *in England* through CRHT (crisis resolution and home treatment) which are, in some places, specifically trained for mental healthcare to older people. *In France*, occasionally, elderly mobile teams collaborate with adult crisis teams. The French AFT organisation sometimes admit older people in acute mental health situations. Cognitive-behavioural units are also available in case of crisis. *In the Netherlands*, 87% of the regional GGZ centres have a mobile team and 24-hour care but crisis services are through GP’s referral. *In Canada*, geriatric emergency nurses take care of older people with mixed somatic, mental health and social problems in ED. In case of emergency at home, crisis team and intensive home care, although not specialized in seniors ‘care, are also available for seniors.

- At home liaison service:

Mental health at home liaison services for older people exists in the four countries. *In France*, following that the 2005-2008 Mental Health Plan asks for a better availability of mental healthcare services to older people at home or in EHPAD, some CMP have developed old age psychiatric mobile teams in which a specialized nurse acts as a care manager supervised by either a psychiatrist or a geriatrician. The latter takes part of the team because of the high frequency of somatic conditions. Old age psychiatric mobile teams’ intervention is usually limited in the time, favouring a reorientation to the right in- or out-patient service. An interesting concept was introduced by a private old age psychiatric hospital with a coordinating nurse following the discharged patient at home. *In the Netherlands*, three-quarters of GGZ centres offer home-based cares. The care manager of ACTE (Assertive Community Treatment for the Elderly) is involved in the care at home. *In England*, mental health liaison service for older people exist like in the Pennine Care NHS Foundation Trust (Pennine Trust). *In Canada*, geriatric mental health outreach teams share some of the characteristics of geriatric



medicine outreach teams with an additional training in old age mental health. They offer a consultation, non-emergency treatments and follow-up. They have specialized training in mental health and geriatric issues. They provide education and support to primary and long-term care providers. They offer a treatment in a time-limited frame for the older people who have severe, complex and/or persistent illnesses.

- Dementia service:

In the Netherlands, GGZ centres include dementia services. In England, memory clinics exist in some place but assessment and treatment of dementia are also done in community mental healthcare for older people. In France, there is a separate channel for dementia.

- Residential sector:

Residential sector is very well developed *in France* with specialized institutions according to the dependence level or the presence of behavioural problems (UHR). *In the Netherlands*, residential homes provide housing care and support for those who cannot live independently, even with home care support. Nursing homes provide rehabilitation care and supported accommodations to help people to manage their life on a day-to-day basis. But actually, the Netherlands long term institutions are falling down in favour of community long term care. The variety of facility-based long-term care *in Canada* ranges from residential care with some assisted living services to chronic care facilities – which used to be called nursing homes – with 24-hour a day nursing supervision. A lot of residents in nursing homes have at least one psychiatric or cognitive disorder or a combination of both in addition to their medical problems. In some Canadian regions, residential facilities have become, *de facto*, longer-term mental health facilities.

- Hospital:

When care cannot be delivered in the community, hospitalization in psychiatric hospitals or in psychiatric wards in general hospitals is available in all four countries. *In England*, admission criterion in wards for older people with mental health problems is to be aged 65 and older, to present organic or functional mental illness, and to not be possibly cared in the community. Admissions in old age psychiatric wards are facilitated by CMHT and crisis

teams' intervention. English older people can also be admitted in ageless wards but the NHS Taskforce noted in 2016 that old-age psychiatric services have to be favoured until the ageless psychiatric wards were able to fulfil older people needs. Older adult services should be the preferred model. In the Pennine Trust, the older people's RAID team addresses mental health needs of older people hospitalized for a physical illness. *In France*, following the 2005-2008 Plan, specific wards were developed for older people with mental health problems in general and psychiatric hospitals where psychiatrists, geriatricians and neurologists ideally collaborate with the aim of improving the care of the patients. An innovative third line centre offers wards for emergencies like suicidal attempts, behavioural decompensation and elderly abuse. *In the Netherlands*, the treatment of serious and complex psychiatric disorders sometimes requires a patient to be admitted to a mental health institution but official priority is reducing the number of beds by 30% in 2020. Mental health institutions may be specific to the older people. Older patients with multiple issues (physical and psychological) tend to be referred to general hospitals under the supervision of a clinical geriatrician. *In Canada*, acute inpatient mental health setting (<30 days) are needed when detailed assessment, diagnostic workups, or acute treatment and medication management are required. In large acute care settings, consultation liaison services provide consultation in inpatient services, to patients who may have concurrent mental health problems that complicate their medical care. A small number of medium-stay geriatric psychiatry inpatient services (<90 days) is considered by the guidelines 2011 authors as essential to the overall functioning of the system as vital back-up for the first line. Highly specialized and trained staff provides care to older people with behaviours or complex disorders referred from acute care mental health inpatient services and geriatric mental health community and outreach teams. Longer stay beds, also called rehabilitation beds (>90 days to years) admit patients with more than one psychiatric illness and several physical problems insufficiently treated in a medium stay specialized inpatient service.

- Community mental healthcare:

Community mental healthcare is well developed in England, France, Canada and the Netherlands with main centres delivering different types of care in out-patient clinics, at home, in day-care or in nursing homes. *In*



England, community mental healthcare is organised by CCGs and can deliver specific care to older people. *In France*, each mental healthcare areas have its CMP with some centres dedicated to older people. *In the Netherlands*, specialised GGZ centres provide diagnosis, treatment and counselling services to older people with psychological and/or psychiatric problems. Old age psychiatry targeted diseases include cognitive disorders and psycho-organic disorders. Focus are made on the best of optimal functioning. In parallel to specialised care, GGZ centres provide also 'basic psychiatric functions' (level 2-basis-ggz). Access to Dutch mental healthcare in community centres are always under referral by a GP or another doctor. *In Canada*, geriatric mental health community teams have specialized training in mental health and geriatric issues. They work to enhance the capacity of services to provide appropriate mental healthcare to older adults, particularly in rural and remote regions. Ambulatory consultations are less prevalent than at home services.

- Day hospital:

Day hospitals in England take care of older people to help them to continue a normal everyday life and hobbies. Day hospitals in France offer activities to maintain autonomy, follow-up and social life but also psychotherapeutic programmes. In the Netherlands, day-care are provided to older people with psychological problems to gain social contacts and to promote well-being. In Canada, geriatric psychiatry day hospitals are located in large academic centres. They provide an alternative to specialized inpatient care and a way to shorten the length of stay, by giving access to seniors to an ambulatory rehabilitation service after their discharge.

- Social support and intermediary services:

In the Netherlands, social support is provided by home care organisations to people with a (mental or physical) disability with the aim of helping them to participate in society and in organising their lives. Among the elderly above the age of 80 years, 23.5% received home care or social support. Local authorities are responsible for facilitating short stays in mental health institutions which may not exceed three days a week. *In France*, intermediary services are in relation to dementia and are organised on a daily basis. In Ile-de-France, the social sector collaborates with the psychiatric institutions through the Regional resource centre for old age

psychiatry. *In England*, social workers take part of CRHTs, psychiatric hospital multidisciplinary teams, crisis resolution teams, assertive outreach teams and CMHT. *In Canada*, social supports encompass housing, meals, transportation, and activities to prevent isolation. Their impact on overall health and wellbeing is important. Intermediary services are also named in Canada, alternate level of care. Those "acute" hospitals' beds are often used to accommodate seniors, waiting for a place in home care, a rehabilitation facility, or a residential facility.

Roles of caregivers

Among all those services, each caregiver assumes a specific role in the management of older people with mental health problems, varying from one country to another:

- General practitioner:

In all countries, GPs are in first-line and often in the position of secondary care gatekeepers. In the Netherlands care system, GPs are the central figure even if registration with a GP is not formally required. For mental health problems without DSM-IV disorders, the GP will treat the patient with the support of a mental health nurse (MHN) and can be assisted by physicians who are trained in the "social management" for geriatric patients living in the community. Large group practices with multiple GPs might be able to collaborate with several MHNs with varying expertise, for example, in elderly mental healthcare. GPs can also decide to treat patients themselves, or refer patients to specialized mental healthcare. In France, GPs although they can practice psychotherapies, are not a mandatory step of mental healthcare as psychiatrists are open to access without referral. In England, GPs are responsible for the mental well-being of older people either directly or by facilitating access to psychological services (referral to IAPT) or to secondary mental health services (CMHT). A study in Canada has shown that 80% of GPs saw a least six patients a week with mental health problems but they were often frustrated with the quality of the services they gave to their patients.



- Nurses:

Except in the Netherlands, specialized psychiatric nurses work mainly in secondary care (psychiatric hospitals, crisis resolution teams, assertive outreach teams, psychotherapy, and CMHT in England; CMP, mobile teams and AFT external teams in France; counselling services, liaison in-hospital team and geriatric psychiatry community and outreach team in Canada), ensuring that care plans are implemented and offering support. In addition, in England, highly trained nurses, including nurse prescribers, are taking on roles traditionally allocated to doctors. In the Netherlands, mental health nurses are available to see adults of any age including the older people in primary care settings. MHNs are trained in nursing and receive some training in mental health. They help with diagnosis and improve the quality of the referral to other mental health services. They deliver short-term care, such as counselling to patients with psychological symptoms or social problems. MHNs work under the supervision of a GP. Still in the Netherlands, district nurses play a key role in keeping people in their homes by visiting them, assessing their needs and coordinating the care between patient, informal carers, GP, other healthcare professionals and social care professionals. They provide nursing care and personal care, such as dressing and bathing. Dutch specialized psychiatric nurses can also take part in ACTE teams. In Canada, data from one of the author of the 2011 guidelines (Mrs Tourigny-Rivard) showed that geriatric mental health nurse-psychiatrist teams can induce a significant decrease of the rate of admission to hospital ²⁸⁷. Nurses are the preponderant professionals among geriatric mental health community and outreach teams.

- Psychologist:

Psychologists work sometimes in primary care like in England (IAPT) but mainly in secondary care. In England, they give specific, evidence-based talking therapies, where appropriate, in psychiatric hospitals, crisis resolution teams, assertive outreach teams and CMHTs. In France, they offer psychotherapies in CMP or old age psychiatric hospital or in private practice on an out-of-pocket payment basis. They also provide psychological support and follow-up in the context of social welfare provisions. In the Netherlands, psychologists offer an added value to ACTE and provide mental healthcare to patients with DSM-IV conditions in basic and secondary GGZ centre in GGZ institutions. In Canada, the services provided

by psychologists are paid out-of-pocket or through private insurance. They also could be under salary in counselling services or in specialized geriatric mental health community and outreach teams.

- Psychiatrists:

Psychiatrists work in secondary care following the referral of GPs or emergency services in England and in the Netherlands. Old age psychiatry training exists in England, the Netherlands, Canada and France. In England, psychiatrists work in psychiatric hospitals, crisis resolution teams, assertive outreach teams, CMHT and CRHT. In France, psychiatrists work in CMP and are part of mobile teams and of external teams in AFT. Private psychiatrists practice psychotherapies and collaborate with neurologists and geriatricians to improve the treatment to the older people with mental health problems among multidisciplinary teams. In the Netherlands, psychiatrists provide secondary mental healthcare to patients with DSM-IV conditions in collaboration with clinical psychologists in clinical institutions. In Canada, psychiatrists are required to work within the geriatric mental health outreach teams and in some hospitals for consultation, liaison (with the support of the general psychiatry inpatient services) and sometimes supervision of old age psychiatry beds. This specialized level of services is limited to a small proportion of the older adults who require psychiatric consultation.

- Social workers:

Social workers are present in primary and secondary care. In France they are involved in gerontologic networks but also in CMP and AFT external teams. In England, they ensure people are receiving any benefits they are entitled to, help with any accommodation issues as well as planning management, follow-up, discharge and practical help for social care needs. They are an integral part of CRHTs, psychiatric hospital multidisciplinary teams, crisis resolution teams, assertive outreach teams and CMHT. In the Netherlands, social workers take part in ACTE teams. In Canada, social workers are involved in consultation liaison services in hospitals and complex continuing care in primary care, counselling services and in specialized geriatric mental health community and outreach services.



- Occupational therapist:

Occupational therapists are involved in secondary care among multidisciplinary teams in psychiatric hospitals, crisis resolution teams, assertive outreach teams and CMHT in England; gerontologic network and old age psychiatric hospital in France; and in ACTE team in the Netherlands. Their role near older people in England is defined as risk assessment such as for falls, potential fire hazards, wandering and road safety, assessing the person's environment and need for aids, and developing the care program to help maximizing the independence and activities of daily living of the older people and to plan discharge from hospitals. This role is not specific to older people with mental health. In Canada, they are involved in complex continuing care after in-hospital discharge and in specialized geriatric mental health community and outreach services.

- Geriatricians:

Geriatricians are present in mental healthcare for the older people in France, Canada and the Netherlands. In France, they can take part of the multidisciplinary teams in old age psychiatric hospitals, in mobile teams and in third line centres. In the Netherlands, geriatricians work in basic GGZ centre in counselling older people with mental health problems after GP referral. They also practice consultation in nursing homes (revalidation centre) and provide care in acute hospital admission units in general hospitals. In Canada, geriatrician may be involved in care of older adults in specialized geriatric mental health community and outreach services.

4.7.4 Barriers to implementation of elderly services of mental healthcare

This part of the analysis is largely inspired from the EIU report.

Stigma on mental health and/or on the older people:

Stigma represents an important concern for all the countries and focuses either on age or on mental health conditions or on both. In the Netherlands, official strategy have been published to tackle it. In France, the creation of a specific subspecialty of old age psychiatry aims, among others, to struggle stigma. In Canada, It is thought that only a third of people in Canada will

seek treatment for their issues due to the stigma of seeking mental healthcare.

In England, stigmas were identified in the funding of the healthcare, among older people themselves and their families, and among care providers. Indeed, older people may be prevented from accessing psychological therapies because mental health problems may be perceived as a reaction to physical health problems or losses of old age (bereavements, poor health) and therefore undertreated. Of particular relevance, GPs may believe that sadness is part of ageing or that psychological therapies do not work for older people, and so prioritise referring younger people.²⁹¹

Many older people think that mental health issues such as depression and anxiety are a part of growing old, which prevents people seeking access as they do not see the benefit of treatment or do not know they could be treated with psychological therapies. Older people may also see mental health problems as shameful and something to be hidden.²⁹¹

Poor communications (not elderly specific)

In Canada, GPs collaborate with other professions to manage their patients' mental health problems but the co-management with psychiatrists is particularly dissatisfied.²⁸¹

In England, health professionals in CMHTs felt that there was inadequate provision of information technology resources, which had implications on information continuity.²⁹² Within secondary care, poor communication is a common issue with regard to integrated working, particularly between psychiatrists and GPs.²⁹³ When a community approach is introduced in health system, a better service could be delivered to patients if responsibilities are evenly distributed across the teams.²⁹⁴

Lack of experience and training of care teams

Programmes implementing Geriatric Emergency Management Nurses in the Netherlands faced a number of barriers because emergency department staff often lacked the knowledge, education, experience, and also interest in dealing with the complex needs of the older people²⁹⁵. Emergency department staff sometimes feels that the older people present challenging or time consuming issues.²⁹²



A study on the implementation of IAPT teams in England found that specialist mental health teams often lacked confidence in working with older people, especially if patients have physical health problems or social, economic or communication difficulties. IAPT professionals may also have concerns about their ability or skills to build therapeutic relationships with older people.²⁹¹

Lack of access to effective services

According to Statistics Canada, in 2012 almost a third of Canadians who sought mental healthcare reported that their needs were not met or only partially met. A reported lack of access to family physicians, psychiatrists and other healthcare providers contributes to this deficit. The Canadian Medical Association and Canadian Psychiatric Association stated that much therefore still needs to be done to translate heightened awareness into improvements in service provision.

Social isolation

Social isolation amongst the older people can also prevent access to psychological therapy services. The Health Survey for England in 2005 found that social isolation was common among older people in England, with 18% of men and 11% of women reporting a severe lack of social support from family or friends.

4.7.5 Potential ways to overcome these barriers

This part of the analysis is largely inspired from the EIU report (see appendix 4, available in a separated document on the same webpage).

Against “Stigma”:

The main barrier to implement services in mental healthcare is stigma attached to mental illness and ageing. This is probably the hardest barriers to overcome as there are so many factors involved. Different ethnic or age groups within the community, whether it be ethnic or age groups, can have very different views and ideas. In order to break down these barriers, each group should be targeted.²⁹¹ In England there have been many awareness

campaigns aiming to reduce stigma in the healthcare system and society in general.

In order to encourage people to seek help for their mental health issues, educational programmes may be put in place to reduce stigma and make people more aware that their symptoms are signs of illness and not of aging. Educational programmes to inform young people on ways to prevent mental illness could help to reduce the burden of disease in the future but this education can also reduce the stigma attached to mental illness occurring at all ages. For some people mental health issues are inevitable, allowing that easy access to care within the community is vital.

Against “Poor communications”:

Knowledge and resource centres are good examples on how to overcome poor communications between different settings of care. In the Netherlands, an old age psychiatry network is well developed on the national level through the Nederlands Kenniscentrum Ouderenpsychiatrie within the Trimbos Institute. Old age psychiatry networks are also emerging in France like the Regional Resource Centre of Psychiatry for older people in Ile-de-France. Also in France, numerous gerontologic networks in which medico-psychological care centres can be involved, insure the communication between the social field and the psycho-medical one.

On the patient level, each country has different methods of information integration across the different levels of care provision. These systems apply to all adults; there are no specific issues around information integration for older adults. In the Netherlands, integration of information systems is present across different levels of mental care provision and settings²²⁵. It is possible to track patients through their mental care pathway, though personal information is encrypted for privacy. This data is separated from physical health data information systems.

Multidisciplinary teams, already well implemented in old age care, are often reliant on an effective system using a shared patient registry, an integrated IT system, clinical protocols, and care conferences among the various professionals involved.



The best approach would be to have a highly integrated system to track patients throughout their entire mental health pathway and all of the countries could do more in this respect.

Against “lack of experience and interest of care teams”

In order to overcome the lack of experience and interest of care teams concerning the mental healthcare to older adults, it has been suggested to form partnerships between mental health professionals, geriatric medicine, emergency medicine and general practice to increase awareness of the needs of older adults and how to meet their needs. Assessing the skills, knowledge and attitudes of physicians and nursing staff within the emergency department and enhanced staff supports, such as the addition of a geriatric nurse clinician, could help break barriers.

Geriatrics involvement in mental healthcare for older people varies from one country to another. In England, geriatricians can be part of CMHT. In France, geriatricians are sometimes involved in old age psychiatric mobile teams. In the Netherlands, geriatricians are involved in the second step of primary mental healthcare after a referral of a GP and old age psychiatry wards exist in nursing homes. Still in the Netherlands, old age psychiatry programs are developed in GGZ centre and Geriatric Emergency Management Nurses were recently implemented. A further suggestion for long term improvement in care was to influence universities and colleges to incorporate formalized geriatric programs into emergency program curriculums.²⁹⁵

Finally, adopting best practices and educational tools developed by groups such as the Geriatric Emergency Medicine Task Force of the Society of Academic Emergency Medicine in the United States could also be of use.²⁹⁵

One of the strategies suggested to improve staffing issues in mental health teams in England was to put in place mechanisms to maximize recruitment and retention of staff and minimize workforce turnover.²⁹²

Training can also help to improve the interest and expertise of health care professionals in old age mental healthcare. In England, a subspecialty in old-age psychiatry exists since 1950 and the Royal College of Psychiatrists coordinates training, support and career development for old-age psychiatry. In Canada, the Canadian academy of geriatric psychiatry promotes mental health in the Canadian population through the clinical,

educational and research activities of its members. This academy supports and delivered education of students, residents and fellows in the field of seniors' mental health. It also develop curriculum guidelines for general training in geriatric psychiatry and rewarded specialist in Geriatric Psychiatry. It informed the population through newsletters and website and organized an annual scientific meeting.

Against “Financial disincentives”

Funding is complex and countries have a mixture of funding arrangements, also depending on the type of care and the setting. Provision of most mental health services is free at the point of care in three of the four countries; France has a different system whereby people are required to pay up front for their care and then a portion of this is reimbursed except for psychological therapy which is entirely paid out of pocket.

Local governments can play a part in optimising mental healthcare for the older people by making it a priority. Protected funding and policies can be put in place to provide a more accessible and better quality of care for the ageing population.

In the aim of proving the effectiveness of new programmes and helping at their implementation, performance indicators to assess mental healthcare in older people are used in the four countries. In England, mental health outcome measures include the GDS. An elderly specific measure is also in use in France and England, this is the Health of the Nation Outcome Scales for Elderly People (HoNOS65+).

In Canada, it was noticed that a highly integrated home-based care system can be a cost-effective alternative to a facility-based care system. A better publicly funding of home care have shown to reduce the use of hospital services, to reduce reliance on informal caregivers and to increase self-perceived levels of health status.



Key points

Generalities:

- Official state priorities are rarely focused on mental healthcare for the older people.
- Countries have partially moved away from an institutionalized approach to mental healthcare for the older people towards care in the community or at home/nursing home.
- The main difference between all adult and older adult services is that staff have more specialized knowledge of older people particularly on their increased likelihood of comorbidities and dementia.

Characteristics of care:

- Care plans at home are very common.
- Physical care within mental healthcare for the older people represents a major concern in each country.
- E-healthcare exists for the elderly in England, France and The Netherlands.
- Multidisciplinary teams are present in almost all the services described in England and France.
- Providing good quality psychological services rather than issuing medication is a key-point to reduce the risks of polypharmacy.

Types of services:

- In all countries, primary care is based on GPs in first line management of mental healthcare in the older people.
- Second line of mental healthcare is usually provided by a psychiatrist or a clinical psychologist.

- Acute services like crisis teams exist in each country and take care of older people but teams specifically dedicated to elderly mental health problems are quite scarce.
- There are specific old age psychiatry wards in 3 of the analysed countries.
- Community mental healthcare is available in England, France and The Netherlands with centres delivering mainly different types of care at home, in day-care, in- or out-patient clinics or in nursing homes and sometimes inside the hospital under liaison teams.

Roles of caregivers:

- In all countries, GPs are care gatekeepers for the access to the second line caregivers.
- Except in The Netherlands, specialized psychiatric nurses work mainly in secondary care. In The Netherlands, mental health nurses are available to see adults of any age including the older people in primary care settings.
- Psychologists work sometimes in primary care in England (IAPT) and The Netherlands (second step (level2) of primary care) and always in secondary care settings.
- Old age psychiatrists exist in England, The Netherlands and France.
- Social workers work in primary and secondary care.
- Geriatricians are present in mental healthcare for the older people in France, England and The Netherlands.

Barriers to implementation of elderly services of mental healthcare:



- **Stigma can be a particular issue in the older people and can concern ageing or mental health issues: GPs may believe that sadness is part of ageing or that psychological therapies do not work for older people; older people may also see mental health problems as shameful. Targeting each group of age or ethnicity, low-threshold service available, educational programs and awareness campaigns are used to overcome stigma.**
- **Poor communication between different caregivers is a common issue with regard to integrated working. National network in old age psychiatry, collaboration between social and psycho-medical fields, and highly integrated system are intervention of interest to fight against communication problems.**
- **Social isolation amongst the older people can prevent them accessing psychological therapy services.**
- **Emergency department staff often lack the knowledge, education, experience, and interest in dealing with the complex needs of the older people. To overcome the lack of experience of care team some interventions produced evidence of effectiveness, such as partnerships between geriatric medicine, emergency medicine and general and family practice in primary care, to introduce formalized geriatric training into program curriculums, and to maximize recruitment and retention of staff and minimize workforce turnover.**
- **Specialist mental health teams often lacked confidence in working with older people.**
- **There may be a financial disincentive for the care of older patients who tend to require more time due to the need for comprehensive assessments. To overcome financial disincentives, the following interventions may be considered: protected funding and policies put in place by government, use of specific elderly mental health instruments as a tool to guide initial management and to monitor progress and effectiveness.**

5 DESCRIPTION OF THE BELGIAN SITUATION

Responsibility for healthcare policy is shared between the federal government and federated entities.²⁹⁶

Federated entities include the communities [gemeenschappen – communautés] and the regions [gewesten – régions].²⁹⁷ At present there are three communities (The French Community, the Flemish Community and the German speaking Community) and three regions (the Brussels-Capital Region, the Flemish Region and the Walloon Region (which geographically also includes the German speaking community)). In the bilingual Brussels-Capital Region three commissions share responsibilities in different areas, including mental healthcare: the Flemish Community Commission ('Vlaamse Gemeenschapscommissie (VGC)'), the French Community Commission ('Commission communautaire française (COCOF)' and the Common community commission (Gemeenschappelijke Gemeenschapscommissie van Brussel-Hoofdstad (GGC) – Commission communautaire commune de Bruxelles-Capitale (COCOM).

The successive state reform operations and the resultant change in responsibilities regarding healthcare have significantly influenced mental health policy in Belgium, increased the complexity of the system and have directly influenced the financing of healthcare. There is a movement towards allowing federated authorities to build the organisation of the mental health system and they are also responsible for financing some services (e.g. community mental health centres (CGG – SSM)). The federal level remains responsible for the financing of general and psychiatric hospitals and for services included in the nomenclature (see the next chapter for more details). To keep this complex system workable, coordination is done by the 'Interministerial Conference on Public Health (Interministeriële conferentie volksgezondheid – Conférence interministérielle santé publique)' in which ministries from the different policy levels regularly gather.

The most recent 6th institutional state reform transferred a broad range of responsibilities to the communities concerning mental healthcare and care for older persons (including allowance for help for the elderly (Allocation d'aide aux personnes âgées (APA) – Tegemoetkoming voor hulp aan



(THAB)), isolated geriatric beds and the financing of residential care facilities for older persons.²⁹⁸ To ensure a smooth transfer, the Federal institutions temporarily continue organising and financing mental healthcare while the federated entities gradually incorporate their new responsibilities. The transfer of broad range of responsibilities regarding the organisation and financing of mental healthcare services will come into force from 1 January 2019 onwards. The following chapter provides an overview of the current situation (2017) mental health sector with an emphasis on the organisation of mental healthcare for elderly persons, to the extent data are available.

5.1 Aim and methods

The aim of this section is to describe the present situation of mental healthcare services for older persons in Belgium. Since most sources we used in this chapter do not include a unique patient identifier linkable to other sources, we do not provide a description of the care pathway of older patients with mental health problems and as such we did not analyse the diagnostic and situation of older patients in non-psychiatric hospital beds (e.g. geriatric beds (G-index)). The extensive work of Van Audenhove et al. (2009)³ on services that can be used by patients with dementia was used to assess whether specific services targeted older persons with isolated memory problems only, that fell outside of the scope of this report (i.e. memory clinics).

The description provided hereafter heavily relies on the findings of previous KCE reports^{9-12, 299, 300} and the report 'Organisation and financing of mental healthcare in Belgium'.⁴ Websites from insurance bodies, Governmental bodies and committees, legislative publications (e.g. Het Staatsblad – Le Moniteur Belge), websites and publications of care networks were screening to retrieve more recent information. Relevant databases were searched for concrete figures regarding mental healthcare in the elderly population. Further on, the database of the European Observatory on Health Systems and Policies, WHO and OECD was searched.

The analysis includes the use 'classical mental health services' by older patients: ^{4, 301, 302}.

- Psychiatric hospital (Psychiatrisch Ziekenhuis (PZ) – Hôpital Psychiatrique (HP)).
- Psychiatric service of general hospital (Psychiatrische Afdeling Algemeen Ziekenhuis (PAAZ) – Service Psychiatrique en Hôpital Général (SPHG)).
- Initiative for sheltered living (Initiatief Beschut Wonen (IBW) – Initiative d'Habitation Protégée (IHP)).
- Psychiatric care home (Psychiatrische verzorgingstehuis (PVT) – Maison de Soins Psychiatriques (MSP)).
- Community mental health service (Centrum voor Geestelijke Gezondheidszorg (CGG) – Service de Santé Mentale (SSM)).
- Psychiatric rehabilitation centres conventioned with National Institute for Health and Disability Insurance (RIZIV – INAMI).

In addition to the above mentioned structures, we presented the situation in residential nursing care facilities for the older adults and psychiatric annexes in prisons. In non-residential settings, we included an analysis of the role of psychiatrische zorg in the thuissituatie (PZT) – Soins Psychiatriques pour personnes séjournant à Domicile (SPAD), healthcare professionals (specialists and general practitioners) and a description of mental healthcare initiatives with a focus on older persons. In order to obtain more information on these specific initiatives 19 umbrella organizations and legal bodies were contacted by mail, to identify and describe 'innovative' projects for mental healthcare for the elderly. This yielded 17 responses with coordinates of 18 organizations. Two organizations did not fit the inclusion criteria as they belonged to the 'classic' mental healthcare organizations. Two other candidate project were found to be of the same project (old and new organization name). Based on the coordinates that were provided, we invited the 15 included organizations to complete an online survey to collect information about organizational goals, functioning and financing. After one month, a reminder was sent to the non-responders.



The chapter is structured as follows. First, a picture on the use of mental healthcare services by older adults is provided. Second, a closer look to specific care approaches for mental healthcare for the older persons in Belgium is added in order to have an overall vision of the current supply of services. Finally, a review KCE reports was done to highlight the evidence and recommendations in relation to the mental healthcare and the care for elderly.

5.2 The Belgian mental healthcare system today and the elderly

5.2.1 *In-hospital settings*

In Belgium, general hospitals can be categorised into acute, specialised (Sp) and geriatric hospitals (although geriatric hospitals could also be classified under specialised hospitals). Specialised hospitals provide chronic treatment and/or revalidation for different types of patients and multiple conditions (e.g. locomotive diseases and psycho-geriatric care). Geriatric hospitals encompass geriatric departments (G), only. Psychiatric hospitals are not considered a sub-category of general hospitals as they are exclusively designed for psychiatric care (see following section for brief description). Table 13 provides an overview of the psychiatric beds that can accommodate older adults in different hospital settings.

**Table 13 – Hospital bed types.**

Bed type	Target population	Type of hospital / service	Specific for older persons
Neuropsychiatric beds for observation and treatment, A <ul style="list-style-type: none"> Service A1 – day bed Service A2 – night bed 	Beds for neuropsychiatric observation and treatment of adult patients needing urgent care or active treatment. A1 and A2 beds correspond to day/night hospitalisation.	<ul style="list-style-type: none"> Psychiatric hospital Acute hospitals Specialised hospitals (between 2014 and 2016)^c 	No
Psychiatric beds for treatment^a, T <ul style="list-style-type: none"> Service T1 – day bed Service T2 – night bed 	Beds for neuropsychiatric treatment for an active social rehabilitation of adult patients. T1 and T2 beds correspond to day/night hospitalisation.	<ul style="list-style-type: none"> Psychiatric hospital Acute hospitals Specialised hospital 	No
Psychiatric beds for geriatric patients requiring neuro-psychiatric treatment, Tg	Tg beds are for geriatric patients requiring neuro-psychiatric treatment.	<ul style="list-style-type: none"> Psychiatric hospital 	Yes
Intensive treatment of psychiatric patients, I	Beds for intensive treatment of psychiatric young (less than 18 years) and adult patients (patients with greatly disturbed behaviour and aggressive patients).	<ul style="list-style-type: none"> Psychiatric hospital 	No
Specialised psychogeriatric beds, Sp(6^b)	Beds for psychogeriatric patients requiring a diagnostic or treatment by multidisciplinary team.	<ul style="list-style-type: none"> Psychiatric hospital Acute hospital Specialised hospitals/geriatric hospitals 	Yes

Source: Federal Public Service (FPS) Health, Food Chain Safety and Environment (2011)⁴. Neuropsychiatric beds (K) for children and adolescents and family placement beds are not included in the table. National Council of hospitals NRZV – CNEH (2009)^{303a} T-beds are only available in psychiatric hospitals, with the exception of limited number of beds in general hospitals in Wallonia. ^b The Sp index designates all rehabilitation beds, the index for psychogeriatric beds is Sp-6. In the text we will use Sp to designate psychogeriatric beds. ^c According to FPS data these beds were available in specialised hospitals between 2014-2016

5.2.1.1 Psychiatric hospitals

Target population: Psychiatric hospitals provide treatment and care for patients with severe psychiatric problems. Besides fulltime hospitalization for all patients regardless of their age, a psychiatric hospital can also offer ambulatory treatment, day- and night care. ⁴

Competence and financing: Federal authorities (SPF Public health and RIZIV – INAMI) are responsible for financing and programming of psychiatric hospitals. In general, hospitals receive their revenue from different sources.

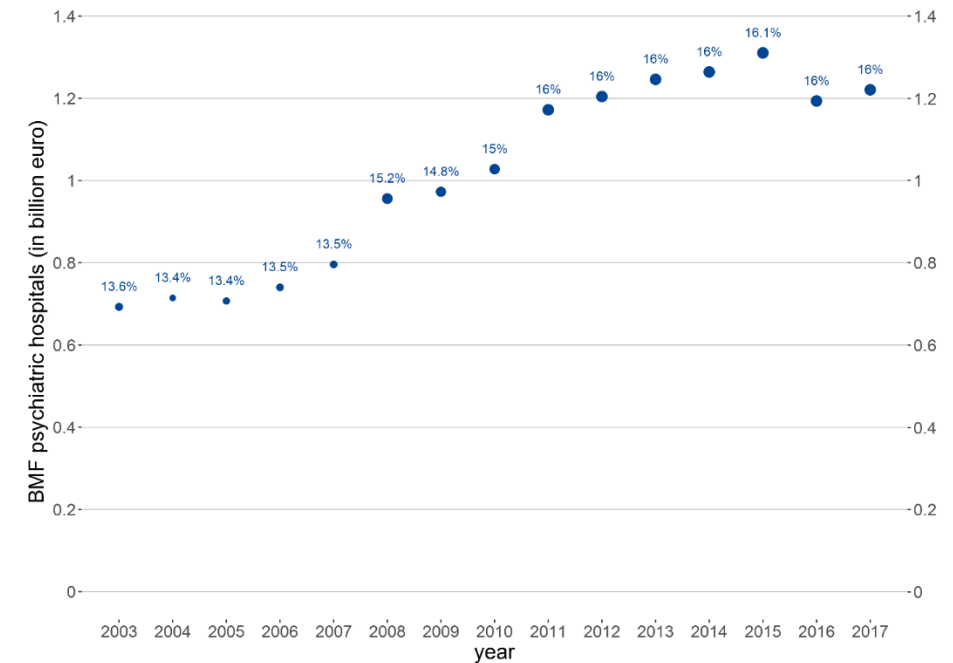
The two primary sources of public funding are a global budget, called the 'Budget of Financial Means (BFM)' and physician fees.³⁰⁴ The BFM is divided into different sub-budgets and is allocated to individual hospitals according to specific rules for each sub-budget. ⁴ Since the 6th state reform, the budget for infrastructure and investment from the BMF (part A1 and A3) and recognition norms are the responsibility of the federated authorities. The BMF B2 budget for psychiatric hospitals and psychiatric wards in general hospitals is allocated individually based on the number of recognised beds, the quotas of hospitalisation days and the occupancy rate. ⁴



The latter differs from the financing of acute hospitals and other hospital wards that receive a budget based on 'justified activities'.

The 'justified activity' of the hospital is based on the national average length of stay (LOS) per pathology group (All Patient. Refined Diagnosis Related Groups (APR-DRGs), which is then applied to the case-mix of each hospital.³⁰⁴ Patients pay a daily fee for a hospital stay that covers the cost of 'board and lodging' and of healthcare services with the exception of pharmaceuticals, physician's consultations and technical acts ('technische verstrekkingen' — 'prestations techniques'). The daily fee varies according to the patient's status (e.g. eligibility to increased reimbursement) and the length of stay. For inpatient pharmaceuticals, hospitalized patients pay a fix sum of € 0.62 per day independently of their pharmaceutical consumption.^{304, 305} Figure 21 shows the evolution of the BMF for psychiatric hospitals.

Figure 21 – BMF per year for psychiatric hospitals (percentages are the percentage of the total BMF).



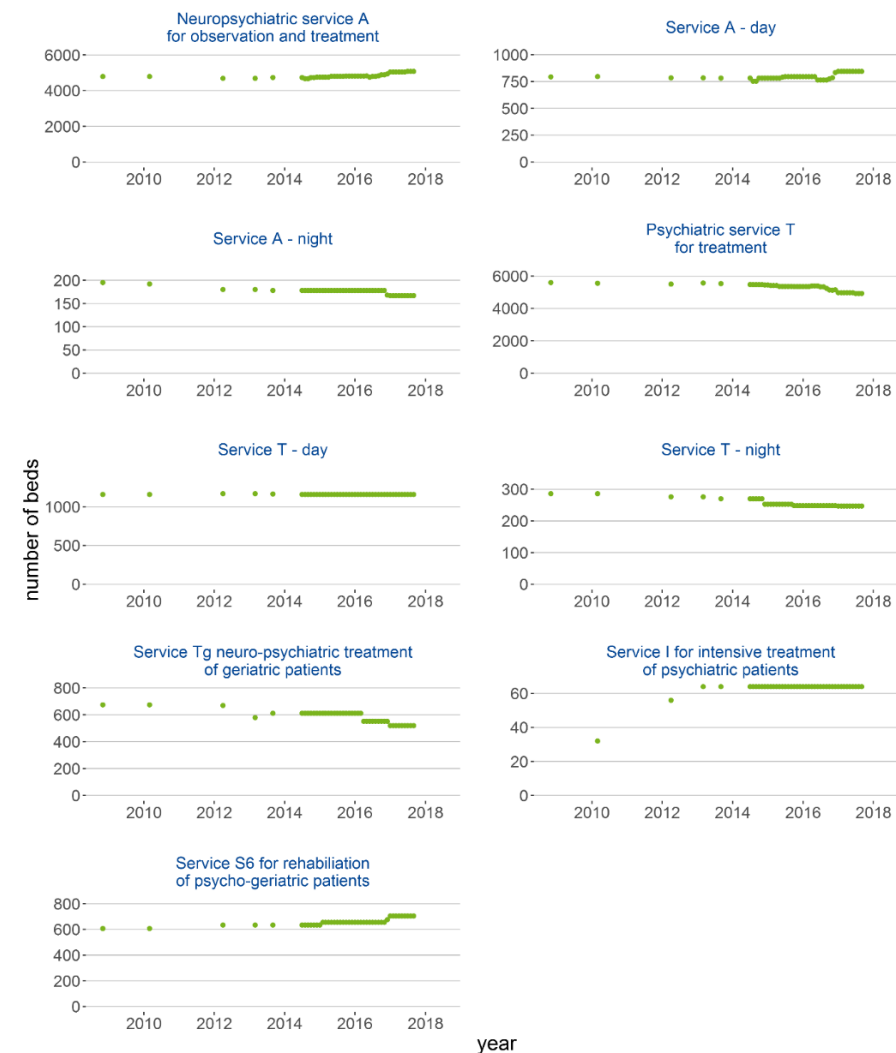
Source: Federal Public Service (FPS) Health, Food Chain Safety and Environment



Numbers: Due to the reconversion operation into alternative residential or ambulatory care options for persons with mental healthcare disorders, bed capacity in psychiatric hospitals has evolved towards a higher availability of A and A1 – beds and fewer T and A2– night beds (see Figure 22). There is, however, a relatively stable evolution of the number of different bed types since the mid 2000s (see Figure 22 and Figure 23). The geographical location of the different bed types is shown in Figure 24.

In September 2017, psychiatric hospitals had 14 927 recognized beds (10 012 in Flanders, 4 085 in Wallonia and 830 beds in Brussels). The majority of beds (42.7%) are T-beds. T-beds are intended for the neuro-psychiatric treatment of adult patients with a chronic disorder that need a short or medium-long hospital stay. Another type, the A-beds (40.5%), are meant to be used for observation and treatment of adults in a crisis situation for whom an emergency admission is needed or for persons who need an observation or treatment with a short or medium-long hospital stay. Although the map shows clear differences at the different geographical levels, we did not dispose of further information to meaningfully interpret these differences.

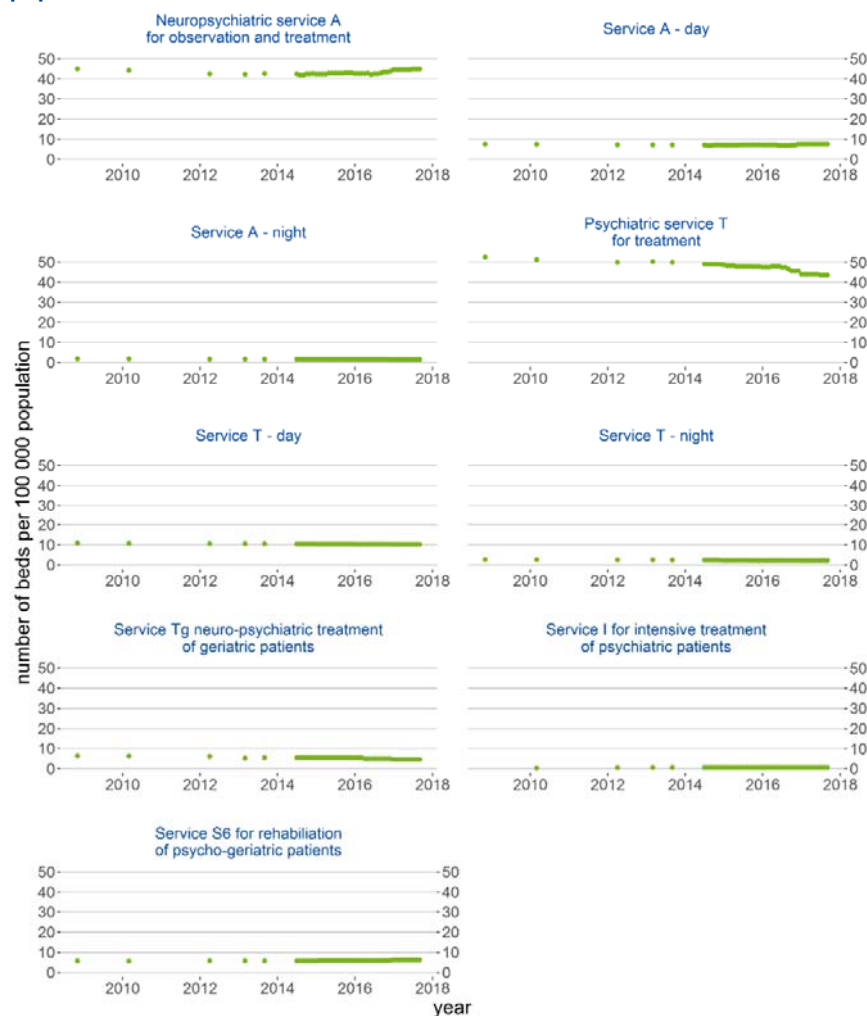
Figure 22 – Evolution of recognized beds in psychiatric hospitals.



Source: FPS Health, Food Chain Safety and Environment (since July 2014, monthly updates are available for hospital characteristics).

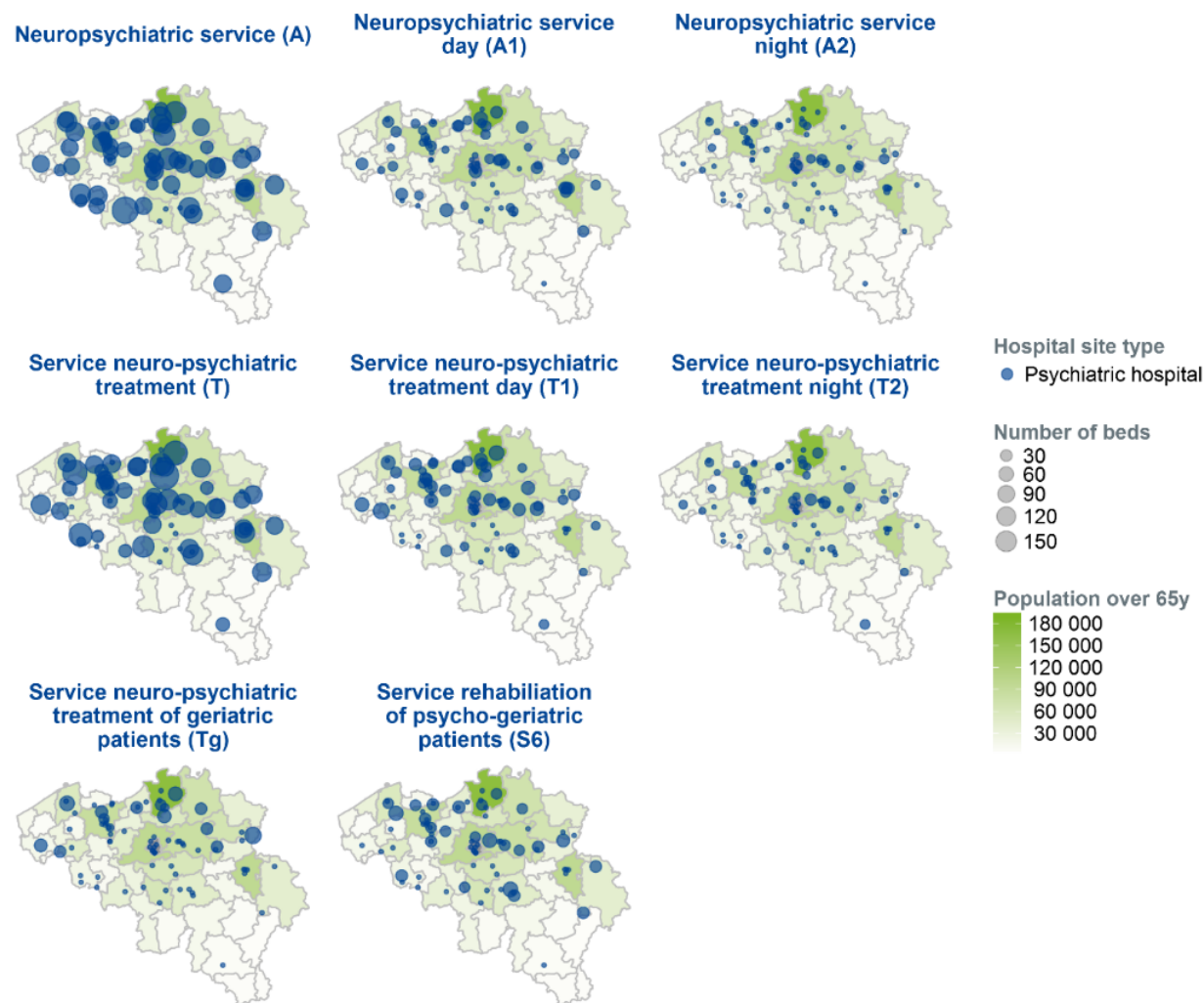


Figure 23 – Evolution of recognized beds in psychiatric hospitals per 100 000 population.



Source: FPS Health, Food Chain Safety and Environment (since July 2014, monthly updates are available for hospital characteristics); Statistics Belgium: Belgian population 2008-2017.

Figure 24 – Geographical distribution of the number of beds in psychiatric hospitals in September 2017



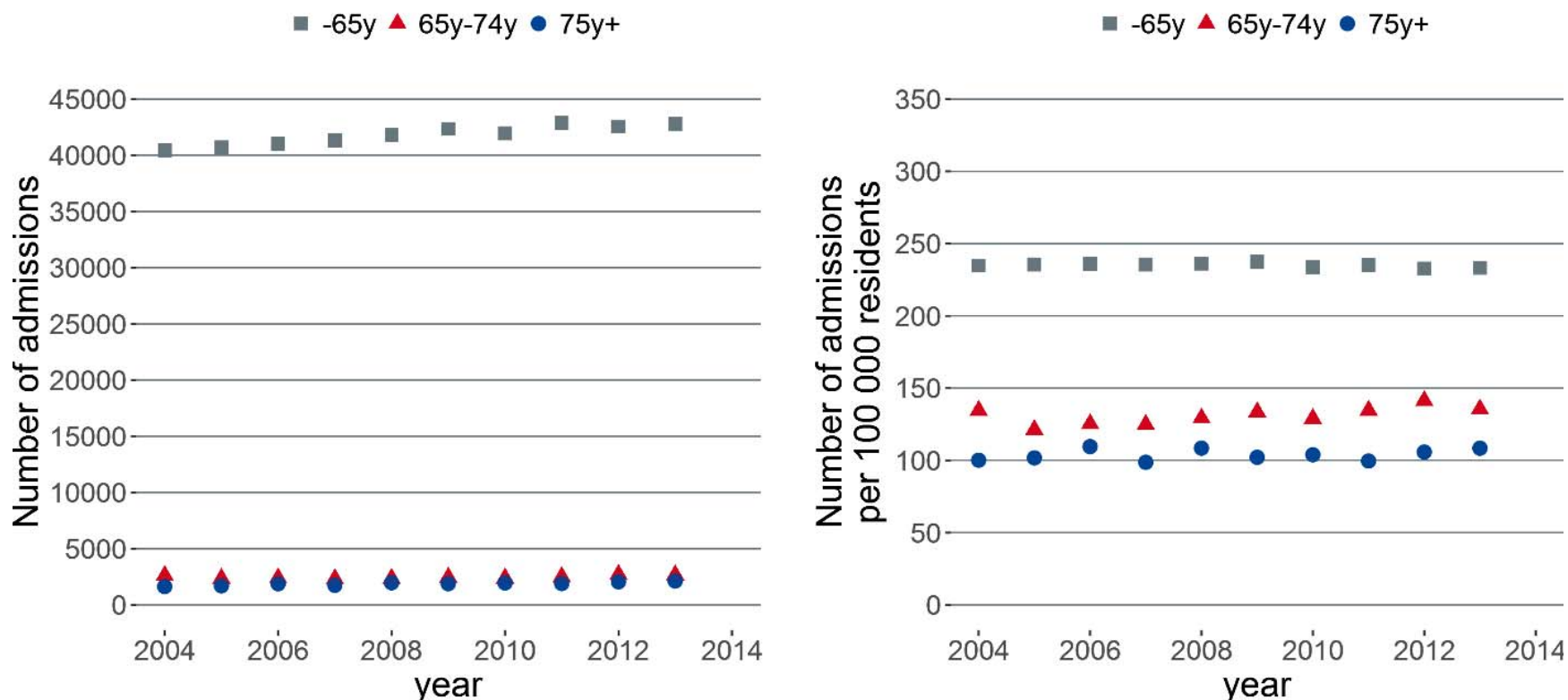
Source: FPS Health, Food Chain Safety and Environment (since July 2014, monthly updates are available for hospital characteristics); Statistics Belgium: Belgian population 2008-2017



The number of admissions and admitted population for older persons remains reasonably stable between 2004 and 2013 (see Figure 25).

During the same period, the number of admissions per 100 000 Belgian population by age category is lower in the older age groups (i.e. 65-74 years and 75 years or older) than for people aged 65 years or older.

Figure 25 – Number of admissions (left panel) and number of admissions per 100 000 Belgian population (right panel) by age category per year for psychiatric hospitals.



Source: annual reports MPG – RPM by FPS Public Health. Population data from Eurostat (1st January of each year)



Box 2 – Psycho-geriatric beds a complex puzzle

Psycho-geriatric beds can be found in psychiatric, general or categorical hospitals. The functioning and financing of psycho-geriatric beds are linked to the rules that apply to rehabilitation services (Sp). Many of these services originated from the reconversion of the formal R-, S- or V-beds.³⁰⁶ In 1993, the hospital 'rehabilitation' wards under the Sp index were created for several target populations (e.g. cardiopulmonary diseases, neurological disorders, etc.) The norms for psycho-geriatric beds were established in 1995.³⁰³ The specific financing for rehabilitation services and the different types of beds depends on rules that applied to the original bed-type (acute or chronic, general or 'categorical' hospital) and varies substantially.²⁹⁹ At the moment of their conversion, the historical budgets per hospitals were maintained and used to calculate the number of beds resulting from the conversion rules in force.³⁰⁷ The per diem rate for the new rehabilitation Sp-beds was mostly based on the structure of the hospital (e.g. recognized beds, activity levels)^{303, 306-308} As a consequence, specialized psycho-geriatric beds may be financed in different ways depending on whether they are located in a psychiatric, general or specialized hospital. The current allocation of the BMF is still based on the historical characteristics of the hospital, and as such, the financing of psycho-geriatric beds does not depend on the notion of 'justified activities'.³⁰⁶ The 6th State reform transferred the competence for specialized and geriatric hospitals, including their financing to federated authorities.

Challenges for the future: Psycho-geriatric services face different challenges notably that recruiting geriatricians and psychiatrists with expertise (or experience) in the treatment of older adults is not straight forward.³ Limited training of nurses and paramedical staff focusing on geriatrics and psycho-geriatric patients was also mentioned as an issue of concern. Overall services focusing on the care of older persons face labour force shortage, in particular for geriatricians and nurses specialised in geriatric care^{47, 309}

Projections relating to long-term care and chronic care needs show that an increase in hospital capacity for psycho-geriatric beds is needed to accommodate the increasing need. In terms of days and beds, the projected increase for Sp6 beds in 2025 amounts to 25%.³¹⁰ Van de Voorde et al. (2017)³¹⁰ point out that capacity for psycho-geriatric beds can be extended by shifting a part of the hospital care capacity to other care settings (e.g. increased specialised beds in nursing homes). The latter is in line with the recommendations of the NRZV-CNEH. The NRZV-CNEH has highlighted that psycho-geriatric beds are used to accommodate patients who cannot return to their home and/or cannot find an accommodation in a residential care facility for older persons.³⁰⁶ In order to avoid this situation, the NRZV-CNEH recommends to develop temporary housing alternatives for patients not been able to immediately join their home as well as specialised 'psycho-geriatric' beds in residential care facilities for older persons.³⁰⁶

5.2.1.2 Psychiatric departments in non-psychiatric hospitals

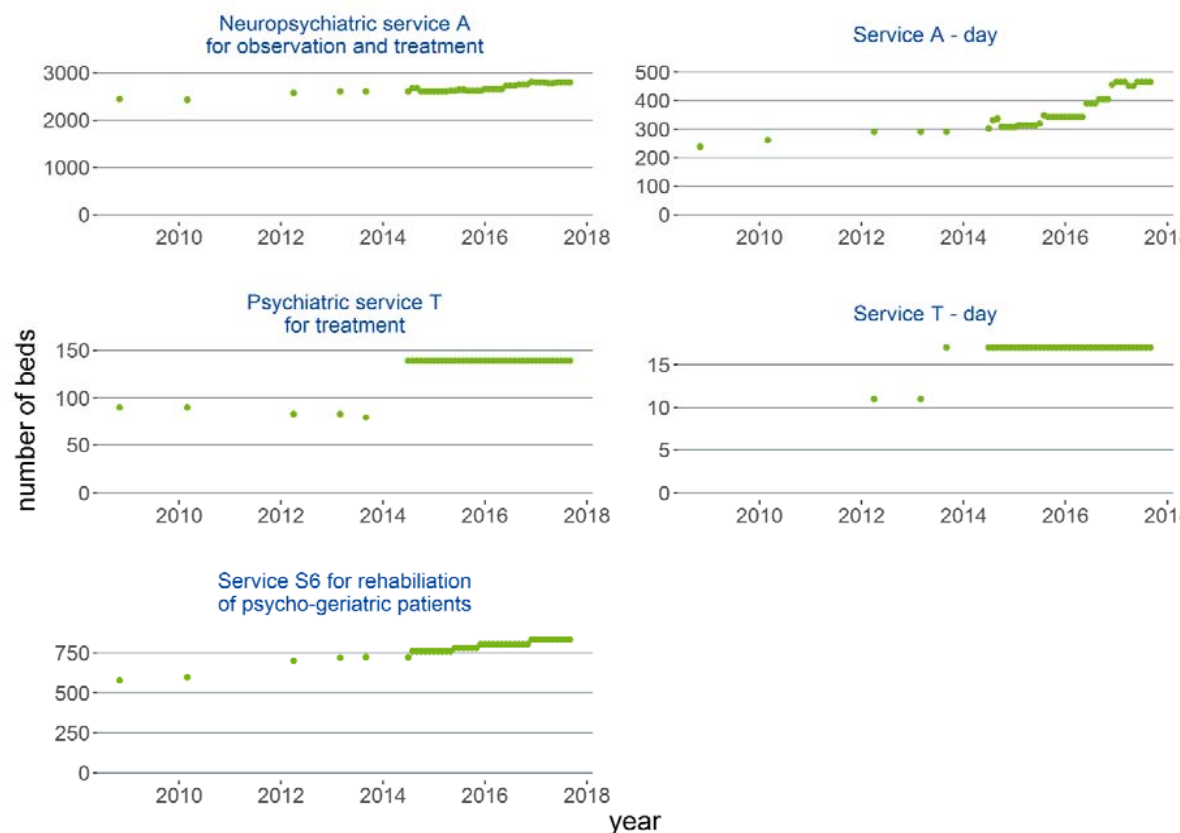
Target population: Psychiatric wards in acute general hospitals (PAAZ – SPHG) provide short-term in-hospital treatment for patients with mental health disorders. The PAAZ – SPHG aim to provide a response for a psychiatric emergency crisis and a 'liaison' function within the hospital. Another type of in-hospital psychiatric services integrated in the emergency departments is the psychiatric emergency intervention unit (Eenheid voor Psychiatrische Spoed Interventie (EPSI) – Unité de Crise et d'Urgences Psychiatriques (UCUP). In general, psychiatric wards in general hospitals reserve 10% of their beds for psychiatric day care or night care.³⁰¹ The perceived advantage of PAAZ – SPHG-services is the lower threshold for consultation compared to psychiatric hospitals (destigmatizing), the immediate accessibility of somatic care in a mental healthcare environment (trend towards liaison psychiatry) and the 'short stay' treatment vision (with focus on ambulatory care). In geographical regions with a PAAZ– SPHG there is a trend towards permanence for emergency interventions (e.g. EPSI – UCUP) in these services.³¹¹



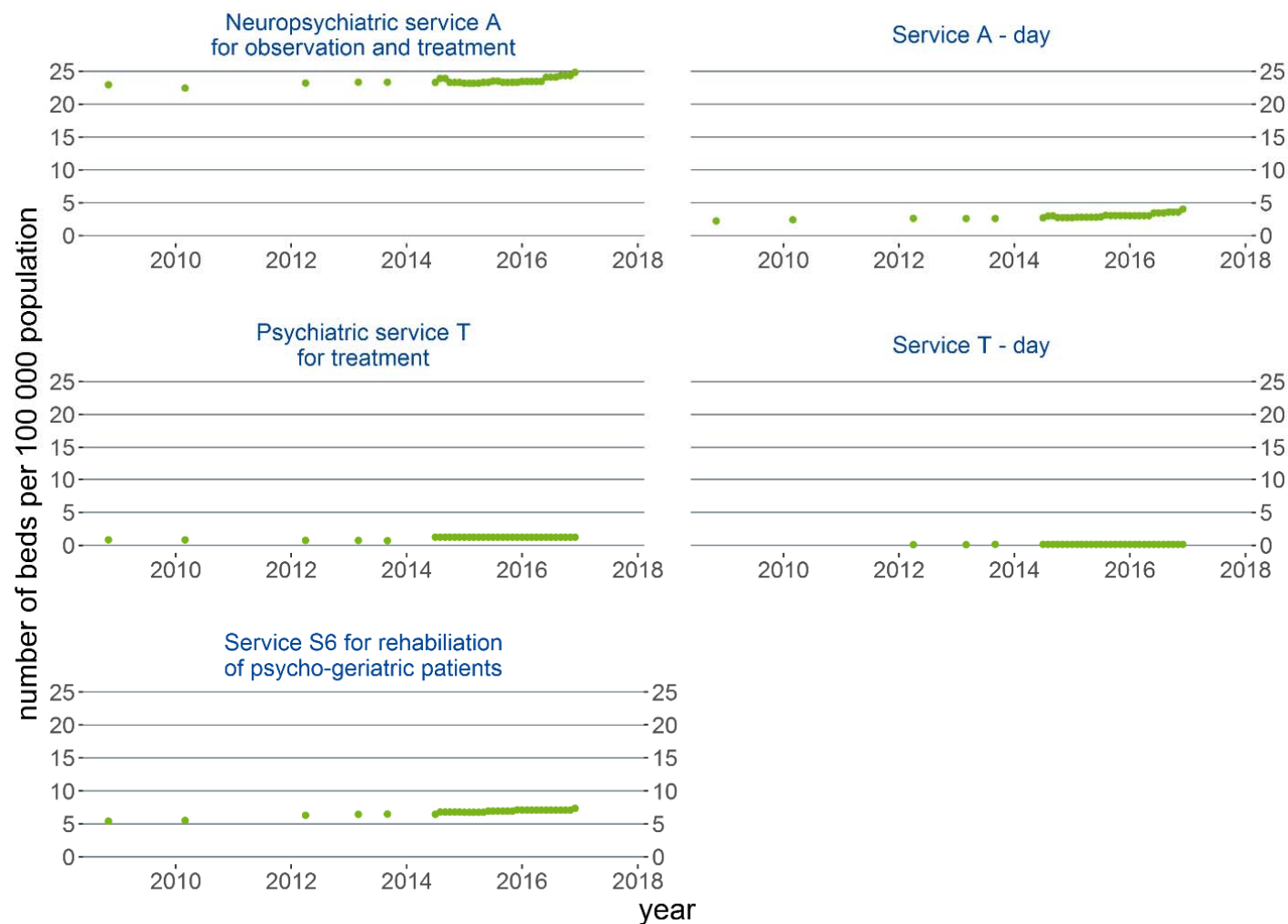
Competence and financing: The competence and the financing for PAAZ – SPHG as well as patient cost-sharing follow similar rules than those applied to psychiatric hospitals (see section for details). The budget for these services does not depend of the notion of justified activities but rather on historically based parameters (e.g. number of recognised beds) ⁴.

Numbers: The number of recognized A-beds have increased steadily since 2008, while T beds increased in 2014 only and have since remained stable (Figure 26). Taking into account the growth of the Belgian population, the number of beds per 100 000 population still follows the same pattern as the crude number of beds (see Figure 27).

Figure 26 – Evolution of recognized beds in non-psychiatric hospitals.



Source: FPS Health (since July 2014, monthly updates are available for hospital characteristics).

**Figure 27 – Evolution of recognized beds per 100 000 population in non-psychiatric hospitals.**

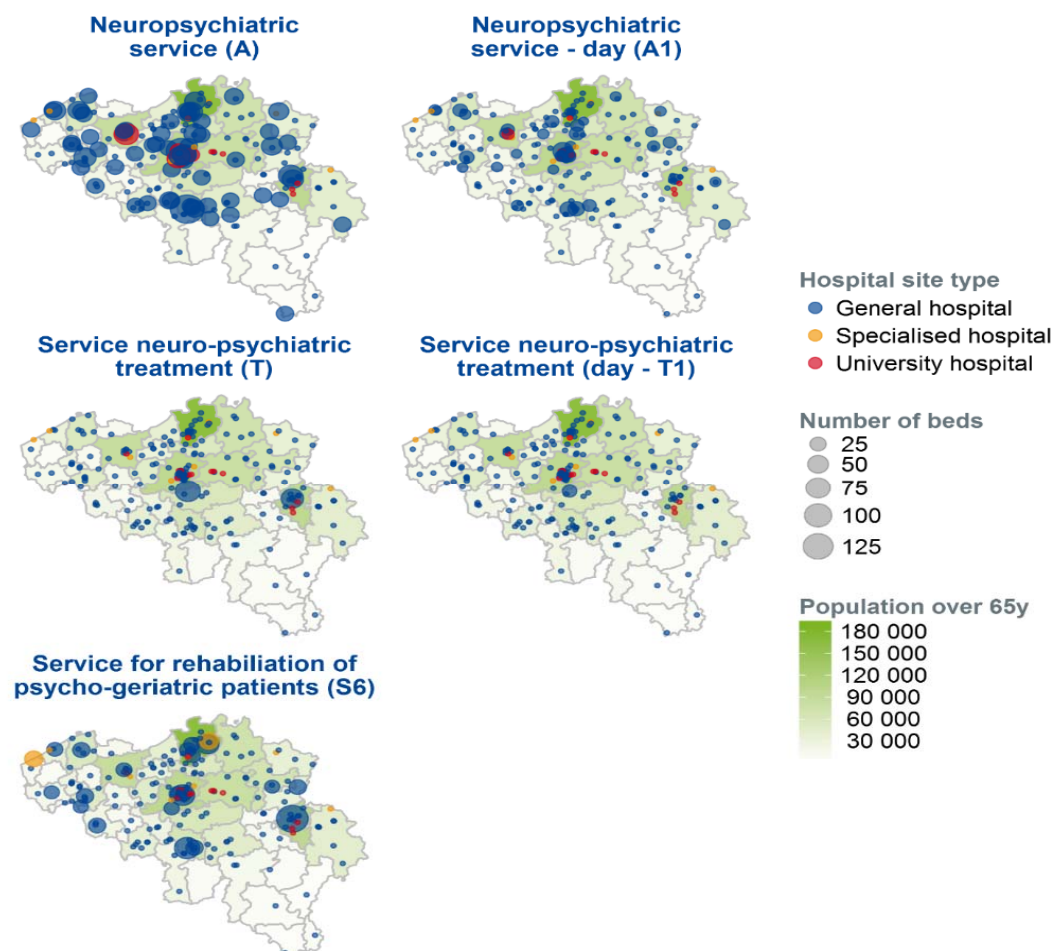
Source: FPS Health, Food Chain Safety and Environment (since July 2014, monthly updates are available for hospital characteristics); Statistics Belgium: Belgian population 2008-2017.



The geographical distribution of these beds according to the hospital type is shown in Figure 28.

Most psychiatric beds are found in general hospitals and in a very limited number, in specialized hospitals

Figure 28 – Geographical distribution of the number of beds per hospital site in September 2017 by hospital type for non-psychiatric hospitals.



Source: FPS Health (since July 2014, monthly updates are available for hospital characteristics); Statistics Belgium: Belgian population 2008-201

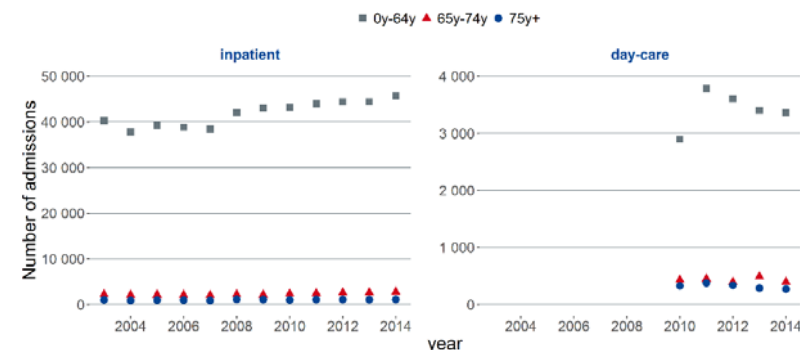


The above statistics concern only the supply side of the non-psychiatric hospitals expressed in recognised hospital beds. These statistics are for the entire age range. On the use side, the Hospital discharge dataset (MZG – RHM)) and the compulsory registration of hospital stays provides the possibility to look at the use for different age ranges. The following section concerns descriptive statistics from the MZG – RHM for patients aged 65 years or older.

Psychiatric stays in non-psychiatric hospitals (in psychiatric wards) are registered in MZG –RHM as either entirely psychiatric or mixed^j. For the entirely psychiatric stays, only administrative data is recorded as diagnostic and treatment information in the compulsory minimal psychiatric data (MPG – RPM) (see below). For the mixed stays, the regular Minimum Hospital Discharge (MZG – RHM) registration is applicable.

The number of entirely psychiatric stays for patients aged 65 to 74 and 75 and over is shown in Figure 29.

Figure 29 – Number of entirely psychiatric admissions in non-psychiatric hospitals for patients aged 65 and older by admission type.



Source: annual reports MPG – RPM by FPS Public Health. Population data from Eurostat (1st January of each year).

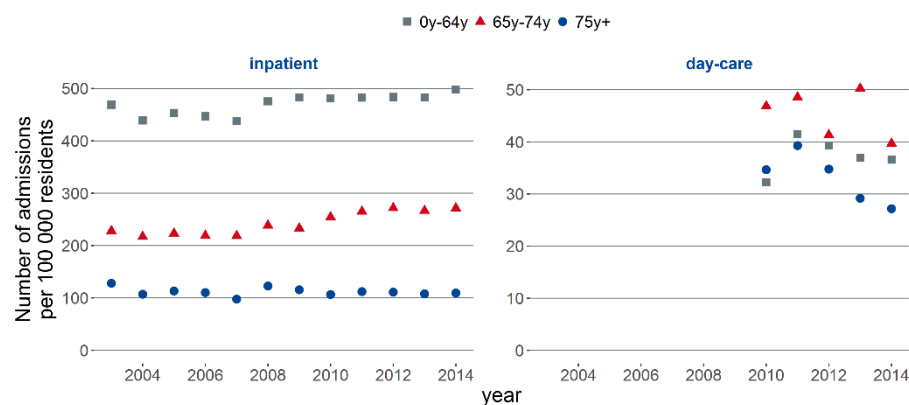
Taking into account the Belgian population, the number of inpatient admissions in psychiatric wards per 100 000 Belgian population by age category is lower in the older age groups (i.e. 65-74 years and 75 years or older) than for people aged 65 years or older (see Figure 30).

For day-care, the three age groups are much closer to each other in terms of admissions per 100 000 population. Day-care is defined as care in an institution with established procedures for selection of patients, safety, quality control, continuity, reporting and cooperation with various medico-technical services.³¹² The interventions provided in day-care may include individual and collective treatment, multiple activities and social support.

^j Entirely psychiatric stays are identified by having an APR-DRG 'AAA' (planned admission) or 'UAA' (admission through emergency room).



Figure 30 – Number of entirely psychiatric admissions in non-psychiatric for different age groups by admission type per 100 000 population.

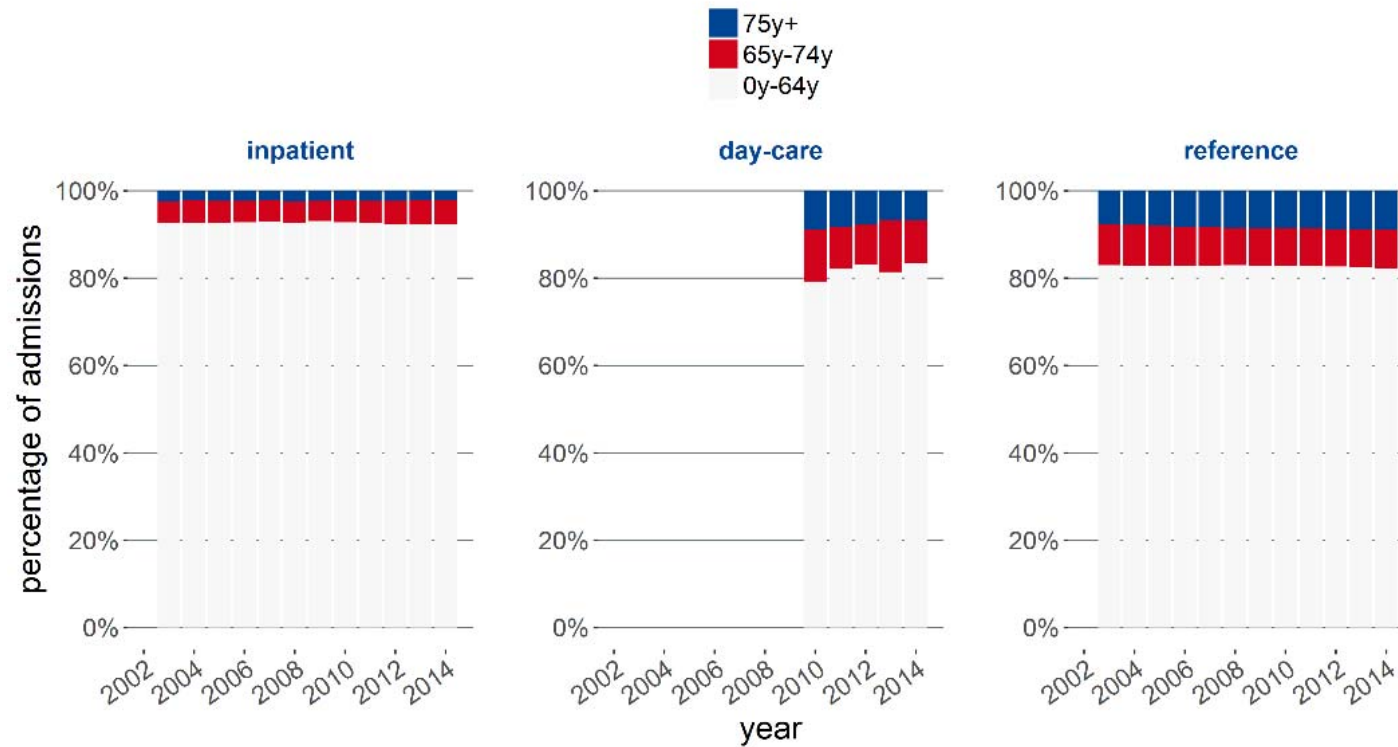


Source: annual reports MPG – RPM by FPS Public Health. Population data from Eurostat (1st January of each year).

The entirely psychiatric admissions for patients aged 65 or older represent less than 10% of all entirely inpatient psychiatric admissions (see Figure 31). Day care entirely psychiatric admissions for patients aged 65 or older are similar in proportion to the reference age distribution



Figure 31 – Percentage of entirely psychiatric admissions in non-psychiatric hospitals by age category (the right panel shows the distribution of the age categories in the Belgian population).



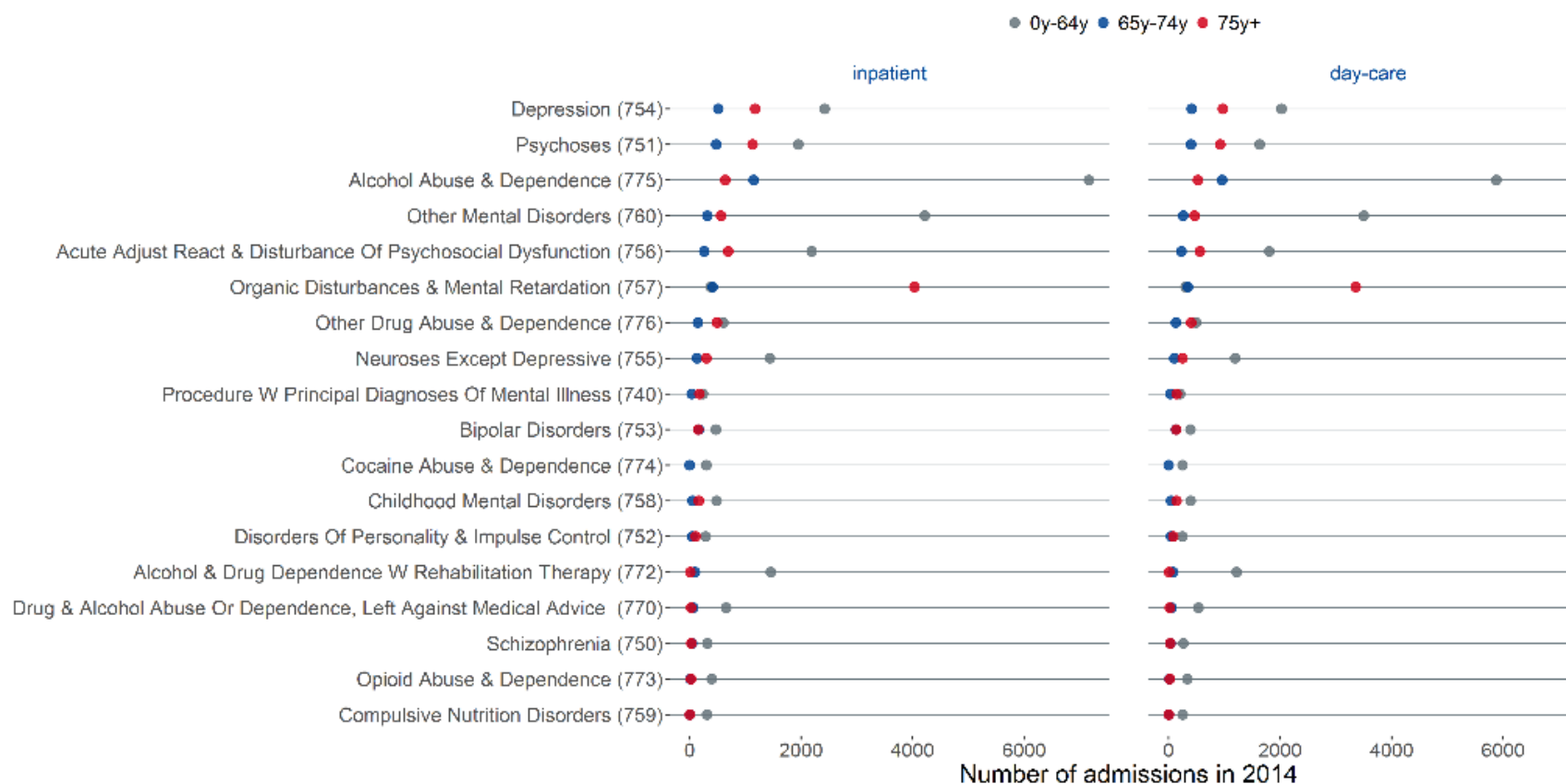
Source: annual reports MPG – RPM by FPS Public Health. Population data from Eurostat (1st January of each year).



For the mixed stays in general hospitals, diagnostic information is available.

Figure 32 and Figure 33 show the number of admission per APR-DRG version 15 in 2014.

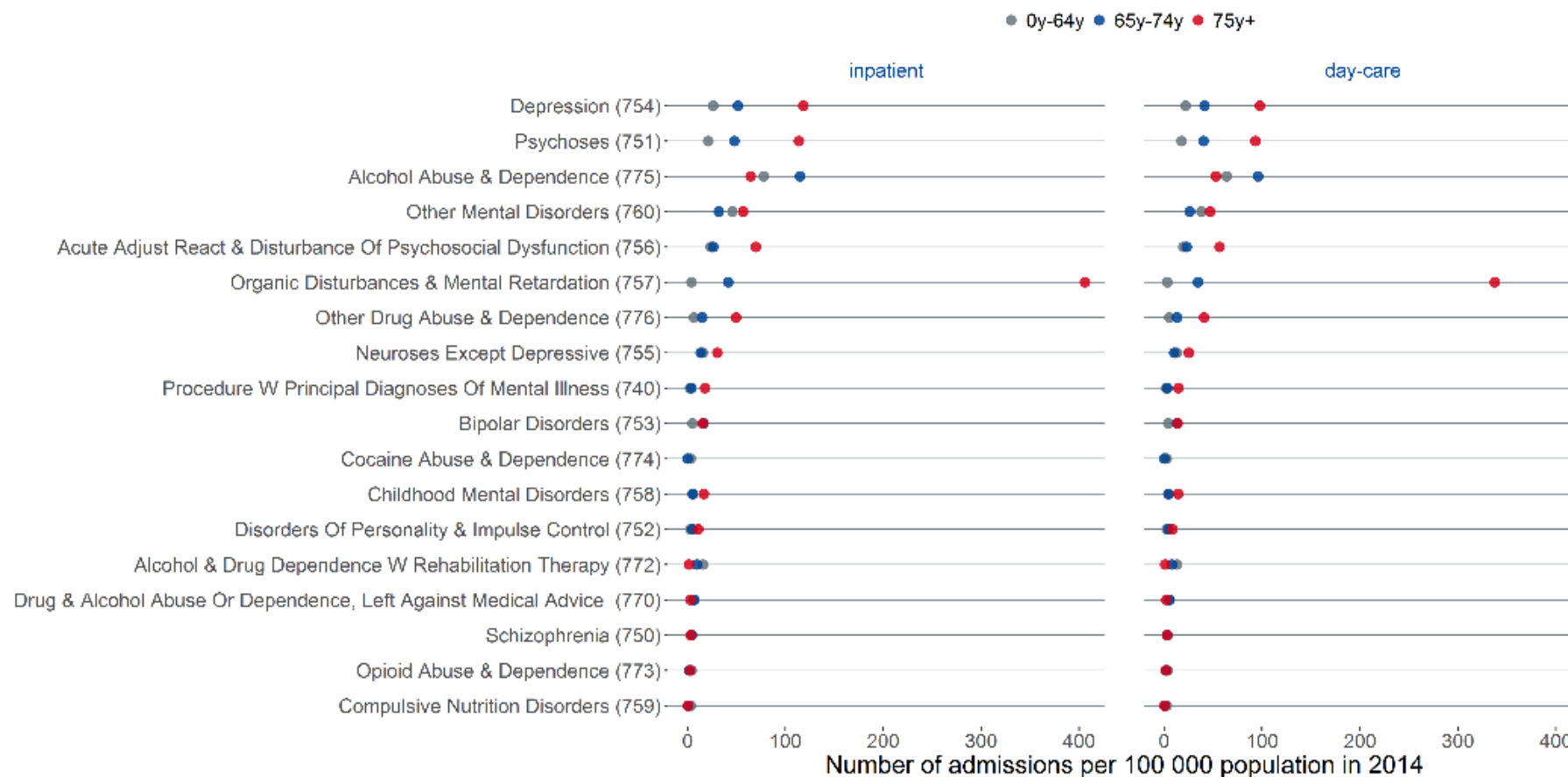
Figure 32 – Number of mixed admissions in 2014 by APR-DRG and age category.



Source: Hospital discharge dataset (MZG – RHM)



Figure 33 – Number of mixed admissions in 2014 by APR-DRG and age category per 100 000 population.



Source: Hospital discharge dataset (MZG – RHM)



5.2.2 Residential settings

We pointed out in above, the reconversion of 'classic' psychiatric beds lead to the creation of residential alternatives for psychiatric patients (i.e. Psychiatric care homes (psychiatrische verzorgingshuizen (PVT) – maisons de soins psychiatriques (MSP)) and initiatives for sheltered living (Initiatieven Beschut Wonen – Initiatives Habitation Protégée) (IBW – IHP)). Older persons with mental healthcare problems may also attend other residential alternatives that are not directly linked to the mental healthcare sector (e.g. nursing homes). In this section, we describe the existing alternatives.

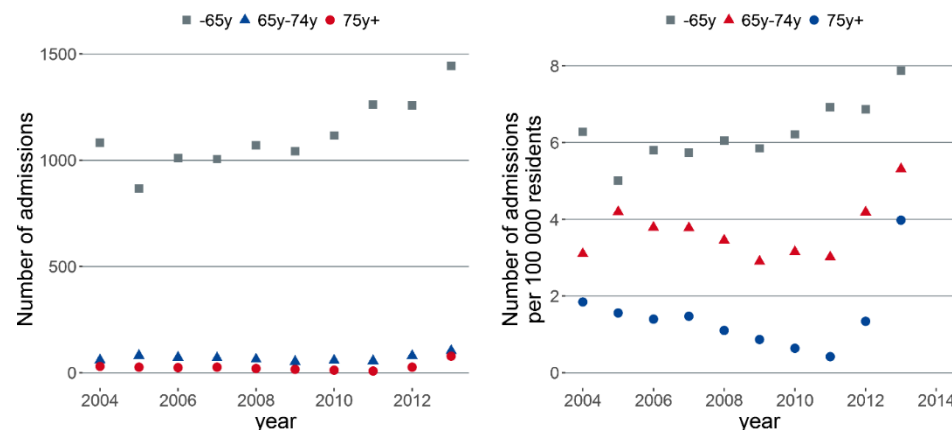
5.2.2.1 Psychiatric care homes

Target population: Psychiatric care homes (PVT – MSP) take care for patients of all ages with a stable psychiatric condition who need permanent care for a long-term mental health problem and for mentally disabled persons who need permanent supervision. The people who live in this secure collective living facilities do not need intensive in-hospital specialist (neuro-) psychiatric treatment but are unable to live independently in the community or in other living communities (e.g. initiatives for sheltered living, nursing homes for older persons). In most of the cases, these facilities are located outside the hospital and are connected to the local community.⁴

Competence and financing: The 6th institutional state reform transferred the competence of programming, recognition and financing of PVT – MSP to the communities. At the moment of the writing of the report and until the end of 2017, the federal authorities remain responsible for the financing of PVT – MSP. RIZIV – INAMI pays a lump-sum to cover healthcare services and the help required to provide support for the activities of the daily living.³¹³ Patient's participation in the cost of board and lodging is fixed by the Minister of Public health and depends on the patient's status and family situation.³¹⁴ Patients must paid a fixed co-payment for pharmaceuticals delivered in the PVT – MSP.

Numbers: In May 2017, there were 1896 places in Flanders, 818 in Wallonia (including 30 in the German speaking community) and 229 in the Brussels region. The number of new admissions for older patients have been fairly stable between 2004 and 2011, while showing a relative increase in 2012 and 2013 (see Figure 34). This increase is also present among younger adults.

Figure 34 – Number of admissions or admitted residents by age category per year for psychiatric care homes per 100 000 population.

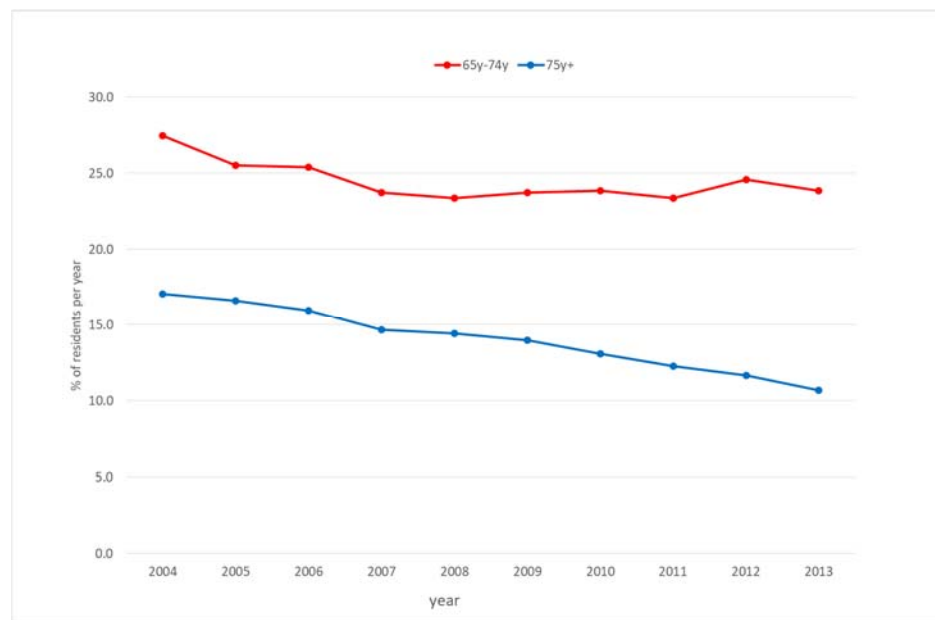


Source: annual reports MPG – RPM by FPS Public Health.

The share of older patient admission (see Figure 35) residing at the end of year in the facilities has declined since 2004, in particular for the older age group (75 years or older).



Figure 35 – Percentage of admitted patients residing in the facilities on the 31 December of each year by age group.



Source: annual reports MPG – RPM by FPS Public Health.

5.2.2.2 Initiatives for sheltered accommodation (IBW – IHP)

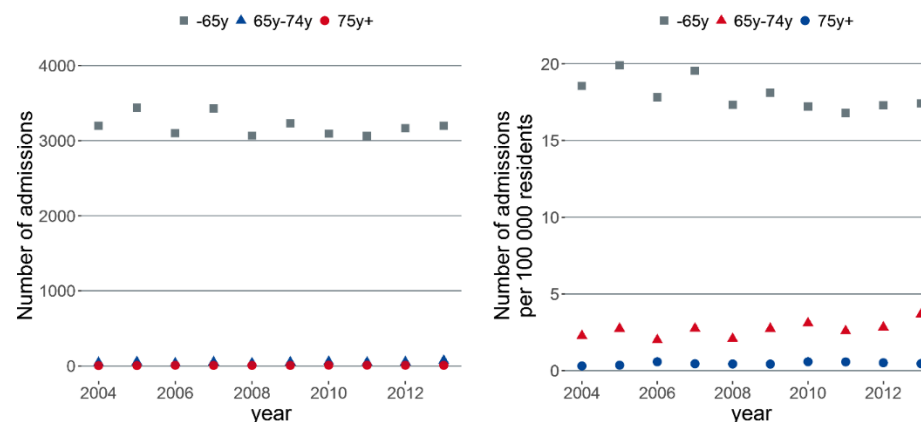
Target population: Sheltered accommodation (IBW) – IHP³¹⁵ are residential structures as an alternative for or in addition to psychiatric hospitals. They take care of adult patients who can be dismissed from psychiatric hospitals and who do not need permanent follow-up but who have to be assisted in their living environment to acquire certain social skills. The main aim is to support people with mental health problems to (learn to) live independently. The patients are supported by a multidisciplinary team and appropriate day activities are organized. Residents can live in different types of arrangements with a limited number of other patients in ordinary houses (three to eight persons). Since 2000, people can also live in individual houses; however, their number cannot exceed 20% of the total.

Competence and financing: As for psychiatric care home (PVT – MSP), the 6th institutional state reform transferred the competence of programming, recognition and financing of IBW – IHP to the communities. Until the complete transfer of responsibilities between the entities, RIZIV – INAMI pays a daily lump-sum that covers the staff salary according to the established norms for the minimum personnel availability.^{313, 316} The federated authorities can also provide funds for infrastructure.³¹⁷ Patient's participation in the cost of board and lodging varies between the institutions.^{314, 317}

Numbers: In May 2017, the number of recognised institutions in Flanders, Wallonia and Brussels amounted to 43 facilities (2899 beds), 27 facilities (798 beds) and 18 facilities (560 beds), respectively.³¹⁸

The number of new admissions (see Figure 36) and the share to older patients (see Figure 37) residing at the end of year in the facilities have been fairly stable between 2004 and 2013, with the exception of a relative increase in 2013 for residents aged 65 to 74.

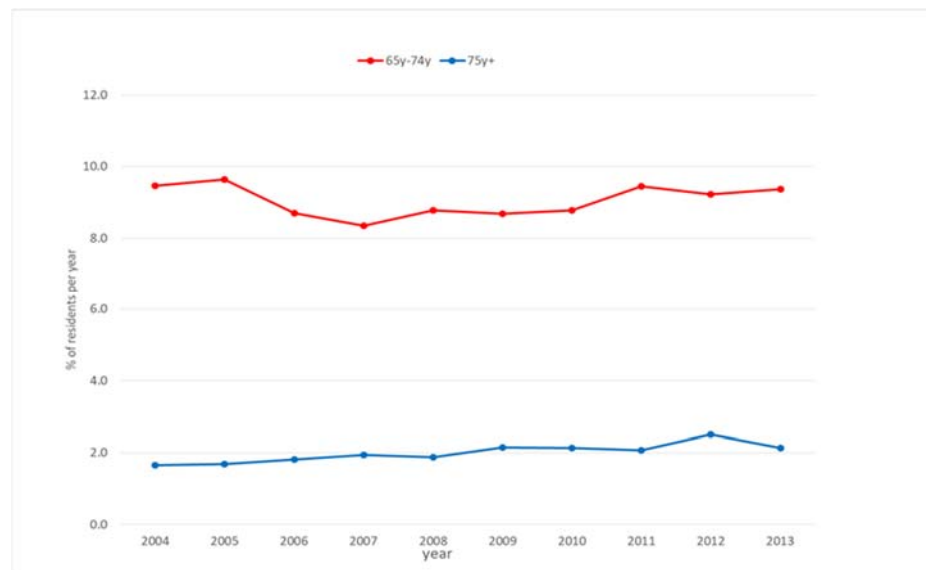
Figure 36 – Number of admissions or admitted persons by age category per year for sheltered accommodation.



Source: annual reports MPG-RPM by FPS Public Health.



Figure 37 – Percentage of admitted patients residing in the facilities on the 31 December of each year by age group



A traditional form of sheltered accommodation in Belgium for people with chronic mental health problems is care within a host family (Tf index, 'gezinsverpleging' – placement familial).^{9, 319, 320} Patients participate in family life and sleep in the family house, but are still considered as being hospitalised. They spend part of the day or all day in hospital doing various activities and can go back to the hospital for observation or in case of crisis. RIZIV – INAMI finances Tf beds via a daily lump that is increased when the patient reaches 65 years and 75 years. In 2010, there were 538 family accommodation places (Tf beds) available in the Flemish region (Geel) and 120 in the Walloon region (Lierneux).³²⁰

5.2.2.3 Residential care homes for older persons

Target population: In Belgium, residential care homes for elderly target older persons no longer being able to stay in their home. Competent authorities (federated entities) establish the minimum age allowing persons to access these services (60³²¹ or 65³²² years or older). Two types of homes for older persons can be found in Belgium. Homes for the elderly ('rustoorden voor bejaarden (ROB) – maison de repos personnes âgées (MRPA)) provide nursing and personal care as well as living facilities to older persons with mainly low to moderate limitations. Older persons who are strongly dependent can be admitted to nursing homes (rust-en verzorgingstehuis (RVT) – maison de repos et de soins (MRS)).^{323, 324}

The current organisation of residential care homes for older persons has been delineated by protocol agreements (1997, 2003 and 2005) between the federal and federated authorities. The agreements aimed at progressively replacing lower-care to higher-care beds and at the same time at reinforcing the supply of home care services. The third protocol agreement specifically aimed at supporting alternative forms of care, such as crisis care services, night care services, services supporting intergenerational housing arrangements or care pathway initiatives. The most recent agreement between federal and federated entities (the so-called 'Protocol 3') further pursues the development of services allowing older patients to stay as long as possible in the community. The objective of the call for projects was to develop services with a multidisciplinary approach, in order to delay an early entrance to a nursing home (see section 4.4.3.2 for more details on projects financed via Protocol 3).

**Box 3 – Long-term care in Belgium: definition and objective**

The long-term care system³²⁵ that supports older persons with decline in physical and mental capacity includes both residential (i.e. institutions other than hospitals that provide accommodation and long-term care package) and home care (i.e. aid services, personal care and supportive, technical and rehabilitative nursing home).³²⁶

The Belgian LTC system can be characterized as a mixed system with extensive publicly financed formal care services which complement significant informal care provided mainly within the family and aims at allowing older care dependent persons to keep on living in their own homes for as long as possible.³²⁴

Competence and financing: Federated authorities are responsible for programming rules, recognition, quality monitoring and pricing of all residential facilities for older persons.^{321, 322, 327} The 6th institutional state reform transferred the competence of residential care financing to the communities.³²⁷ At the moment of the writing of this report, financing of residential homes remained the responsibility of the federal authorities. RIZIV – INAMI funding takes the form of a daily lump-sum that varies according to the number of recognised beds, the care dependency profile of the residents and the numbers of qualified staff. There are different dependency profiles based on the Katz scale: low-dependency (O and A in homes for the elderly (ROB –MRPA), only), high-dependency (B, C and D in homes for the elderly (ROB –MRPA) and nursing homes (RVT – MRS)) and dementia (D nursing homes (RVT – MRS), only).^{323, 324} Dependent people and their families cover the costs of board and lodging. In exceptional cases, dependent people can rely on the help from Public municipal welfare centres ('Openbare Centra voor Maatschappelijk Welzijn (OCMW) – Centre Public d'Aide Sociale (CPAS)').^{324, 328} Patient's participation in the cost of board and lodging is fixed by the federated entities.^{321, 322}

Numbers: The percentage of older adults living in a home for the elderly or a nursing home remains relatively stable by gender and age group (see Table 14). About 6% of the adults aged 65 years or older live in a residential care institution for the elderly.

Table 14 – Percentage of the older adults living permanently in a home for the elderly or a nursing home by gender and age group

Gender	Age	2008	2009	2010	2011	2012	2013	2014
Men	65-74	0.90	0.90	0.90	0.90	0.90	0.90	0.90
	75-84	3.40	3.40	3.40	3.30	3.20	3.20	3.20
	85+	14.40	14.50	14.60	14.40	14.30	14.40	14.40
Women	65-74	1.10	1.10	1.10	1.00	1.00	1.00	1.00
	75-84	6.90	6.90	6.70	6.40	6.30	6.20	6.10
	85+	29.90	29.90	29.80	29.00	28.90	28.90	28.70
TOTAL	65+	5.90	6.00	6.00	5.90	5.90	5.90	5.90

Source: <http://atlas.aim-ima.be/>

Data on the prevalence of mental health problems and diagnostic of psychiatric disorders in residential homes for older persons is scarce. Van Rensbergen et al. (2010)³²⁹ point out that the reasons behind an admission to a nursing home are lacking or not clearly stated in the resident's file. Using a small sample of nursing homes in Flanders (n=7) the authors point out that most persons with a mental disorder suffer from dementia. Few patients were found to have a psychiatric disorder or mental retardation.³²⁹

Since 2008, the percentage of persons living in a home for the elderly (ROB –MRPA) or in a nursing home (RVT – MRS) entitled to a highly dependency lump-sum (B, C and D) has increased since 2013 (see Table 15).³³⁰

**Table 15 – Type of lump-sum for residents in homes for the elderly and nursing homes (in %)**

Lump sum	2008	2009	2010	2011	2012	2013	2014
O/A	35.50	34.80	33.80	32.20	31.10	28.70	27.10
B	22.70	23.40	24.40	25.10	26.00	26.40	27.10
C	41.80	41.90	41.80	42.60	42.90	42.80	43.20
D	2.10	2.60
	100	100	100	100	100	100	100

Source: <http://atlas.aim-ima.be/>

One study assessed the extent of the cooperation between residential care facilities for older persons with other services aiming at helping them to cope with the specific needs of older persons with mental health problems^{331, 332}. Research conducted by Vlaams Onderzoeks- en Kenniscentrum derde leeftijd (VONK3) between 2009 and 2012 aimed at understanding the role and function of residential care homes for the elderly in the care provided to older persons with psychiatric problems.^{331, 333} The authors of the study sent a survey to all residential care homes in Flanders (n=749) in order to determine the main issues faced by these institutions. The survey was filled by 179 institutions. The study revealed that these organisations reported caring for patients with dementia (96.7%), depression (92.3%), addiction (69.1%), Korsakov (61.8%), personality disorders (61.0%) and mental retardation (53.7%). The study does, however, not report the number of patients affected by different mental health problems. The survey showed that specific care programs can be found in different institution for patients with dementia patients (28%), Korsakov (12%), schizophrenia (7%) and mental retardation (5%). In order to cope with the specific needs of these patients, 84% of the residential care homes reported working with other healthcare services including: psychiatric hospitals (40%), GP (39%) and the centre of expertise for dementia (26%).

5.2.2.4 Psychiatric annexes in prisons

Target population: Internment [internering/internement] is defined by the law of 21.04.2007 (regarding internment of persons with a psychiatric disorder) as “a safety measure to protect the society as well as to ensure that care is provided to the interned person as required by his/her mental state in view of his/her reintegration into society”.³³⁴ As people who are interned have to be perceived as having a mental illness, they need to get treatment in a specialized institution. In Belgium, a large number of psychiatric institutions offer mental healthcare for people who are interned or convicted by Belgian courts. In 2015, about 10%^k of these facilities had an age limit (< 65 years old) for forensic patients. The others did not mention a specific limitation. Most of the latter however had departments for specific psychogeriatric or geronto-psychiatric care.³³⁵

Competence and financing: The organisation and financing of healthcare provision within the prisons is primarily a Federal competence (Federal Public Service Justice) whereas RIZIV – INAMI covers the cost of healthcare outside of the prison (extra-muros hospital care and medical treatment). The RIZIV – INAMI is also responsible for most of the costs linked to the healthcare of interneers (also called mentally ill offenders). In addition, the Communities are competent for the organisation of services of wellbeing, preventive healthcare, health promotion, social and professional reintegration, education, culture and sports in prisons.³³⁶

Numbers: Although not in line with the requirements of the European Court of Human Rights, in 2013 1153 interned people in Belgium (28.3% of the interned population) were housed in prisons instead of specialized psychiatric institutions³³⁷, i.e. psychiatric wards of correctional facilities, institutions and departments of ‘Social Defence’ and regular correctional facilities. In most of these facilities, no or limited therapeutic mental health interventions are provided.³³⁷

^k Incomplete data

**Table 16 – Number of internments in prisons in Belgium based on conviction in 2010-2016 per age category**

Age group	2010	2011	2012	2013	2014	2015	2016
55-60	12	12	14	21	14	6	10
60-65	13	10	10	9	6	7	8
65-70	7	3	6	6	6	9	6
70+	9	9	5	7	12	3	6

Source: *Dienst voor het Strafrechtelijk beleid – Service de la Politique criminelle (2017)*³³⁸

Data on prevalence of mental health problems in Belgian prisons are rather sparse. The Epicure dataset³³⁹, containing the electronic medical files of the persons in prison (i.e. the healthcare of persons under electronic surveillance is not included), gives some opportunities to get insight in mental health problems in elderly in prisons. A recent KCE report (2017)³³⁹ showed that there was an overall high proportion of patients receiving anti-psychotics (21%), antidepressants (25%) and anxiolytics (31%). The latter was the case for all types of prisoners and not only for interneers.

5.2.3 Non-residential settings

5.2.3.1 Community mental healthcare centres (CGG – SSM)

Target population: Patients with a mental health problem can be referred to a mental healthcare centre by any healthcare professional, a family member or acquaintance. Self-referral to the centres is also possible.^{340, 341} These centres provide ambulatory second-line provision of specialized care, and in some cases visits to patients' home. Care is provided by a multidisciplinary team (often consisting of a psychiatrist, psychologist, social worker and a nurse) facilitating a bio-psycho-social approach of the patient's problems. The care provided in these centres can be curative as well as preventive (in terms of screening and early detection) and covers for sub-groups such as children or elderly. The extent of the activities concerning older persons may vary between the centres. Professionals working in these services must accommodate care demands for older persons in a challenging

environment, with teams often facing a high workload related to the care demands of the general population. Professionals do not always have the opportunity to follow adequate training allowing them to respond to the specific demands of these group that include the management of multiple actors (family, home care services) and the identification of the older adult needs. Older adults with physical decline may face limited out-of-home mobility and therefore the accessibility to treatment may depend on the professionals' capacity and willingness to go to the person's home.^{3, 342}

In Wallonia, federated authorities provide specific funds to the community mental healthcare centres that developed 'specific initiatives for older persons' ('Initiatives spécifiques Personnes Agées' - IPSA)³⁴³. These initiatives will be described in the section 5.2.4. Patient cost sharing depends on the type of services received. For non-medical consultations a maximum co-payment varying according to the patient status is established. For a consultation with psychiatrist, the reimbursement rules established in the nomenclature of healthcare services apply. Since 2012, the Flemish Community provides additional subsidies for teams providing care to older patients. The number of full-time teams devoted to persons aged 60 years or older increased from 33.4 to 42.2 in 2012 and 2016, respectively.³⁴⁴

Competence and financing: Mental healthcare centres are the responsibility of the communities (federated entities). Recognition standards ('erkenningnormen' – 'normes d'agrément') depend from different federated institutions, i.e. the Flemish Agency for care and healthcare ('Vlaams Agentschap Zorg en Gezondheid' competent in Flanders), Commission communautaire française (COCOF) and Commission Communautaire commune (GCC – COCOM – competent in Brussels) and the Walls government ('Gouvernement wallon' competent for Wallonia).

Competent authorities provide direct funding for the centres.⁴ Federated entities provide subsidies to cover the cost of the staff (mostly employees), running costs including a budget for the administrative board and a budget for the liaison function. The majority of staff in these centres works as an employee. Physician's consultations (e.g. psychiatrist) activities are reimbursed according to the RIZIV – INAMI nomenclature of healthcare expenses.



Numbers: The Flemish Agency for care and healthcare, the COCOF and the Walls government recognise 20 (one in Brussels), 23 and 65 centres, respectively.³⁴⁵ A recognise centre can have different antennas. The percentage of persons aged 60 years or older among the users of the CGG – SSM recognised by Flemish Agency for care and healthcare and by the Walls government amounts to 11% (year 2016)³⁴⁴ and 7.5% (between 2008-2011).³⁴⁶ CGG – SSM under the responsibility of the Flemish community have seen increases in the percentage of older patient attending the centres (i.e. from 8% in 2010 to 11% in 2016) as well as in the number of new treatments ('nieuwe zorgperiodes'). The latter has been attributed by the Flemish authorities to the provision of new subsidies that aim at strengthened the 'older adult' teams³⁴⁴

5.2.3.2 Psychiatric rehabilitation centres

Target population: Specific agreements ('conventies' – 'conventions') between RIZIV – INAMI and specialised rehabilitation centres ('Gespecialiseerde centra en revalidatiecentra – Centres spécialisés et centres de rééducation) provide the framework for the activities of the centres and their financing.³⁴⁷ The activities provided in these centres may include ambulatory and (semi-) residential care. The detail description of the conventions is outside of the scope of this report. Some of these conventions situate in mental healthcare, among which only two programs focus on adults (i.e. psycho-social rehabilitation for adults (772) and rehabilitation for addiction problems (773)). Psycho-social rehabilitation for adults ('Inrichtingen voor psychosociale revalidatie van volwassen psychiatrische patiënten / Etablissements de rééducation des troubles mentaux adultes (772)) offers specific programs of limited duration that are complementary to other psychiatric treatment plans. The objective of these programs is adapted to each person situation and is to improve their quality of life, (social) skills in order to reintegrate in the community as well regaining access to the labour market. In addition, the ambulatory centres for rehabilitation (centra voor ambulante revalidatie (CAR) – les centres de rééducation ambulatoire (CRA) (953965)) fall under the RIZIV – INAMI conventions and provide ambulatory rehabilitation sessions. These centres mostly target children and adolescents but can provide services to adults as well.³⁴⁷

Conventions for rehabilitation for addiction problems (773) take care for persons addicted to illegal drugs, medication, alcohol or other psycho-active substances. Some of these centres focus on crisis intervention. Different types of ambulatory or residential treatment options are applied focusing on detoxification, elimination of addiction and a better social (re)integration. The duration of care is limited.³⁴⁷ Patient's participation in the cost of care depends on the patient's status, family situation and whether care is provided residential settings.³⁴⁸

Competence and financing: The 6th institutional state reform transferred the responsibilities for these centres to the communities, but RIZIV – INAMI remains temporarily responsible for the recognition and financing of a series of programs for different kinds of rehabilitation.³⁴⁹ Until the complete transfer of responsibilities between the entities, RIZIV – INAMI pays lump-sum that varies according to the activities provided in the centre that aim to cover staffing costs. The federated authorities can also provide funds for infrastructure, however, in practice this is seldom the case. The institutions must introduce a request for infrastructure budgets to RIZIV – INAMI that decides whether they are allocated.³⁴⁹

Numbers: According to Zorgnet-Icuro (2016)³⁴⁹ less than 2% of the patients participating in psycho-social rehabilitation programs for adults were aged 65 years or older in 2015. In 2015, the percentage of patients aged 60 years or older treated in specialised rehabilitation centres for addictions amounts to 0.3%, 2.1% and 3.5% in Flanders, Wallonia and Brussels, respectively.³⁵⁰

5.2.3.3 Psychiatric home care teams (PZT – SPAD)

Target population: Since 2009, the psychiatric home care teams (PZT – SPAD) are structurally linked to the initiatives of sheltered living.⁹ Initially, the PZT – SPAD aimed to "care for persons (patients) with psychiatric symptoms, referred, detected and diagnosed by care professionals, who are in need of and might benefit from specific care to maintain themselves in their home situation" and the specific tasks of the team were defined as "reception, screening, diagnosis, treatment, counselling, activation, psycho-education and other care to people that can be treated in their home situation"³⁵¹ Today, the PZT – SPAD teams can develop specific expertise depending on the needs of their catchment area. The main tasks include i) coaching professionals working in the first line of care, ii) coordinating



actors around the patients and iii) providing direct support to patients in their home environment.^{352, 353} It has been suggested that the teams providing interventions in the patients' home should be extended to cover the needs of older adults.^{354, 355}

Competence and financing: Since 2009, the PZT – SPAD budgets are allocated via the initiatives of sheltered living.⁹ The PZT – SPAD can receive further resources from different actors or networks working in their catchment area^{353, 356}. After a first decade of their existence, the projects are still labelled as 'pilot project' but have found a new working framework in the function 2 of the 107 reform, i.e. "*Treatment teams in home setting as alternative for hospital stay in case of sub-acute (2a) and chronic (2b) problems.*" As a consequence of the 107 reform, some PZT – SPAD were integrated in the mobile teams within the 107-networks.³⁵⁷

Numbers: Data on the activities of the teams per age group was not available.

5.2.3.4 The role of healthcare professionals

The regulation of healthcare professionals delimits the scope of action for healthcare professionals working in the field of mental healthcare. With regard to medical specialties, doctors can specialise in psychiatry and obtain further accreditation criteria in adult psychiatry and in child and adolescent psychiatry. The title of neuropsychiatry is still retained by some physicians who acquired it before that the Ministerial Decree of 29 July 1987³⁵⁸ repealing this specialty, came into force.

Other healthcare professionals working on the field of mental healthcare include clinical psychologists. Please note that the practice of psychotherapy is also regulated (see hereafter for more details).³⁵⁹ Nurses can obtain a particular professional title of nursing professional specialised in mental Healthcare and psychiatry ('verpleegkundige gespecialiseerd in de geestelijke gezondheidszorg en psychiatrie – infirmier spécialisé en santé mentale et psychiatrie'). Besides the healthcare professionals mentioned above, other healthcare providers not directly dedicated to mental health may manage some patients with mental health problems. Their role is not easily assessed given that there is no mandatory registration of their activities and that different professionals do not share a common patient file where the activities are recorded according to well-defined definitions.³⁶⁰

Private practices of psychiatrists

A psychiatrist is a physician who has a supplementary specialisation in psychiatry besides his training in medicine. A part of the psychiatrists also has an additional training in psychotherapy. Besides their job in (psychiatric) hospitals or community mental health centres (where the vast majority works as self-employed healthcare professional), psychiatrists often also have a private practice.³⁶¹ They provide consultations, set diagnoses, start up or alter (pharmacological) treatment and some of the psychiatrist also provide psychotherapy. A certain group of psychiatrists is specialized in mental healthcare for the elderly.

As shown in Table 17 the total number of psychiatrists increase slightly over the years and as expected, the number of neuro-psychiatrists decreases and will tend zero in future years as the title is no longer granted.

Table 17 – Number of physicians with proven practice – 2007-2015

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Psychiatrists	1 547	1 593	1 626	1 656	1 697	1 738	1 782	1 795	1 827
Neuropsychiatrists	308	298	288	276	168	152	117	112	103

Source: I.N.A.M.I: Service des soins de santé – Direction RDQ



Medical acts as provided by psychiatrists are (partly) reimbursed based on nomenclature by the statutory insurance body (RIZIV – INAM). All the reimbursed health related acts are included in the IMA – AIM database (reimbursed medical acts, reimbursed pharmaceutical products, reimbursed acts performed during hospitalization ...)

The selection of nomenclatures codes for analyses covered:

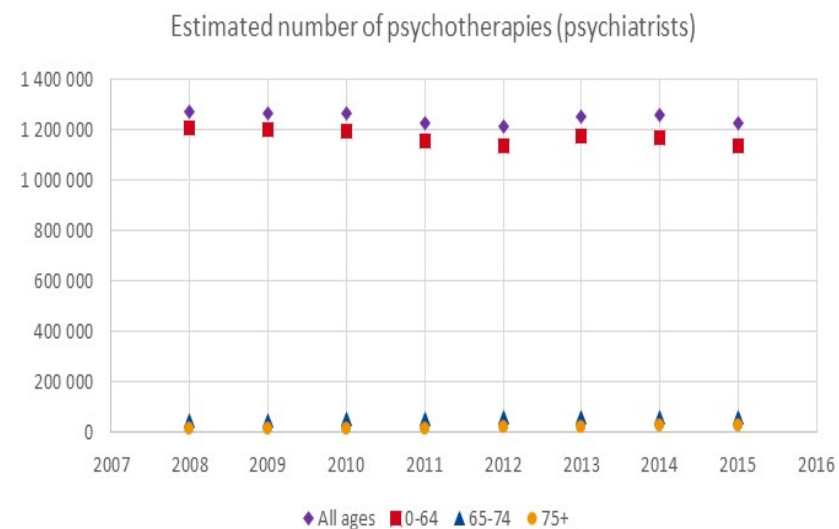
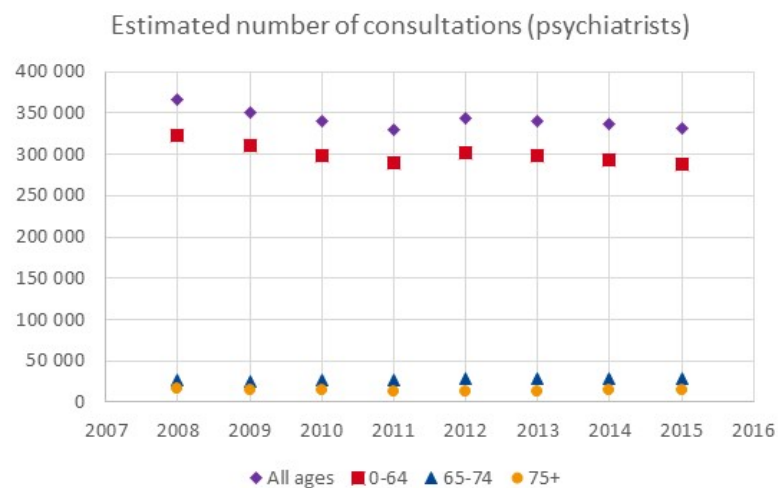
- consultations by neurologists, psychiatrists or neuro-psychiatrists;
- psychotherapy (psychiatrists);
- Emergency medicine (neurologists, psychiatrists or neuro-psychiatrists).

Nomenclature codes related to these items are listed in Appendix 5 (available in a separated document).

The data used for the analyses have some limitations:

- Nomenclature codes related to acts with reimbursement only;
- Psychologists' visits/consultations are not included in the acts reimbursed by the RIZIV – INAMI and therefore could not be analysed;
- For this report, estimation of the numbers was based on Permanent Sample (EPS) data, which is a sample of the Belgian health reimbursed data (20% of the population 65+ and 40% of the population <65y).
- We restricted the analyses to the acts performed to the psychiatrists because for the neuro-psychiatrists the information contained in the sample were not representative of the total population (no extrapolation possible).

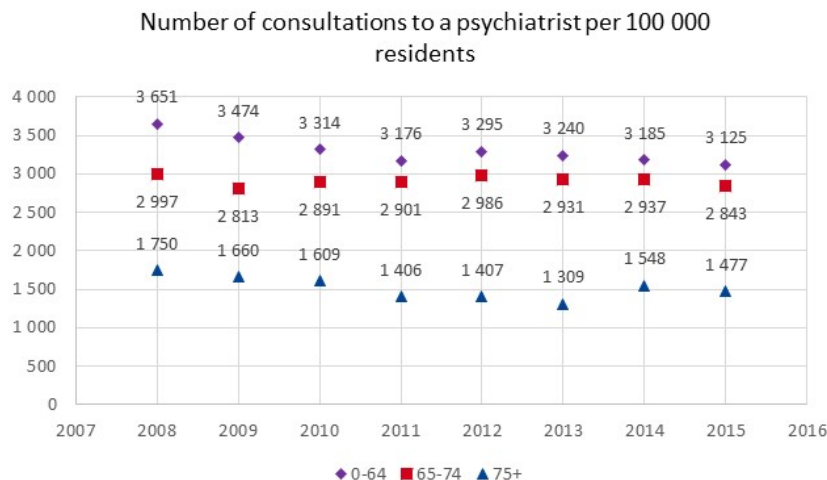
The total number of acts performed by psychiatrists decreases over the years for the whole population (Figure 38) (from an estimation of 1 271 620 sessions of psychotherapy in 2008 to 1 224 980 in 2015 (reduction of 10%) and from an estimation of 366 220 consultations in 2008 to 331 640 in 2015 (reduction of 3%)). However, for the population 65+, there is an increase in the number of psychotherapies per 100 000 residents (Figure 39) from 3 538 to 4 428 (increase of 25%) between 2008 and 2015. For the consultations to psychiatrists, there is a slight decrease in all age categories in the number per 100 000 residents.

**Figure 38 – Estimated number of reimbursed acts – Population (all ages) and by age category (2008-2015)**

Source: Permanent Sample (EPS) data.



Figure 39 – Estimated number of consultations per 100 000 residents per age category (2008-2015)



Source: Permanent Sample (EPS) data.

Practices of clinical psychologists and psychotherapists

Clinical psychologist is an independent health profession, as defined by the Law of 10 July 2016 (SB/MB 01.09.2016)³⁶² amending the law of 4 April 2014 governing mental health professions and amending the Royal Decree n° 78 of 10 November 1967. In order to practice clinical psychology, the Clinical Psychologist must possess accreditation which can only be granted to a person who holds a university degree in the field of clinical psychology recognising at least 5 years of study or 300 ECTS credits including a placement in the field of clinical psychology. The Law defines the practice of clinical psychology as the usual performance of independent actions seeking to or presented as seeking to prevent, review, screen or establish a psycho-diagnosis, for an individual and within a scientifically-backed reference framework for clinical psychology, for real or imagined, psychological or psychosomatic suffering and the care or support of that

person.³⁶³ Although the law was in effect at the end of December 2016, the procedures for recognition were not yet operational.³⁶⁴

Clinical psychologists in the first line of care work in private practices, in multidisciplinary centres such as 'wijkgezondheidscentra'—'maisons médicales', or in first-line institutions such as 'Centra voor Algemeen Welzijnswerk' (CAW) – 'centres de planning familial'. Patients do not pay additional out-of-pocket expenses in these centres.

In the line of specialised care, they work in community mental healthcare centres (CGG – SSM) and in psychiatric or general hospitals. They also work in projects set up under the legislation of art. 107 of the Hospital Act. A lot of psychologists work as an employee in the above-mentioned organisations, often in combination with a private practice. Another significant group of psychologists is entirely self-employed.

The title of psychotherapist is also regulated by the law of 10 July 2016 (SB/MB 01.09.2016). According to the law, candidates for a recognised practice of psychotherapy need to have a bachelor diploma in a health profession, psychology, educational sciences or social sciences, of at least 3 years or 180 ECTS. In addition, they have to be trained in basic notions of psychology in a university or 'high school' ('hogeschool'—'haute école') and must have followed a course in psychotherapy of at least 70 ECTS during 4 years in one of the psychotherapeutic orientations recognised by the law (psychoanalytic or psychodynamic; cognitive-behavioural; systemic and family psychotherapy; humanist person-centred and experiential). Although the law was in effect at the end of December 2016, the procedures for approval to practice were not yet operational at that time.³⁶⁴



To date, partly due to the lack of reimbursement, no exact figures are available concerning the number of consultations of independently working clinical psychologists and psychotherapists in Belgium. As a consequence, no figures are available regarding this kind of psychotherapy in the elderly population.

Practices of general practitioners

The ESEMeD/MHEDEA (2000) study³⁶⁵ showed that about 30% of Belgian people with mental health problems searches professional support. In 30% of these cases, the patient consults the GP and in 43% of the cases he contacts the GP and the psychiatrist. This implies that in more than seven cases out of ten cases, the GP is involved in the detection, diagnosis or treatment of mental disorders in primary care.

For the elderly population, the role of the GP might be even more important as the GP often has a close and long lasting relationship with these persons³⁶⁶ and has frequent contacts with them. In addition, the GP plays a central role in the detection of psychosocial problems that involve 'medical or somatic problems as well as poor functioning in the daily life of the patient'.³⁶⁷ International research shows that 50 to 70% of the elderly who committed suicide had contact with a primary care provider in the months preceding the attempt.³⁶⁸⁻³⁷⁰

As proposed in a recent report, further developments for the role of GP include an active participation in first line psychological care but should have the opportunity to conduct a limited number of long consultations.¹⁴ In order to allow them to fulfil this role, several points of attention need to be taken into account:³⁷¹

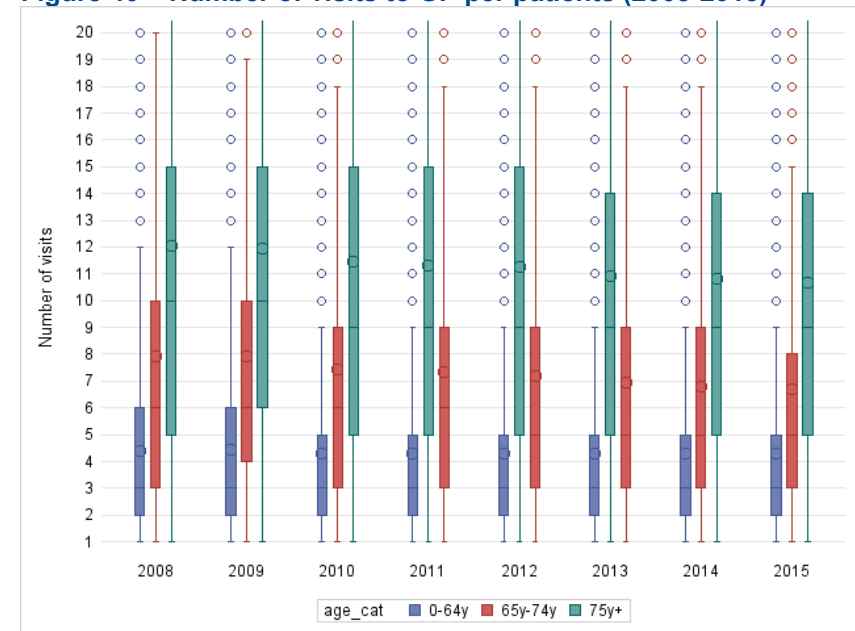
- Improve the collaboration between GPs and specialised mental health professionals. GPs are not always informed of the type of support they can get from specialised mental health professionals.
- General physicians could more often refer patients to psychologists, psychotherapists or psychiatrists.
- When a patient is hospitalised in a psychiatric service, there is relatively limited information exchange between the hospital and the GP.

- General physicians could receive more training in order to allow them to better tackle mental health problems.

The Permanent sample including all the reimbursed services was used to compute the number of patient with GP consultations and the number of GP's visit per patient. The list of nomenclature code corresponding to a GP visit are included in Appendix 5 (available in a separated document).

As shown in Figure 40 and as expected, the number of visits to GP increases with age. Unfortunately, it is difficult to determine the proportion of visits linked to mental health problems and it is well known that elderly have more frequent contacts with their GP for diverse reasons than younger people. From Table 18, we see that the number of visits to a GP per patient varies in median from 3 visits per year for patients younger than 65 years to 10 visits per year for patients elder than 75 years.

Figure 40 – Number of visits to GP per patients (2008-2015)



Source: Permanent Sample (EPS) data.

**Table 18 – Number of GP visits per patients – Patients from the Permanent sample with at least one GP visit (2008 – 2009)**

Age Category	Descriptive statistics	2008	2009	2010	2011	2012	2013	2014	2015
0-64y	n	161 045	164 983	160 524	162 938	163 528	164 715	163 630	163 606
	mean	4.4	4.4	4.3	4.3	4.3	4.3	4.3	4.3
	median	3	3	3	3	3	3	3	3
	Q1-Q3	(2 - 6)	(2 - 6)	(2 - 5)	(2 - 5)	(2 - 5)	(2 - 5)	(2 - 5)	(2 - 5)
	P10-P90	(1 - 9)	(1 - 9)	(1 - 9)	(1 - 9)	(1 - 9)	(1 - 9)	(1 - 9)	(1 - 9)
65y-74y	n	41 190	41 616	41 671	42 908	43 924	44 751	45 683	46 833
	mean	7.9	7.9	7.4	7.4	7.2	7.0	6.8	6.7
	median	6	6	6	6	5	5	5	5
	Q1-Q3	(3 - 10)	(4 - 10)	(3 - 8)	(3 - 9)	(3 - 9)	(3 - 9)	(3 - 9)	(3 - 9)
	P10-P90	(2 - 15)	(2 - 15)	(2 - 14)	(2 - 14)	(2 - 14)	(2 - 14)	(2 - 13)	(2 - 13)
75y+	n	46 162	47 145	47 653	48 156	49 038	49 654	50 187	50 606
	mean	12.0	11.9	11.4	11.3	11.2	10.9	10.8	10.7
	median	10	10	9	9	9	9	9	9
	Q1 - Q3	(5 - 15)	(6 - 15)	(5 - 15)	(5 - 15)	(5 - 15)	(5 - 14)	(5 - 14)	(5 - 14)
	P10-P90	(3 - 23)	(3 - 23)	(3 - 22)	(3 - 22)	(3 - 22)	(3 - 21)	(3 - 21)	(3 - 20)

Source: Permanent Sample (EPS) data.

Q1 – Q3: interquartiles values; P10 – P90: percentile 10 and percentile 90.



Other kinds of therapists

Besides clinical psychologists and psychotherapists, there is a broad scale of therapists, trained in private institutions or by professional organisations, without any official regulation on their content. They offer mental support, counselling and different sorts of treatment in case of mental problems. However, they are not recognized by the law of 10 July 2016 and are not allowed to carry the title of 'psychologist' or 'psychotherapist'.

No clear figures are available regarding healthcare use in elderly for these therapists.

Home care services

To allow older adults to stay in the community, the diversification of long-term services include provision of home nursing care and family aid as well as the creation of initiatives which purpose is to improve the collaboration between care providers in different settings (residential, semi-residential, community care).³⁷² While these actors do not provide mental healthcare interventions, we highlight hereafter interventions that focus on the needs of patients with mental healthcare problems.

RIZIV – INAMI finances home nursing care via a mixed system of fee-for-service payment for technical acts and lump sum payments for nursing interventions for patients suffering from dependency/deficiencies in the activities of daily living (ADL) (see Table 19).

Table 19 – Percentage of persons not living in a residential care facility that received at least one lump sum for nursing care at home

Gender	Age	2008	2009	2010	2011	2012	2013	2014
Men	65-74	1.60	1.70	1.70	1.80	1.80	1.80	1.80
	75-84	6.00	6.10	6.20	6.30	6.40	6.00	6.30
	85+	15.70	15.80	16.20	16.90	17.40	16.90	17.70
Women	65-74	2.60	2.60	2.70	2.70	2.70	2.70	2.80
	75-84	10.10	10.30	10.50	10.70	10.90	10.60	10.70
	85+	20.20	20.60	20.90	21.60	22.00	21.50	22.40
Total	65+	6.70	6.90	7.10	7.30	7.40	7.20	7.50

Source: <http://atlas.aim-ima.be/>

Additional reimbursements are foreseen for nursing interventions for patients with a specific medical disease or condition. In order to obtain additional reimbursements or service, a physician's certificate must be introduced for³⁷²:

- daily hygienic care for patients with moderate to severe dementia, documented by a doctor's certificate.
- payment of preparation and administration of medication in patients with mental health disorders (schizophrenia or bipolar mood disorder).

Patient's intervention in the cost of nursing activities usually varies between 15 % and 25 % of the official tariff. Some interventions, however, require no additional patient's contribution.

Federated entities subsidised domestic aid and personal care services. Yearly quotas limit the volume of subsidized care hours that accredited organisations can provide. The quota of subsidised hours per service differs per region. The hourly fee depends on the user's income and household composition. Both nurses and family aids may receive special training to detect and manage persons with mental health problems. The latter, however, has not been structurally implemented in Belgium.



The experience gained via the 'therapeutic projects' opened the way for the introduction of a specific reimbursement for the 'concertation around the psychiatric patient at home' ('Overleg rond de psychiatrische patiënt in de thuissituatie' – 'Concertation autour du patient psychiatrique à domicile, since 1 April 2012).³⁷³ This intervention is only due if:

- the conditions for each target group (children and adolescent, adults and older persons) are met.;
- at least 3 different health and care providers/professionals are involved. It is required that at least one representative from the mental healthcare sector and one from primary care participate in the concertation.
- a care plan is established and / or followed and includes the activities of the different health and care providers/professionals.

The concertation around the psychiatric patient is only foreseen for persons with a main diagnostic based on the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or the International Classification of Diseases (ICD 10). The latter do not include persons with a main diagnosis of dementia, cognitive problems due to a cardiovascular or traumatic accident, epilepsy, neurological problems or mental disability.

As a general rule, Integrated Services for Home Care (Samenwerkingsinitiatieven Eerstelijnsgezondheidszorg (SEL (GDT) – Services Intégrés de Soins à Domicile (SISD)) are responsible for the implementation of the concertation meetings.

Please note that the Integrated Services for Home Care may also organise multidisciplinary consultation of primary care professionals and to support the elaboration of multidisciplinary care plans for other dependent persons living in their home.

In 2016, 175 concertation plans for older persons (65+) (11.7% of total – 1502 concertation plans) benefited from a reimbursement for concertation around the psychiatric patient at home' ('Overleg rond de psychiatrische patiënt in de thuissituatie' – 'Concertation autour du patient psychiatrique à domicile. This percentage of concertation plan for older persons (11.7%) is in line with the percentage of consultations to the psychiatrists for older persons (11.8%).³⁷³

5.2.4 Mental healthcare initiatives with a focus on older adults

In recent years, 'classic' mental healthcare organisations (e.g. community mental healthcare centres) were asked to organize care programs corresponding to the needs of children, adults and older patients. The fourth reform of the mental healthcare sector (art. 107) financed projects targeting adolescents aged 16 years or older and adults, only. The focus on older persons was left out, outside of the scope of this reform. The latter did not imply, however, that new and existing initiatives for older persons were not pursued by actors from the field. Federal and federated authorities provided funds for these initiatives. Hereafter we present a description of four initiatives that were contacted and provided data on their activities via an online survey (see appendix 6, available in a separate document on the webpage).

5.2.4.1 Work performed within the consultation platforms

In 2017, eight ³⁷⁴⁻³⁸¹ out of the thirteen consultation platforms in mental healthcare have an on-going 'working group' for older patients. For the remaining five platforms, it was not possible to retrieve information on their activities around older patients. The scope of the work within the platforms is heterogeneous, varying from providing advice and recommendations to being involved in piloting some initiatives.

5.2.4.2 Projects financed under the 'Protocol 3'

In 2009, a protocol between the federal and the federated authorities was signed to meet the changing and increasing care needs of older persons, i.e. 'Protocol n°3'.^{382, 383} The objective of the call for projects was to develop services with a multidisciplinary approach, in order to delay institutionalisation (focusing on avoiding early entrance to a nursing home) whilst improving/maintaining the quality of life to persons aged 60 years or older. Overall, they combine:

- Management of chronically ill patients in primary care structures: occupational therapy at home, day care centres, psychological/psychosocial supports, nutritional care, night care at home, nights hotels in nursing homes, day care centres for specific population (e.g.; with dementia);



- Models of care delivery and services: organisation of the care process (case-management, coordination of care) and support for self-management (respite care to support both the patient and the informal carer);
- A clinical information system and data registration through the main use of the patient assessment tool known as 'BelRAI'.

RIZIV – INAMI has launched two consecutive call for projects in 2010 (66 projects) and 2014 (23 projects). Funding is only provided for activities that are not financed through the nomenclature. These projects are developed on an experimental basis for a fixed period. All projects are evaluated and the results of the evaluation for the first wave are available.³⁸⁴

The projects were classified into 6 categories that describe the core services provided. Eight projects were considered as having a focus on 'psychological or psychosocial support or therapy'.³⁸⁴ There were five projects in Flanders, two in Wallonia and one in Brussels. Half of the projects were structurally linked to a home care association (SEL(GDT) – SISD or CCSSD). The type of intervention provided varied from psychological consultations, psychotherapy to social support (i.e information on services) and was aligned to the target population needs. The target population included persons aged 60 years or older suffering from non-complex psychosocial problems (most often common early stage of dementia, depression, mourning, loneliness and fear). Not all projects could reach their case load. Staffs clinical expertise and stability were considered as a key success factors for these initiatives.

Five additional projects focusing on case management also provided psychological or psychosocial to persons with mental healthcare problems and their families. There were two projects in Flanders, two in Wallonia and one in Brussels. These projects were always linked to a home care association (SEL(GDT) – SISD or CCSSD), provided case management and often psychological consultations organized at the patient's home. The projects targeted older persons with different levels of severity of psychiatric disorders and reached their estimated case load. The projects provided specific training to case managers in order to better cope with the person and families' needs.³⁸⁴ In both types of projects, older persons seem to better accept psychological interventions when they take place at home.³⁸⁴

During the second wave, two characteristics of the RIZIV – INAMI projects call were, amongst others, the enlargement of the psychological support and the use of the BelRAI instrument.³⁸⁵ Indeed, according to the Royal decree of the 17th of August 2017, the convention between the innovatives projects and the RIZIV – INAMI requires the use of the BelRAI all along the care path of the older frail adults in the aim of elaborating the care plan and of transmitting data to the scientific team in charge of the evaluation.³⁸⁶

The Resident Assessment Instruments (RAI) was developed in the US to highlight the state of health and well-being of older people in institutions. After, it was tested by researchers and experts from more than 30 countries and is now internationally recognized and named InterRAI. Subsequently, RAI instruments for other areas of care like mental health have been developed. Its goal is to achieve high quality care planning and quality control.^{387, 388}

It has been decided in Belgium, based on scientific studies, to implement the interRAI both at the federal level and in the Federated. As a first step, this tool has been implemented in care of the elderly. In 2015, the Interministerial Conference extended its use to other care environments and categories of patients as the chronically ill patients. The interRAI suite has since been adapted to the Belgian context (which has become the BelRAI tool) to facilitate its use in the clinic and improve communication between healthcare providers.³⁸⁹

BelRAI allows to record, via a web application, data of clients benefiting of home care (HomeCare-HC), living in institutions (Long Term Care Facilities-LTCF), admitted for acute care in a hospital setting (Acute Care-AC)/at the emergency department (Emergency department screener-EDS) or in a palliative care project (Palliative Care-PC). BelRAI tool is integrated in the Belgian government's eHealth platform and has been approved by the Sector Committee of the Commission for the Protection of Privacy. For Belgian persons suffering of mental health problems, two additional InterRAI tools are currently in a preliminary implementation phase: the community mental health (CMH) tool and the mental health (MH) tool.^{387, 388}

It is also decided in Belgium that BelRAI instruments will be used to assess care needs. The use of this instrument can be a good way to get more clear data on MH problems in elderly and if used in every kind of setting it also



gives a view on continuity of care. However, the BELRAI module for mental health is still in a project phase.

Hereafter we present a detailed overview of the current activities of four projects that are financed via the Protocol 3 initiatives.

PIOT

Target population: PIOT (Psychotherapeutische Interventies voor Ouderen thuis met Trajectbegeleiding), situated in the region of Leuven, is an innovative collaboration between a number of different organisations focusing on frail elderly, aged 60 or above, with mental health problems for whom an ambulatory treatment for some reason is inaccessible or insufficient. PIOT offers psychotherapeutic interventions and support for this group, giving them the opportunity to stay (longer) in their home environment and maintaining (or improving) their quality of life without extra burden for the informal carer. The patient or its caregiver can contact the coordinator (who is defined as 'case manager') for an intake consultation. When the intake contact results in inclusion of the person, a therapist is involved to develop an individual care program, consisting of therapeutic counselling in the home-environment and case management. The short lasting intervention (minimum one consultation per month and maximum once a week) is provided by an experienced psychotherapist, who is connected to a community mental health centre (CGG - SSM). Therapists often evaluate the therapy of their patients during team discussions and intervisions (supported by a psychiatrist). The case manager coordinates the organisation of home care and assesses the patient in several life domains, by means of specific instruments (such as the BelRAI HC). In the case that problems are detected in other life domains than mental health (e.g. social or financial problems), the case manager will organise additional care in close consultation with the patient. This can result in the start-up or expansion of additional care such as day care, family care, home support or transport service. To align all of these different services, a multidisciplinary consultation (MDO PSY) can be organized. The operational working model is quite mobile, giving the project members the opportunity to cover a broad region, in collaboration with local partners (e.g. CM Sickness Fund, CGG - SSM).

Financing and numbers: Funds for this project have been allocated since the first wave (2010). No out-of-pocket cost is associated with this approach. PIOT has a broad network of partners in different settings and levels of care and welfare. Eight employees (+/- 4.5 FTE) are involved in the project, which reaches about 100 newly enrolled patient every year (the objective as set by the financing body (RIZIV – INAM) is in fact 162 new inclusions a year). The waiting list is quite small (+/- 5 persons who have to wait on average 2 weeks for an intake consultation and 4 weeks for therapy) and seems to decrease over time. The effectivity and efficiency of the individual care trajectory is monitored closely (start-up, after 6 months and after last consultation).

The strengths of the project, as defined by the management, are a low threshold for therapy (home care, no out-of-pocket cost), flexibility (pace and content of therapy, duration of treatment) and stability of the team (highly engaged teams with low turnover). The weakness is the temporality of the project (financing until 2018) and the quite low budget.

Langer Thuis met Extra Zorg

Target population: 'Langer Thuis met Extra Zorg'³⁹⁰ is an innovative project, situated in South East Flanders, which provides mental health home care to older persons and is a regional initiative between residential elderly care and home care organisations. The focus is to allow elderly people to live in their home environment as long as possible, by provision of tailored and coordinated care. A central case manager ('trajectbegeleider') coordinates care in close collaboration with the older person. A broad set of support options is available, including psychotherapy, depending on the specific somatic, mental or social needs of the client.

Financing and numbers: Funds for this project were allocated since the second wave. The project employs a diverse group of health professionals; including care managers, occupational therapists, psychologists, speech therapists and consultation coordinators and collaborates formally with community mental health centres in the region. The project reaches about 180 elderly per year, but there is a growing waiting list for the initiative. At present, the project is evaluated by a team of KULeuven, but no results are available yet. No out-of-pocket cost is associated with this approach.



The strengths of the project, as defined by the management, are a low threshold, a broad regional coverage, clear estimates/assessment of mental healthcare needs and the multidisciplinary approach. The weakness of the project is that care provided is sometimes too 'non-committal' for patients and relatives (possibly negatively influencing the commitment with therapy), what might hamper the outcomes.

Project 't Kruidenpand

Target population: 't Kruidenpand is a small alternative (sheltered) living environment, founded in 2005, situated in an ordinary row house and closely connected to an elderly care organisation. The project focuses on the accommodation of elderly (60+) with moderate to high vulnerability with chronic (end-stage) psychiatric problems who are no longer able to live independently. The aim of the project is to provide a safe and stable home environment for these people (with tailored care and guidance) in collaboration with external care provider organisations, and to prevent admission in a psychiatric hospital. A secondary aim is to guide these patients, at their own pace, towards a new attempt to live independently. The team consist of a nurse, a nursing auxiliary and an occupational therapist, supported by professionals experienced in rehabilitation science and with expertise of organisation of day care. External partners of the initiative are home care nurses, physiotherapist, GP, a community mental health service and a psychiatric hospital. Potential patients are often referred from psychiatric services and added to the waiting list. The project underwent an evaluation, validated by the Federal Government, with a positive result.

Financing and numbers: Funds for this project have been allocated since the first wave. The strengths of the project, as defined by the organisation, are the personalised (tailored) care for a specific 'niche' group and the multidisciplinary transmutal approach. A potential threat for the project is a lack of funding (including limitation in time) and recognition.

Dionysos

Target population: Dionysos is an organisation linked to the community mental health service (CGG – SSM) Rivage-den Zaet in Brussels. The core characteristic of this project for elderly (60+) with mental health problems is

case management, with close contact and collaboration with the GP. The mean age of the patient population to date is 79 years old. The first contact with the facility is often made by family member of the aged person or by people from his/her social network and seldom by the aged persons themselves. The most common reasons for these contacts are loss of autonomy (living independently) because of mental or cognitive problems. Although the objective loss of independency is often quite moderate, in most cases there is a significant risk for a crisis in the environment of the patient. The outstanding feature of the system is that they work on the crossroads between the elderly and their formal and informal network. The main aim of the interventions is to restore independency of the patients, improve their quality of life and empower the caregivers work. During the intervention period, regular consultation meetings are organised (3-4 x/year) together with the patient and its formal and informal network. Patients are assessed on their frailty by means of the Edmonton Scale (> 6). The teams are mobile and follow the patient during the recovery phase (home, residential elderly home, hospital ...). The professionals working in these initiative are of the opinion that their approach is very effective for the treatment of mental disorders but also for the secondary prevention of these problems.

Financing and numbers: This project exists since the third way of the reform of the mental healthcare sector and was initially financed via the funds for the 'therapeutic projects'. The project received further funds via the first and second wave of protocol 3 projects. Dionysos works in first line as well as in specialised care environments. Staff consists of social workers (3 FTP), psychologists (4 FTP), occupational therapists (0.5 FTP), nurse (0.5 FTP), GP (0.5 FTP), psychiatrist (0.25 FTP) and administrative support (1 FTP). The project reaches about 185 patients a year. No out-of-pocket cost is associated with this approach. The initiative has a stable waiting list but the organisation tries to prevent long waiting times. There is a formal collaboration with a broad range of organisations on an organisational levels including the 107 networks. There is also an ad hoc collaboration close to the patient depending on specific needs.

The strengths of the project, as defined by the management, are the specific scope to intervene in (potential) crisis situations in frail elderly, for which 'classic' coordination and interventions by GPs are difficult or insufficient. Other strengths are the dynamic and tailored approach, the capacity building



by selecting the right care for the right person, the strong position of the GP as coordinator of care, the effectivity of the collaborative approach, the indirect effect of stakeholder training, increased recognition and mutual trust in the collaborative network, and the recognition of the project by a significant part of the regional hospitals and the ambulatory sector. The weakness of the project is directly related to the strengths: the cost related to the complexity to implement the project. This was especially experienced in the beginning of the project when other organisations feared redundancy of their activities.

5.2.4.3 Projects financed by federated authorities in Flanders

Proeftuinen Woonzorg in Geestelijke Gezondheidszorg

Target population: The Flemish Government launched a call to set up test environments ("proeftuinen") for mental healthcare provision in residential adult care (December 2015- December 2017), and created a policy environment with few regulations ('regelluw'). The primary aim of the project was to give organisations the opportunity to develop adequate therapeutic living environments for chronic psychiatric patients and to develop a system for tailored care with focus on recovery, empowerment of patients, involvement of informal care and integration of the close neighbourhood and the local community. Six out of 26 proposals were selected to be 'proeftuinen' for mental healthcare in adults, of which 4 focus (partly) on elderly.³⁹¹

- (1) '4Veld' is an initiative in Beernem (West-Flanders) that provides a safe living environment at 12 persons with long lasting psychiatric problems. The project is a collaboration of family members, elderly, local care providers, Public municipal welfare centres (OCMW – CPAS), social housing organisations, family care and professionals in mental healthcare.
- (2) 'Reymeers' in Lede (East-Flanders) is also a sheltered living environment, that provides (1) a safe living environment to 5 adult persons, (2) eight places for short stay to relieve caregivers of adult psychiatric patients and (3) 9 semi-residential places for elderly with Korsakov dementia. Organisation is supported by the network art. 107 of Aalst-Dendermonde-Sint-Niklaas.

- (3) 'Samenhuizen' from VZW De Lork in St-Gillis in the Brussels Capital region: integration of Korsakov patients in a living group of disabled elderly and people with high care needs. Various partners work together for a living and care project for clients from both mental health needs and persons with disabilities. The target population concerns persons with dual diagnosis, Korsakoff's syndrome, and elderly with a specific care need (physical or psychological)
- (4) 'Zorgcirkels' from the Expertisecentrum Dementie Vlaams-Brabant Memo: 7 care circles in the region of Leuven are set up for persons with Alzheimer or other forms of young dementia. The care circles want to create (1) a strong primary care, (2) care at home for dementia, (3) a 'meeting house' for young dementia, (4) a specific living unit for people with young dementia and their informal carers, (5) a buddy project for young dementia, (6) training and education for every stakeholder, (4) a 'encounter group' for persons with young dementia and their informal carers.

Financing and numbers: The funding provided by the Flemish Government for every 'proeftuin' is 250.000 € per year. The projects will be evaluated after two years, based on their level of collaboration with other parties, their target audience, the setting of the project, the area of coverage, the provision of innovative and recovery oriented treatment, the involvement of patients and family, the staff needed and the use of clinical assessment instruments. All of the projects have started and will be evaluated in 2017.

LDC initiatives OCSM Gent

Target population: Since more than 25 years local service centres (Lokale Dienstencentra-LDC) provide care to elderly in the community. In 1998 these facilities were recognized and funded by the Flemish Community. In the region of Gent, the public municipal welfare centre (OCMW-CPAS) has expanded the care offer of these LDCs with a psychologist who focuses on prevention and treatment of depression in people aged 60 years and older. This initiative offers low threshold psychological support for elderly in the first line of care (free of charge). This care is provided in the local service centres, as well as in the home environment of the elderly. Specific topics that are touched during these sessions are coping with loss (social, physical and mental), depressive feelings, memory problems and dementia, and



problems with the bearing capacity of informal care givers. The length of the care process is variable but intensive psychological treatment, crisis intervention and care for chronic psychiatric problems are not provided by these psychologists and thus referred to specialty care. As this approach is still in its pilot stage, there is no maximum capacity nor a waiting list. Every person (professional care providers, informal carers, family ...) can ask for the intake of a patient.

5.2.4.4 Projects financed by federated authorities in Wallonia

In Wallonia, there are specific initiatives for older persons ('Initiative Spécifique pour la Personne Agée' (ISPA)) that have obtained structural funding from the federated authorities. These specific initiatives are always linked to a community mental health service (CGG – SSM) and were created bottom-up in the beginning of the 2000s.³⁴³

Avec Nos Aînés (ANA)

Target group: 'Avec Nos Aînés' is an innovative project, founded in 2000 as a quality project situated in the province of Namur, which focuses on persons aged 65 years or above with mental health problems. The project is connected to a community mental health centre for adults (SSM Namur-Astrid) and offers support for mental health problems related to ageing. The team consist of three part-time psychologists, a social worker, a part time psychiatrist (5 hours/week), an operational manager and administrative support. The project has a mobile team providing psychotherapy or psychosocial interventions in the home environment of the patient (residential elderly care or at home). 'Avec Nos Aînés' provides crisis interventions (in case of bereavement, family crises or loss of independency), offers individualized treatment of co-habiting couples in case of problems, and organizes help at home such as day care, family care and home support. The organisation also offers support and empowerment meetings for informal care givers. Avec Nos Aînés has close collaborations with mobile art. 107 teams, psychiatric and general hospitals, and is involved in mental health consultation platforms.

Financing and numbers: No out-of-pocket cost is associated with this approach. The project reaches about 400 persons each year and is financed on a continuous basis by L'Agence pour une Vie de Qualité (AVIQ) and the

Province of Namur. At present, there is no waiting list for this project. The project was evaluated by its funders and was found to be reliable, efficient and effective. The strengths of the project, as defined by the management, are its short term, targeted and fast multidisciplinary and complementary interventions, free of charge and provided in the home environment of the elderly. The experience of 16 years is also a strong added value. Moreover, the project is well integrated in the regional mental healthcare landscape. The weaknesses of the project are the small team (in contrast to the large region) and the lack of a psychiatrist to enter the home environment. Moreover, the large region that needs to be covered implies large displacements of staff. A satellite centre might solve this problem.

Parole d'aînés

Target group: 'Parole d'Aînés' is an innovative project, for people aged 60 years and above, is situated in the district of Liège and Huy-Waremme. It provides first-line and specialized mental health interventions in the home environment of the older person and in residential elderly care (MR, MRS) by a multidisciplinary team, specialized in gerontology. Close collaboration is set up with first-line health practitioners (GP). The mission of the project is improving access to mental health for elderly with complex multi-morbidity problems, detecting psychopathology and cognitive problems in elderly, supporting clinical diagnosis, describing aetiology of disorders, providing functional, medical and psychosocial support, networking, training and supervision of home visitors and residential elderly care, supporting family carer givers, directing and coordinating specific request for mental health needs. The team consists of 1 social worker (0.5 FTE), 1 nurse (0.5 FTE), 2 psychologists (0.5 FTE) and 1 psychiatrist (0.1 FTE) who acts as supervisor. At present, the project focuses on the development of an intervention strategy for frail elderly at risk of poverty ('personnes âgées précarisées') by means of a problem solving therapeutic intervention in combination with active case management.

Financing and numbers: The project reaches about 100 persons a year. The price per month for the elderly is 10 to 40€ (some people are treated free of charge), but interventions are partly reimbursed by the Walloon Government. At present, there is no waiting list. There is a close but ad hoc collaboration with other innovative projects such as Avec Nos Aînés and



SAMRAVI (see under). The strengths of the project, as defined by the management, are the multidisciplinary approach, the mobility of the team, provision of therapy in the home environment or in residential elderly care, continuity of care, the independence of the project regarding life choices, the role of the project to reposition mental healthcare in elderly care at home or in residential care, the flexibility of the team, their insight in the local network and their collaboration with regional care initiatives. The weakness of the project is the small team size, lack of administrative support, existing preconceptions and lack of publicity in society and health professionals regarding old age mental health problems that hamper effective therapy, and lack of training opportunities.

'ISPA – Louvain-la Neuve (previously called SAMRAVI)

Target group: The 'Initiative Spécifique pour la Personne Agée' (ISPA) is situated in Louvain-la-Neuve and is well integrated in the regional mental health services. The project offers an ambulatory, holistic, specialized and multidisciplinary healthcare approach, based on clear diagnoses and recognized therapeutic approaches, for elderly (60+) with mental health problems and their family or their network. The initiative provides an appropriate and tailored therapy taking into account available regional care resources and the beliefs and preferences of the patient. The final aim is to promote quality of life of the patients based on their preferences, motivation, values and specific requests. Other formal and informal carers in the home environment or in the residential care facilities are closely involved in the therapy. The team consists of two psychologists (1FTE), a care coordinator and administrative support (0.5 FTE). There is a formal and informal close collaboration with regional first line healthcare practitioners, with different sorts of family support organisations and with residential elderly care facilities.

Financing and numbers: The price per consultation with a psychologist is set at 10.80€/session (reduced tariff or free of charge is possible depending on the financial situation of the older patient). Direct billing with third party payer system is also foreseen. The initiative covers a broad area of Brabant-Wallon, and is recognized and funded by the Région Wallonne. The initiative reaches about 100 elderly with mental health problems per year. At present, there is no waiting list. The project is closely monitored by the Walloon

Government and is found to meet the criteria for funding for several years. The strengths of the project, as defined by the management, are its ability to provide support, answers and treatment to a targeted audience (patient, relatives and network). An important weakness is the small team.

NOTE: in the past, the ISPA initiative was called SAMRAVI. Besides the activities described above, SAMRAVI also created a database (www.samravi.be -website with free access), that offers an overview of references (contact details of home care, ambulatory care, residential care, day and night care, emergency care) in Brabant-Wallon for elderly people with mental health problems. The references are listed based on the type of service or the region where the care is offered. Unfortunately, the database was not updated recently.

L'Espoir

Target population: L'Espoir ASBL is a non-profit organisation working in the regions of Malmédy. Since 2003 the initiative is recognized by the Government as a specific initiative for elderly and has an agreement for an indefinite period (agrément à durée indéterminée). This initiative situates itself in the second line of care (specialized care) and provides guidance (information, referral, counselling ...) for elderly and very old people with mental health problems or problems related to ageing. Care is provided in the living environment of the elderly (at home or in residential elderly care), in close collaboration with family, informal carers and health professionals. The team consist of 2 psychologists (1 FTE) and 1 administrative support (1/2 FTE). L'Espoir directly reaches about 100 patients per year and also realizes indirect follow-up of a larger group of elderly.

Financing and numbers: The initiative was founded in 1993 and receives a structural funding from federated authorities since 1998. The activities performed by the team are reimbursed by the sickness funds (depending on specific agreements) and the out of pocket payment for the elderly is 11€ for a home visit (+ 2 to 6 € travel cost). The initiative also has a 'Therapeutic club' (Club thérapeutique) in Stavelot, where activities for the target population are organized (e.g. contact activities, various workshops, cultural excursions). The project also provides information sessions and trainings for professionals regarding 'psychology and psychopathology of the elderly', in close collaboration with healthcare organisations, care networks and policy



makers. The project cooperates with the other centres specialized in mental healthcare for the elderly in the Brussels (discussion meetings, joint projects, symposia). Internal (the team) and external (AVIQ and the L'Association pour la Diffusion des Initiatives G rontologiques) audits have led to positive evaluation results.³⁹² The strengths of the project, as defined by the management, are its proximity, availability, involvement, deep integration in the network of care and its transversality. The weakness is lack of financial means to realize all of these objectives

5.3 Analysis of previous KCE reports

5.3.1 Method

For this section, two KCE researchers (NB, MF) performed the selection of the KCE reports (published since 2007) in relation to the mental healthcare and care for elderly. Inclusion criteria were:

- Relation to the organisation of mental healthcare whatever the patient's age considered;
- Relation to the organisation of care for elderly;
- Proposed recommendations relevant for mental healthcare for elderly.

Two researchers (NB, MF) tabulated all recommendations relevant mental healthcare for elderly and draft a synthesis.

5.3.2 Search results

5.3.2.1 Organisation of inpatient care for older people

In general hospitals, the geriatric patient care is organized based on the care programme for geriatric patients.⁴⁷ The target group is described in the law as "the care programme for geriatric patients targets patients with an average age ≥ 75 years who need a specific approach for the following reasons: a frailty profile, active multi-pathology, a limited homeostasis, atypical clinical appearances of diseases; disturbed pharmacokinetics, risk for functional decline; risk for malnutrition; trend to be inactive and bedridden, with an increased risk for institutionalisation and for dependency

in activities of daily living; psychosocial problems." Younger patients may be included in the programme if they fulfil the criteria of a geriatric profile as specified in the care programme for geriatric patients.

Because of the growing demand for geriatric beds due to the aging of the population and a shortage of geriatricians to run the geriatric units, the care programme for geriatric patients organised an internal and an external liaison.

The internal liaison (also called inpatient geriatric consultation teams)³⁰⁹ is a mobile team that visits high-risk patients (e.g. identified by a screening procedure) admitted to non-geriatric units to perform the assessment and to make recommendations to the treating physician/care team. This team allows to share geriatric principles in all hospital units (i.e. in psychiatric wards). Older inpatients with mental health problem can benefit from the geriatric approach even if they were not admitted in geriatric wards. However, the authors of KCE reports 245³⁰⁹ showed that the demand of geriatric expertise clearly outweighs the supply of available financial and human resources (geriatricians and specialised nurses).

The external liaison (also called external geriatric consultation function) aims to make the geriatric principles and expertise available to general practitioners and primary caregivers. The purpose is to optimize the continuity of care, to avoid inappropriate (re-)admissions, to create synergy and to develop networking between care givers before and after hospitalisation. In practice, the authors of KCE reports 245 found that the external liaison is not implemented by the general hospitals. However, this function of the care programme for geriatric patient may insure seamless mental health from hospital to home.

Unfortunately, the care programme for geriatric patients is limited to general hospital. Therefore external liaison is not intended for these geriatric patients with mental health problem admitted in specialised hospital in rehabilitation (Sp beds) and psychiatric hospitals.

To answer to the international tendency towards de-institutionalisation of psychiatric care,³⁹³ external liaison³⁰⁹ and organisation of seamless care with regard to medication between hospital and home as described in KCE report 131³⁹⁴ are key elements of success.



It is important to note that, since 6th reforms of the state, the organisation of care programme for geriatric patients is now a competence of federated entities.

5.3.2.2 *De-institutionalization and outpatient care*

Organisation of mental healthcare for persons with severe and persistent mental illness

According to the declaration on the future mental healthcare policy in 2002, mental healthcare has to be tailored to the specific needs of each person with a mental disorder and his family in the natural living environment.

Therapeutic project programme

In 2007, a three year government program for experimental 'therapeutic projects' for mental healthcare was implemented. The therapeutic projects are intended to implement an 'integrated health services model' in clearly defined catchment areas, providing services adapted to the needs of the patient and promoting his rehabilitation in society and guaranteeing continuity of care. About one out of eight therapeutic projects concerned older persons with mental health problems. The evaluation of the projects suggested that they aimed at identifying, treating and supporting older persons with behavioural and emotional problems. However, it remains uncertain whether the projects also targeted older persons with severe mental disorders.^{11, 12} The large scope of some therapeutic projects for older persons may have led them to be considered to stop their participation in the programme and to submit a request for new budgets via RIZIV — INAMI Protocol 3 projects.

The professionals working in the projects pointed out that older patients suffered from multiple barriers in the access to services. First, stigmatisation of mental illness inhibits patients and their families to seek help from specialised healthcare professionals (e.g. psychiatrist). Second, many projects pointed out that there is a shortage of psychiatric services that target older patients. The support provided via the projects aimed at facilitating the transition between different services (e.g. from hospitals to nursing homes), to reduce the waiting lists and to improve the availability of specific services. The latter included, among others, follow-up meetings

(e.g. for instance with a psychologist) at the patient home that were perceived to be more easily accepted by the patient.^{11, 12}

The professionals working in the therapeutic projects stated that enhanced support for healthcare professionals improved the care provided to older persons. They argued that it increases the healthcare professionals' awareness of the substantial but undetected psychosocial problems (e.g. depressed older persons (even suicidal), allows to mobilise specialised care providers more rapidly (other partners in the project) and to plan adequate care in order to avoid a decline in the health of the older persons. In addition the professionals involved in the projects pointed out that support to families allowed to optimise the care of the patient and to make decisions regarding the transfer of patients to a residential form of care.^{11, 12}

Support to families and informal caregivers of older adults

There is a wide agreement that supporting informal caregivers is essential in order to allow them to fulfil their caring role without compromising their own health or their income.³²⁸ Public support to informal caregivers is a complex issue encompassing multiple aspects of the social security system (e.g. pension, unemployment, compulsory insurance for medical care), which may make it difficult to establish one single and coherent strategy to cover the needs of informal caregivers. Moreover, it is important to note that when discussing support measures with the informal caregivers, they automatically linked such support to formal care services for the dependent older person. In a sense, support measures for the caregivers are complementary to professional home care services. Without appropriate formal care at home, support measures for the informal caregiver may prove to be ineffective. The findings in this report highlight that caregivers of older adults struggle to navigate the very fragmented system between health and care providers, between federal authorities, regional authorities and even within municipalities. The lack of a well-known information channel adapted to all informal caregivers and their families will preclude the use of services even if they are available and affordable. In the current fragmented system, people with a high socio-economic status may be more prepared than people with a low socio-economic status to find information and to use available services. In order to improve the situation for older persons and their informal caregivers, it is necessary to not only improve the organisation



and display of available information on services but also to have a pro-active policy towards their diffusion. The latter should be fostered by health and social care professionals who should include actively the informal caregiver in the dependent person's care plan. For highly dependent people, case managers or discharge managers could be involved in implementing the care plan.

5.3.2.3 *Psychiatric emergency lesson learned from children and adolescents*

As older people, children and adolescents are considered as specific group in term of mental healthcare needs. For this reason, we summarized the main findings.

Report 135 showed that theoretically, as well as in terms of goals and processes, emergency psychiatric (medical) care may be distinguished from crisis intervention. The former is generally considered hospital based, the latter community based. This distinction may also be important when mental healthcare for older people is considered.

In this report, emergency psychiatric care emerges as a particular component in an overall care process aiming to facilitate further development. Emergency psychiatric care may be considered as a separate function within the global care spectrum, rather than a particular organisational entity. Different organisational configurations could contribute in the fulfilling of this function. This function should be conceptually embedded in all other functional components of mental healthcare (such as acute and chronic care functions).

The report concluded that emergency psychiatric care is preferentially linked to or embedded in the existing general hospital based emergency care, a system familiar to most people and institutions such as e.g. police. Within this emergency system, registration, stabilization and assessment could at least partially take place. Therefore, an emergency psychiatric intervention team can be set up and consists of several types of professionals (psychiatrists, competent nursing professionals, psychologists and administrative support). Minimally, an emergency psychiatric care function thus assumes a close collaboration between a specialised emergency

service (well-known entrance), a psychiatric department and a hospital department.

5.3.2.4 *Older people with mental health problem as chronic patients*

The prevalence of at least 2 conditions in the population aged 70 years or more ranges between 50-70%.³⁹⁵ Therefore older people with mental health problem are at high risk to have multiple morbidity. For these patients, complex drug management and interactions with multiple care providers are challenging.

When one of the diseases is of long duration and generally with slow progression³⁹⁶, the older person is a chronic patient. Chronic diseases covers a wide range of health problems, mostly non-communicable diseases e.g. diabetes, cancer, musculoskeletal, respiratory, neurodegenerative, mental and cardiovascular diseases.

KCE report 190³⁸³ provides 20 recommendations to organise chronic care in Belgium. These recommendations can be apply to older persons with a mental health diseases. They cover the following aspects:

- the individualized care plan;
- the provision of routine care and support for the chronic patient;
- the monitor and evaluate progress and quality of care;
- the provision of acute episode response and specialised services;
- the early identification of the patients' chronic profile;
- the support of patient and informal caregiver empowerment;
- the implementation and follow-up of a dynamic care model.



5.3.2.5 *Human resources*

Mental healthcare

The KCE report 245³⁰⁹ on the inpatient geriatric consultation teams stressed the need of specialised healthcare professionals for older people. In Belgium, specialists in internal medicine can obtain additional accreditation as geriatricians via a 'special competency in geriatric care'. For nurses, a particular professional title of nursing specialised in 'geriatrics' is available ('verpleegkundige gespecialiseerd in de geriatrie – infirmier spécialisé en gériatrie'). The KCE report 265³⁵⁹ provides an overview of the regulation of healthcare professionals working in the field of mental healthcare. The authors recommended to increase the attractiveness of the geriatric specialisation for physicians, to consider the creation of advanced practice nurses in geriatric care, to make geriatric specialisation for nurses a special point of attention and, to design a compulsory 'geriatric training (i.e. courses and clinical placement). The lack of skill healthcare professionals for geriatric patients is also seen for older persons with mental health problems especially when those patients have a geriatric profile.

5.3.2.6 *Treatment of some mental healthcare problems*

Recommendations regarding the non-pharmaceutical interventions for dementia (KCE report 160)³⁹⁷, the treatment of adult major depression (KCE report 230)³⁹⁸, problematic alcohol use (KCE report 258)³⁹⁹ and, psychological care (report 265)³⁵⁹ can be applied to older person with those mental health problems

6 CONCLUSIONS AND RECOMMENDATIONS

The previous chapters analysed the literature and the organisation of mental healthcare for older people in Belgium and abroad. Based on this information we present the conclusions and the recommendations for a mental healthcare organisation for older adults in the short report and in the synthesis of the study, which are published as a separate document on our website. It can be accessed from the same webpage as the current document.



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