Collaborative Care:
Aging & Dual Diagnosis
(CCADD)

Presented by:
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Today's Objectives

• Background information

• Subspecialty populations

• Development of work group and model

• Progress and successes

• Future directions
Mental Health Centre Penetanguishene

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

• Committed to serving those individuals who have been diagnosed with a complex, serious mental illness.

• Continuing multiple and complex needs which cannot be met at the primary and secondary levels of service.

• Our goal is to transition clients into the community.

• Services are provided on four distinct programs.
Bayview Dual Diagnosis Program (BDDP)

• Adults with a developmental disability and a mental health need.
• Individuals within MHCP’s catchment area and LHIN12
• Full multidisciplinary team providing inpatient and outpatient consultation, assessment, treatment, transitional discharge and community follow-up.
Geriatrics Services Program (GSP)

• Inpatient and outpatient psychiatric services to clients 65 years of age or older within North Simcoe Muskoka

• The Program has five main components: a 26 bed inpatient unit; a consultative outreach team; a Day Clinic; and two Nursing Home Clinics

• Full inter-professional team providing assessment, treatment, rehabilitation, transitional discharge and ongoing monitoring via outpatient services
GSP and BDDP: Working Together

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

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

• The longer a client is admitted to an institution, the higher the mortality rate once transferred to community

• Behaviour disorders occur less often in older adults with developmental disabilities as compared to younger groups
Elderly people with developmental disabilities have a greater prevalence of psychiatric morbidity than younger controls.

Rates of anxiety and depression are high and dementia is common.

Psychiatric and behavioural disorders declined with increasing age, at least through 70 years of life.

Elderly people with developmental disabilities had significantly more medical problems than did their non-disabled counterparts of the same age.
Findings

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

Purpose:

- System Development
- Promote Excellence

Mandate:

- Research
- Leading Practices
- Recommendations
- Advise
The ‘Specialty’ of Working with Aging & Dual Diagnosis

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

CLIENT IDENTIFICATION
For COLLABORATIVE CARE: AGING & DUAL DIAGNOSIS MODEL

TELEPHONE CONSULTATION/INFO. SHARING
Between GSP & BDDP intake

JOINT INITIAL ASSESSMENT
by GSP & BDDP (staff from CCADD)

CARE CONFERENCE with CCADD

NOT APPROPRIATE FOR EITHER
APPROPRIATE FOR GSP
APPROPRIATE FOR BDDP

JOINT EFFORT FOR CCADD
(client deemed appropriate for CCADD; designate joint leads for ongoing collaboration no matter what decision)

INPATIENT ADMISSION
OTHER AGENCY SERVICE
(i.e. day clinic, day programming)
COMMUNITY TEAM SERVICES (define service; define lead)

GSP
BDDP

COMMUNITY TEAM FOLLOW-UP
COMMUNITY TEAM FOLLOW-UP

BOTH PROGRAMS FOLLOW-UP
“Mr. A”

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

*With CCADD…..*

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

- Age range
- Previous diagnosis
- Origin of request
Diagnoses

- Intellectual Disability: 8
- Down's Syndrome: 5
- Existing Dementia: 2
- Existing Depression: 3
- Disruptive Behaviour: 10
Origin of Requests

- CCAC: 1
- Developmental Services: 7
- LTC: 4
- HSC: 1
Client Base

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

• Where
  • Place of residence

• When
  • Following intake process

• Who attends
  • Client, Caregivers and the CCADD clinicians
Assessment Outcome

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

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

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

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

• Reason for referral
  • Through geriatric service program
  • Presenting problems: aggression, sleep disturbance, and relocation stress

• Assessment
  • Observational assessment only
  • Examined physical status, intellectual, emotional, capabilities, environmental, social and mental status
Case Study Continued

• Outcomes/Recommendations
  • Psycho-geriatric consultation; medication review
  • Letter of support to extend 1:1 staffing
  • Baseline cognitive function
  • OT assessment
  • Appropriate levels of staffing

• Appropriateness for CCADD
  • Intellectual disability
  • Aging
  • Serious mental illness
Case Study - Larry

• 81 year old male

• Diagnoses
  • Axis I
    • Depression, OCD
    • Dementia that dates back to 1999
  • Axis II
    • Intellectual disability
  • Axis III
    • Osteo-arthritis
    • Positive for Hepatitis A
    • Shingles
Case Study  Continued

• Reason for referral
  • Depressive symptoms
  • Change in behaviour

• Assessment
  • Observational assessment
  • Examined physical status, intellectual, emotional, capabilities, environmental, and mental status
Case Study cont'd

• Outcome/Recommendations
  • Geriatric psychiatrist to assess
  • Referral to Alzheimer’s society for staff education
  • Me & U First education for staff
  • Behavioural intervention strategies

• Appropriateness for CCADD
  • Intellectual disability
  • Cognitive changes
  • Depression
  • Older adult
Sustainability

• Infrastructure
  • Forms
  • Testing
  • Tracking
  • Commitment from management

• Workload
  • Accountability

• Tools
  • Trial for a year
  • Evaluation
Future Direction

• Develop an assessment framework to use for all clients who meet the CCADD criteria.
• Conduct an evaluation of the selected test battery
• Recruit MHCP doctor
• Engage in partnerships
• Program evaluation
No wrong door!

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

• Specialty approach to meet a uniquely identified need
• Seamless process
• Central access point
Questions?

Thank You
References


References  Continued


Hammel, J., et al. (2002). The impact of assistive technology and environmental interventions on function and living situation status with people who are aging with developmental disabilities. Disability and Rehabilitation, 24(1/2/3), 93-105


