KCE REPORT 301S

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

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

SUPPLEMENT





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HEALTH SERVICES RESEARCH

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APPENDICES

1. SEARCH STRATEGY OF THE NARRATIVE SCOPING REVIEW

1.1. Research Question

What are the concepts and dimensions specific to the organisation or improvement of mental health care for the elderly, as reported in grey (including publications of institutions such as WHO) and scientific literature?

1.2. PICO

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

1.3. Definitions

Elderly: The elderly population is defined as people aged 65 and over. However, as certain research sources make distinction between 65-74 and 75+, this has to be taken into account for the present literature search. (OECD)

Mental health: Mental health is defined as a state of well-being in which every individual realizes 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. (WHO; OECD)

Mental disorder: A mental disorder is 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. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political,

religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (DSM-V). 'Mental illness' refers to one portion of the broader term 'mental impairment', and is different from other covered mental impairments such as mental retardation, organic brain damage, and learning disabilities. The term 'psychiatric disability' is used when mental illness significantly interferes with the performance of major life activities, such as learning, working and communicating, among others (Boston University).

Health care policy: Health policy can be defined as the "decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society" (WHO). Health care policy targets the organization, financing and delivery of health care services and includes the licensing of health professionals and facilities, health information privacy protections, measures of health care quality and mistakes, malpractice, electronic medical records and efforts to control health care costs (Acuff, 2015).

Effectiveness of health care: Effectiveness is the relationship between the level of resources invested and the level of results, or improvements in health. Assessing effectiveness consists of measuring the effects of medical practices and techniques -- therapeutic, diagnostic, surgical and pharmacological -- on individuals' health and wellbeing. This must take into consideration not only observed improvements in health but also negative impacts, such as side effects and iatrogenic effects (Government of Canada).

Efficiency of health care: Efficiency is the relationship between the level of resources invested in the health care system and the volume of services, or, what amounts to the same thing, improvements in health achieved.(6) The purpose of efficiency is to maximize results effectively, or services delivered, given a particular budget (Government of Canada).

1.4. Potential search terms

P: elderly, "older adult", "Aged"[Mesh], "Frail Elderly"[Mesh], Aged, "Aged, 80 and over"[Mesh]

AND

P: "Mental Disorders"[Mesh], "psychological problem", "psychological disorder", "psychic disorder", "mental illness", "Mental Health"[Mesh]

I: "Mental Health Services"[Mesh], "mental health care",

AND

I: "Health Policy"[Mesh], "organisational model", "organisation of", "integrative care", "collaborative care", "stepped care", "chronic care model"

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],

2. SEARCH STRATEGY

2.1. Medline

Date	13/05/2016 16:00 GMT+1	
Database	Medline@Pubmed including Pubmed not medline	
Search strategy		
#57	Search (((((((("Mental Disorders"[Mesh] OR “psychological problem”OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh])) AND (elderly, “older adult”OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh]))) AND ("Health Policy"[Mesh] OR “organisational model” OR “organisation of” OR “integrative care” OR “collaborative care” OR “stepped care” OR “chronic care model”))) AND ("Outcome Assessment (Health Care)"[Mesh] OR "Outcome and Process Assessment (Health Care)"[Mesh] OR efficiency OR effectiveness OR “cost effectiveness” OR “quality of care” OR "Cost-Benefit Analysis"[Mesh] OR "Quality of Health Care"[Mesh] OR "Health Care Quality, Access, and Evaluation"[Mesh] OR "Quality Assurance, Health Care"[Mesh] OR "Quality Indicators, Health Care"[Mesh]))) NOT (("Adolescent"[Mesh]) OR "Child"[Mesh]) Schema: nomesh Sort by: Relevance Filters: published in the last 10 years	*474*
#55	Search (((((((("Mental Disorders"[Mesh] OR “psychological problem” OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh])) AND (elderly, “older adult” OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh]))) AND ("Health Policy"[Mesh] OR “organisational model” OR “organisation of” OR “integrative care” OR “collaborative care” OR “stepped care” OR “chronic care model”))) AND ("Outcome Assessment (Health Care)"[Mesh] OR "Outcome and Process Assessment (Health Care)"[Mesh] OR efficiency OR effectiveness OR “cost effectiveness” OR “quality of care” OR "Cost-Benefit Analysis"[Mesh] OR "Quality of Health Care"[Mesh] OR "Health Care Quality, Access, and Evaluation"[Mesh] OR "Quality Assurance, Health Care"[Mesh] OR "Quality Indicators, Health Care"[Mesh]))) NOT (("Adolescent"[Mesh]) OR "Child"[Mesh]) Sort by: Relevance	*688*
#54	Search ("Adolescent"[Mesh]) OR "Child"[Mesh] Sort by: Relevance	*2577840*
#50	Search ((((((("Mental Disorders"[Mesh] OR “psychological problem” OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh])) AND (elderly, “older adult” OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh]))) AND ("Health Policy"[Mesh] OR “organisational model” OR “organisation of” OR “integrative care” OR “collaborative care” OR “stepped care” OR “chronic care model”))) AND ("Outcome Assessment (Health Care)"[Mesh] OR "Outcome and Process Assessment (Health Care)"[Mesh] OR efficiency OR effectiveness OR “cost effectiveness” OR “quality of care” OR "Cost-Benefit Analysis"[Mesh] OR "Quality of Health Care"[Mesh] OR "Health Care Quality, Access, and Evaluation"[Mesh] OR "Quality Assurance, Health Care"[Mesh] OR "Quality Indicators, Health Care"[Mesh]) Sort by: Relevance	*957*
#49	Search "Outcome Assessment (Health Care)"[Mesh] OR "Outcome and Process Assessment (Health Care)"[Mesh] OR efficiency OR effectiveness OR “cost effectiveness” OR “quality of care” OR "Cost-Benefit Analysis"[Mesh] OR "Quality of Health Care"[Mesh] OR "Health Care Quality, Access, and Evaluation"[Mesh] OR "Quality Assurance, Health Care"[Mesh] OR "Quality Indicators, Health Care"[Mesh] Sort by: Relevance	*6386792*

#48	Search ((("Mental Disorders"[Mesh] OR “psychological problem” OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh])) AND (elderly, “older adult” OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh]))) AND ("Health Policy"[Mesh] OR “organisational model” OR “organisation of” OR “integrative care” OR “collaborative care” OR “stepped care” OR “chronic care model”) Sort by: Relevance	*1085*
#46	Search "Health Policy"[Mesh] OR “organisational model” OR “organisation of” OR “integrative care” OR “collaborative care” OR “stepped care” OR “chronic care model” Sort by: Relevance	*91892*
#45	Search (("Mental Disorders"[Mesh] OR “psychological problem” OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh])) AND (elderly, “older adult” OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh]) Sort by: Relevance	*334770*
#44	Search "Mental Disorders"[Mesh] OR “psychological problem” OR "psychological disorder" OR "psychic disorder" OR “mental illness” OR "Mental Health"[Mesh] Sort by: Relevance	*1052992*
#43	Search elderly, “older adult” OR "Aged"[Mesh] OR "Frail Elderly"[Mesh] OR Aged OR "Aged, 80 and over"[Mesh] Sort by: Relevance	*4379659*

2.2. Cochrane Database of Systematic Reviews

Date	**13/06/16 10:56:18.9**	
Database	Cochrane Database of Systematic Reviews	
Search strategy		
#1	[mh "Mental Disorders"]	49216
#2	"psychological problem":ab,ti	15
#3	"psychological disorder":ab,ti	18
#4	"psychic disorder":ab,ti	1
#5	"mental illness":ab,ti	1307
#6	[mh "Mental Health"]	893
#7	#1 or #2 or #3 or #4 or #5 or #6	50402
#8	"elderly":ab,ti	16902
#9	"older adult":ab,ti	311
#10	[mh Aged]	1003
#11	[mh "Frail Elderly"]	595
#12	Aged:ab,ti	43560

#13	[mh "Aged, 80 and over"]	104
#14	#8 or #9 or #10 or #11 or #12 or #13	58096
#15	#7 and #14	4230
#16	[mh "Health Policy"]	664
#17	"organisational model":ab,ti	1
#18	"organisation of":ab,ti	223
#19	"integrative care":ab,ti	12
#20	"collaborative care":ab,ti	426
#21	"stepped care":ab,ti	400
#22	"chronic care model":ab,ti	78
#23	#16 or #17 or #18 or #19 or #20 or #21 or #22	1770
#24	#15 and #23	45
#25	[mh "Outcome Assessment (Health Care)"]	116555
#26	[mh "Outcome and Process Assessment (Health Care)"]	118551
#27	efficiency:ab,ti	8339
#28	effectiveness:ab,ti	70153
#29	"cost effectiveness":ab,ti	15600
#30	"quality of care":ab,ti	1085
#31	[mh "Cost-Benefit Analysis"]	17719
#32	[mh "Quality of Health Care"]	399977
#33	[mh "Health Care Quality, Access, and Evaluation"]	405863
#34	[mh "Quality Assurance, Health Care"]	3860
#35	[mh "Quality Indicators, Health Care"]	370
#36	#25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35	445585
#37	#24 and #36 Publication Year from 2006 to 2016	39
Notes	Cochrane database of systematic reviews: 2 CENTRAL: 37	

2.3. CINAHL

Date	2016-06-13	
Database	CINAHL	
Search strategy		
S1	(mh "Mental Disorders+")	273,840
S2	(AB "psychological problem") OR (TI "psychological problem")	92
S3	(AB "psychological disorder") OR (TI "psychological disorder")	81
S4	(AB "psychic disorder") OR (TI "psychic disorder")	4
S5	(AB "mental illness") OR (TI "mental illness")	8,812
S6	(mh "Mental Health+")	13,600
S7	(S1 OR S2 OR S3 OR S4 OR S5 OR S6)	285,045
S8	(AB elderly) OR (TI elderly)	44,450
S9	(AB "older adult") OR (TI "older adult")	2,572
S10	(mh "Aged+")	375,582
S11	(mh "Frail Elderly+")	3,859
S12	(AB Aged) OR (TI Aged)	64,221
S13	(mh "Aged, 80 and over")	127,505
S14	S8 OR S9 OR S10 OR S11 OR S12 OR S13	423,283
S15	(S7 AND S14)	57,550
S16	(mh "Health Policy+")	51,822
S17	(AB "organisational model") OR (TI "organisational model")	8
S18	(AB "organisation of") OR (TI "organisation of")	4,881
S19	(AB "integrative care") OR (TI "integrative care")	84
S20	(AB "collaborative care") OR (TI "collaborative care")	708
S21	(AB "stepped care") OR (TI "stepped care")	216
S22	(AB "chronic care model") OR (TI "chronic care model")	230
S23	(S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22)	57,703
S24	((S15 AND S23)	609

S25	(MH "Outcomes (Health Care)+")	196,994
S26	(MH "Process Assessment (Health Care)+")	5,232
S27	(AB efficiency) OR (TI efficiency)	12,347
S28	(AB effectiveness) OR (TI effectiveness)	60,149
S29	(AB "cost effectiveness") OR (TI "cost effectiveness")	8,682
S30	(AB "quality of care") OR (TI "quality of care")	13,010
S31	(MH "Cost Benefit Analysis+")	15,396
S32	(mh "Quality of Health Care+")	350,445
S33	(MH "Health Services Accessibility+")	46,476
S34	(S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33)	449,594
S35	S24 AND S34	181
S36	(MH "Child+")	325,015
S37	S35 NOT S36	166
S38	S37 Limiters - Published Date: 20060101-20161231	137
Notes		

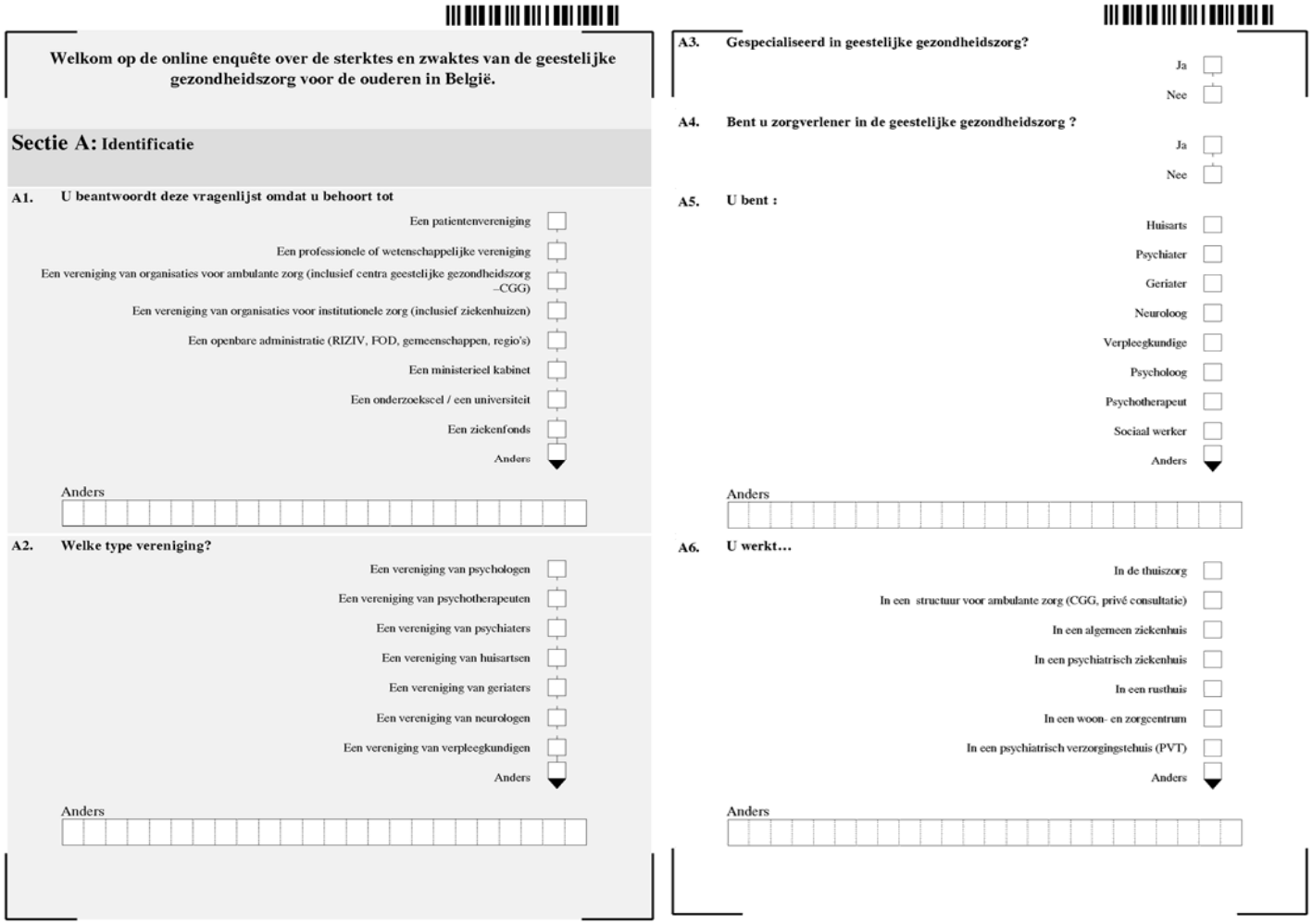
2.4. Embase

Date	**2016-06-07**	
Database	Embase	
Search strategy		
1	'aged'/exp	2380168
2	aged:ab,ti	550891
3	elderly:ab,ti	263925
4	'older adult':ab,ti	5601
5	#1 OR #2 OR #3 OR #4	2821424
6	'mental disease'/exp	1786871

7	'psychological problem':ab,ti OR 'psychological disorder':ab,ti OR 'psychic disorder':ab,ti OR 'mental illness':ab,ti	26472
8	'mental health'/exp	105934
9	#6 OR #7 OR #8	1841088
10	#5 AND #9	285585
11	'health care policy'/exp	158729
12	'organisational model':ab,ti	85
13	'organisational models':ab,ti	56
14	'organisation of':ab,ti OR 'integrative care':ab,ti OR 'collaborative care':ab,ti OR 'stepped care':ab,ti OR 'chronic care model':ab,ti	12716
15	#11 OR #12 OR #13 OR #14	171223
16	#10 AND #15	1725
17	'outcome assessment'/exp	322650
18	'treatment outcome'/exp	1131745
19	'efficiency':ab,ti OR 'effectiveness':ab,ti OR 'cost effectiveness':ab,ti OR 'quality of care':ab,ti OR 'quality indicators':ab,ti	776483
20	'cost benefit analysis'/exp	70323
21	'health care quality'/exp	2282574
22	#17 OR #18 OR #19 OR #20 OR #21	2947958
23	#16 AND #22	699
24	'adolescent'/exp OR 'child'/exp	2993763
25	#23 NOT #24	604
26	#25 AND [2006-2016]/py	405
27	#26 NOT [medline]/lim	121
28	#27 NOT ([conference abstract]/lim OR [conference paper]/lim OR [conference review]/lim)	100
Notes		

3. ONLINE SURVEY TO STAKEHOLDERS

3.1. Dutch version



Welkom op de online enquête over de sterktes en zwaktes van de geestelijke gezondheidszorg voor de ouderen in België.

Sectie A: Identificatie

A1. U beantwoordt deze vragenlijst omdat u behoort tot

- Een patientenvereniging ☐
- Een professionele of wetenschappelijke vereniging ☐
- Een vereniging van organisaties voor ambulante zorg (inclusief centra geestelijke gezondheidszorg –CGG) ☐
- Een vereniging van organisaties voor institutionele zorg (inclusief ziekenhuizen) ☐
- Een openbare administratie (RIZIV, FOD, gemeenschappen, regio's) ☐
- Een ministerieel kabinet ☐
- Een onderzoekscel / een universiteit ☐
- Een ziekenfonds ☐
- Anders ☐

Anders

A2. Welke type vereniging?

- Een vereniging van psychologen ☐
- Een vereniging van psychotherapeuten ☐
- Een vereniging van psychiaters ☐
- Een vereniging van huisartsen ☐
- Een vereniging van geriaters ☐
- Een vereniging van neurologen ☐
- Een vereniging van verpleegkundigen ☐
- Anders ☐

Anders

A3. Gespecialiseerd in geestelijke gezondheidszorg?

- Ja ☐
- Nee ☐

A4. Bent u zorgverlener in de geestelijke gezondheidszorg ?

- Ja ☐
- Nee ☐

A5. U bent :

- Huisarts ☐
- Psychiater ☐
- Geriater ☐
- Neuroloog ☐
- Verpleegkundige ☐
- Psycholoog ☐
- Psychotherapeut ☐
- Sociaal werker ☐
- Anders ☐

Anders

A6. U werkt…

- In de thuiszorg ☐
- In een structuur voor ambulante zorg (CGG, privé consultatie) ☐
- In een algemeen ziekenhuis ☐
- In een psychiatrisch ziekenhuis ☐
- In een rusthuis ☐
- In een woon- en zorgcentrum ☐
- In een psychiatrisch verzorgingstehuis (PVT) ☐
- Anders ☐

Anders

A7. **Hoeveel jaar ervaring hebt u in het veld van de geestelijke gezondheidszorg ?**

- < 5 ☐
- 5- 10 ☐
- 11-20 ☐
- >20 ☐

A8. **Waar werkt u?**

- Antwerpen ☐
- Vlaams-Brabant ☐
- Waals-Brabant ☐
- Brussels ☐
- West-Vlaanderen ☐
- Oost-Vlaanderen ☐
- Henegouwen ☐
- Luik ☐
- Limburg ☐
- Luxemburg ☐
- Namen ☐

Sectie B: Perceptie van het systeem voor geestelijke gezondheidszorg voor ouderen

We zullen u nu een aantal vragen stellen met betrekking tot uw perceptie van het systeem voor geestelijke gezondheidszorg voor ouderen.

De vragen baseren zich op elementen die nuttig kunnen zijn voor een performant gezondheidszorgsysteem zoals beschreven in de literatuur.

U hebt ook de mogelijkheid om commentaren te geven om te verduidelijken waarmee u niet (volledig) akkoord bent met betrekking tot een stelling.

In het kader van dit onderzoek, bedoelen we met de 'ouderen' personen van 65 jaar en ouder.

Dementie op zich maakt geen deel uit van wat we in dit onderzoek verstaan onder 'geestelijke gezondheidsproblemen'

Sectie C: Doelstellingen van een geestelijk gezondheidszorgsysteem dat beantwoordt aan de noden van de ouderen

C1. **Voor oudere personen met geestelijke gezondheidsproblemen laat de actuele organisatie van geestelijke gezondheidszorg toe om ...**

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
eenzaamheid te voorkomen	☐	☐	☐	☐	☐
sociaal isolement te voorkomen	☐	☐	☐	☐	☐
mishandeling te voorkomen	☐	☐	☐	☐	☐
gevoelens van onveiligheid te voorkomen	☐	☐	☐	☐	☐
zolang mogelijk de autonomie te behouden	☐	☐	☐	☐	☐
zolang mogelijk de zelfzorg te behouden	☐	☐	☐	☐	☐
zolang mogelijk het zelfbeschikkingsrecht te behouden	☐	☐	☐	☐	☐
de persoon zolang mogelijk in zijn eigen woning te laten wonen	☐	☐	☐	☐	☐
gebruik van urgentiediensten te voorkomen	☐	☐	☐	☐	☐
zolang mogelijk een leven te leiden dat betekenisvol is	☐	☐	☐	☐	☐

C2. **Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?**

C3. **Welke oplossingen stelt u voor om deze aspecten te verbeteren?**

Sectie D: Doelstellingen van een geestelijk gezondheidszorgsysteem voor de ouderen -2

D1. Het huidige gezondheidszorgsysteem biedt

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
ondersteuning voor de ouderen	☐	☐	☐	☐	☐
ondersteuning voor de mantelzorgers	☐	☐	☐	☐	☐
specifieke programma's voor kwetsbare groepen	☐	☐	☐	☐	☐
ondersteuningsprogramma's in de eigen woonomgeving van de patiënt	☐	☐	☐	☐	☐

D2. Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?

D3. Welke oplossingen stelt u voor om deze aspecten te verbeteren?

Sectie E: Doelstellingen van een geestelijk gezondheidszorgsysteem voor de ouderen -3

E1. Het huidige gezondheidszorgsysteem laat toe om ...

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
geestelijke gezondheidsproblemen van de ouderen te detecteren	☐	☐	☐	☐	☐
adequaat tegemoet te komen aan de geestelijke gezondheidsproblemen van de ouderen	☐	☐	☐	☐	☐

E2. Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?

E3. Welke oplossingen stelt u voor om deze aspecten te verbeteren?

Sectie F: Doelstellingen van een geestelijk gezondheidszorgsysteem voor de ouderen -4

F1. In het algemeen

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
Het huidige gezondheidszorgsysteem biedt een globale aanpak voor fysieke, psychische en sociale noden van ouderen	☐	☐	☐	☐	☐
De aanpak van het systeem is patient centered	☐	☐	☐	☐	☐
De zorgverlening is financieel draaglijk voor de patient	☐	☐	☐	☐	☐
De zorgverlening draagt oplossingen aan voor de patienten (is responsief)	☐	☐	☐	☐	☐
De zorgverlening houdt rekening met de verwachtingen en voorkeuren van de patient	☐	☐	☐	☐	☐
De zorgverlening houdt rekening met de verwachtingen en voorkeuren van de familie van de patient	☐	☐	☐	☐	☐
De zorgverlening is transdisciplinair, met andere woorden ze optimaliseert de bijdrage van ieders competentie (met inbegrip van niet-professionelen en vrijwilligers) en bevordert de samenwerking tussen de instellingen en de diensten aangeboden in de gemeenschap	☐	☐	☐	☐	☐
De zorgverlening impliceert dat elke zorgverlener verantwoordelijkheid moet dragen voor zijn/haar bijdrage	☐	☐	☐	☐	☐
De zorgverlening integreert alle beschikbare diensten om de continuiteit van zorg te garanderen. Dit gebeurt op een gecoördineerde wijze (lokaal, regionaal en nationaal niveau)	☐	☐	☐	☐	☐
Geestelijke gezondheidszorg voor de ouderen in de eerste lijn krijgt de nodige aandacht	☐	☐	☐	☐	☐

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
De rollen en taken van de verschillende zorgprofessionals in de geestelijke gezondheidszorg voor de ouderen zijn duidelijk gedefinieerd	☐	☐	☐	☐	☐
De performantie van het geestelijk gezondheidszorgsysteem voor de ouderen wordt correct geëvalueerd	☐	☐	☐	☐	☐

F2. **Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?**

F3. **Welke oplossingen stelt u voor om deze aspecten te verbeteren?**

Sectie G: Doelstellingen

G1. **Heeft u nog bedenkingen bij de doelstellingen van een syteem van geestelijke gezondheidszorg voor de ouderen?**

Sectie H: Functioneren

De volgende vragen richten zich op het functioneren van geestelijke gezondheidszorg voor de ouderen. We voorzien twee gelijkaardige reeksen vragen

- de eerste is gefocust op de residentiële zorg, zoals deze aangeboden wordt in een psychiatrisch ziekenhuis, in psychiatrische diensten van algemene ziekenhuizen, rusthuizen, woon- en zorg centra, psychiatrische verzorgingstehuizen, initiatieven beschut wonen,

- de andere is gefocust op niet-residentiële (ambulante) zorg aangeboden in de leefomgeving van de patient, zoals zijn thuissituatie, tijdens privé consultaties, in centra voor geestelijke gezondheidszorg.

H1. **Wil u vragen met betrekking tot residentiële zorg beantwoorden ?**

Ja ☐
Nee ☐

H2. **Wil u vragen met betrekking tot niet-residentiële (ambulante) zorg beantwoorden ?**

Ja ☐
Nee ☐

Sectie I: FUNCTIONEREN VAN RESIDENTIËLE ZORG

De residentiële zorg is deze die aangeboden wordt in een psychiatrisch ziekenhuis, in psychiatrische diensten van algemene ziekenhuizen, rusthuizen, woon- en zorgcentra, psychiatrische verzorgingstehuizen, initiatieven beschut wonen,...

I1. **Wat is uw mening over de volgende uitspraken?**

De huidige aanpak van geestelijke gezondheidsproblemen bij ouderen in residentiële zorg...

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
biedt een gezamenlijke aanpak op meerdere vlakken	☐	☐	☐	☐	☐
is een vorm van getrapte zorg (stepped care)	☐	☐	☐	☐	☐
voorziet een (regelmatige) opvolging van de oudere patiënt	☐	☐	☐	☐	☐
bevordert de communicatie tussen betrokken professionals (waaronder de huisarts)	☐	☐	☐	☐	☐
volgt een gestructureerd plan van aanpak	☐	☐	☐	☐	☐

I2. **Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?**

I3. **Welke oplossingen stelt u voor om deze aspecten te verbeteren?**

Sectie J: FUNCTIONEREN VAN RESIDENTIËLE ZORG

J1. **Wat is uw mening over de volgende uitspraken?**

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
Het aanbod van residentiële geestelijke gezondheidszorg voor de ouderen is geografisch goed gespreid	☐	☐	☐	☐	☐
De zorgprofessionals die werken in geestelijke gezondheidszorg in residentiële settings zijn voldoende gevormd voor de zorg voor de ouderen	☐	☐	☐	☐	☐
De oudere patienten in residentiële settings die geestelijke gezondheidsproblemen vertonen zijn voldoende betrokken bij de beslissingen rond hun behandeling	☐	☐	☐	☐	☐
Het systeem voorziet een adequate voorlichting van oudere patienten met geestelijke gezondheidsproblemen in residentiële settings	☐	☐	☐	☐	☐
Oudere patienten met geestelijke gezondheidsprblemen die verzorgd worden in residentiële settings krijgen voldoende, voor hen begrijpbare, informatie.	☐	☐	☐	☐	☐
De residentiële settings voor geestelijke gezondheidszorg zijn voldoende gefocust op de oudere patient	☐	☐	☐	☐	☐
De residentiële settings voor geestelijke gezondheidszorg houden voldoende rekening met de voorkeuren van de oudere patient	☐	☐	☐	☐	☐
De zorgprofessionals in residentiële geestelijke gezondheidszorg houden voldoende rekening met de culturele context van de oudere patient	☐	☐	☐	☐	☐
De residentiële geestelijke gezondheidszorg voor ouderen is veilig	☐	☐	☐	☐	☐
De residentiële geestelijke gezondheidszorg voor ouderen is effectief	☐	☐	☐	☐	☐
De toegang voor ouderen tot residentiële geestelijke gezondheidszorg is tijdig	☐	☐	☐	☐	☐
Evidence-based geestelijke gezondheidszorg voor ouderen in residentiële zorg wordt aangemoedigd	☐	☐	☐	☐	☐
Er is ondersteuning om oudere personen met mentale gezondheidsproblemen in residentiële zorg te helpen om de juiste beslissingen te nemen	☐	☐	☐	☐	☐
Er is ondersteuning om zorgprofessionals die zich richten op oudere personen met mentale gezondheidsproblemen in residentiële zorg te helpen om de juiste beslissingen te nemen	☐	☐	☐	☐	☐

J2. **Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?**

J3. **Welke oplossingen stelt u voor om deze aspecten te verbeteren?**

Sectie K: FUNCTIONEREN VAN NIET RESIDENTIËLE ZORG

De niet-residentiële (ambulante) zorg aangeboden in de leefomgeving van de patient, zoals zijn thuissituatie, tijdens privé consultaties, in centra voor geestelijke gezondheidszorg,....

K1. **Wat is uw mening over de volgende uitspraken?**

De huidige aanpak van geestelijke gezondheidsproblemen bij ouderen in een niet-residentiële setting...

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
biedt een gezamenlijke aanpak op meerdere vlakken	☐	☐	☐	☐	☐
is een vorm van getrapte zorg (stepped care)	☐	☐	☐	☐	☐
voorziet een (regelmatige) opvolging van de oudere patiënt	☐	☐	☐	☐	☐

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
bevordert de communicatie tussen betrokken professionals (waaronder de huisarts)	☐	☐	☐	☐	☐
volgt een gestructureerd plan van aanpak	☐	☐	☐	☐	☐

K2. **Aangezien u het niet of niet helemaal eens bent met een of meer van de voorstellen zou u uw bovenstaande antwoorden kunnen verduidelijken met (een) concreet(e) voorbeeld(en)?**

K3. **Welke oplossingen stelt u voor om deze aspecten te verbeteren?**

Sectie L: FUNCTIONEREN VAN NIET RESIDENTIËLE ZORG - 2

L1. **Wat is uw mening over de volgende uitspraken?**

	Helemaal akkoord	Eerder akkoord	Eerder niet akkoord	Helemaal niet akkoord	Ik heb onvoldoende kennis om hierop te antwoorden
Het aanbod van niet residentiële geestelijke gezondheidszorg voor de ouderen is geografisch goed gespreid	☐	☐	☐	☐	☐
De zorgprofessionals die werken in niet-residentiële geestelijke gezondheidszorg zijn voldoende gevormd voor de zorg voor de ouderen	☐	☐	☐	☐	☐
De oudere patienten in niet-residentiële zorg die geestelijke gezondheidsproblemen vertonen zijn voldoende betrokken bij de beslissingen rond hun behandeling	☐	☐	☐	☐	☐
Het systeem voorziet een adequate voorlichting van oudere patienten met geestelijke gezondheidsproblemen in niet-residentiële zorg	☐	☐	☐	☐	☐
Oudere patienten met geestelijke gezondheidsproblemen die verzorgd worden in niet-residentiële zorg krijgen voldoende, voor hen begrijpbare, informatie	☐	☐	☐	☐	☐
De niet-residentiële geestelijke gezondheidszorg is voldoende gefocust op de oudere patient	☐	☐	☐	☐	☐
De niet-residentiële geestelijke gezondheidszorg houdt voldoende rekening met de voorkeuren van de oudere patient	☐	☐	☐	☐	☐

Sectie M: Afsluitende vraag

M1. **Wat zijn volgens u de belangrijkste problemen van ons gezondheidszorgsysteem wanneer het gaat over de aanpak van geestelijke gezondheidsproblemen bij ouderen? Kan u uw antwoorden toelichten?**

M2. **Welke (andere) piste(s) stelt u voor om het systeem te verbeteren?**

M3. **Is er volgens u een specifieke nood voor een zorgcircuit voor ouderen met geestelijke gezondheidsproblemen?**

Ja ☐
Nee ☐
Ik weet het niet ☐

M4. **Zou u uw bovenstaande antwoord kunnen verduidelijken ?**

M5. **Zou de zorg voor ouderen met geestelijke gezondheidsproblemen best geïntegreerd zijn in de geestelijke gezondheidszorg voor volwassenen?**

- ☐ Ja
- ☐ Nee
- ☐ Ik weet het niet

M6. **Zou u uw bovenstaande antwoord kunnen verduidelijken ?**

M7. **Is er volgens u een specifieke nood voor een zorgcircuit voor 75-plussers met geestelijke gezondheidsproblemen (in vergelijking met jongeren)?**

- ☐ Ja
- ☐ Nee
- ☐ Ik weet het niet

M8. **Zou u uw bovenstaande antwoord kunnen verduidelijken ?**

Hartelijk dank voor uw deelname. Zonder uw tegenbericht (te sturen naar laurence.kohn@kce.fgov.be) contacteren we u terug in mei-juni 2017 voor het vervolg van de studie.

3.2. French version

Bienvenue dans l'enquête sur l'identification des forces et faiblesses des soins de santé mentale

pour les personnes âgées en Belgique

Partie A: Identification

A1. Vous répondez à ce questionnaire parce que vous représentez

- ☐ Une association de patients
- ☐ Une association professionnelle ou scientifique
- ☐ Un groupement d'institutions de soins ambulatoires (y compris centre de santé mentale)
- ☐ Un groupement d'institutions de soins résidentiels (y compris hospitaliers)
- ☐ Une administration publique (INAMI, SPF, Région, Communauté)
- ☐ Un cabinet ministériel
- ☐ Un centre de recherche / une université
- ☐ Une mutualité
- ☐ Autre

Autre

A2. Quel type d'association?

- ☐ Une association de psychologues
- ☐ Une association de psychothérapeutes
- ☐ Une association de psychiatres
- ☐ Une association de médecins généralistes
- ☐ Une association de gériatres
- ☐ Une associations de neurologues
- ☐ Une association d'infirmier(e)
- ☐ Autre

Autre

A3. Spécialisées en santé mentale?

- ☐ Oui
- ☐ Non

A4. Etes-vous prestataire dans le secteur des soins de santé mentale?

- ☐ Oui
- ☐ Non

A5. Vous êtes :

- ☐ Médecin généraliste
- ☐ Psychiatre
- ☐ Gériatre
- ☐ Neurologue
- ☐ Infirmier(e)
- ☐ Psychologue
- ☐ Psychothérapeute
- ☐ Assistant(e) social(e)
- ☐ Autre

Autre

A6. Vous exercez ...

- ☐ A domicile
- ☐ En ambulatoire (CSS, cabinet privé,...)
- ☐ En hôpital général
- ☐ En hôpital psychiatrique
- ☐ En maison de repos
- ☐ En maison de repos et de soins
- ☐ Maison de soins psychiatrique
- ☐ Autre

Autre

A7. **Combien d'année d'expérience avez-vous dans le domaine de la santé mentale ?**

- < 5 ans ☐
- 5-10 ans ☐
- 11-20 ans ☐
- > 20 ans ☐

A8. **Où exercez-vous ?**

- Anvers ☐
- Brabant flamand ☐
- Brabant wallon ☐
- Bruxelles-Capitale ☐
- Flandre-Occidentale ☐
- Flandre-Orientale ☐
- Hainaut ☐
- Liège ☐
- Limbourg ☐
- Luxembourg ☐
- Namur ☐

Partie B: Perception du système de santé

Nous allons maintenant vous poser tout une série de questions sur votre perception du système de santé quand il s'agit de santé mentale des personnes âgées.

Ces questions se basent sur les éléments utiles pour un système de santé performant identifiés dans la littérature.

Vous aurez également l'occasion de donner un commentaire pour justifier en quoi vous n'est pas (du tout) d'accord avec l'une ou l'autre proposition.

Dans le cadre de ce questionnaire, nous entendrons par personnes âgées, les personnes âgées de 65 ans et plus.

La démence en tant que telle ne fait pas partie de ce que nous entendrons ici par 'problèmes de santé mentale'.

Partie C: Objectifs d'un système de soins de santé mentale répondant aux besoins des personnes âgées -1

C1. **Selon vous, pour les personnes âgées souffrant de problèmes de santé mentale, les soins de santé mentale, comme ils sont organisés actuellement en Belgique permettent de :**

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Prévenir la solitude	☐	☐	☐	☐	☐
Prévenir l'isolement social	☐	☐	☐	☐	☐
Prévenir la maltraitance	☐	☐	☐	☐	☐
Prévenir les sentiments d'insécurité	☐	☐	☐	☐	☐
Maintenir l'autonomie le plus longtemps possible	☐	☐	☐	☐	☐
Maintenir le soin de soi le plus longtemps possible	☐	☐	☐	☐	☐
Maintenir la prise de décision autonome le plus longtemps possible	☐	☐	☐	☐	☐
Maintenir la personne au domicile le plus longtemps possible	☐	☐	☐	☐	☐
Prévenir le recours aux urgences	☐	☐	☐	☐	☐
Maintenir le plus longtemps possible une vie qui a du sens	☐	☐	☐	☐	☐

C2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

C3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie D: Objectifs d'un système de soins de santé mentale répondant aux besoins des personnes âgées -2

D1. Le système de soins en santé mentale actuel offre :

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
un soutien pour les personnes âgées	☐	☐	☐	☐	☐
un soutien pour les aidants proches	☐	☐	☐	☐	☐
des programmes spécifiques pour les groupes vulnérables	☐	☐	☐	☐	☐
des programmes de soutien dans l'environnement de résidence du patient	☐	☐	☐	☐	☐

D2. Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?

D3. Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?

Partie E: Objectifs d'un système de soins de santé mentale répondant aux besoins des personnes âgées -3

E1. Le système de soins de santé actuel permet de

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
détecter les problèmes de santé mentale des personnes âgées	☐	☐	☐	☐	☐
traiter manière adéquate les problèmes de santé mentale des personnes âgées	☐	☐	☐	☐	☐

E2. Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?

E3. Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?

Partie F: Objectifs d'un système de soins de santé mentale répondant aux besoins des personnes âgées -4

F1. De manière générale,

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Le système de soins de santé mentale actuel offre une approche globale des besoins physique, psychique et sociaux des patients âgés	☐	☐	☐	☐	☐
L'approche est centrée sur le patient	☐	☐	☐	☐	☐
Les soins sont financièrement abordables pour le patient	☐	☐	☐	☐	☐
Les soins apportent des solutions aux patients (réactif)	☐	☐	☐	☐	☐
Les soins tiennent compte des attentes et préférences du patient	☐	☐	☐	☐	☐
Les soins tiennent compte des attentes et préférences de la famille *du patient*	☐	☐	☐	☐	☐
Les soins sont transdisciplinaires, càd qu'ils optimisent l'apport des compétences de tous (y compris les non-professionnels et les bénévoles) et favorise les collaborations entre institutions et les services offerts à la communauté.	☐	☐	☐	☐	☐
Le système de soins implique que chaque soignant soit responsable de ses prestations	☐	☐	☐	☐	☐
Les services offerts intègrent tous les services disponibles pour assurer la continuité des soins. Ceux-ci sont coordonnés (niveau local, régional et national)	☐	☐	☐	☐	☐
Les soins de santé mentale utiles aux personnes âgées en première ligne sont suffisamment mis en valeur	☐	☐	☐	☐	☐

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Les rôles et tâches des différents intervenants en soins de santé mentale pour les personnes âgées sont clairement définis	☐	☐	☐	☐	☐
La performance du système de soins de santé mentale pour les personnes âgées est correctement évaluée	☐	☐	☐	☐	☐

F2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

F3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie G: Objectifs

G1. **Avez-vous d'autres commentaires relatifs aux objectifs d'un système de santé mentale répondant aux besoins des personnes âgées**

Partie H: Fonctionnement

Les questions suivantes porteront sur le fonctionnement des soins de santé mentale pour les personnes âgées. Nous avons prévus deux blocs de questions similaires,

- l'un est consacré aux soins résidentiels, soit à tous les soins délivrés en hôpital psychiatrique, service hospitalier psychiatrique, maison de repos, maison de repos et soins, maisons de repos psychiatriques, habitat protégé

- l'autre est consacré aux soins non résidentiels (ambulatoires), prodigués dans la communauté, soit à domicile, en cabinet privé, en Service de santé mentale.

H1. **Souhaitez-vous répondre aux questions relatives aux soins résidentiels ?**

Oui ☐

Non ☐

H2. **Souhaitez-vous répondre aux questions relatives aux soins non résidentiels (ambulatoires) ?**

Oui ☐

Non ☐

Partie I: FONCTIONNEMENT SOINS RESIDENTIELS

On entend par soins résidentiels, tous les soins délivrés en hôpital psychiatrique, service hospitalier psychiatrique, maison de repos, maison de repos et soins, maisons de repos psychiatriques, habitat protégé,...

I1. **Que pensez-vous des affirmations suivantes ?**

La prise en charge de la santé mentale des patients âgés en institution résidentielle aujourd'hui...

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Est multifacette	☐	☐	☐	☐	☐
Est échelonnée (stepped care)	☐	☐	☐	☐	☐
Prévoit un suivi (régulier) du patient âgé	☐	☐	☐	☐	☐
Encourage la communication entre les professionnels concernés (y compris les médecins généralistes)	☐	☐	☐	☐	☐
Suit un plan de management structuré	☐	☐	☐	☐	☐

I2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

I3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie J: FONCTIONNEMENT SOINS RESIDENTIELS - 2

J1. **Que pensez-vous des affirmations suivantes?**

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
L'offre des soins de santé mentale résidentiels qui concernent des personnes âgées est géographiquement bien répartie	☐	☐	☐	☐	☐
Les prestataires de soins travaillant en santé mentale dans les institutions résidentielles sont suffisamment formés pour soigner des personnes âgées	☐	☐	☐	☐	☐
Les patients âgés présentant des troubles mentaux soignés en institution résidentielle sont suffisamment impliqués dans les décisions relatives à leur traitement	☐	☐	☐	☐	☐
Le système prévoit une éducation adéquate du patient âgé présentant des troubles mentaux en institution résidentielle	☐	☐	☐	☐	☐
Les patients âgés présentant des troubles mentaux soignés en institution résidentielle reçoivent des informations compréhensibles	☐	☐	☐	☐	☐
Les soins de santé mentale résidentiels sont suffisamment centrés sur le patient âgé	☐	☐	☐	☐	☐
Les soins de santé mentale résidentiels tiennent compte des préférences du patient âgé	☐	☐	☐	☐	☐
Les prestataires en santé mentale intervenant en institution résidentielle tiennent compte du contexte culturel du patient âgé	☐	☐	☐	☐	☐
Les soins de santé mentale résidentiels sont sûrs pour les personnes âgées	☐	☐	☐	☐	☐
Les soins de santé mentale résidentiels sont efficaces pour les personnes âgées	☐	☐	☐	☐	☐
L'accès des personnes âgées aux soins de santé mentale résidentiels est obtenu en temps opportun	☐	☐	☐	☐	☐

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Les soins de santé mentale résidentiels pour les personnes âgées basées sur les données probantes (evidence-based) sont encouragés	☐	☐	☐	☐	☐
Il existe des supports pour guider les patients âgés présentant des troubles mentaux soignés en institution résidentielle à prendre les bonnes décisions	☐	☐	☐	☐	☐
Il existe des supports pour guider les prestataires en santé mentale intervenant auprès de personnes âgées soignées en institution résidentielle à prendre les bonnes décisions	☐	☐	☐	☐	☐

J2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

J3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie K: FONCTIONNEMENT SOINS NON RESIDENTIELS

On entend par soins non résidentiels, tous les soins *(ambulatoires) prodigués dans la communauté, soit à domicile, en cabinet privé, en Service de santé mentale....*

K1. **Que pensez-vous des affirmations suivantes ?**

La prise en charge non résidentielle de la santé mentale des patients âgés aujourd'hui...

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
Est multi facette	☐	☐	☐	☐	☐
Est échelonnée (stepped care)	☐	☐	☐	☐	☐
Prévoit un suivi (régulier) du patient âgé	☐	☐	☐	☐	☐
Encourage la communication entre les professionnels concernés (y compris les médecins généralistes)	☐	☐	☐	☐	☐
Suit un plan de management structuré	☐	☐	☐	☐	☐

K2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

K3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie L: FONCTIONNEMENT SOINS NON RESIDENTIELS - 2

L1. **Que pensez-vous des affirmations suivantes?**

	Tout à fait d'accord	Plutôt d'accord	Plutôt pas d'accord	Pas du tout d'accord	Je ne suis pas compétent pour répondre
L'offre des soins de santé mentale non résidentiels qui concernent des personnes âgées est géographiquement bien répartie	☐	☐	☐	☐	☐
Les prestataires de soins travaillant en santé mentale (soins non résidentiels) sont suffisamment formés pour soigner des personnes âgées	☐	☐	☐	☐	☐
Les patients âgés présentant des troubles mentaux soignés en non-résidentiel sont suffisamment impliqués dans les décisions relatives à leur traitement	☐	☐	☐	☐	☐
Le système prévoit une éducation adéquate du patient âgé présentant des troubles mentaux soigné dans la communauté	☐	☐	☐	☐	☐
Les patients âgés présentant des troubles mentaux soignés dans la communauté reçoivent des informations compréhensibles	☐	☐	☐	☐	☐
Les soins de santé mentale délivrés dans la communauté sont suffisamment centrés sur le patient âgé	☐	☐	☐	☐	☐
Les soins de santé mentale non résidentiels tiennent compte des préférences du patient âgé	☐	☐	☐	☐	☐
Les prestataires en santé mentale intervenant dans la communauté tiennent compte du contexte culturel du patient âgé	☐	☐	☐	☐	☐
Les soins de santé mentale non résidentiels sont sûrs pour les personnes âgées	☐	☐	☐	☐	☐
Les soins de santé mentale non résidentiels sont efficaces pour les personnes âgées	☐	☐	☐	☐	☐
L'accès des personnes âgées aux soins de santé non résidentiels est obtenu en temps opportun	☐	☐	☐	☐	☐
Les soins de santé mentale non résidentiels pour les personnes âgées basées sur les données probantes (evidence-based) sont encouragés	☐	☐	☐	☐	☐
Il existe des supports pour guider les patients âgés présentant des troubles mentaux soignés dans la communauté à prendre les bonnes décisions	☐	☐	☐	☐	☐
Il existe des supports pour guider les prestataires en santé mentale intervenant auprès de personnes âgées soignées dans la communauté à prendre les bonnes décisions	☐	☐	☐	☐	☐

L2. **Puisque vous n'êtes pas ou pas du tout d'accord avec l'une ou l'autre proposition, pourriez-vous justifier ou clarifier votre/vos réponse(s) par quelques exemples ou explications concrètes?**

L3. **Quelles pistes proposeriez-vous pour améliorer cet/ces aspect(s) ?**

Partie M: Questions de clôture

M1. D'après vous, quels sont les problèmes principaux de notre système de santé quand il s'agit de prendre en charge la santé mentale des personnes âgées ? Merci d'expliciter votre réponse.

M2. Quelle(s) (autre(s)) piste(s) proposeriez-vous pour améliorer ce système ?

M3. Voyez-vous un besoin spécifique de système de soins pour les personnes âgées présentant des troubles mentaux ?

- ☐ Oui
- ☐ Non
- ☐ Je ne sais pas

M4. Merci d'expliciter

M5. Les soins pour les personnes âgées devraient-ils mieux être intégrés dans les soins de santé mentale pour adultes ?

- ☐ Oui
- ☐ Non
- ☐ Je ne sais pas

M6. Merci d'expliciter

M7. Voyez-vous un besoin spécifique de système de soins pour les personnes âgées de 75 ans et plus présentant des troubles mentaux (en comparaison avec les plus jeunes) ?

- ☐ Oui
- ☐ Non
- ☐ Je ne sais pas

M8. Merci d'expliciter

Nous vous remercions pour votre participation. Sauf contre ordre de votre part (en écrivant à laurence.kohn@kce.fgov.be), nous vous recontacterons en mai - juin 2017 pour participer à la suite de l'étude.

4. COMPARATIVE STUDY OF FIVE COUNTRY'S APPROACHES TO THE IMPLEMENTATION OF MENTAL HEALTH CARE FOR THE ELDERLY

Authors: Alan Lovell, Rosie Martin, Nishanthi Talawila (The Economist Intelligence Unit – EIU)

4.1. Introduction

The provision of mental health services has become increasingly important for many health systems, including Belgium. One of the questions that all healthcare systems face is whether to integrate all population age-groups under one policy, or rather to create separate policies. In 2015, Belgium approved a Plan for mental health policy for children and adolescents. As the population ages it is also necessary to evaluate the quality of mental health care for the elderly, and ask whether separate policies and programmes should be developed and implemented for this age group.

The aim of this study is to compare experiences and implementation of the re-organisation and transformation of mental health care for the elderly in five countries with similar health systems to Belgium. The comparison includes addressing aspects of health and social care, and investigating the necessity, feasibility and acceptability of a specific organizational model for mental health care for the elderly in Belgium.

The following section (1.2) describes the report's methods, including the selection of countries and case studies. Section 1.3 describes the healthcare systems, with a focus on mental healthcare for the elderly, of each country. Section 1.4 takes a deeper look at the implementation of two or three specific programmes in each country, while section 1.5 is a transversal analysis that compares countries across important themes such as the role of primary care, how services are funded and the use performance indicators. Study limitations are discussed in section 1.6, and the conclusion section (1.7) brings together the lessons learned and offers suggestions for the development of policy in Belgium.

4.2. Methods

Initial scoping searches were carried out 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 health care. 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 (Table 1). The chosen countries were:

- England
- France
- The Netherlands
- Spain
- Canada

A structured and pragmatic literature search performed by a health information specialist was performed to prioritise the retrieval of high quality evidence to inform a) country profiles and b) the writing of case studies. The bibliographic database searches were not designed to be comprehensive in scope, given that the purpose of the report is to describe qualitatively experiences of programmes and their implementation. However, structured database searches were complemented by grey literature and supplemental searching. Search terms were used for the population, including geriatric and 'later life', for mental health services, such as 'Mental Health Services' and 'mental AND community', and also for the models of care.

The bibliographic databases searched were:

- MEDLINE
- EMBASE
- CRD (HTA, NHS EED, DARE)
- PubMed Cochrane search
- PubMed guideline search

The first-pass sift of the search results was at the level of title and abstract and removed clearly non-relevant information outside the scope of the study. Following this a more detailed sift took place to select studies relevant to the scope. The selected studies were obtained in full text.

Additional grey literature top-up searching was performed using reference harvesting and citation tracking. Only those materials identified as potentially relevant were added to the reference database.

Based on the findings of the literature search, a number of specific mental health services from each country were selected to be covered in more detail in a case study. These were chosen based on the pragmatic implementation of a number of criteria. First, they had to serve elderly people with mental health problems, though not necessarily exclusively (e.g. they could be services that cover the entire adult population, including both the working and retired populations). Second, they had to be of reasonable size and scope, either national or regional. Third, they had to show evidence of innovation and support the transition from institutional to community care. Fourth, there had to be enough information and evidence available in order to be able to describe their implementation. Case studies were further chosen in order to complement each other. Many countries have similar services, and we attempted where possible to avoid selecting very similar services from two or more countries.

Once each case study was selected, separate searches were carried out for each in order to investigate factors related to implementation. Findings of the studies were synthesized narratively.

In order to validate the report, experts in the delivery of mental health care for the elderly from each country were approached for interview. Two interviews were performed for each of the Netherlands, Canada and the UK. Experts from France and Spain also offered their comments on the report.

Table 1 – Comparison of countries for inclusion

Country	Availability of case studies	Demonstrate co-ordination between providers[1]	Demonstrate funding similarities in community health and social care[2]	Other arguments to be taken into account
	Medline search finds examples?	*Score 1 to 4. (case management, memory clinics, group dwelling, case finding)*	*Is funding through social insurance, or local government or municipality*	*Information from Mental Health Atlas 2014, OECD and (Healthcare in Transition) HiT online*
France[3]	Yes	2.5	1) Social insurance or local government/municipality 2) Local government or municipality	
England[3]	Yes	2.5	1) Central or regional government 2) Local government or municipality	Experiences with IAPT (Improving Access to Psychological Therapies) project
Spain[3]	Yes	2	1) Social insurance 2) Local government or municipality	Specific programs for mental health care for the elderly
Sweden[3]	Yes	3	1) Local government or municipality 2) Local government or municipality	No information found on outpatient care.
Canada	Yes	2.5	1) Local government or municipality 2) Local government or municipality	Important efforts for mental health care for the Elderly (e.g. projects in Ottawa)
Netherlands[3]	Yes	2	1) Social insurance 2) Social insurance	75% outpatient treatment. In 2014 health care reform with more emphasis on ambulatory care
Germany[3]	Yes	1	1) Social insurance 2) Social insurance	No 'stand-alone' plan for mental health care for the elderly. No figures for outpatient treatment found.
Finland[3]	Yes	2	1) Local government or municipality 2) Local government or municipality	
Estonia[3]	Yes	1	Unknown	

4.3. General description of the mental healthcare systems of the selected countries

We describe here the top level structure of healthcare systems in the five comparison countries. Demographics of each country's elderly population and burden of mental health are provided, along with an introduction to their mental health care services specifically for elderly people, if any, and their funding.

4.3.1. England

4.3.1.1. Overview

Health care system in general

England's (and indeed the United Kingdom's) National Health Service (NHS) was launched in 1948 to provide "good healthcare to all, regardless of an individual's wealth". The NHS is available to all UK residents and is generally free at the point of care. However there are some exceptions, such as subsidised charges for prescriptions, optical services and dental services. The NHS in England deals with over 1 million patients every 36 hours. It is designed to cover all of an individual's health needs, including antenatal screening, routine screenings (such as the NHS Health Check), treatments for long-term conditions, transplants, emergency treatment and end-of-life care.[4]

The provision and commissioning of NHS healthcare services in local areas is the remit of General Practice (GP) led clinical commissioning groups (CCGs).[5] 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.

Demographics on elderly population

The elderly proportion of 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.[6]

Burden of mental health in elderly in the country

The burden of mental health in older people is large. Data suggests that on an average day in a 500 bed general hospital, 330 of the beds will be occupied by older people, of whom 220 will have a mental disorder.[7] 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.[7]

4.3.1.2. Organisation of mental *healthcare*

Reform

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. This reached its height in the 1950s and 60s and was fuelled by a number of scandals in the 1970s around the ill-treatment of mental health patients.[8]

In 2011, NHS England published a mental health strategy. 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 stigma.[9] The strategy was well received but according to a 2016 report by an independent taskforce to NHS England, there were implementation challenges and an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years.[10]

Numerous campaigns have sought to address stigmatizing public attitudes towards mental health for everyone including older people, notably the Time to Change campaign (http://www.time-to-change.org.uk). 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 NHS.[10]

Mental health has 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 services. This is described as a triple approach to improve mental health care – a "fresh mindset for mental health within the NHS and beyond".[10]

Specifically for older people, 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.[11] It further suggested that older people with mental health problems should have access to integrated mental health services provided by the National Health Service (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.[11]

A number of specific mental health programmes are available to older people in England, though there is some regional variation. Services include elderly-focussed Community Mental Health Teams, Memory Services, Psychology Services and Specialist Dementia Services.

Delivery of care

Provision of mental health care 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 elderly, in residential/nursing homes and hospices.[12] Since the late 1950s, secondary mental health care for older people in England (including for conditions such as dementia, depression, anxiety, schizophrenia, suicidal feelings, personality disorder and substance misuse) has been provided by specialised old age psychiatry services, consisting of consultant-lead, multidisciplinary teams. However in recent years there has been a move to integrate these with those for working age adults, creating "ageless" services.[13]

In the primary care setting, GP's can offer advice and treatment, or a referral to secondary mental health care or psychology services through the Improving Access to Psychological Therapies (IAPT) system.[5] 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.[14] 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, occupational therapy, and social work expertise, according to need.[14] 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 for the elderly; or inpatient care in an elderly mental health unit. Due to differing local priorities, the structure and eligibility criteria of these services vary slightly across the country.

In addition to inpatient and outpatient teams, other key actors involved in the provision of mental health care 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.[12]

In addition to NHS and council services, a range of local organizations also offer help.[15] The Rethink Mental health problems support groups cater to the needs of patients or their carers of all ages.[16] 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.

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.[17] Hospital staff directly involved in care and organizations such as social services have access to these records, although often social care, mental health care, acute care and primary care use different electronic systems (because they are separate organisations) making interfaces challenging.[17]

To assess care, a number of elderly specific outcome measures are in use including the Geriatric Depression Scale (GDS) and the Cornell Scale for Depression in Dementia (CSDD). Some Trusts in England also use the elderly specific HoNOS65+ (Health of the Nation Outcome Scale for older people) measure.[18] Non-age specific measures in use are HoNOS for working age adults, and patient-reported outcome measures such as the Short Warwick & Edinburgh Mental Well Being Scale.[19]

Funding

The Department of Health funds mental health services, relying on a system of assurance around the commissioning, provision and regulation of healthcare.[20] 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.[20] 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.

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 2015/16.[21] Home care and community based services saw 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.[21]

4.3.2. France

4.3.2.1. Overview

Health care system in general

The French healthcare system provides universal health care mostly financed by government statutory health insurance. The French government pays for a proportion of care with patients expected to cover a proportion of their care costs through copayments, co-insurance and extra billing. The level of cover through the Statutory Health Insurance varies by the type of care provided. For example, patients face co-insurance payments of 20% for inpatient care and 30% for doctor visits. Highly effective drugs are exempt from co-insurance, while other drugs are subject to co-insurance rates of between 40% and 100%. Most people take out private health insurance to cover these costs. Registration with a general practitioner is not compulsory, although there are financial incentives available to those that register. GP act as gatekeepers to specialist care.[22] If a patient is referred by a GP to specialist care then they are able to choose the specialist they see, with the exception of gynaecology, ophthalmology, psychiatry, and dental medicine. 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 income.[22] Specialists working in public hospitals may see private-pay patients, on an outpatient or an inpatient basis. Care is also provided in private clinics where patients would be responsible for paying for their own care.

The 2015 Health Reform Law stipulated that by 2017 patients will pay directly only for balance billing, and the reimbursable fee will be paid directly by Statutory Health Insurance. Public hospitals are funded mainly by statutory health insurance (80%), with voluntary insurance and direct patient payment making up the remainder.[22] Public and private non-profit hospitals also benefit from grants that compensate research and teaching as well as the provision of emergency services and organ harvesting and transplantation.[22]

Demographics on elderly population

In the mid-2000s, France was near the European Union average, with about 16% of the population aged 65 and older. 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. 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.[23]

Burden of mental health in elderly in the country

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.[24]The proportion of people aged over 65 years with depressive symptoms is 12.2%, 5.4% of these having major depressive symptoms; at 75 years and over, this proportion grows to 18.2%, 8.3% of whom have major depressive symptoms.[25] A 2010 study of elderly people in France used the Mini International Neuropsychiatric Interview tool to assess the prevalence of depression, anxiety, addiction and psychiatric disorders; the prevalence of people 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.[26]

4.3.2.2. Organisation of mental healthcare

Reform

Similar to many other European countries, there has been a shift away from the institutionalised approach of the past and community based services are generally preferred.[27] Due to the deinstitutionalization policy that started in the 1980s, most psychiatric care is in the community, with 77% of patients in 2011 treated exclusively on an outpatient basis. In terms of hospital care, part-time stays accounted for 89% of hospitalizations.[27] Due to increasing healthcare spending, the state has played more of a role in planning and regulation since the mid-1990s. Regional Health Agencies (Agences Régionales de Santé) coordinate ambulatory and hospital care on a regional level as well as health and social care for the elderly and the disabled

through a regional strategic health plan (Plan stratégique régional de santé).[27]

In 2014 the Social Security Finance Act included a programme of regional pilot projects which were aimed at improving care coordination for frail elderly people and finding alternatives to the existing fragmented care organization.[27]

Delivery of care

In France, people with mental health problems are managed by both the public and private health sector, and for the elderly and disabled, by the social and health care sector.[27]

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.[27]

There is no official sub-specialty of old age psychiatry, despite the presence of postgraduate training in geriatric care being available for psychiatrists. France splits mental health services into geographical areas called “mental health care areas” which are each coordinated by a hospital to provide both inpatient and outpatient settings.[27] Most areas have no specific teams and wards for elderly patients, although some have chosen to collaborate in the development of common structures for treating older people.[28] An example of an old age team is in Grenoble, where they have a psychiatry multidisciplinary team at the Centre Hospitalier Alpes-Isère.[29] The old age team is set within a broader team including inpatient and outpatients centres, and adult and child psychiatry.

In France national data for mental health care includes services utilisation data, treatment and procedures data, staff data and structure data.[30] Mental morbidity aggregate and individual data is 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+).

Funding

For older adults in France, three main sources of funding are available for health and social care. On a national level, the Caisse Nationale de Solidarité pour l'Autonomie/National Solidarity Fund for Autonomy (CNSA) is responsible for financial aid for elderly, frail and disabled people. The fund is generated from the revenue of an unpaid working day for the French working population, and the additional solidarity and autonomy contribution which is 0.3% tax applied to retirement and disability pension income.[27] The CNSA funds a share of the personal autonomy allowance that is used to finance domiciliary staff, home care devices or residential care for frail elderly people.[27]

Local authorities also fund care for older adults by financing a large share of long-term care allowances for the frail elderly. People aged over 60 receive a universal financial benefit called the Personal Allocation of Autonomy/Allocation Personnalisée d’Autonomie (APA), provided by the local authority.[31] The APA is received whether the person is in their home or an institution. The amount given will depend on the income of the person and their degree of dependency. 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 to help them afford a nursing home, although there is no specific funding available to older people.[31]

In total, the estimated expenditure on mental health services in France was €16.6 billion in 2007.[27] Of this, €13.4 billion was associated with health care services and the remaining €3.2 billion for the health and social health care sector for the elderly and disabled.[27] In 2012, departments contributed €4 billion to APA, supplemented with €1.7 billion from the CNSA. Many other local providers undertake social actions to support the frail elderly.[27] Finally, some payments for care are out of pocket; for example, residential care services are currently €1500 per month on average, though access is covered under public health insurance if it has been prescribed.[32, 33] Also, all patients in France, including elderly 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.

4.3.3. Netherlands

4.3.3.1. Overview

Health care system in general

The healthcare system in the Netherlands provides universal cover and is funded through residents joining the social health insurance and an income-dependent employer contribution taken from salaries. Complementary voluntary health insurance can be taken, which may cover health services that are not covered under social health insurance.[34] In the Netherlands there were over 11,300 GPs in 2014 and more than 20,400 specialists in 2013. Nearly 33% of practicing GPs worked in group practices of three to seven, 39% worked in two-person practices, and just over 28% worked solo. The GP is the central figure in Dutch primary care. 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. Referrals from a GP are required for hospital and specialist care. 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.

GPs decide whether patients need to be referred to hospital. 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.

Demographics on elderly population

The Netherlands has an ageing population and there are currently around 2.1 million people aged over 65 years, 600,000 of whom are aged over 80 years. It is expected that by 2050 the proportion of adults over the age of 80 in the Netherlands will increase from 3.9% of the total population in 2010 to 10.2%.[35]

Burden of mental health in elderly in the country

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.[24] In a sample of 5,686 older people (55 years and over) attending GP practices in The Netherlands, major depression was found in 13.7% of patients and minor depression in 10.2%.[36] Findings from the Longitudinal Aging Study Amsterdam (LASA) suggests that psychiatric disorders are more prevalent in elderly women than in men for major depressive disorder, panic disorder, social phobia and generalised anxiety disorder.[37] 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%.[37]

4.3.3.2. Organisation of mental healthcare

Reform

In the 1990s rising health costs put a strain on the Dutch government which led to a capping of budgets. This was later abolished due to longer waiting lists. More recently changes were put in place which raised the threshold for accessing care and have detailed care duties that family members are expected to perform that will not be covered by social insurance.[38]

In 2006 the Dutch Government authored a plan for the development of a sustainable mental healthcare sector.[39] The plan included measures to help regulate competition for healthcare, so that providers had to negotiate on cost as well as quality of care (outcomes, client options and patient safety). Following this 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.[39] Measures included:

- 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% in 2020.
- A programme to reduce stigma and facilitate social inclusion of people with mental disorders.
- A reduction of coercive measures.

Also in 2014, the government introduced a reform of the mental healthcare system to further reduce the number of patients receiving specialist care. The reform only allowed GPs to refer patients with diagnosed psychiatric disorders, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, to other professionals working in mental healthcare. Patients without a psychiatric disorder were not to be referred but instead be treated within general practice.[40]

Delivery of care

Provision of mental health care in the Netherland 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 others provide a variety of services in care pathways, usually offering prevention, primary mental health care, ambulatory care, acute hospital facilities and long-stay residential care.

The first point of contact for a person with a mental health disorder is usually a GP or welfare worker.[41] Efforts are made to resolve issues in general practice. This is possible if the problems are mild, and the primary care practitioner is sometimes assisted by a general practice mental health worker. It is estimated that 90% of mental health issues are dealt with in primary care. However in some cases GPs will refer patients to primary mental health providers or to secondary care. Mental healthcare provided in primary cares include counselling from a psychologist, psychotherapist, geriatric specialist, online mental health support or a combination of these.

Provision of secondary mental healthcare, based on the DSM-IV, is given by a psychiatrist or clinical psychologist working in a mental health institution; this may be a hospital or inpatient facility. These services may be for adults of all ages or be specific to the elderly. Older patients with multiple issues tend to be referred to hospitals. Here they are assessed but only admitted if the patient has 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.

Supported accommodation is available for those needing a safe and stable environment. If a patient is in crisis there are crisis services available, although access to these is through a GP. Finally, nursing homes offer a setting where mental health care may be provided. In these cases care is provided by a GP, supported by nursing staff and secondary care services when necessary.[42]

National level data collected to assess care includes mental morbidity aggregate and individual data, services utilisation data and treatment and procedures data.[30] Routine Outcome Monitoring (ROM) is used to regularly measure the condition of people for the purpose of evaluation and possible adjustment of the treatment.[43] The Geriatric Depression Scale (GDS-15) is used for the elderly in the Netherlands.

Funding

There is a contributory social insurance scheme that covers home-based personal care and long term institutional care for all those with chronic conditions. This means the risk of heavy costs falling on vulnerable individuals is avoided by sharing the cost across the whole population.

All Dutch residents including the elderly are required to purchase a health insurance policy, at a cost of approximately €100–150 (US$130–190) per month per person. Insurance providers are obliged to accept all applicants. A further national insurance system for long-term care and exceptional medical expenses is paid for by public insurance contributions.[35]

Basic mental health care for mild to moderate mental disorders are generally covered under insurance schemes, including up to five sessions with a primary care psychologist[44]. Since 2014, the Health Insurance Act provides

coverage for the first three years of inpatient treatment.[34] Beyond this the Long-Term Care Act provides funding for more vulnerable groups in society, including elderly people in more advanced stages of dementia; the Act is a compulsory health insurance policy supported by income tax.[45]

4.3.4. Spain

4.3.4.1. Overview

Health care system in general

Access to Spanish Healthcare is free for all residents at the point of use, with co-payments restricted to pharmaceutical products.[46] Funding of mental health is de-centralised. However, the national government has spent around 9 million Euros over the last four years in funding the implementation of various projects within the individual provinces of Spain.[47] Mental health expenditures by the government make up around 5% of the total health budget. In 2010, there were reported to be 39.6 physicians per 10,000 people and in 2011 there were 8.6 psychiatrists per 100,000 people.[48]

Demographics on elderly population

Similar to the rest of Europe, Spain has an aging population. Estimates show the share of the population aged over 65 years is approximately 17%, equal to over seven million people, a quarter of whom are over 80 years old.[49] Projections suggest that by 2050 the over 65s will make up more than 30% of the total population and over 80s over 10% of the total adult population.[49]

Burden of mental health in elderly in the country

The number of people over 65 in Spain that died as a result of mental and behavioural disorders was 183.5 per 100,000 inhabitants in 2013.[24] The proportion of people aged over 65 years with depressive symptoms is 10.3%, 4.1% of these having major depressive symptoms.[25] At 75 years and over, this proportion grows to 12.3%, 5% of whom have major depressive symptoms.

4.3.4.2. Organisation of mental healthcare

Reforms

Deinstitutionalization was initiated in Spain in the late 1970s, a shift away from a system based on old asylums to one centred on community care. A decline in beds followed along with integration of the mental health system that incorporated outpatient, inpatient and residential facilities, as well as multidisciplinary teams of health and social care resources.[46]

A network of mental health centres, each covering population catchments of between 200,000 and 250,000 people, developed rapidly. By 1994 there were 550 centres; however reform has been geographically uneven and there appear to be marked differences between availability of services due to differences in regional priorities.

Reforms to the Mental Health Care system were initiated with the establishment in 1983 of the Ministerial Commission for Psychiatric Reform; its official report was published in 1985. This helped to define the package of services included within the NHS. The General Health Act of 1986 was a major step forward in the integration of mental health within the general health care system. Psychiatric care, except for psychoanalysis and hypnosis, was for the first time included among the package of benefits covered by the NHS.

A report from 2002 provides a list of objectives for establishing specific mental health services for older adults.[50] These actions described the need to put together national and local strategies designed to improve prevention, timely detection and treatment of mental health problems in old age, including diagnostic procedures, appropriate medication, psychotherapy and education for professionals and informal caregivers. The report also proposed ways to diagnose conditions, provide support for the patient and their families, and promote personal dignity.

The Mental Health Plan from the Ministry of Health, Social Services and Equality for the period 2011 to 2020 includes: improvement of early detection of mental health problems; continuity of care and treatment; measures to support the autonomy and self-management of patients with

mental disorders; combating stigma; support for studying and working; support for families of those with mental health problems; research into determinants and causes of mental disorders. The plan covers the working age population as well as the elderly.
There has been no specific reform for the elderly.

Delivery of care

Access to mental health services is most often provided within primary care. GPs, but not primary health care nurses, are authorized to prescribe psychotherapeutic medicines.[47] Nurses are also not allowed to independently diagnose and treat mental disorders within the primary care system. The majority of GPs have received official in-service training on mental health within the last five years. However, official referral procedures for referring people from primary care to secondary/tertiary care, or back again, do not exist.[47] The lack of referral procedures means joined up care is challenging to deliver.

However, local regions are able to implement procedures to improve integration. An example of a network set up with the intention of achieving better integration is Castilla-La Mancha. This initiative was founded in response to the perception that there was a need for a mental health unit which makes referrals to other units such as rehabilitation or residences for older people.

Coordination of health and social care services is a problem in Spain within local catchment areas, something which is largely undertaken by Community Mental Health Centres across the country. Adding to this are complexities in the governmental structures (regional, provincial, county and local), making coordination inefficient. The lack of a specific department for mental health within the Spanish Ministry of Health has not helped co-ordination efforts.

Common mental disorders make up a large number of visits to GPs, although training is not always adequate to diagnose and treat them effectively.[51] Many patients therefore only receive pharmacological treatment, when in many cases they could benefit from multidisciplinary approaches with support and brief psychological advice strategies and techniques.

The community based approach in Spain varies across the highly autonomous regions. Service providers include mental health centres, day hospitals, rehabilitation units, and therapeutic communities, to name a few. Regions also show differences in the definition of facilities which are considered healthcare and those considered social, as well as the access and financing of these.

In most areas of Spain there are no specialized mental health services for older people, though this depends on the region. For example Madrid has a Mental Health plan that includes older adults, and has improved services by introducing mental health outreach, home treatment and psychosocial services for older people in all districts. The city also funds a carer subsidy for those providing home care to older family members.[52]

National surveys on health care utilisation, drug consumption, and morbidity are used in Spain.[30] There are also a number of national registries that are able to provide data on mortality and morbidity. Many of the validated indicators are not routinely in use at a national level in Spain, only the General Health Questionnaire (GHQ-12), and it does not appear that any elderly specific measures are in use.

Funding

Mental health is financed in the same way as other health care services in Spain. Private insurance does not play a prominent role.[53] Spending on public mental health services in Spain remains modest at around 5% of total health care expenditure. The national government announced a €3134m cut for 2013, including an additional €1108m to be taken from the dependency fund for elderly people and people with disabilities.[53]

All people in Spain are required to make co-payments for pharmaceutical products

4.3.5. Canada

4.3.5.1. Overview

Health care system in general

Canadian citizens are covered by health insurance that provides care regardless of medical history, personal income, or standard of living.[54]

The healthcare system is publicly funded and whilst following guidelines set by the government the 13 provinces each have their own health insurance plans and systems. Residents do not face any out of pocket costs for hospital and physician services that have been deemed medically necessary. Payment for prescription drugs, differs by province and every provincial and territorial government has a plan that covers outpatient prescription drugs for populations such as the elderly and social assistance recipients.[55]

Preventative care and medical treatments are provided through primary care services as well as hospitals, dental surgery and additional medical services. If a patient would be better treated by a specialized service then they are referred from their primary care provider.

Roles and responsibilities for all general health care services are shared between provincial and territorial governments and the federal government.[54] The provincial and territorial governments manage, organise and deliver health care 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.[54]

The Canada Health Act states that essential physician and hospital care is to be provided to citizens, 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.

Demographics on elderly population

Canada has an aging population.[56] The number of seniors in 2011 was 4.9 million, up from 4.3 million in 2006. At present, 14% of Canadians are aged 65 or over, and this is expected to be nearly 25% by 2036.

Burden of mental health in elderly in the country

In Canada around half the population will experience mental health problems by the age of 40, and 20% of Canadians suffer from mental health issues in any given year. Almost 25% of people aged 80 and over use health services for a mental illness (including dementia).[57]

4.3.5.2. Organisation of mental healthcare

Reforms

In 2006, the Standing Senate Committee on Social Affairs, Science and Technology recommended that a national commission be established to develop a cross province policy for mental health in Canada. This led to the Mental Health Commission of Canada being established by the federal government, endorsed by all provinces and territories except Quebec. In 2012, the Commission released its first major report setting out a mental health strategy, including specific measures for the elderly.[58] Their elderly-specific recommendations were:

- 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.

There is a great deal of provincial autonomy in Canada, and many reforms are at this level. An example of mental health reform was seen in Ontario where again there has been a move from an institutionalized approach to a system that emphasizes a comprehensive continuum of services based on level of need.

However, there is a lack of focus on seniors in mental health policy. For example, a 10 year strategy is being developed in Ontario by the provincial government. The strategy's Advisory Group on Mental Health and Addictions have proposed the following as some of the critical factors but they do not specify the elderly:

- mental health and addiction services to be fully integrated within the system
- patients and families to be involved in planning, decision-making, implementation and service delivery
- community based services supported by best practice evidence and professional development
- reduction in the stigma and under-funding of addiction and mental health services.

Delivery of care

There is universal coverage for physician-provided mental health care, however treatment from psychologists, who may work privately, are paid out-of-pocket or through private insurance, or under salary in publicly funded organizations. Hospital mental health care is provided in specialty psychiatric hospitals and in general hospitals with adult mental health beds.[22] The provinces and territories all provide a range of community mental health and addiction services including case management, community-based crisis response, and supported housing. Mental health has not been formally integrated into primary care; any coordination or colocation of mental health services within primary care is unique to its particular practice.

It is thought that only a third of people in Canada will seek treatment for their issues due to the stigma of seeking mental health care.[55] 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 health care reported that their needs were not met or only partially met. A reported lack of access to family physicians, psychiatrists and other health care providers contributes to this deficit. The Canadian Medical Association (CMA) and Canadian Psychiatric Association (CPA) stated that much therefore still needs to be done to translate heightened awareness into improvements in service provision.[55]

There are a number of specific services for the elderly in Canada, although these tend to be in the larger cities. An example of a facility is Baycrest Health Sciences, who provide services including geriatric residential living, healthcare, research, innovation and education, with a special focus on brain health and aging.[59]

In Canada a number of elderly specific performance indicators are in use. These include the Geriatric Depression scale, Brief Assessment Schedule for the Elderly (BASDEC) and the Geriatric Mental State Schedule (GMSS).[30]

Funding

The impact of mental health problems on Canada's health care system and economy is large. It is estimated that mental health problems cost Canada over $50 billion per year, including health care costs, lost productivity and reductions in health-related quality of life.[55]

The Canada Health Act covers the funding of services from psychiatrists but excludes hospitalization or institutionalization costs, though this is covered in some provinces. Treatment by psychologists or psychotherapists is not covered unless the practitioner delivering care is also a medical doctor. Older people fund access to psychologists out-of-pocket. The Health Act also specifies that access to medically necessary pharmaceuticals outside of hospital care is not covered for all groups, including the elderly.[60]

Some coverage for mental health care and substance abuse treatment is available under specific provincial programs, such as in Alberta, where funding for mental health care is provided and funded through Alberta Health Services.[54] To take another provincial example, Ontario provides a wide range of mental health services, ranging from Assertive Community Treatment Teams who provide assertive outreach, individualized treatment and ongoing care, to Clubhouse facilities where psychosocial rehabilitation is provided to those with serious mental health problems.

4.4. Service case studies

We describe below detailed case studies of particular elderly mental health services from across the five countries. The specific service is described in detail, and the model or models of care utilised.

4.4.1. Description of the case studies

4.4.1.1. Community Mental Health Teams (England)

The service

Commissioning guides describe the services that should be available to people in England with mental health problems. Whether a specialist older people's or 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 a multidisciplinary team, often termed Community Mental Health Teams (CMHTs).[61] These multidisciplinary teams usually include old age psychiatrists and nurses, social workers, occupational therapists, psychologists, and support staff.[62, 63] Regional variation determines whether people with suspected dementia are referred to a memory service (organizationally 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.[64]

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 an older 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.

Models of care used

CMHTs follow the 'stepped care' model, incorporating the collaborative care model for more severe cases.[65] 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.[66]

4.4.1.2. Improving Access to Psychological Therapies (England)

The service

The Improving Access to Psychological Therapies (IAPT) programme was introduced in 2006 with the goal of improving the utilisation of cognitive behavioural therapy for depression and anxiety disorders. Before the programme began, psychological therapy services were often not evidence-based and were inconsistent in both quality and geographical provision.[67]

Take up of the programme has increased each year. In 2015 to 2016 there were:[68, 69]

- 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.

In order to promote compliance in IAPT services 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. The programme assumes that delivering effective and evidence-based treatment will result in improved clinical recovery rates and provide wider benefits to the individual, family and community.[67]

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.[67] In the 2010 spending review, the government agreed an additional £400 million to be spent over the next four years.[70]

The IAPT programme has brought in evidence-based therapies using an integrated and stepped model of care. 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.[67]

Older people's specialist workers 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.[71]

Models of care used

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.[67] Lower intensity IAPT therapies include computerised cognitive behaviour therapy and self-directed learning. Higher intensity therapies are conducted face to face with a therapist.

4.4.1.3. Crisis Teams (England)

The service

Crisis teams, also known as Crisis Resolution and Home Treatment teams, are multidisciplinary and operate all day, every day on a mobile basis.[72] The teams were originally introduced throughout England for adults, but dedicated teams are now being set up for older adults.[73, 74] 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.[72]

Staff members are normally mental health care professionals. Psychiatrists are able to assess, diagnose, prescribe medication and manage treatment, whilst community psychiatric nurses usually ensure care plans are implemented and offer support, although in some areas highly trained nurses, including nurse prescribers are taking on roles traditionally allocated to doctors. Mental health social workers give practical help with social care needs.[75] 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.[75] 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.

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.[76]

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 around half of community teams were able to offer an adequate 24/7 crisis service.[77]

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.[78]

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.

4.4.1.4. Hospitalisation at home (France)

The service

Hospitalisation at home (L'hospitalisation à domicile (HAD)) is a general health service including mental health issues where care is provided at the person's home, helping them to avoid hospitalisation or institutionalisation.[79] This can be offered to any older person with a clinical need if their residence allows. The programme is available throughout France and it was initiated in response to the growing aspiration of the population to be treated in a familiar environment when the situation permits.[79]

Referral to the service is by a hospital doctor or physician. Care is arranged by a coordinating doctor and is carried out by a multidisciplinary team of nurses, rehabilitators, social workers, psychologists, and dieticians. HAD patients tend to be people with chronic, complex conditions, often involving one of more aspects of mental health.

In the event of an emergency the patient always has access to some form of contact. The minimum level of contact is a nursing telephone hotline, which allows the patient to contact the HAD institution at any time. Some of the hospitalisation at home services offer a home nurse shift at night; when this is not possible there is a nurse on the end of a telephone that can arrange crisis care.

Whilst the service is called “Hospitalisation at home”, the service is not equivalent to a stay in a hospital as the patient is not accommodated and care is not provided at all times. It does however involve assessment and adaptation of the home to the needs of care, and coordination with health and social care professionals.

In 2014 there was a total of 162,000 HAD “stays”, for a total of 4.4 million days, at a cost of € 944 million to health insurance.

Models of care used

The HAD is primarily a collaborative care model where care is provided by a multidisciplinary team of nurses, rehabilitators, social workers, psychologist, and dieticians. The coordinating physician formulates the care protocol, which is then planned by the care coordination team and brought to the attention of the caregiver. Where possible, care will take into account the personal wishes of the patient and their families. Staff within the coordination team are employed by the service, although the professionals performing the care are not necessarily employed in the service.

4.4.1.5. Therapeutic host families (France)

The service

Therapeutic host families (L’accueil familial thérapeutique) are another alternative to hospitalisation for mental health care for the elderly.[80] East Lille is one of a number of towns that has been experimenting with this approach.[51] Referred patients are often in an acute situation and are sent to the host family either directly, after a consultation, or secondarily after a hospitalisation. Host families are instructed to just host the patient - their role is not to try and cure them.[81]

A nurse and the social and medical team support the patient during home visits. These visits involve the management of treatment, therapeutic activities and consultations with the wider sector. Support is similar to that offered within the full-time hospitalisation unit located in the local hospital: medication, hydrotherapy and therapeutic activities are carried out in the city in consultation centres and the towns' activity centres.[81]
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.[81]

Models of care used

The use of therapeutic host families uses 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.

4.4.1.6. Flexible Assertive Community Treatment (The Netherlands)

The service

The basis of the Flexible Assertive Community Treatment service originates from the traditional Assertive Community Treatment model (ACT). The ACT model of care delivers care and treatment for severely mentally ill patients within the community;[82] it is effective for older adults as well as the working age population.[83] The Flexible ACT is, as its name suggests, a more flexible version of ACT, with a multidisciplinary approach that involves the management of each individual case, which means it is able to serve a broader range of mental health problems.[82]

Flexible ACT teams were designed to serve the entire population of long-term psychiatric patients in the community. They are able to provide two types of care:

1. Individual case management by a multidisciplinary team for the more stable patients
2. Shared case management and assertive outreach for less stable patients

The more stable patients in the programme are visited by a case manager between two and four times a month within their home. The case manager is responsible for their care and treatment plan, which includes goals for rehabilitation, social support and a crisis plan with early warning symptoms, and arrangements for intensification of care if necessary. Regular appointments with the psychiatrist and the psychologist take place at Flexible ACT centres. Family interventions and supported employment may be added to this treatment plan.

Those with more severe mental health problems at risk of readmission have their name placed on a whiteboard by the case manager. At this point the patient will be served by assertive outreach, and they must be seen by the psychiatrist within two days and the crisis plan updated and initiated. The case manager informs the patient that more intensive care will be organised. The team reviews the whiteboard daily, patients are discussed and appointments for home visits and other actions are made. Care for these patients is based on a shared caseload, and if necessary all the team members will visit a patient at home. If the patient becomes normal risk they are removed from the list. For patients that remain on the list and at risk, the case manager maintains contact, but gradually the other team members step back.

An average Flexible ACT team serves 200 to 220 patients and consists of approximately one case manager per 20 patients. The team consists of psychiatrists, psychologists and supported employment workers. Every team has about 50 clients who are very stable and need little contact. Some teams assess their patients annually with the help of standard instruments such as the Health of the Nation Outcome Scale and Manchester Short Assessment of Quality of Life, which give an indication of unmet needs on a personal level.

A "real life" study found that Flexible ACT is associated with a better quality of life, a reduction in the percentage of unmet needs and an increase in compliance and the desire for improved patient outcomes. At the same time, there is less hospital use and a decrease in the number of outpatient contacts. The strength of Flexible ACT is its ability to adapt to patient's needs, without discontinuation of care.[84]

Models of care used

Flexible ACT follows the collaborative care model for more severe cases and a 'watch and wait' approach for those with less serious conditions. The 'watch and wait' approach assumes that regular assessments should prevent the need for more extensive care. Severe cases are seen by their case manager who arranges their care with other providers.

4.4.1.7. Mental health nurses in General Practice (The Netherlands)

The service

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.[40] MHNs are available to see adults of any age including the elderly.

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.[40] MHNs work under the supervision of the GP. Access to MHNs is normally 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.[40] 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. Mental Health nurses most often treat adult female patients with common psychological symptoms, such as depressive feelings.

Between 2010 and 2014, the percentage of Dutch general practices with an MHN increased considerably from 20% to 83%.[40]

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 are probably more cost-effective than GPs and can treat certain patients who otherwise would have been treated in more expensive specialized care.[40]

Models of care used

The use of MHN within general practice uses a stepped care model that involves both nurses and doctors providing care to patients. The nurse will most often be involved in screening the patient, diagnostic assessments, treatment, counselling and where necessary referral to other services.

4.4.1.8. Community Mental Health Centres (Spain)

The service

Community Mental Health centres in Spain provide care and training to people of all ages with mental health issues such as schizophrenia, depression, personality disorders, Alzheimer's and other types of dementias and addictions.[85] They are integrated into the existing network of health services in the country, to provide care that goes beyond physical health. Some examples of the care provided includes: psychiatric treatment, pharmacotherapy, psychological assessments, psychotherapy and workshops.[85]

The centres are usually staffed by a multidisciplinary team, including psychiatrists, psychologists, nurses, social workers and administrative staff.[86] Patients attending the clinic will have been referred by their GP or by emergency services following discharge from an acute ward in a general hospital.

In Zarate, in the Basque region of Spain, within the first six months of opening, the first Community Mental health centre received about 5,000 patients, with the most requested services being psychiatry, psychology and occupational therapy.[82]

Models of care used

Community mental health centres use a collaborative care model. Care is provided by a multidisciplinary team to patients that have been referred by their GP or by emergency services following discharge from an acute ward in a general hospital.

4.4.1.9. Ribera Salud (Spain)

The service

Ribera Salud is a private integrated healthcare provider that was contracted by the government of Valencia to manage the provision of public health care services in over two dozen departments of health in the autonomous community of Valencia for older adults. It should be noted that Ribera Salud is not typical of healthcare in Spain, as Spain has relative few private healthcare services. Therefore this case study should not be taken as a typical case study of care in the Spanish healthcare system. However, it is a useful example of an innovative, if controversial, approach. Ribera Salud is paid via a capitation funding arragement, receiving a fee for each person in the region. This public-private partnership is a move away from the traditional approach of public or private facilities usually found in Spain.

The service takes responsibility for managing the delivery of services, employs most of the physicians involved in care and provides property maintenance for all hospitals and primary care centres in the network. It is estimated that 720,000 patients receive care within the network.[87]

The organization launched the Complex Care Plan to respond to the specific needs of patients with two or more chronic diseases who require integrated care across many healthcare professionals. These patients are elderly (75 years and older) and require support for one or more mental health disorders. Many patients are near the end of life or are frequently admitted to hospital. The plan is designed to provide better patient care, as specialized attention is provided across primary, secondary and home based care, whilst also theoretically reducing costs.[87]

The structure supports team-based care provided by an integrated team of clinical and non-clinical health care providers. Members of this multidisciplinary team include social workers, mental health professionals, home aides, caregivers and the patient.[87]

Models of care used

This service follows an integrated model of collaborative care where coordination seeks to improve patient health care outcomes. The integrated model of care in this case coordinates care across primary, secondary and home-based care in order to address concerns about fragmentation and the lack of service coordination for patients.

4.4.1.10. Clubhouse facilities (Canada)

The service

A Clubhouse is a local community centre where people with mental health problems come together to achieve a common goal.[88] The Clubhouse provides a restorative environment for people whose lives have been severely disrupted because of their mental health problems, and who need the support of others who are in recovery and who believe that mental health problems are treatable.[88] The service is organised to support people living with mental health problems and members gain access to opportunities to re-join the worlds of friendships, family, employment and education, and to the services and support they may individually need to continue their recovery. As a number of older people who attended the traditional clubhouses wished to 'retire' when they reached the age of around 55, Seniors Clubhouses were created. When planning the Senior Clubhouse programme it was found that there were no senior services that included support for people living with mental illness, only for those with Alzheimer's disease and dementia. The goal of a Seniors Clubhouse was to bring services to a marginalized, underserved, high need community. The main

difference between the traditional and senior specific programme is that rather than then main focus being on rehabilitation to get people back to work or education, the focus is instead on good mental and physical health.

Clubhouses operate using a system known as a 'work-ordered day' which can be followed by members of any age including older people who still wish to participate. The idea is to have an eight-hour period, typically Monday through Friday, similar to that of the working community where the Clubhouse is located. Members and staff work side by side as colleagues to perform the work that is important to their community. There are no clinical therapies or treatment-oriented programs in the Clubhouse.[88] Members volunteer to participate as they feel ready and according to their individual interests.

Clubhouses provide members with opportunities to return to paid employment in integrated work settings through both Transitional Employment and Independent Employment programs.[88] The only requirement for the member to participate in Transitional Employment is the expressed desire to work.

In terms of the social and recreational programme, the Clubhouse provides evening and weekend structured and non-structured social activities. These activities are scheduled outside of the work-ordered day. Activities are scheduled both at the Clubhouse and in the community.

People living with mental health problems often require a variety of social and medical services. Help is given to members in acquiring and keeping affordable and dignified housing, psychiatric and general medical services, government disability benefits and any other needed services. Members and staff from the Clubhouse ensure all such support and assistance.

Part of the daily work of the Clubhouse involves keeping in contact with all active members. When a member does not attend the Clubhouse or is in the hospital a "reach-out" telephone call or visit is made. Each member is reminded that he or she is missed, and welcome and needed at the Clubhouse. This process not only encourages members to participate, but it is also an early warning system for members who are experiencing difficulties and may need extra help. [88]

Models of care used

This is an interesting form of care as all clinical input has been removed and individuals are considered to be members rather than patients. The most appropriate model for this programme is indicated prevention as the programme includes people at risk of developing further conditions.

4.4.1.11. Geriatric Mental Health Outreach (Canada)

The service

The Geriatric Mental Health Outreach teams serve people 65 years and older with serious mental health issues.[89] The service offers a comprehensive psychogeriatric assessment, psychoeducation, counselling and psychiatric treatment. Patients can be seen for most interventions at home.[89]

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. The outreach teams also work to enhance the knowledge and skills of family caregivers. Physician referral is required for access to the programme.[89]

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.

4.4.1.12.Geriatric Emergency Management Nurses (Canada)

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 patients.[90]

Geriatric Emergency Medicine 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.[90]

There are plans in place for patients attending the emergency department to be 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 seniors if they feel there is a need. Seniors 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.[90]

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.

4.4.1.13.Summary characteristics of case studies

Table 2 presents a summary of case study characteristics.

Table 2 – Summary characteristics of case studies

		Service for general or mental health	Target population	Specificities of elderly focused services	Geographic level	Financing Service	Availability of elderly specific cost effectiveness data	Model of care
ENGLAND	**CMHT**	Mental health only	All adults + Elderly specific	Includes care for organic illnesses, incl. conditions associated with memory loss and cognitive impairment, like dementia, functional mental illness. Elderly services can also cater for younger people with early onset dementia.	National	National Health Service	Yes	Stepped care
	IAPT	Mental health only	All adults + Elderly specific	In home and clinic appointments Adapted publications and material Use of outcome measures appropriate for older people Staff trained to deal with people with dementia.	National	National Health Service	No	Stepped care
	Crisis teams	Mental health only	All adults + Elderly specific	Team members with expertise in the problems faced by older adults including cognitive assessment, social care for the elderly and managing medical comorbidities.	National	National Health Service	No	Stepped care
FRANCE	**Hospitalisation at home**	General health (incl. mental health)	Elderly	Offered to older people to provide care within their home if the residence allows it.	National	State Health Insurance	No	Collaborative care

		Service for general or mental health	Target population	Specificities of elderly focused services	Geographic level	Financing Service	Availability of elderly specific cost effectiveness data	Model of care
	Therapeutic host families	Mental health only	All adults	No specifically different approach for the elderly other than appropriate placement according to physical and mental health.	Regional	Local authority	No	Indicated prevention
NETHELANDS	**FACT**	Mental health only	All adults + Elderly specific	CMH nurse and a psychiatrist specialized in treating older adult in the team.	National	Government and private insurers	No	Collaborative care Watch and wait
	Mental Health Nurses in GP	Mental health only	All adults	No reported specificities for the elderly	National	Funds from health insurance	No	Stepped care
SPAIN	**Community Mental Health Centres**	Mental health only	All adults	No reported specificities for the elderly	National	Government funding	No	Collaborative care
	Ribera Salud	General health (inc. mental health)	Elderly	Patients are elderly (75 years and older) and require support for one or more mental health disorders. Specialized attention is provided across primary, secondary and home based care.	Regional	Government funding	No	Collaborative care
CANADA	**Clubhouse Facilities**	Mental and physical health	All adults + Elderly specific	Senior clubhouses: more holistic approach focused on good mental and physical health rather than rehabilitation aimed at work or education	National	Government and public/private foundations	Yes	Indicated prevention
	Geriatric Emergency Management Nurses	Mental health only	Elderly	Specialized staff have good understanding of aging, geriatric symptoms and the most appropriate intervention and prevention strategies.	National	Government funding system	No	Indicated prevention

4.4.2. Barriers to implementation of specific services of MHC

The case studies provided evidence of a range of potential barriers to the successful implementation of mental health services. They are presented in Table 3.

Most barriers related to the wider population, and are not elderly specific. However, stigma can be a particular issue in the elderly, and as age increases so does multi-morbidity, so the challenges around communication between healthcare teams and professionals become more acute. Older people are also more likely to experience hearing or visual impairment or mobility problems, cognitive decline, social isolation and financial hardship, all of which may potentially be barriers to accessing services.

Table 3 – Barriers to implementation services of MHC in general, identified in the cases studies

England	France	Netherlands	Spain	Canada
• **Poor communication between healthcare professionals** • **Inappropriate referral by GPs due to lack of agreement between primary and secondary care about referral thresholds** • **Lack of experience and training** • **Patients not seeking access** • **Stigma**		• Lack of experience and training • Stigma		• No clear vision for programme • No strong governance or role clarity • Lack of education of nurses • Poor communication between healthcare professionals • Lack of resources • Lack of commitment to patient-centred care • Stigma

4.4.2.1. Poor communications and inappropriate referral

In England, evaluations of Community Mental Health Teams and their continuity of care found that health professionals felt there was inadequate provision of information technology resources, which in turn had implications on information continuity.[91] The surveys highlighted a need to link different methods of record keeping by health and social services. It also found that participants felt that funding of CMHTs should prioritise the provision of equipment for staff, such as an adequate number of computers.[91]

Within secondary care, barriers to the successful implementation of CMHTs can also be due to a lack of understanding of primary care and uncertainty over roles and responsibilities. Poor communication is a common issue with regard to integrated working, particularly between psychiatrists and GPs about issues such as non-attendance of appointments.[92]

Challenges of referral to CMHTs have been evaluated in a trial to assess the impact of appropriateness of referral. The analysis found that referral to and acceptance by CMHTs was influenced by the respondent's understanding of the service. CMHTs were found to often have to deal with referrals which they felt were inappropriate, such as from GPs who had not

started any basic treatments. Tensions exist regarding the criteria for referral, with CMHTs defining increasingly stricter referral criteria in order to use their scarce resources most effectively, and GPs feeling they are left to look after people with conditions that are beyond their expertise.[65]

Finally, when a community approach was first introduced there was some confusion of responsibility. For example, it has been suggested that consultant psychiatrists seemed to transfer their old responsibilities to the new setting, taking on more responsibility than was required in this new approach[93] Action was then taken to distribute responsibility more evenly across the teams, which saw a more formal split between acute or hospital based care and care planned in the community. It was hoped that introducing these roles meant a better service could be delivered to patients.

4.4.2.2. Lack of experience and training of care teams

Programmes implementing Geriatric Emergency Management Nurses in the Netherlands were found to be subject to a number of barriers. Emergency department staff often lacked the knowledge, education, experience, and also interest in dealing with the complex needs of the elderly.[94] As well as this there was a lack of support staff available to support the implementation of the new programme. Emergency department staff sometimes showed a lack of interest in treating people they feel have challenging or time consuming issues. Similarly, in Canada, it was found that in ACT teams the retraining of staff took time, even when team members already had experience with intensive case management.[84]

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. Training was recommended in integrated team working and team leadership, role development and competencies within CMHTs, change management, and management of temporary workers.[91]

In investigating the implementation of IAPT teams in England, it was also found that specialist mental health teams often lacked confidence in working with older people, especially if they have physical health problems or social, economic or communication difficulties. They may also have concerns about their ability or skills to build therapeutic relationships with older people.[95]

Finally, the complexity of patients' needs was also a potential barrier. People with complex mental health problems may not comply with the recommended care, their needs may change, and services may struggle to keep up with such changes.[91]

In order to overcome these barriers, it has been suggested that it may be possible to form partnerships between geriatric medicine, emergency medicine and general and family practice to increase awareness of the needs of older adults and how to go about meeting their needs. Also, assessing the skills, knowledge and attitudes of physicians and nursing staff within the emergency department to identify opportunities for formal geriatric emergency training and/or enhanced staff supports, such as the addition of a geriatric nurse clinician, could help break barriers. A further suggestion for long term improvement in care was to influence universities and colleges to incorporate formalized geriatric programs into emergency program curriculums. [94] 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.[94]

4.4.2.3. Lack of understanding and experience in primary care

There is evidence that at times a lack of understanding and experience in providing mental healthcare in primary care, particularly from GPs, can be a barrier to patients getting the most effective care. In the Netherlands, It is plausible that GPs collaborating with a Mental Health Nurse see a smaller number of patients with psychological or social problems themselves, or use fewer or shorter consultations per patient, perhaps leading to a lack of experience in dealing with this patient group.

In England, older people may be prevented from accessing psychological therapies because of time constraints in GP surgeries that prevent effective diagnosis of mental health problems. 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 to the elderly population, GPs may also believe that sadness is part of ageing or that psychological therapies do not work for older people, and so prioritise referring younger people.[95]

4.4.2.4. Patients deciding not to seek access

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.[95]

Social isolation amongst the elderly can also prevent access to psychological therapy services. The Health Survey for England in 2005 found 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.

Certain ethnic groups in the UK, such as Indian, Bangladeshi and Chinese people, also have consistently low referral rates to crisis teams. However, once they are assessed by the teams, minority groups are much more likely to be admitted to hospital and are more likely to be receiving treatment once they are seen by the crisis teams.[96] A report by the charity MIND suggests that there may be cultural and practical barriers to accessing care, including mental health stigma in some communities or differences in how people are treated.[96]

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 of the signs of illness, and not that their symptoms are a sign of aging.

4.4.2.5. Financial disincentives

It is critical when setting up a new service to get the financial incentives right. For example, in terms of fee-for-service payments, as these can be volume-driven 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.

In a more general sense, the implementation of a new programme takes both time and money. During periods of economic uncertainty, it can be difficult to secure funding for a new programme without known effectiveness, so evaluation is a must.[84]

4.5. Transversal analysis

4.5.1. Approaches to mental health care and mental health services for elderly

In the past few decades there has been a widespread shift from an institutionalized approach to more community focused care relying on outpatient, inpatient and residential facilities as well as health and social care facilities. This has been the case for all five countries for older people.

The case studies assessed are all examples of community based services and included examples of three models of care: stepped care, collaborative care and indicated prevention.

The overall approach to mental health care of the elderly does not appear to differ significantly from care of all adults across the five countries.

All of the included countries have moved away from an institutionalized approach to mental health care for the elderly in favour of providing care in the community or even in the home. With an aging population and a large burden of disease, this shift aims to allow health services to provide a good standard of care within health budgets as theoretically care within the community comes at a lower price. A number of services are available to older people, some of which are elderly specific and others which are for all adults. This reflects a shift in opinion as older people do not always want or need to be seen as different from the rest of the adult population.

Population aging also leads to people living with a number of comorbidities. Polypharmacy is associated with multi-morbidity and the prevalence increases with deprivation, with people in deprived areas having similar levels to more affluent patients who are 10 to 15 years older. [97] Providing good quality psychological services rather than issuing medication within primary care can benefit many older adults' medical and other health concerns and reduce the need for and risks of polypharmacy.[98]

Many services are available to all adults, however a number have a specialized version which has been tailored to older patients. For example, in England all of the case studies we have discussed have an elderly specific form of the service. Some differences between all adult and older adult services aside from age of access are that staff have more specialized knowledge of older people and the conditions associated with the age group such as increased likelihood of comorbidities and dementia. Ways to make the service more accessible to the elderly are to use materials and publications designed for this group and also offer in home care as many older people are frail and less mobile.

But elderly people for the most part access the same services that are available for the working age population. For example, health care in general is mainly accessed through primary care or GPs; although a number of patients will also present to emergency departments or crisis services. GPs refer patients, elderly or not, to specialized services if they are unable to treat the patient themselves. In England, GP's offer advice and treatment, but will also refer patients to secondary mental health care or psychology services. This is similar to France and Spain. [47] Older people in the Netherlands will also usually make contact with a general practitioner or welfare worker, where mild issues are dealt with; 90% of issues are dealt with in primary care.[41] Finally, most Canadian elders receive preventative care and medical treatments from generally available primary care services, hospitals, and other medical services. Referrals to specialized services, as is the case with the wider population, are also from these providers.

Table 4 presents a top-level comparison of the five national healthcare systems regarding their specificities for mental health in elderly.

Table 4 – Specificities for the elderly in the organization of mental health care across the five countries

	England	France	Netherlands	Spain	Canada
Mental health care services					
Specific access to MHC for elderly	No	No	No	No	No
Specific MH programs/services for elderly	• CMHT • Memory services • Psychology services • Specialist Dementia Services • Crisis resolution service for the elderly • Elderly mental health units	• Local old age multidisciplinary psychiatric teams (e.g. Grenoble)	• Specialized Flexible ACT team in (e.g.) Amsterdam	Regional plans (e.g. Madrid)	In larger cities
Specialized caregivers	• Social workers • Occupational therapists • Old age psychiatrists	• Post-graduate training in geriatric care for psychiatrist	• Old age psychiatry • Gerontology specialists	• Psycho-geriatric care	• Geriatric psychiatrists
Other organizations offering help for elderly	Age UK	-	-	-	-
Financial aspects					
Out of pocket costs for MHC	Services: No (for all?) Prescriptions: free for +60y	Yes, for all patients	Yes, for all patients, by subscribing health insurance	Yes, for all patients	Yes, for all patients
Specific funding for the (mental) health care of elderly	No	• Caisse Nationale de Solidarité pour l'Autonomie (CNSA).	• The Long-term care act: funding for vulnerable groups incl. elderly in	No	No

	England	France	Netherlands	Spain	Canada
		• Allocation Personnalisée d'Autonomie (APA), for the 60+	advanced stages of dementia		
Performance indicators					
Specific indicators for elderly	• Geriatric Depression Scale (GDS) • Cornell Scale for Depression in Dementia (CSDD)	• Health of the Nation Outcome Scales for Elderly People (HoNOS65+)	• Geriatric Depression Scale (GDS-15)	-	• The Geriatric Depression Scale (GDS) • Brief Assessment Schedule for the Elderly (BASDEC) • The Geriatric Mental State Schedule (GMSS) • The Cornell Scale for Depression in Dementia • Rate of suicide in those over 65 years.

In assessing these five countries a number of barriers to implementation and appropriate use of care have been highlighted as well as potential ways to overcome these. The main barrier is stigma attached to mental illness itself or to seeking help. This is probably the hardest barrier to overcome as there are so many factors involved. Different groups within the community, whether it be ethnic or age groups, can have very different views and ideas and in order to break down these barriers each group should be targeted. Elderly people may not seek access for their issues as some believe that mental health issues, such as depression and anxiety, are a part of growing old.[95] Some ways to improve this are to hold focus groups within the community and establish the best methods to use. An example of this was in Canada when the Senior Clubhouse service was set up. The idea arose because older people in the traditional clubhouse facilities had wished to 'retire' but rather than setting up the senior service using the same model the idea was discussed with people in the community and the service tailored accordingly.

Most of the other barriers are not specific to the elderly and are related to the system in general. The barriers include poor communication and inappropriate referral, lack of experience and training, and lack of understanding and experience in primary care. [95]

Poor communication was another identified issue. This included the inadequacy of information technology resources, which had implications for setting up collaborative care models where good systems for transferring information between providers are needed.[91] Poor communication is a common issue with regard to integrated working, particularly between psychiatrists and GPs.[92]

Lack of education, experience and training were common barriers to implementation. Sometimes there is a lack of interest in dealing with the elderly by some staff, because of the complexities and time involved.[94] A paucity of trained staff and discrimination against elderly people was also common. The training of staff to improve this situation is time consuming, and therefore is not always put in place.[84]

Finally, financial barriers are also present - this may be financial disincentive for the care of older patients, difficulties in securing funding for new initiatives, or out of pocket costs faced by patients.

4.5.2. Information systems

Each country has different methods of information integration across different levels of care provision. These systems apply to all adults; there are no specific issues around information integration for older adults. Information systems are essential for collaboration between different services in order to effectively and efficiently meet a patient's needs. Multidisciplinary teams 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.

Examples of good practice include the Netherlands, where integration of information systems is present across different levels of mental care provision and settings.[30] 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. In Spain some regions have case registries and patients can be tracked through their mental health care pathway, but in other areas patients can only be tracked inside each of the levels of care but not across them. Most of the different data sources available include both mental health care and physical health care. Similarly in Canada often patients can be tracked within certain levels of care but not across them; some tracking is possible from emergency care to inpatient stays, and in a very limited way to outpatient care, when the outpatient setting is hospital based. The differences in integration of information between settings and levels of care mean that patients may suffer poor continuity of care. 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.

4.5.3. The use of performance indicators

All of the included countries use performance indicators to assess mental health care in the elderly. In some countries this also includes indicators that are specific to or recommended for elderly patients. In England there are a number of outcome measures that are used in mental health, including elderly specific measures. These include the Geriatric Depression Scale (GDS), also used in Canada. Canada also use the Geriatric Mental State Schedule (GMSS). 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+). However, all of these instruments are available for use in each of these countries. The issue is that they do not appear to be mandated for routine data collection at a national level. Rather, they are used as a tool to guide initial management and to monitor progress.

Regional level data is collected in most countries and regions. We have mentioned in the Netherlands there is ROM whilst in the UK data is collected for the Hospital Episode Statistics database. In Ontario, regional level data is collected for the Ontario Mental Health Reporting system.

4.5.4. The provision of funding

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 four of the five countries; France has a different system whereby older people are required to pay up front for their care and then a portion of this is reimbursed. There are some significant exceptions however. In Canada, treatment by psychologists or psychotherapists is not covered unless they have also trained as a medical doctor[54], and in France all psychological therapy is also paid out of pocket. In Spain, older people need to co-pay for medicines.

Funding for services is mainly provided by the government through various forms of taxation, although in the Netherlands residents are required to purchase statutory health insurance from private insurers.[99] This provides them with basic mental health care for mild to moderate mental disorders, including maximally five sessions with a primary care psychologist, and specialized outpatient and inpatient mental care for complicated and severe mental disorders. If care is needed for over a year the Health Insurance Act and Long-Term Care Act take over and care is considered long-term. In Spain the system offers universal coverage and does not involve any out of pocket payments other than for drugs.[22] In England, funding for the health service comes from tax revenue. In France patients are covered by a statutory health insurance system, whose funding also comes from taxation. Finally in Canada, patients have free access to hospital and physician services deemed medically necessary, although funding arrangements for other services often depend on provincial arrangements.

Financial issues were also a key barrier to implementation. Budget cuts, changes to insurance policies and general uncertainty make it hard to secure funding to set up new programmes which may have unproven effectiveness. In the Netherlands, where care is covered by changing insurance schemes, there are growing concerns that reduced funding is putting medical facilities in jeopardy. General practice centres vary in size from just one practitioner to a multidisciplinary team. Smaller practices can often not afford to take on mental health nurses, especially if there is the possibility of changes to allocated funding. However, there are agencies in place that can supply staff on shorter term contracts which takes away some of the financial and administrative burden.

Local governments can play a part in optimising mental health care for the elderly 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. 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, the conditions can be distressing to the patient and their families and is often life changing. Allowing easy access to care within the community is vital.

4.5.4.1. Key messages

- **Organisation of mental health care is broadly similar across all five countries, as they all face similar challenges.**
- **All countries have aimed to reduce hospitalization, through not only the provision of community care and crisis response teams and similar services, but also the creation of therapeutic families and other innovative approaches**
- **Healthcare services have aimed to maximise treatment in primary care settings, instead of more expensive secondary care**
- **Most systems have increased the amount of care provided by nurses and other non-doctor staff, with the aim of providing more cost-effective support**
- **Patient information integration does not differ for elderly patients.**
- **Elderly specific performance indicators are used in some of the countries: the Geriatric Depression Scale (GDS), Health of the Nation Outcome Scales for Elderly People (HoNOS65+), and the Cornell Scale for Depression in Dementia (CSDD)**
- **Whilst most services are funded by the government or insurance there are some special cases for the elderly. In England people over the age of 60 years are exempt from prescription charges, so medications do not place out-of-pocket costs on patients.**

4.6. Limitations

The main limitation to this comparative study of five countries was the ever-changing nature of the healthcare systems and services being studied. All the countries covered naturally have evolving healthcare systems and institutions, and even recent secondary sources were often found to be at least partially out of date upon further investigation. To mitigate this we performed a series of interviews of country experts, who were able to provide us with the latest news on one or more services. Also, we considered that being a year or two out of date in places did not make the information provided invalid. All of the case studies contain ideas and experiences that could be applied or adapted for the development of the Belgium health care system, whether their descriptions are one, two or five years old. As we describe in the history of reform in each country, healthcare systems by their nature tend to be a blend of intermittent bouts of design alongside ongoing evolutionary drift.

A second limitation was the often patchy nature of available information. While official documentation may be available on a particular service, it is more difficult to find information around actual implementation - particularly when there were serious challenges. To mitigate this we prioritised schemes that had been evaluated or audited, or had been academically researched with a focus on barriers and facilitators to implementation. Naturally, the implementation of some services were better described than others. Related to this, it was often not possible to find reliable figures relating to co-payments, funding, and other specific financial questions. Financial information that we did find and attempt to verify was often found to be out of date. We have presented data when available. In other cases we have attempted to describe qualitatively where the financial burden lies.

Finally, while not a limitation as such, it is important to note that this report is not a systematic review of the effectiveness of the schemes in question, or of the optimal organisation of a healthcare system. Its aim is to describe a selection of services and the experience of implementation, with a focus on barriers and implementation.

4.7. Conclusions

Deinstitutionalization has led to mental health care taking a community based approach across all five countries studied. Easily accessible care that is appropriate to the population is critical for optimising mental health services. In order for community care to work we have described how it is necessary to ensure adequate training for staff, provision of funding and ways to create awareness and reduce stigma.

As noted in the transversal analysis, the case studies covered three models of care: stepped care, collaborative care and indicated prevention. All three are needed for successful mental health care to be delivered cost-effectively to elderly people. The alternative to doctor or consultant led care makes stepped care possible, and ensures scarce resource is used effectively. Joined up, holistic care delivered via a collaborative care model can meet the needs of people with multiple morbidities. Finally enabling self-care, through schemes such as the clubhouse, deliver indicated prevention, preventing more serious issues down the line.

Each country has a mixture of services available to all adults (including both the working age population and the elderly) and separate elderly specific services. Where separate adult and older people's services are present, patients usually transfer between the services at age 65 or when their needs are better met by a service designed for those with cognitive decline or physical frailty. If the services are separate then it is vital that good integration of the services and medical records are in place for people with continuing mental health conditions.

There are arguments for both joined up (all adult) and separate (elderly specific) services. In favour of joined up services is the observation that programmes specifically for older adults can be subject to stigma and may not be as well resourced. Also elderly people often do not necessarily want to be treated separately, making them feel old or infirm. Another consideration is that if separate services exist then it potentially adds a complication as it would require the development of transfer protocols, as patients pass from adult to elderly. Following this line of thought, services do not have to be unique to the elderly. Indeed a number of the services we described are extensions of those that cover the wider adult population.

On the other hand, separate services allow teams to focus on, and gain expertise in, the unique combinations of challenges that typify the elderly population, including co-morbidity, social isolation and end of life care. The mental and physical health needs of older people may be different enough to justify specialist services; for example older people are more likely to be frail or isolated, or have sensory impairment or cognitive decline. Elderly people tend to be the least likely age group to ask for help, as they often respond to illness through withdrawal, and are less likely to present to services through other routes, such as risk of violence. The danger therefore of having a joined up system for all is that older people will present later, with associated risk of hospitalization.

In conclusion, because this is a review of five countries experiences of implementing a selection of services, rather than a review of effectiveness, it is not possible to offer recommendations on "what works". However, we've described some common themes that emerge across all or most countries, and which should be considered when implementing models of mental health care for the elderly in Belgium.

5. NOMENCLATURE CODES

Table 5 – Nomenclature codes for psychiatrists' consultation/psychotherapies and emergency medecine

Groepdetail FR	Groepdetail NL	Nomenclature code (ss00020)
Consultation d'un neurologue, d'un psychiatre ou d'un neuropsychiatre	Raadplegingen van een neuroloog, van een psychiater of van een neuropsychiater	102056
		102196
		102211
		102690
		102712
Psychothérapies	Psychotherapieën	109513
		109535
		109550
		109572
		109631
		109653
Médecine d'urgence	Urgentiegeneeskunde	590914
		590995

Table 6 – Nomenclature codes for GP visits

Nomenclature code	Nomenclature description (F)	Nomenclature description (N)	Author doc
101010	Consultation au cabinet du médecin de médecine générale	Raadpleging in de spreekkamer door een huisarts op basis van verworven rechten	KB1984001804
101032	Consultation au cabinet du médecin porteur d'un certificat de formation complémentaire	Raadpleging in de spreekkamer door een huisarts	KB1984001804
101076	Consultation au cabinet du médecin accrédité porteur d'un certificat de formation complémentaire	Raadpleging in de spreekkamer door een geaccrediteerde huisarts	KB1995022359
103036	Honoraires du médecin appelé en consultation : s'il s'agit d'un médecin de médecine générale	Honorarium van de ter consult bijgeroepen geneesheer : indien het om een algemeen geneeskundige gaat	KB1984001804

Nomenclature code	Nomenclature description (F)	Nomenclature description (N)	Author doc
103110	Visite au domicile du malade par le médecin de médecine générale	Bezoek door een huisarts op basis van verworven rechten	KB1984001804
103132	Visite au domicile du malade par le médecin porteur d'un certificat de formation complémentaire	Bezoek door de huisarts	KB1984001804
103213	Visite par le médecin de médecine générale ou le médecin spécialiste en pédiatrie à plusieurs bénéficiaires à leur résidence ou domicile commun, à l'occasion d'un même déplacement : deux bénéficiaires, par bénéficiaire	Bezoek door een huisarts op basis van verworven rechten, naar aanleiding van eenzelfde reis voor twee rechthebbenden	KB1984001804
103235	Visite par le médecin de médecine générale ou le médecin spécialiste en pédiatrie à plusieurs bénéficiaires à leur résidence ou domicile commun, à l'occasion d'un même déplacement : trois bénéficiaires ou plus, par bénéficiaire	Bezoek door een huisarts op basis van verworven rechten, naar aanleiding van eenzelfde reis voor meer dan twee rechthebbenden	KB1984001804
103316	Visite par le médecin de médecine générale ou le médecin spécialiste en pédiatrie dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à un bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten in een instelling waar kinderen, herstellenden of gehandicapten verblijven (dagverblijf, overnachting, dagverblijf en overnachting) : bij één rechthebbende	KB1984001804
103331	Visite par le médecin de médecine générale ou le médecin spécialiste en pédiatrie dans un établissement où séjournent des enfants, des personnes êgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à deux bénéficiaires, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten in een instelling waar kinderen, herstellenden of gehandicapten verblijven (dagverblijf, overnachting, dagverblijf en overnachting) : bij twee rechthebbenden, bij eenzelfde reis, per rechthebbende	KB1984001804
103353	Visite par le médecin de médecine générale ou le médecin spécialiste en pédiatrie dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, sèjour de jour et de nuit) : à trois bénéficiaires ou plus, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten in een instelling waar kinderen, herstellenden of gehandicapten verblijven (dagverblijf, overnachting, dagverblijf en overnachting) : bij drie rechthebbenden of meer, bij eenzelfde reis, per rechthebbende	KB1984001804
103412	Visite par le médecin porteur d'un certificat de formation complémentaire à plusieurs bénéficiaires à leur résidence ou domicile commun, à l'occasion d'un même déplacement : deux bénéficiaires, par bénéficiaire	Bezoek naar aanleiding van eenzelfde reis voor twee rechthebbenden door de huisarts	KB1984001804

Nomenclature code	Nomenclature description (F)	Nomenclature description (N)	Author doc
103434	Visite par le médecin porteur d'un certificat de formation complémentaire à plusieurs bénéficiaires à leur résidence ou domicile commun, à l'occasion d'un même déplacement : trois bénéficiaires ou plus, par bénéficiaire	Bezoek naar aanleiding van eenzelfde reis voor meer dan twee rechthebbenden door de huisarts	KB1984001804
103515	Visite par le médecin porteur d'un certificat de formation complémentaire dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à un bénéficiaire	Bezoek door de erkende huisarts in een instelling waar kinderen, herstellenden of mindervaliden verblijven (verblijf overdag, verblijf 's nachts, verblijf overdag en 's nachts) : bij één rechthebbende	KB1984001804
103530	Visite par le médecin porteur d'un certificat de formation complémentaire dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à deux bénéficiaires, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de erkende huisarts in een instelling waar kinderen, herstellenden of mindervaliden verblijven (verblijf overdag, verblijf 's nachts, verblijf overdag en 's nachts) : bij twee rechthebbenden, naar aanleiding van een zelfde reis, per rechthebbende	KB1984001804
103552	Visite par le médecin porteur d'un certificat de formation complémentaire dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à trois bénéficiaires ou plus, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de erkende huisarts in een instelling waar kinderen, herstellenden of mindervaliden verblijven (verblijf overdag, verblijf 's nachts, verblijf overdag en 's nachts) : bij drie rechthebbenden of meer, naar aanleiding van een zelfde reis, per rechthebbende	KB1984001804
103552	Visite par le médecin porteur d'un certificat de formation complémentaire dans un établissement où séjournent des enfants, des personnes âgées, des convalescents ou des handicapés (séjour de jour, séjour de nuit, séjour de jour et de nuit) : à trois bénéficiaires ou plus, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de erkende huisarts in een instelling waar kinderen, herstellenden of mindervaliden verblijven (verblijf overdag, verblijf 's nachts, verblijf overdag en 's nachts) : bij drie rechthebbenden of meer, naar aanleiding van een zelfde reis, per rechthebbende	KB1984001804
103913	Visite effectuée par le médecin de médecine générale porteur d'un certificat de formation complémentaire à un malade dans un établissement pouvant porter en compte une intervention forfaitaire telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5 avril 1995 concernant respectivement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à un bénéficiaire	Bezoek door de erkende huisarts bij één rechthebbende in instellingen met gemeenschappelijke verblijven	KB1999022423
103935	Visite effectuée par le médecin de médecine générale porteur d'un certificat de formation complementaire à un malade dans un établissement pouvant porter en compte une intervention forfaitiare telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5	Bezoek door de erkende huisarts, bij de zieke in een inrichting die een forfaitaire tegemoetkoming zoals voorzien in de ministeriële besluiten van 19 mei 1992 en 5 april 1995 met betrekking tot respectievelijk de rust- en verzorgingstehuizen en de rustoorden	KB1999022423

Nomenclature code	Nomenclature description (F)	Nomenclature description (N)	Author doc
	avril 1995 concernant respectivement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à deux bénéficiaires, à l'occasion d'un même déplacement, par bénéficiaire	voor bejaarden, in rekening kan brengen : bij twee rechthebbenden, bij eenzelfde reis, per rechthebbende	
103950	Visite effectuée par le médecin de médecine générale porteur d'un certificat de formation complémentaire à un malade dans un établissement pouvant porter en compte une intervention forfaitaire telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5 avril 1995 concernant respectivement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à trois bénéficiaires ou plus, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de erkende huisarts, bij de zieke in een inrichting die een forfaitaire tegemoetkoming zoals voorzien in de ministeriële besluiten van 19 mei 1992 en 5 april 1995 met betrekking tot respectievelijk de rust- en verzorgingstehuizen en de rustoorden voor bejaarden, in rekening kan brengen : bij drie rechthebbenden of meer, bij eenzelfde reis, per rechthebbende	KB1999022423
104112	Visite effectuée par le médecin de médecine générale à un malade dans un établissement pouvant porter en compte une intervention forfaitaire telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5 avril 1995 concernant respectivement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à un bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten bij één rechthebbende in instellingen met gemeenschappelijke verblijven	KB1999022423
104134	Visite effectuée par le médecin de médecine générale à un malade dans un établissement pouvant porter en compte une intervention forfaitaire telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5 avril 1995 concernant respectivement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à deux bénéficiaires, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten bij de zieke in een inrichting die een forfaitaire tegemoetkoming zoals voorzien in de ministeriële besluiten van 19 mei 1992 en 5 april 1995 met betrekking tot respectievelijk de rust- en verzorgingstehuizen en de rustoorden voor bejaarden in rekening kan brengen: bij twee rechthebbenden, bij eenzelfde reis, per rechthebbende	KB1999022423
104156	Consultations au cabinet du médecin et visites au domicile du malade : Visite effectuée par le médecin de médecine générale à un malade dans un établissement pouvant porter en compte une intervention forfaitaire telle que prévue dans les arrêtés ministériels des 19 mai 1992 et 5 avril 1995 concernant respectievement les maisons de repos et de soins et les maisons de repos pour personnes âgées : à trois bénéficiaires ou plus, à l'occasion d'un même déplacement, par bénéficiaire	Bezoek door de algemeen geneeskundige met verworven rechten bij de zieke in een inrichting die een forfaitaire tegemoetkoming zoals voorzien in de ministeriële besluiten van 19 mei 1992 en 5 april 1995 met betrekking tot respectievelijk de rust- en verzorgingstehuizen en de rustoorden voor bejaarden in rekening kan brengen: bij drie rechthebbenden of meer, bij eenzelfde reis, per rechthebbende	KB1999022423
104215	Visite effectuée par le médecin porteur d'un certificat de formation complémentaire au domicile du malade entre 18 heures et 21 heures	Bezoek afgelegd tussen 18 en 21 uur door de huisarts	KB1991003881

Nomenclature code	Nomenclature description (F)	Nomenclature description (N)	Author doc
104355	Consultation du médecin porteur d'un certificat de formation complémentaire appelé par un médecin au domicile du malade	Consult van een erkende huisarts bij de zieke thuis door een geneesheer aangevraagd	KB1991003881
104370	Visite effectuée par le médecin généraliste agréé à un patient palliatif à domicile	Bezoek door de erkende huisarts thuis bij een palliatieve patiënt	KB2002022484
104392	Visite effectuée entre 18 heures et 21 heures, par le médecin généraliste agréé à un patient palliatif à domicile	Bezoek door de erkende huisarts tussen 18 en 21 uur thuis bij een palliatieve patiënt	KB2002022484
104510	Visite effectuée par le médecin de médecine générale au domicile du malade entre 18 heures et 21 heures	Bezoek afgelegd tussen 18 en 21 uur door een huisarts op basis van verworven rechten	KB1991003881
104650	Consultation du médecin de médecine générale appelé par un médecin au domicile du malade	Consult van de algemeen geneeskundige met verworven rechten bij de zieke thuis door een geneesheer aangevraagd	KB1991003881
104672	Visite effectuée par le médecin généraliste avec droits acquis à un patient palliatif à domicile	Bezoek door de algemeen geneeskundige met verworven rechten, thuis bij een palliatieve patiënt	KB2002022484
104694	Visite effectuée, entre 18 heures et 21 heures, par le médecin généraliste avec droits acquis à un patient palliatif à domicile	Bezoek door de algemeen geneeskundige met verworven rechten, tussen 18 en 21 uur thuis bij een palliatieve patiënt	KB2002022484
109701	Honoraires du médecin de médecine générale porteur d'un certificat de formation complémentaire, pour la visite dans un hôpital à un patient dans un service Sp (soins palliatifs) à la demande du patient ou à la demande d'un membre de sa famille ou d'un de ses proches	Bezoek, in een Sp-dienst (palliatieve zorg) door de huisarts op verzoek van de patiënt of van één van zijn naastbestaanden	KB1999022425
109723	Honoraires du médecin de médecine générale porteur d'un certificat de formation complémentaire, pour la visite à un bénéficiaire hospitalisé à son intervention, à la demande de ce bénéficiaire ou d'un membre de sa famille	Bezoek in het ziekenhuis door de behandelende huisarts	KB1986000302

6. ONLINE SURVEY TO INNOVATIVE INITIATIVES

6.1. Dutch version

MAIL VOOR KOEPELS

Geachte,

Het Federaal Kenniscentrum voor de Gezondheidszorg (KCE) werkt op dit ogenblik aan een studie naar de organisatie van geestelijke gezondheidszorg voor ouderen in België. De WHO[1] beveelt immers aan om de noodzaak te overwegen om een subgroep-specifiek beleid uit te bouwen voor geestelijke gezondheidszorg (GGZ). Voor kinderen en adolescenten heeft de Belgische overheid in 2015 hierin al belangrijke stappen gezet. Voor ouderen is dit tot op heden nog niet grondig onderzocht.

De huidige studie beoogt het ontwikkelen van aanbevelingen om GGZ voor ouderen te optimaliseren. Hiervoor wordt gebruik gemaakt van een literatuurstudie, verkenning van buitenlandse modellen, een overzicht van Belgische initiatieven en een iteratief proces van stakeholders-consultatie.

Uit meerdere bronnen vernemen we dat er in België interessante initiatieven ontwikkeld zijn, opgericht buiten de traditionele zorgverlening, met het oog op GGZ voor ouderen. We zijn nu op zoek naar deze innovatieve projecten om een beschrijving hiervan op te nemen in ons rapport. Zou u ons kunnen helpen met deze opdracht?

Kent u initiatieven in uw netwerk die passen in ons onderzoek? Kan u ons de coördinaten van deze organisaties dan doorgeven? Gezien we de inventarisatie en beschrijving willen afsluiten **eind september**, zou ik u willen vragen om ons zo spoedig mogelijk te antwoorden. Indien u ons echter niet kan helpen, zou u ons dit dan ook kunnen laten weten?

Alvast hartelijk dank bij voorbaat.

Met vriendelijke groeten,

Jef Adriaenssens,
Laurence Kohn,
Marijke Eyssen

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MAIL VOOR INITIATIEVEN

Geachte,

Het Federaal Kenniscentrum voor de Gezondheidszorg (KCE) werkt op dit ogenblik aan een studie naar de organisatie van geestelijke gezondheidszorg voor ouderen in België.

De WHO beveelt immers aan om de noodzaak te overwegen om een subgroep-specifiek beleid uit te bouwen voor geestelijke gezondheidszorg (GGZ).

Voor kinderen en adolescenten heeft de Belgische overheid in 2015 hierin al belangrijke stappen gezet. Voor ouderen is dit tot op heden nog niet grondig onderzocht.

De huidige studie beoogt het ontwikkelen van aanbevelingen om GGZ voor ouderen te optimaliseren.

Hiervoor wordt gebruik gemaakt van een literatuurstudie, verkenning van buitenlandse modellen, een overzicht van Belgische initiatieven en een iteratief proces van stakeholders-consultatie.

Uit meerdere bronnen vernemen we dat er in België interessante initiatieven ontwikkeld zijn, opgericht buiten de traditionele zorgverlening, met het oog op GGZ voor ouderen.

We zijn nu op zoek naar deze innovatieve projecten om een beschrijving hiervan op te nemen in ons rapport.

Ook uw organisatie is opgenomen in onze lijst. Zou u ons kunnen helpen met deze opdracht?

Hieronder vindt u een link naar een online enquête. Zou het mogelijk zijn deze te beantwoorden vóór 25 oktober? Bijkomende informatie over uw initiatief (rapporten, folders, …) is zeker ook welkom.

Indien u ons echter niet zou kunnen helpen, zou u ons dit dan ook kunnen laten weten?

Mocht u vragen hebben ivm de enquête, aarzel dan niet om ons te contacteren per mail of telefoon (02 287 33 49 NL of 02 287 33 69 FR)

De links:

Nederlands : http://www.kcenet.be/surveys/index.php/534755?lang=nl

Frans : http://www.kcenet.be/surveys/index.php/534755?lang=fr

Alvast hartelijk dank bij voorbaat.

Met vriendelijke groeten,

Jef Adriaenssens,

Laurence Kohn,

Marijke Eyssen

BEVRAGING: OVERZICHT INITIATIEVEN GGZ VOOR OUDEREN IN BELGIË

1. Wat is de naam van uw initiatief rond geestelijke gezondheidszorg voor de ouderen?

2. Kan u dit initiatief beschrijven? Welke acties onderneemt het? Welke methodes of manier van aanpak gebruikt het?

3. Wat is het doel van dit initiatief ?

4. Sinds wanneer bestaat uw initiatief?

5. In welke landsdeel/landsdelen is dit initiatief actief?

6. Hoeveel vestigingen heeft uw initiatief?

7. Vanuit welke organisatie/vereniging/overheid/... is het initiatief ontstaan ?

8. Richt uw initiatief zich enkel op ouderen of ook op andere leeftijdsgroepen?

9. Richt uw initiatief zich op een specifieke subgroep van ouderen of op de volledige breedte van de ouderen-populatie?

10. In welke lijn van de gezondheidszorg situeert dit initiatief zich? (meerdere antwoorden zijn mogelijk)

O Eerstelijnszorg?
O Tweede lijn (gespecialiseerde ambulante zorg)?
O Derde lijn (semi-residentiële of residentiële gespecialiseerde zorg)?

11. Hoeveel medewerkers heeft uw initiatief?
    a. Welke zijn de disciplines van deze medewerkers? (graag oplijsting van het aantal FTE en het aantal personen per discipline)

12. Hoeveel ouderen bereikt uw initiatief per jaar?

13. Komt uw iniatief in aanmerking voor terugbetaling aan de oudere vanuit de sociale zekerheid of vanuit een andere (zorg)verzekering of instantie? Verklaar u nader.

14. Wat is de persoonlijke bijdrage per maand voor de oudere voor de zorg die het initiatief aanbiedt?

15. Heeft uw initiatief een wachtlijst van ouderen die niet onmiddellijk kunnen geholpen worden?
    O Ja O Nee
    a. Zo ja, hoe groot is deze wachtlijst?
    b. Zo ja, is deze wachtlijst groeiend of afnemend? Verklaar u nader.

16. Wordt uw initiatief op dit ogenblik gesubsidieerd?
    O Ja O Nee
    a. Zo ja, door welke instantie of overheid?
    b. Zo ja, is dit een projectsubsidie met beperkte looptijd of is dit een continuerende subsidie/betoelaging? Verklaar u nader.

17. Is de werking van het initiatief sinds zijn ontstaan geëvalueerd?
O Ja O Nee
a. Zo ja, door een externe instantie of onderzoeksgroep? Verklaar u nader.
b. Zo ja, welke elementen zijn er bestudeerd?
c. Zo ja, welke waren de bevindingen van deze evaluatie?

18. Werkt het initiatief samen met andere initiatieven voor geestelijke gezondheidszorg voor ouderen?
O Ja O Nee
a. Zo ja, met welke initiatieven?
b. Zo ja, kan u deze samenwerking beschrijven?
c. Zo ja, is dit een formele (geofficialiseerde) samenwerking of is dit ad hoc? Verklaar u nader.

19. Welke zijn de sterktes en zwaktes van uw initiatief ?

20. Heeft u als inrichtende organisatie al problemen ervaren met betrekking tot de werking van uw initiatief of samenwerking met andere organisaties? Zo ja, kan u deze hieronder beschrijven ?

21. Hebt u aanbevelingen om de (samen)werking van het initiatief te verbeteren?

22. Hebt u nog aanvullingen of opmerkingen bij deze vragenlijst?

23. Indien we op basis van uw antwoorden nog bijkomende vragen hebben, mogen we u dan terug contacteren? Zo ja, kan u hiervoor een telefoonnummer vermelden?
O Ja O Nee

6.2. French version

MAIL VOOR KOEPELS

Madame,
Monsieur,

Le Centre d'expertise des soins de santé (KCE) travaille en ce moment sur une étude concernant l'organisation des soins de santé mentale pour les personnes âgées en Belgique. En effet, l'OMS recommande d'envisager la nécessité d'élaborer une politique spécifique pour un sous-groupe concernant la santé mentale (SSM ?). Pour les enfants et les adolescents, le gouvernement belge a déjà mis en place, en 2015, des mesures importantes. A ce jour, l'aspect des soins de santé mentale pour les personnes âgées n'a pas encore été étudié.

L'étude actuelle vise à élaborer des recommandations pour optimiser les soins de santé mentale des personnes âgées. Pour ceci, nous ferons usage d'une étude de la littérature, de l'exploration des modèles étrangers, d'un aperçu des initiatives belges et d'un processus interactif de consultations de parties-prenantes (stakeholders).

Différentes sources nous apprennent qu'il y a des initiatives intéressantes développées en Belgique, établies hors des soins traditionnels, en vue de soins de santé mentale pour personnes âgées. Nous sommes à la recherche de projets innovants afin d'en inclure une description dans notre rapport. Pourriez-vous nous aider dans cette tâche ?

Connaissez-vous, au sein de votre réseau, des initiatives qui entrent dans le cadre de notre recherche? Pourriez-vous nous communiquer les coordonnées des organisations concernées ? Etant donné que nous souhaitons clôturer l'inventorisation et la description pour la **fin du mois de septembre**, je me permets de vous demander de nous envoyer votre réponse au plus vite. Toutefois, si vous ne pouvez pas nous aider, pouvez-vous nous en informer également.

Nous vous en remercions d'avance.

Bien cordialement,

Jef Adriaenssens,
Laurence Kohn,
Marijke Eyssen

Mail 13.09: 'psychologues.apsih@gmail.com'; 'aemtc.rfccc@scarlet.be'; 'secretariat@srmmb.org'; 'info@patientenrat.be'; 'ipf.sante.mentale@gmail.com', 'doc.orban@gmail.com'; 'c.linotte@aigs.be'; 'beatricedispaux@gmail.com'; 'info@dionysos.brussels'; 'webercarmen@live.be'; 'a.dellisse@luss.be'; 'stephane.hoyoux@santhea.be'; 'omariage23@gmail.com'; 'vmartens@jodogne.irisnet.be'

MAIL VOOR INITIATIEVEN

Madame,
Monsieur,

Le Centre d'expertise des soins de santé (KCE) travaille en ce moment sur une étude concernant l'organisation des soins de santé mentale pour les personnes âgées en Belgique. En effet, l'OMS recommande d'envisager la nécessité d'élaborer une politique spécifique pour un sous-groupe concernant la santé mentale (SSM ?). Pour les enfants et les adolescents, le gouvernement belge a déjà mis en place, en 2015, des mesures importantes. A ce jour, l'aspect des soins de santé mentale pour les personnes âgées n'a pas encore été étudié.

L'étude actuelle vise à élaborer des recommandations pour optimiser les soins de santé mentale des personnes âgées. Pour ceci, nous ferons usage d'une étude de la littérature, de l'exploration des modèles étrangers, d'un aperçu des initiatives belges et d'un processus interactif de consultations de parties-prenantes (stakeholders).

Différentes sources nous apprennent qu'il y a des initiatives intéressantes développées en Belgique, établies hors des soins traditionnels, en vue de soins de santé mentale pour personnes âgées. Nous sommes à la recherche de projets innovants afin d'en inclure une description dans notre rapport. Votre organisation est reprise dans notre liste. Pourriez-vous nous aider dans cette tâche ?

Vous trouverez, en annexe, un lien d'une enquête en ligne. Pourriez-vous y répondre avant le 25 octobre ? Tout renseignement complémentaire à propos de votre initiative (rapports, brochure, …) est bienvenu. Toutefois, si vous ne pouvez pas nous aider, pouvez-vous nous en informer également.

Pour toute information complémentaire propos de l'enquête, n'hésitez pas à nous contacter par mail ou par téléphone (02 287 33 49 NL of 02 287 33 69 FR)

Les liens :
Néerlandais : http://www.kcenet.be/surveys/index.php/534755?lang=nl
Français : http://www.kcenet.be/surveys/index.php/534755?lang=fr

Nous vous en remercions d'avance.

Bien cordialement,

Jef Adriaenssens,
Laurence Kohn,
Marijke Eyssen

QUESTIONNAIRE: APERCU DES INITIATIVES EN SOINS DE SANTE MENTALE POUR PERSONNES AGEES EN BELGIQUE

1. Quel est le nom de votre initiative en soins de santé mentale pour personnes âgées?

2. Pouvez-vous décrire cette initiative? Quelles actions entreprenez-vous? Quelles méthodes ou moyens/approches utilisez-vous?

3. Quel est le but de cette initiative ?

4. Depuis combien de temps cette initiative existe-t-elle?

5. Dans quelle(s) partie(s) du pays cette initiative est-elle d'application?

6. Combien de localisations reprennent votre initiative?

7. A partir de quelle organisation/association/gouvernement/... votre initiative a-t-elle été créée ?

8. Votre initiative s'adresse-t-elle uniquement aux personnes âgées ou également à d'autres catégories d'âges?

9. Votre initiative s'adresse-t-elle exclusivement à un sous-groupe spécifique de personnes âgées ou à l'ensemble de celles-ci ?

10. Dans quelle ligne de soins de santé votre initiative se situe-t-elle ? (plusieurs réponses sont possibles)

O Soins de première ligne?
O Deuxième ligne (soins ambulatoires spécialisés)?
O Troisième ligne (soins spécialisés semi-résidentiels of résidentiels)?

11. Combien de collaborateurs compte votre initiative?

a. Quelles sont les disciplines de ces collaborateurs? (liste du nombre de ETP (?) et de personnes par discipline)

12. Combien de personnes âgées votre initiative touche-t-elle par an?

13. Est-ce que votre initiative fait l'objet d'un remboursement pour les personnes âgées, soit de la sécurité sociale soit d'un autre organisme (assurance maladie) ? Pouvez-vous préciser ?

14. Quelle est la contribution personnelle mensuelle pour les personnes âgées qui ont recours aux soins offerts par votre initiative ?

15. Existe-t-il une liste d'attente pour les personnes âgées qui ne peuvent bénéficier immédiatement des soins offerts par votre initiative ?

O Oui O Non

a. Si oui, de quelle taille est cette liste?

b. Si oui, cette liste augmente-t-elle ou diminue-t-elle? Pouvez-vous préciser ?

16.Votre initiative est-elle actuellement subsidiée?

O Oui O Non

a. Si oui, par quelle autorité ou gouvernement?

b. Si oui, ceci est-il un projet subsidié pour une durée déterminée ou un subventionnement continu? Pouvez-vous préciser ?

17.Les résultats de cette initiative font-ils l'objet d'une évaluation depuis sa création?

O Oui O Non

a. Si oui, cette évaluation est-elle réalisée par une institution ou un groupe de recherche externe? Pouvez-vous préciser?

b. Si oui, quels sont les éléments étudiés?

c. Si oui, quels ont été les résultats de cette évaluation?

18.Cette initiative fait-elle l'objet d'une collaboration avec une autre initiative pour la santé mentale des personnes âgées?

O Oui O Non

a. Si oui, avec quelle autre initiative?

b. Si oui, pouvez-vous décrire cette collaboration?

c. Si oui, s'agit-il d'une collaboration formelle (officialisée) ou non? Pouvez-vous préciser?

19.Quelles sont les forces et faiblesses de votre initiative ?

20.En tant qu'initiateur, avez-vous rencontré des problèmes liés à l'application de votre initiative ou à la collaboration avec une autre organisation? Si oui, pouvez-vous en faire la description ci-dessous ?

21.Avez-vous des recommandations permettant d'améliorer l'application ou la collaboration de/à cette initiative?

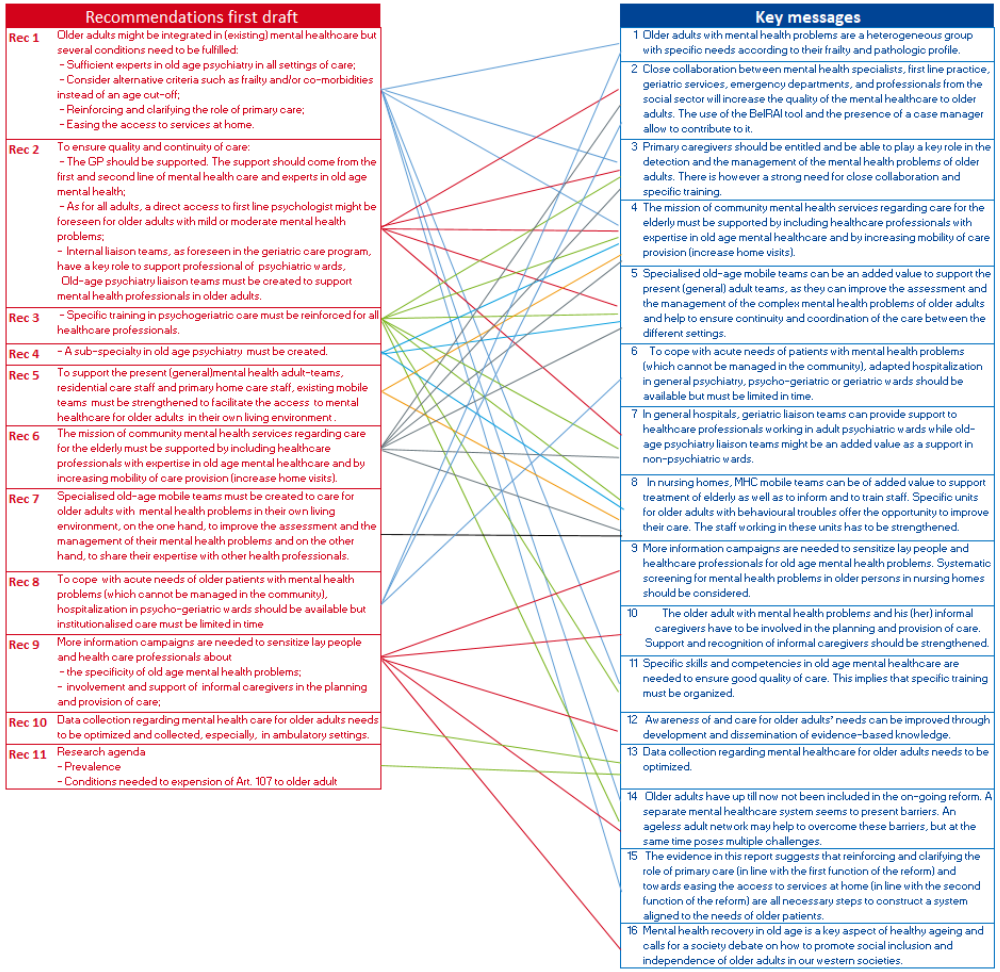
22.Avez-vous des ajouts ou commentaires sur ce questionnaire?

23.Si nous avons des questions complémentaires en fonction de vos réponses, pouvons-nous vous contacter ? Si oui, pouvez-vous indiquer ici le numéro de téléphone auquel nous pouvons vous joindre?

O Oui O Non

7. RECOMMENDATION BUILDING PROCESS

7.1. First draft building of recommendation based on key findings



7.2. Final wording of recommendation after expert meeting, validation meeting and internal review

Recommendations first draft	Recommendations last version
Wording	Recommendations
Rec 1	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federal Public Service Health, Food chain safety and Environment** **- To the Federated entities responsible for the healthcare and the care of the elderly and the disabled and their respective governments and administrations**
Older adults might be integrated in (existing) mental healthcare but several conditions need to be fulfilled: - Sufficient experts in old age psychiatry in all settings of care; - Consider alternative criteria such as frailty and/or co-morbidities instead of an age cut-off; - Reinforcing and clarifying the role of primary care; - Easing the access to services at home.	Mental healthcare to older adults could be integrated in the existing mental healthcare services organisation only if several conditions are fulfilled o Alternative criteria such as frailty and/or pathological profile instead of an age cut-off are taken into account when deciding on the type of intervention needed; o The role of primary care is reinforced and clarified; o Sufficient experts trained in old age psychology/psychiatry are present in all settings of care; o The access to mental healthcare at home is facilitated.
Rec 2	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federal Public Service Health, Food chain safety and Environment** **- To the Federated entities responsible for the healthcare and the care of the elderly and the disabled and their respective governments and administrations**
To insure quality and continuity of care: - The GP should be supported. The support should come from the first and second line of mental health care and experts in old age mental health; - As for all adults, a direct access to first line psychologist might be foreseen for older adults with mild or moderate mental health problems; - Internal liaison teams, as foreseen in the geriatric care program, have a key role to support professional of psychiatric wards, Old-age psychiatry liaison teams must be created to support mental health professionals in older adults.	To ensure quality and continuity of care: o The GPs have to be supported by mental healthcare professionals including experts in old age psychology/psychiatry (third line); o Mechanisms such as the 'concertation around the psychiatric patient at home' and the identification of a case manager have to be extended and activated more often to enhance the collaboration between care providers; o Old-age psychiatry liaison teams should be created to support mental health professionals in non-psychiatric wards; o Geriatric liaison teams have to continue to support professionals in psychiatric wards; for older adults without a geriatric profile, "somatic" liaison teams should be envisaged.

Recommendations first draft	Recommendations last version
Wording	Recommendations
Rec 3	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federal Public Service Health, Food chain safety and Environment** **- To the Ministers of Higher Education**
- Specific training in psychogeriatric care must be reinforced for all healthcare professionals.	Specific training in old age psychology/psychiatry must be developed o All healthcare professionals have to be sensitized for specificities of old age mental health problems during their basic training; o Specific training in psychogeriatric care should be considered for healthcare professionals who frequently encounter older adults; o Specific training in psychogeriatric care has to be reinforced for all mental healthcare professionals; o A specific competency in old age psychiatry has to be created.
Rec 4	
- A sub-specialty in old age psychiatry must be created.	
Rec 5	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federal Public Service Health, Food chain safety and Environment**
To support the present (general)mental health adult-teams, residential care staff and primary home care staff, existing mobile teams must be strengthened to facilitate the access to mental healthcare for older adults in their own living environment .	Existing mobile teams (Art. 107 & PZT-SPAD) have to be strengthened and increased in number to facilitate access to mental healthcare for older adults in their own living environment (home and nursing homes). These mobile teams have to be geographically well spread and take into account the existing initiatives.
Rec 6	**- To the Federated entities responsible for the healthcare and their respective governments and administrations**
The mission of community mental health services regarding care for the elderly must be supported by including healthcare professionals with expertise in old age mental healthcare and by increasing mobility of care provision (increase home visits).	The mission of community mental health services regarding care to older adults has to be supported by including healthcare professionals with expertise in old age mental healthcare and by increasing mobility of care provision (increased number of home visits such as foreseen in the ISPA model).

Recommendations first draft	Recommendations last version
Wording	Recommendations
Rec 7	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federal Public Service Health, Food chain safety and Environment** **- To the General Council of the RIZIV – INAMI**
Specialised old-age mobile teams must be created to care for older adults with mental health problems in their own living environment, on the one hand, to improve the assessment and the management of their mental health problems and on the other hand, to share their expertise with other health professionals.	Mobile teams specialized in old-age psychiatry (third line) should be created o To provide care to older adults with complex mental health problems; o To share their expertise with other health professionals (eventually by means of new communication techniques).
Rec 8	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federated entities responsible for the healthcare and their respective governments** **- To the Federal Public Service Health, Food chain safety and Environment**
To cope with acute needs of older patients with mental health problems (which cannot be managed in the community), hospitalization in psycho-geriatric wards should be available but institutionalised care must be limited in time	It is necessary to maintain a sufficient hospitalisation capacity in psychiatric, geriatric or psycho-geriatric wards to cope with older adults presenting acute mental health problems which cannot (anymore) be managed in the community. The hospitalisation modalities have to be customized to the needs of older adults.
Rec 9	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federated entities responsible for the healthcare and their respective governments and administrations** **- To the Federal Public Service Health, Food chain safety and Environment**
More information campaigns are needed to sensitize lay people and health care professionals about - the specificity of old age mental health problems; - involvement and support of informal caregivers in the planning and provision of care; - evidence-based knowledge; - social role of older adults in their way towards recovery (e.g. to regain a meaningful life, despite mental illness).	Specific campaigns are needed to sensitise healthcare professionals as well as lay people about o The specificity of old age mental health problems; o The importance to recognise, include and support informal caregivers in the planning and provision of care; o The added value of evidence-based knowledge and the collaborative approach; A societal awareness is needed about the persistence of a meaningful life, the feeling of usefulness and the (re)inclusion in the society of older adults (notably those affected by mental illness).

Recommendations first draft	Recommendations last version
Wording	Recommendations
Rec 10	**- To the Federal Minister of Social Affairs and Public Health** **- To the Federated entities responsible for the healthcare and the care of the elderly and the disabled and their respective governments and administrations** **- To the Federal Public Service Health, Food chain safety and Environment** **- To the General Council of the RIZIV – INAMI** **- To all services taking care of older adults with mental health problems**
Data collection regarding mental health care for older adults needs to be optimized and collected, especially, in ambulatory settings.	Data collection regarding mental health (care) for older adults needs to be optimised, especially in ambulatory settings and nursing homes (e.g. BelRAI tools). **- To the Federated entities responsible for the healthcare and the care of the elderly and the disabled and their respective governments and administrations**
	New recommendation Specific initiatives focusing on older adults with behavioural troubles should be encouraged. Those initiatives should be developed in an adapted architectural frame with staff trained in psychogeriatrics and which should offer therapeutic activities in the aim to support functional and cognitive abilities.
Rec 11	**To research institutions**
Prevalence Conditions needed to expension of Art. 107 to older adults	Studies are needed • To document the prevalence of mental health problems (psychiatric diseases and psychological distresses) in the older adults population in Belgium; • To build strategies to operationalize the reform “art 107” to the older adults population; • To evaluate the usefulness and effectiveness of a systematic screening of mental health diseases/distresses in the older adults population.

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