

## SHORT REPORT

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





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## ■ KEY MESSAGES

- Older adults with mental health problems are a heterogeneous group with specific needs according to their frailty and pathologic profile.
- Close collaboration between mental health specialists, first line practice, geriatric services, emergency departments, and professionals from the social sector will increase the quality of the mental healthcare to older adults. The use of the BelRAI tool and the presence of a case manager allow to contribute to it.
- Primary caregivers should be entitled and be able to play a key role in the detection and the management of the mental health problems of older adults. There is however a strong need for close collaboration and specific training.
- 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).
- Specialised old-age mobile teams can be an added value to support the present (general) adult teams, as they can improve the assessment and the management of the complex mental health problems of older adults and help to ensure continuity and coordination of the care between the different settings.
- To cope with acute needs of patients with mental health problems (which cannot be managed in the community), adapted hospitalization in general psychiatry, psycho-geriatric or geriatric wards should be available but must be limited in time.
- In general hospitals, geriatric liaison teams can provide support to healthcare professionals working in adult psychiatric wards while old-age psychiatry liaison teams might be an added value as a support in non-psychiatric wards.
- In nursing homes, MHC mobile teams can be of added value to support treatment of elderly as well as to inform and to train staff. Specific units for older adults with behavioural troubles offer the opportunity to improve their care. The staff working in these units has to be strengthened.
- More information campaigns are needed to sensitize lay people and healthcare professionals for old age mental health problems. Systematic screening for mental health problems in older persons in nursing homes should be considered.
- The older adult with mental health problems and his (her) informal caregivers have to be involved in the planning and provision of care. Support and recognition of informal caregivers should be strengthened



- Specific skills and competencies in old age mental healthcare are needed to ensure good quality of care. This implies that specific training must be organized.
- Awareness of and care for older adults' needs can be improved through development and dissemination of evidence-based knowledge.
- Data collection regarding mental healthcare for older adults needs to be optimized.
- Older adults have up till now not been included in the on-going reform. A separate mental healthcare system seems to present barriers. An ageless adult network may help to overcome these barriers, but at the same time poses multiple challenges.
- The evidence in this report suggests that reinforcing and clarifying the role of primary care (in line with the first function of the reform) and towards easing the access to services at home (in line with the second function of the reform) are all necessary steps to construct a system aligned to the needs of older patients.
- Mental health recovery in old age is a key aspect of healthy ageing and calls for a society debate on how to promote social inclusion and independence of older adults in our western societies.



## ■ FOREWORD

Is the question of mental health care for older adults a relevant subject for a report? To be sure, the type of ‘youth culture’ attitudes that often lead us to consider aging as a deviation from normality, at times even as a pathology, need to be deconstructed. The term itself – ‘older adults’ – is indicative of a position that views old age as a type of ‘sunset clause’ whereby people must enter a different world in which they are no longer commercially productive, where health problems begin to accumulate and their appearance reminds us that human life is finite – how impertinent! What is certain is that the period of life that is marked by the end, or reduction, of one’s professional (or volunteering) activity, by a certain loss of mobility, flexibility and various other abilities, and by the disappearance of people who had been beside us for many years can generate certain vulnerabilities. Of course, special types of care will be needed; and obviously, such care should ideally be well-adjusted and efficient.

But there are deeper societal and anthropological issues that one should not cast aside too quickly by focusing exclusively on a few ‘simple’ organisational reforms. As in many other areas of life, we all have a shared responsibility towards our elders which also involves our responsibility as individuals. The people whom we call ‘older adults,’ regardless of whether they suffer from mental health issues, are ‘transmitters of life,’ ‘transmitters of culture,’ ‘transmitters of history’ – both the greater history, in which they may have played a role themselves, and the smaller family histories that can teach us about who we are. Maintaining them as a part of human society is a concern for all of us. It is important, on a daily basis, to help build a truly inclusive society that can serve as the core foundation from which a strongly rooted type of health care, based on caring for others, can then arise.

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## List of Abbreviations

<b>ABBREVIATION</b>	<b>DEFINITION</b>
<b>BPSD</b>	Behavioural and psychological symptoms of dementia
<b>CCM</b>	Chronic Care Model
<b>CGG – SSM</b>	Centrum voor Geestelijke Gezondheidszorg – Service de Santé Mentale
<b>CRRPSA</b>	Centre Ressource Régional de Psychiatrie du Sujet Agé
<b>DSM-IV</b>	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
<b>EHPAD</b>	Etablissements d'hébergement pour personnes âgées dépendantes
<b>EIU</b>	Economist Intelligence Unit
<b>ESEMeD</b>	European Study on the Epidemiology of Mental Disorders
<b>FAMGB</b>	Fédération des Associations de Médecins Généralistes de Bruxelles
<b>FTE</b>	Full Time Equivalent
<b>GGZ</b>	Geestelijk Gezondheid Zorg
<b>GP</b>	General Practitioner
<b>HIS</b>	Health Interview Survey
<b>IAPT</b>	Improving Access to Psychological Therapies
<b>IBW – IHP</b>	Initiatieven Beschut Wonen – Initiatives d'Habitations Protégées
<b>IMA – AIM</b>	InterMutualistisch Agentschap - Agence Intermutualiste –
<b>IPSA</b>	Initiatives spécifiques Personnes Agées
<b>KCE</b>	Federaal Kenniscentrum voor de Gezondheidszorg – Centre fédéral d'expertise des soins de santé
<b>MHC</b>	Mental Healthcare
<b>MPG – RPM</b>	Minimale psychiatrische gegevens – Résumé Psychiatrique Minimum
<b>MZG – RHM</b>	Minimale Ziekenhuis Gegevens – Résumé Hospitalier Minimum



<b>NRZV – CNEH</b>	Nationale raad voor ziekenhuisvoorzieningen – Conseil national des établissements hospitaliers
<b>PAAZ – SPHG</b>	Psychiatric wards in acute general hospitals
<b>PVT – MSP</b>	psychiatrische verzorgingshuizen - maisons de soins psychiatriques
<b>PZ – HP</b>	Psychiatrisch Ziekenhuis – Hopital Psychiatrique
<b>PZT – SPAD</b>	psychiatrische zorg in the thuissituatie – Soins Psychiatriques pour personnes séjournant à Domicile
<b>RIZIV – INAMI</b>	Rijksinstituut voor ziekte- en invaliditeitsverzekering – Institut national d'assurance maladie-invalidité
<b>ROB – MRPA</b>	rustoorden voor bejaarden – maison de repos pour personnes âgées
<b>RVT – MRS</b>	rust-en verzorgingstehuis - maison de repos et de soins
<b>UHR</b>	Unité d'hébergement renforcé
<b>WHO</b>	World Health Organization
<b>WZC</b>	Woon Zorg Centra



## 1. INTRODUCTION

### Ageing population as driver for new and adapted services

Population projections show a rapid and continuous increase of the proportion of Belgians aged over 65 from 18.7% in 2018, to 22.3% in 2030 and 24.2% in 2040, after which the trend is expected to level somewhat.<sup>1</sup> For those aged 75 and over, the projected increase is from about 1 million in 2018 to almost 1.7 million in 2040. With the growth of the aging population the overall healthcare system is confronted with an increasing pressure. As a consequence, the system, including mental health services, will need to be reinvented or reorganised to deal with the increasing demands of these population group.

### Defining 'older adults' remains an issue of debate

Most developed countries accepted the age of 60 (or 65) years as a definition of older people.<sup>2</sup> But this might be misleading as older people are a very heterogeneous group. Indeed, the decrease in functional reserves with higher levels of comorbidities leads to increased vulnerability often described as 'frailty'.<sup>3</sup> But some very old persons remain vigorous while others, even younger and without any apparent disease, fail to rebound following illness or hospitalization. Physiologically and pharmacologically, frail older people may react differently to sickness and (psychotropic) drugs than more robust adults.

### Poor mental health is an ageless problem

The Belgian Health Interview Survey (HIS)<sup>4, 5</sup> provides a quite distressful view of the mental health of the general population aged 15 years or older. In 2013, one out of three persons suffered from psychological distress. Compared to the general population, data from the HIS show that adults aged over 65 years are increasingly at risk to suffer from sleeping disorders and depression. Older adults (aged over 65 years) have also a higher suicide rate than younger groups with 23 and 15.6 suicides per 100 000 inhabitants, respectively. The HIS showed that older adults are more likely to have used tranquilizers or antidepressants in the past two weeks.

### Specificities of older adults' mental health

There are different factors that can more affect the mental health of older adults than the one of younger adults. Older people are more likely to experience events such as bereavement or physical disability. It can result in isolation, loss of independence, loneliness and psychological distress leading to poorer mental health.<sup>2, 6</sup> In addition this group is more likely to experience themselves or live with a person with behavioural and psychological symptoms related to dementia (BPSD). According to Alzheimer Europe (2014)<sup>7</sup>, in 2012 the share of the population experiencing dementia aged over 65 and 85 years amounted to 9.7% and 32.7%, respectively. Finally, older adults are also vulnerable to physical neglect and maltreatment, which cannot only lead to physical injuries, but also result in severe, sometimes long-lasting psychological consequences.<sup>6</sup>

An important point of attention is the link between mental health and physical health. For the general population, mental health has an impact on physical health and vice versa.<sup>8</sup> This relation is even stronger in older people, due to vulnerability and under-recognition. It is also very important to pay attention to somatic problems when taking care of older adults with mental health problems as they might (1) be easily missed (unusual symptoms are more frequent in frail older people) and (2) be the underlying factor for mental or behavioural problems.<sup>9</sup>



### Box 1 – Definitions

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

**A mental health problem** affects the person's personality, ability to deal with different aspects of daily life and social interactions. Mental health problems comprise psychiatric disorders and psychological distress.

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

**Psychological distress** is having unpleasant feelings or emotions that impact your level of functioning.

## 2. MAIN AIM

In 2002, federal and federated Ministers responsible for Health signed a common declaration about the future mental health policy.<sup>10, 11</sup> Among other objectives, the intention of the authorities was to construct care networks' or 'care circuits' for specific target groups. Three groups based on aged were identified: children and adolescents, adults, and 'older adults'. In 2010, 'care networks' or 'care circuits' were created for persons aged 16 to 65 years.<sup>12</sup> More recently, the principles of this reform were put into practice in order to build networks for children and adolescents.<sup>13</sup> In this context, a program aiming to enhance the mental health of older adults has not been organised yet.

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

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

The research questions addressed in this report are:

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

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



### 3. METHODS

To answer the previously mentioned research questions, we developed a multimodal approach. This short report focuses on the main messages drawn from the scientific research. For interested readers, detailed methods along with exhaustive results are available in the scientific report. A summary of the methods is presented hereafter:

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

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

**Chapter 4** includes an in-depth analysis of the organization of mental healthcare for older persons in four countries: England, France, the Netherlands and Canada. The four countries were selected 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, additional information regarding mental healthcare for the elderly, similarity to Belgium in the structure of care and the presence of potential case studies. The data collection method to describe the system of the mental healthcare for older persons follows three steps: first a scientific literature search in bibliographic databases; second, an additional grey literature top-up searching; and third, a practical analysis of case studies in grey literature.

A transversal comparison was then performed according to topics identified in other parts of the report. National experts with experience in mental health organisation for older persons validated the results of these chapter.

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



## 4. CONCEPTS AND MODELS APPLICABLE FOR MENTAL HEALTHCARE IN THE ELDERLY

General organisational models and strategies (core elements) for the provision of mental healthcare for older adults were identified as search terms by means of a scoping literature search. Based on the results of this initial search an in-depth literature was conducted. This yielded in 45 studies that applied one or more core elements in an attempt to provide good mental healthcare for the older adults. The effectiveness of the use of these core elements in specific sub-populations are described in this chapter. Based on literature findings, barriers and drivers in implementation of mental healthcare systems for the elderly and the place of primary care in MHC for older adults were then discussed. Finally, the strengths and weaknesses of the Belgian system of mental health delivery for older adults was assessed via an electronic survey.

### 4.1. General models and criteria

A general model is a well-established organizational framework for good care management and practice improvement. This can be applied, together with specific relevant criteria as a foundation to build a qualitative system for mental healthcare for older adults.

#### 4.1.1. The C.A.R.I.T.A.S. criteria

The World Health Organization (WHO) technical consensus paper (1997) was published to be used by all those involved in the development and implementation of policies, programmes and services for promoting the mental health of older people. Therefore it is useful as a foundation for the approaches of mental healthcare for older adults found in the literature. The WHO paper states that good quality of mental healthcare for older adults should take into account 7 specific principles, grouped together in the acronym C.A.R.I.T.A.S.<sup>14, 15</sup>:

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



#### 4.1.2. *The Chronic Care Model (CCM)*

The CCM-model<sup>16, 17</sup> is an organizational approach to care for people with chronic disease in a primary care setting. It describes four levels for delivery of chronic patients' care in a broad societal and policy context<sup>18</sup>:

- **Community level** (resources and policies to realize the model in the community)
- **Health systems level** (creation of a culture, the organization and mechanisms that promote safe, high quality care)
- **Care team or practice level** (this has to be adequately prepared and proactive)
- **Patient level** (who needs to be adequately informed and activated)

The model also defines four areas that have to act in a collaborative and integrated way to deliver high quality care:

- **Self-management support:** to empower and prepare patients to manage their health and healthcare.
- **Delivery system design:** to assure careful planning and coordination of safe, effective, timely, efficient and patient centered care and self-management support with emphasis on primary care.
- **Decision support:** promotion of clinical care that is consistent with scientific evidence and patient preferences (evidence-based information).
- **Clinical information systems:** to organise patient and population data to facilitate efficient and effective care.

#### 4.1.3. *Integrated people-centered health services*

More recently, to deal with the challenges being faced by health systems including the ageing population, WHO developed a strategy on integrated people-centered health services<sup>19</sup>.

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

## 4.2. Implementation strategies to organise mental healthcare in older adults

Operational core elements are specific strategies or approaches that are used in an attempt to provide effective mental healthcare in (sub-populations of) older adults. These operational core elements can be applied within the context of the general models, taking into account the quality criteria.

Four operational core elements were retrieved from the literature:

**The Stepped Care Strategy** is an approach where the least intensive intervention related to the treatment of a disease that is appropriate for a person, is typically provided first, and people can step up or down the pathway according to changing needs and in response to their treatment. Service users may begin their journey at any step of the pathway, in accordance with their specific needs.<sup>20</sup> Stepped care aims to meet the need for long-term management of the disease and to maximize the effectiveness and efficiency of resource allocation. Progress of the disease conditions of the patient is monitored throughout the entire process in order to decide on stepping up or stepping down in intensity of treatment.<sup>21, 22</sup>

**The Indicated Prevention strategy** can be defined as a measure designed to prevent the onset of mental disorders in older adults who do not meet the medical criteria for these disorders but who are showing early risk signs.<sup>23-27</sup> Indicated prevention is a means to overcome under-diagnosing and under-treatment in specific patient populations.





**The Watch-and-Wait strategy**<sup>28</sup> originates from the idea that forcing a rapid mainly pharmacological or somatically oriented treatment for a bio-psychosocial oriented mental problem is expected often not to result in the right outcome. The strategy allows to apply a careful and slow process of care, consisting of assessment, psycho-education, watching and waiting, building trust, weighting options, involving multidisciplinary teams, and then using modules adapted to the needs and preferences of the older adults.

**The Collaborative Care strategy**, also called “integrated-care” model<sup>29</sup> is in fact the operationalisation of the Chronic Care Model (CCM) and aims to provide timely access to specialists for the specific mental health problem of the older adults using tailored multi-modal management approaches. A collaborative care model often consists of a multi-faceted multiphase intervention, scheduled patient follow-up, enhanced inter-professional communication, a structured management plan, trained providers, activated patients, cultural competence, patient centred care and reimbursement that rewards quality of care. Coordination and follow-up of this collaborative care process is done **by a case/care manager**.

The implementation strategies mentioned above were used alone or in combination for interventions for specific mental health problems in older adults such as **major depression**<sup>30-47</sup>, **minor or sub-threshold depression**<sup>48-51</sup>, **depression and anxiety in residential care homes**<sup>52-56</sup>, **suicidal ideation**<sup>57</sup>, **alcohol abuse**<sup>58, 59</sup>, **behavioural symptoms in Alzheimer**<sup>60</sup> and **mental health problems in specific patient groups**.<sup>21, 61-65</sup> Evidence showed that the collaborative care strategy is the more adapted for the organisation of mental healthcare in older adults.



A quick overview of the main study results is shown in Table 1.

**Table 1 – Overview of the effectiveness of operational core elements in a subset of mental health problems**

Conditions	Stepped Care	Indicated prevention	Watch-and-Wait strategy	Collaborative Care
Major depression	☑ when embedded in a collaborative care approach		☒ when embedded in a stepped care approach	☑
Minor & sub-threshold depression	○ (1) when embedded in a collaborative care approach or (2) in combination with interviewer-based questionnaire screening.	☑ when embedded in a stepped care approach starting with a Watch-and-Wait strategy		☑
Depression and anxiety in elderly in residential care homes	☑ starting with a watch-and –Wait strategy	☑	☑ when embedded in a stepped care approach	
Suicidal ideation	☑ when embedded in a collaborative care approach			☑
Alcohol abuse	?			
Behavioural symptoms in Alzheimer				☑

☑ Effective strategy; ☒ Not appropriate strategy; ○ Do not differ significantly from usual care; ? Insufficient evidence

**Studies on severe psychiatric disorders in older adults were sparse.**

Three included studies provide some evidence for the (temporary) effectiveness of treating chronic mental illnesses in the community.<sup>66-68</sup>

**Studies on mental healthcare problems in older adults from minorities or refugees<sup>23, 27, 32, 69-71</sup>**

did not mention a specific care model for mental health in these populations. They emphasize however that it is important to optimize communication between these populations and healthcare professionals, to identify misconceptions and wrong health beliefs and finally to reach out to the community to treat these patients in their own environment.



### 4.3. Barriers in implementation of mental healthcare systems for the older adults

Literature<sup>32-34, 37, 45, 48, 69, 71-73</sup> reveals several barriers and incentives regarding implementation of mental healthcare systems for older adults.

Access to mental healthcare services is reported to be hindered by the fragmentation, lack of communication (data sharing) and inflexibility of the healthcare system that inhibits the access (referral) to specialised care. General Practitioners (GPs) often perceive a lack of access to geriatric mental health specialists for consultation and referral, but also for support from these specialist services. Lack of knowledge and skills, as well as confidence in GPs regarding geriatric mental healthcare (screening, diagnosis as well as treatment) and lack of specific training of healthcare professionals in general also hinder the access to appropriate services. Reaching patients, avoiding stigma, diagnosing mental health problems and therapy adherence also need special awareness. Specific attention is also necessary regarding mental health problems in older adults of ethnic or minority groups. All of these topics have to be taken into account when implementing mental healthcare systems for the elderly

### 4.4. Mental healthcare for older adults in primary care settings

Fifteen studies reporting on mental healthcare delivery for the elderly in primary care settings in UK and USA were retrieved<sup>2, 23, 34, 46, 57, 72, 74-80</sup>.

These foreign researches showed that primary care providers might play a significant role in the care for mental health problems in the elderly. Most of older adults regularly meet their own GP, which implies that these primary care professionals are in fact well-positioned to address mental health problems in their older patients. Moreover, elderly people are found to prefer receiving their (mental) healthcare in primary care settings instead of in specialty mental healthcare institutions<sup>57, 72, 78</sup>. However, some studies show that detection as well as treatment could be substantially improved, because of a lack of knowledge, skills and time available in GPs, the atypical presentation of mental health problems in elderly, a lack of collaboration and communication with specialized mental health services, and preferences, stigma and (cultural) beliefs in patients. GPs may also register depressive

complaints as part of other psychosocial problems to which the depression is related, based on incomplete information from the patient or by foreknowledge of the patient's personal problems and by contextual information.<sup>81</sup> And finally, a (vulnerable) part of the old age population does not visit a GP regularly which might result in the non-detection of existing mental problems.<sup>82</sup>

### 4.5. Perception of the Belgian situation based on theoretical models

In order to test if the Belgian system of mental healthcare delivery for older adults responds to the theoretical requirements identified in the literature review, an online survey was carried out among stakeholders in the mental healthcare sector. Stakeholders included professionals working in residential (general hospital, psychiatric hospital, home for the elderly or nursing homes) and non-residential settings (ambulatory services), patients associations and healthcare authorities. A purposive sample of 62 stakeholders were surveyed regarding their perception of the current system, the specific needs of older persons in comparison with adults and the potential improvements that could be introduced into the system. Two-thirds (43) of the contacted stakeholders filled out the questionnaire, but only 19 participants answered all the questions. The remaining 24 participants answered questions related to residential care or to non-residential care, only. In the sample of respondents, 16 participants were mental health professionals. Overall, 13 respondents worked in a residential setting (general hospital, psychiatric hospital, home for the elderly or nursing home) and 15 worked outside residential settings.

We compiled a list of ten needs of older adults with mental health problems: the preservation of self-reliance, self-care, independent living, independent decision making, meaningful life, and the prevention of loneliness, social isolation, elderly abuse, insecurity feelings and improper Emergency Department use. Almost no respondents perceived the entirety of these needs to be reached by the Belgian MHC system. Therefore, a holistic approach of the patients' needs (physical, psychological and social) seems to be lacking.



The current MHC for older adults in Belgium was perceived by a significant part of respondents not to meet the C.A.R.I.T.A.S principles and the requirements of the Chronic Care Model. Also the implementation principles of the Collaborative Care Model were perceived to be embedded insufficiently. The respondents pointed out the following elements:

- In both residential and non-residential care, points of concern related to delivery of care were evidence-based approach, safety, accessibility in time, geographical spreading and patient centeredness of care. Non-residential care were characterised by the existence of programmes for vulnerable groups and social support for the older adults but also by a lack of community development programmes. Organisation of residential care for older adults (mainly nursing homes) did not meet the specific needs of older adults with mental health problems.
- With the aim of a global and integrated approach, a multidisciplinary approach must be promoted with clear definition of tasks and roles. Beforehand, the problem of weak inter-professional communication and shortage of adequately trained care providers must be solved.
- The lack of evidence-based guidance for MHC for older adults and the lack of patient involvement was found to impede the decision making process.
- A multi-faceted approach (see collaborative model) seemed to be more used in residential than in non-residential care. While the stepped care strategies were not perceived to be implemented well in both residential and non-residential care

An integrated mental healthcare system must take into account the specificities of older adults. There are plenty of opportunities for improvement: optimize organisation of care, management of patients (case manager), training of health professionals and caregivers, efficacy of care, quality of care and societal perception. The respondents of the survey highlighted the following points:

- **Organisation of care:** First, a better structuration of care between primary and secondary care, a better communication among professionals and avoiding competition between care providers were suggested. Second, the MHC for older adults supply is still not well known in the community and expansion of Article 107 might be a solution. The availability of mobile teams, care in the community or at home, and support services for GPs must be increased. Third, better staffing is needed both in terms of number of Full Time Equivalent (FTE), specific skills and training.
- Finally, optimization of funding of MHC for older adults is required in residential and non-residential settings (psychological care, nursing care and primary care in overall).
- **Management of the patients:** The management of mental healthcare in older patients must be provided in a tailored way. A specific approach must be developed with inclusion of screening and detection of mental healthcare problems. In addition, treatment must be adapted to the specific needs of the elderly, to avoid medication as much as possible. When avoiding medication, collaboration between GP and psychiatrist must be optimized. Finally, availability of and access to services must be enhanced.
- **Training of the health professionals and caregivers:** Training of physicians, psychologists, nurses and informal caregivers must be adapted to the specific needs of elderly with mental health problems. Evidence-based approaches have to be promoted to align all practices.
- **Efficacy and quality:** Quality of mental health home care and assessment of the older adults' needs must be promoted. There is a need to collect data for measurement of efficacy and quality of care.
- **Society:** Reconsideration of the social paradigm is essential to reduce loneliness, to support patient's strengths and to adapt the social and urbanistic organisation (i.e. transgenerational or group housing).



## 5. LESSONS FROM ABROAD

This chapter provides an international comparison of the organisation of mental healthcare for older people, allowing to compare Belgium with foreign experiences. We focus on a transversal analysis of 4 countries (England, France, the Netherlands and Canada), chosen on their ability to demonstrate coordination between providers, their integration with health sectors, funding similarities between community health and social care, and additional information regarding elderly mental healthcare.

### 5.1. Approaches to mental healthcare for older people

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

All of the included countries have moved away from an institutionalized approach for mental healthcare in favour of providing care in the community. Regarding older people, the **shift to community** is mainly used to avoid hospitalisation (Crisis Resolution and Home Treatment teams in England, mobile team in France, geriatric mental health community and outreach teams in Canada and Assertive Community Treatment for the Elderly teams in the Netherlands). In France and UK, a large part of the mental health problems is managed in the community. In the Netherlands the shift of mental healthcare provision to the community is quite recent (2014). In Canada, despite a lot of provincial initiatives aiming at transferring care to the community, the organization of the healthcare services, including mental healthcare, is still centred around hospitals and provided by doctors due to the fact that interventions provided in hospital settings are fully reimbursed while acts in community settings are not or only partially reimbursed.

A lot of services simultaneously provide care **to tackle mental and physical problems** like in England in the crisis teams and in elderly psychiatric out- and in-patient units; in the Netherlands in the day care and the community mental health centres; and in France in mobile teams, day hospitals and old age psychiatry wards. Mobility and sensory problems, frequent in older people, are also taken into account in IAPT (Improving Access to

Psychological Therapies) services (England). Acute somatic conditions can be managed by psychiatric mobile teams for older people such as in case of delirium (England) and by geriatric emergency nurses (Canada). In the 'centre régional de référence en psychiatrie du sujet âgé (CRRPSA) in France, old age psychiatrists are trained to identify somatic problems among their patients.

**Multidisciplinary care** is systematically evoked in almost all the services described in England and France. In the Netherlands, the community mental health centres also regroup several disciplines around older people. In Canada, multidisciplinary care was officially recommended (strong evidence of effectiveness for community multidisciplinary teams) in community and day hospital's geriatric mental health teams.

### 5.2. Key recommendations in guidelines for seniors' mental health service organisation

Guidelines on the organisation of mental healthcare services organization for older people were elaborated in England<sup>83</sup> and Canada<sup>84</sup>. The use of these guidelines is however not mandatory but strongly recommended.

The English guidelines recommend that mental healthcare services for older people:

- are based on an integrated approach with social care services;
- are organised in close relation with primary care providers;
- are tailored on seniors needs and not only on age;
- include functional illness such as depression and psychosis as well as dementia;
- take into account that seniors have mental and physical health problems, and that they respond well to psychological input;
- are multidisciplinary and offer both community crisis and home treatment services and a dedicated liaison service in acute hospitals.



The Canadian guidelines recommend that mental healthcare services for older people:

- develop anti-stigma and prevention strategies, public awareness on the journey towards recovery and well-being;
- include education and training of healthcare professionals and caregivers;
- implement the early identification of mental health symptoms;
- assess policies, programs and services with dedicated toolkits;
- modify existing practices and relationships regarding local context and resources, size of population, existing gaps and bottleneck as well as priorities of the community;
- take into account diversities among seniors and among minorities;
- support, value and consider caregivers as active partners; and
- provide community based, primary care, general and specialized mental health services, including outreach teams at home and in residential facilities.

### 5.3. Mental health services for older people

Services for older people with mental health problems are present in multiple settings: primary and secondary care, acute and long-term care institutions, home care, in- and out-hospital settings.

In all four countries, GPs are involved in **first line** management of mental healthcare for older adults. In the Netherlands, the GP is assisted by a mental health nurse or a psychologist. In England, access to psychotherapy via IAPT service is available in primary care.

The **second line** of care includes mental health services and old age psychiatry expertise in in- and out-patient settings. In the Netherlands, a DSM-IV diagnosis of mental illness is mandatory in order to be referred to the second line of care. In France and in the Netherlands, geriatricians and psychiatrists collaborate in community centres.

For **acute care**, there are crisis management mobile teams in the four countries; they can intervene for older people but they are not specifically trained to manage them. In emergency departments in Canada, emergency geriatric nurses can help the staff for the management of older people with acute mental health disorders, particularly for mixed and complex cases (e.g. delirium).

In England, Canada and the Netherlands, **community mental healthcare centres** have specific teams specialised in geriatric mental healthcare providing diagnosis, treatment and counselling services for older people with psychological and psychiatric problems as well as psycho-organic diseases. Regional centres deliver different types of care in out-patient clinics, at home, in day-care or in nursing homes. In the Netherlands, about three out of four community mental healthcare centres offer home-based care.

**Mobile teams services** in the four countries work with multidisciplinary teams that offer support and training to primary care professionals in order to deal with the specific needs of older patients with mental health problems. This approach has proven to be effective in avoiding hospitalization. The professionals visit older patients in their place of residence (home or in a residential facility).

**Day-care in hospitals** offer either activities to maintain autonomy and social life, or psychotherapeutic treatment and rehabilitation care.

In the four countries, in the case that care in the community is not (or no longer) possible, seniors with severe and complex mental health problems can be admitted to general or **specialized old age psychiatry wards** in either psychiatric or general hospitals.

- In England, older adult psychiatry units are available. There is also the possibility to accommodate older persons in general psychiatric wards. There is an on-going debate on whether it is appropriate to create 'ageless' adult wards.
- In France, specific wards were developed for older people with mental health problems under the supervision of psychiatrists and with the collaboration of geriatricians and neurologists.
- In the Netherlands, there is a trend to decrease the number of beds in the psychiatric institutions and to redirect older people with complex and mixed issues towards general geriatrics wards.



- In Canada, three types of geriatric psychiatric beds are recommended by the pan-Canadian guidelines of 2011<sup>84</sup>: 1/ the acute beds, which can be specific to the elderly (<30 days of stay); 2/ the medium-stay beds (30-90 days) essential back-up for the first line care; and 3/ the long-stay beds (>90days) also called rehabilitation beds. Examples of these long-stay beds are the so-called longer-term stabilization treatment units designed for behavioural support for older adults living with persistent mental illnesses or Behavioural and Psychological Symptoms of Dementia (BPSD). Alternate levels of care are provided in acute hospitals' beds to accommodate seniors waiting for a place in home care, a rehabilitation facility or a residential facility. In the future, long-term beds should be replaced by specialized residential long term facilities in the community.

**Liaison mental healthcare teams** are recommended in general hospitals in England, Canada and France for patients with mental health problems hospitalised in non-psychiatric units. The geriatric mental health expertise is a part of the general mental healthcare team.

**The residential sector** in France encompasses specialized institutions organised on the basis of the level of dependence or the presence of behavioural problems ('Unite d'hébergement renforcée' (UHR)). In the Netherlands, the number of long-term institutions is decreasing in favour of long-term community care. In Canada, it is common that residents in nursing homes have at least one psychiatric or cognitive disorder, or a combination of both, in addition to their medical problems. Hence, in some regions, nursing homes become *de facto* long-term mental health facilities.

#### 5.4. Who are the professionals involved in mental healthcare for older adults?

In the four countries, **GPs** are often the first healthcare professionals contacted by the patients and often in the position of secondary care gatekeepers.

- In the Netherlands, GP consultation is a mandatory step for the patients before being referred to specialised mental healthcare. They deal with 90% of the mental health issues in the overall Dutch population.
- In England, GPs are responsible for the mental well-being of older people either directly or by facilitating access to psychological services (referral to IAPT) or refer to secondary mental health services.
- In France and Canada, referral by a GP is not a standard rule.

**Psychiatrists** provide diagnosis, treatment, psychotherapies in secondary care (under referral from GPs or emergency services in England and in the Netherlands). They work in in- and out-hospital settings (consultations, day hospital, and (geriatric) psychiatric wards). **Old age psychiatrists** are found in all four countries but their number is limited, thus restricting them to a role of expert for complex and severe mental health problems. They usually supervise the specialised care in geriatric mental health in-patients wards, ambulatory community centres and outreach teams. They only occasionally have direct contact with patients at home or in residential institutions.

**Geriatricians** are present in mental healthcare for older people in France, Canada and the Netherlands. They usually take care of "mixed cases" where somatic and mental health problems co-exist. They provide expertise for geriatric issues notably in mobile teams. In the Netherlands, they also endorse part of the management of older people referred from GPs to the general mental health community centre.

**Specialised psychiatric nurses** mainly work in secondary care (except in the Netherlands). They provide assessment and follow-up in hospitals, at home or in community centres and ensure that care plans are implemented. In Canada and France, nurses are the preponderant professionals among geriatric mental health community and outreach teams.

In contrast, in the Netherlands, mental health nurses are available for adults



of any age, including the older people, in primary care settings. They help with diagnosis and improve the quality of the referral to other mental health services.

**Psychologists** sometimes work in primary care (in England in IAPT and in the Netherlands in primary care and basis-GGZ level) but their main role remains in secondary care. In England, they give specific, evidence-based, talking therapies in all types of care settings. In Canada and France, their services are out-of-pocket costs for the patients except in salary-based facilities (ex: EHPAD in France). In all countries, they can sometimes take part in old age psychiatric mobile teams.

**Social workers and occupational therapists** are usually involved in secondary care within multidisciplinary teams in in- and out-patients settings, most often for follow-up after discharge in case of complex continuing care in primary care. They are also involved in gerontologic networks in France.

## 5.5. Barriers and levers for the implementation of mental health services for older adults

### 5.5.1. Common barriers

#### **Stigma on mental health and/or on older people**

Stigma represents an important concern for all four countries, whether it focuses on age or on mental health conditions or both. They are present among older people themselves and their families as well as among care providers.

Older people may also be prevented from accessing psychological therapies if mental health problems are perceived, by professionals as well as lay people, as a consequence to physical health problems or as a normal ageing process, and are therefore left undertreated.

#### **Poor communications and inappropriate referral (not elderly specific)**

A main concern regards poor communication between first and second lines of care. Canadian and English mental health systems experience a lack of medical data exchange between GPs and psychiatrists.

#### **Lack of experience and training of care teams**

In England, specialists working in mental healthcare teams often acknowledge lack of self-confidence when working with older people, especially when there are intertwined physical health issues, difficult socio-economic situations or communication problems. They may also have concerns about their ability or skills to build therapeutic relationships with older people.

In the Netherlands, it was mentioned that emergency department staff often lacked the knowledge, education, experience – but also interest – in dealing with the complex needs of older people.

### 5.5.2. Levers to overcome these barriers

The Canadian and English guidelines on the organisation of older adults' mental health services offer a comprehensive guide regarding ways to improve the system. In addition to those guidelines, other levers were identified in each country.

#### **Against 'Stigma'**

In England, there have been many "awareness raising campaigns" aiming at reducing stigma in the healthcare system and in the society in general. There was, however, no information on the efficacy of these campaigns.

Evaluation of the effectiveness of old age psychiatry/psychology care was mentioned as lever to enhance the visibility of the work carried out for older adults. Adopting best practices, educational tools and cost-effective processes could also be of use to fight stigma.





### Against 'Poor communications'

In the Netherlands, there is a well-developed old age psychiatry network on the national level. In France, specific regional networks (as the CRRPSA's) are also emerging. These networks cover the overall needs of older adults, insure the communication between the social field and the psycho-medical one. In addition they provide support and training to healthcare professionals.

Multidisciplinary teams, adequately implemented in old age care, are very effective in communication by using case manager, shared patient registry systems, integrated IT systems, clinical protocols, and care conferences among the various professionals involved.

### Against 'lack of experience in care teams'

Partnerships between geriatric medicine, emergency medicine, family practice and mental health specialists could increase awareness of the needs of older adults and on how to meet these needs. For instance, introducing a geriatric nurse in an emergency department staff could compensate the lack of knowledge (and of interest) about mental healthcare for older people. In England, retention of the staff allows to increase professionals' skills in mobile teams.

The Royal College of Psychiatrists in England, the Nederlands Kenniscentrum Ouderenpsychiatrie in the Netherlands, the Société de Psychogériatrie de Langue Française and the Canadian Academy of Geriatric Psychiatry in Canada coordinate trainings in old-age psychiatry, aiming at spreading knowledge about old age psychiatry.

## 6. OVERVIEW OF MENTAL HEALTH SERVICES FOR OLDER PERSONS IN BELGIUM

An overview of the use of mental healthcare services by older adults is presented hereafter. Services that are not specific for older adults but that can accommodate them (mostly for adults without a clear age limit) and that aim at providing treatment for mental health problems were included in the analysis. An assessment of the sequential use of different types of resources by the same patient (e.g. different types of hospital beds or combination of hospital and community services) was not performed in this report.

### 6.1. Use of mental health services in hospital settings

#### A steady trend in hospitalisations for psychiatric admissions for older patients

Residential acute psychiatric care can be provided in psychiatric and general hospitals<sup>a</sup>. The trend for admissions in psychiatric hospitals and for entirely psychiatric admissions in general hospitals (i.e. patients only admitted in psychiatric wards) remains reasonably stable for older adults between 2003 and 2014 and is about two times lower for older adults than for persons aged 64 years or younger.

In 2013, the number of admissions in psychiatric hospitals per 100 000 population was found to be 233, 135 and 108 for persons aged 64 years or less, 65 to 74 years and 75 years or older, respectively. This estimate encompasses admissions in the different types of beds available in psychiatric hospitals.<sup>b</sup>

<sup>a</sup> General hospitals can be further categorised into acute, specialised and geriatric hospitals <sup>85</sup>

<sup>b</sup> A-beds (day and night) for observation and treatment, T-beds (day and night) for treatment aiming at maximizing (the possibility) of social integration, Sp and Tg beds for psycho-geriatric treatment) and I-beds for intensive treatment for greatly disturbed behaviour and aggressive patients. <sup>86, 87</sup>.



For the same year, the number of inpatient admissions in psychiatric wards in general hospitals per 100 000 population amounts to 498, 272 and 109 for persons aged 64 years or less, 65 to 74 years and 75 or more.

### **The number of day-care admissions in psychiatric wards differs much less among different age groups.**

For day-care entirely psychiatric admission, the three age groups are much closer to each other in terms of the number of admissions per 100 000 residents. In 2014, the number of admissions per 100 000 population amounts to 37, 40 and 27 for persons aged 65 years or less, 65 to 74 years and 75 years or older, respectively.

### **Challenges of specific psycho-geriatric beds for older patients**

Psychiatric hospitals and psychiatric wards in general hospitals encompass different types of beds to provide treatment to adult patients (e.g. beds for acute treatment (A index), for treatment and rehabilitation (T index)). Besides these beds, specific beds for 'psycho-geriatric' patients were created at the end of the 1970s.<sup>88, 89</sup> Today, two types of beds for older adults with mental health problems are available: Tg-beds and Sp(6). Both types of beds exist in psychiatric hospitals. Sp-beds are also available in general hospitals.

Challenges for psycho-geriatric services can be found in three domains. First, *recruiting healthcare professionals* with training and experience in both psychiatry and geriatrics is an issue of concern in psycho-geriatric services (Sp). The latter includes several groups of professionals including psychiatrists, nurses and the paramedical staff.<sup>89</sup> These services may also be affected by the overall high demand for geriatric expertise that outpaces the supply of available resources.<sup>90</sup>

Second, *psycho-geriatric beds may be used to accommodate patients who no longer need to receive acute hospital care* but who cannot return to their home and/or cannot find an alternative form of residential care (e.g. nursing home).<sup>88</sup>

Third, the ageing population and the shift from acute to chronic care will require an *increase in psycho-geriatric beds amounting to up to 25% by 2025*.<sup>91</sup>

## **6.2. Use of mental health services in residential settings**

### **Alternative long-term care**

Part of the required psycho-geriatric care capacity may be switched from the hospitals to other care settings (e.g. increase of specialised beds in nursing homes).<sup>88,91</sup> The latter may provide an opportunity to develop care alternatives in less complex care settings that are closer to the persons' natural environment. These care alternatives can include temporary housing alternatives for patients not being able to immediately join their home as well as specialised 'psycho-geriatric' beds in nursing homes<sup>88</sup>

A further option that may be explored is to create new places or facilitate stays in psychiatric care homes (PVT – MSP) or sheltered accommodations (IBW – IHP) for older adults not being able to live in their home. Between 2004 and 2013, total admissions in psychiatric care homes (PVT – MSP) have remained quite stable for older adults with a tendency to decrease before 2011 but has started to increase again in 2012 and 2013. Per 100 000 population in 2013, 5 adults aged 65 to 74 years and 4 adults aged 75 years or older were admitted, compared to 8 younger than 65. When looking at the share of residents aged 65 to 74 years, a decline is observed from 27.5% to 23.8 % in 2004 and in 2013, respectively. For persons older than 75 years, the share on total residents also decreased from 17.1% in 2003 to 10.3 % in 2013.

In sheltered accommodations (IBW – IHP), both admissions and the share of older adults on total residents has been stable between 2003 and 2013. Per 100 000 population in 2013, 4 adults aged 65 to 74 years and 1 adult aged 75 years or older were admitted, compared to 17 younger than 65. The share of older adults on total residents has fluctuated around 9% and 2% for persons aged 65 to 74 years and for persons aged 75 years or older, respectively.



### Residential care homes for older persons

In Belgium, residential care homes for elderly target older persons (60 or 65 years or older) no longer being able to stay in their home. Two types of homes for older persons can be found in Belgium. Homes for the elderly ('rustoorden voor bejaarden (ROB) – maison de repos personnes âgées (MRPA)) provide nursing and personal care as well as living facilities to older persons with mainly low to moderate limitations. Older persons who are strongly dependent can be admitted to nursing homes (rust-en verzorgingstehuis/Woon-en Verzorgingscentra (RVT/WZC) – maison de repos et de soins (MRS)). Specific units for older people with BPSD are available in some nursing homes and can be called "cantous".

The current organization of residential care homes for older persons has been delineated by protocol agreements between the federal and federated authorities. The agreements aimed at progressively replacing lower-care to higher-care beds and at the same time at reinforcing the supply of home care services.

The percentage of older adults living in a home for the elderly or a nursing home remains relatively stable by gender and age group. About 6% of the adults aged 65 years or older live in a residential care institution for the elderly.

### 6.3. Use of mental health services in non-residential settings

#### Older adults have fewer contacts with community and specialised centres for mental healthcare

Since early in the year 2000, mental health services were mandated to organise services aligned to the needs of children and adolescents (up to 18 years), adults (most often aged between 18 and 65 years) and older persons (aged 65 years or older).

The scope and extent of activities in community mental healthcare centres (CGG – SSM) for older adults depend on the institutions capacity to devote resources to this specific group. According to the most recent available data, the percentage of older patients having at least one contact with a professional in a CGG – SSM amounts to 11%<sup>92</sup> (year 2016) and 7.5% (between 2008-2011)<sup>93</sup> in centres recognised by the Flemish and Walls authorities, respectively.

It has been argued that without specific initiatives, community mental health services do not seem to attract older persons with mental health problems.<sup>89</sup>

<sup>94</sup> Federated authorities have aimed to improve this situation by providing additional funds to the CGG – SSM. In Wallonia, federated authorities provide specific funds to some community mental healthcare centres allowing them to develop 'specific initiatives for older persons' ('Initiatives spécifiques Personnes Agées' - ISPA).<sup>95</sup> These initiatives were created bottom-up in the beginning of the 2000s and today, four structured projects are available.

#### Box 2 – Lessons from the 'Initiatives spécifiques Personnes Agées' - ISPA

The projects provide first-line and specialised mental health interventions (e.g. psychotherapy or psychosocial interventions) in the home environment of the patient (residential care facility or at home). Interventions are provided in close collaboration with informal caregivers and other health and social care professionals caring for the patient. The projects may also provide information sessions and trainings for professionals regarding 'psychology and psychopathology of the elderly', in close collaboration with other mental health services.

The projects highlighted that the strengths of their organisation include a good integration with other mental healthcare services in their catchment area, a multidisciplinary approach and the team's mobility that allows to provide care in the natural environment of the patient.

The perceived weakness include the small size of the team working in a large catchment area, the lack of administrative support, the lack of information campaigns regarding old age mental health problems and the lack of training opportunities.



Since 2012, the Flemish community provides additional funding to strengthen the role of teams specialised in the care provided to older patients.<sup>92</sup> According to the authorities, the latter led to an increase of the percentage of older patient attending the centres among all users (i.e. from 8% in 2010 to 11% in 2016) as well as the number of new treatments ('nieuwe zorgperiodes'). Flemish federated authorities have also provided additional funding for innovative projects targeting older adults with mental health problems. The scope of the projects is broad and varies from developing and supporting alternative therapeutic living environments for chronic psychiatric patients to providing psychological support for older adults.<sup>96</sup> Their main objective remains to provide services adapted to the specific needs of these specific group of patients.

As for community mental healthcare centres, older adults do not often participate in specialised centres who obtained a specific agreement ('conventies' – 'conventions) with RIZIV – INAMI. In 2015, less than 2% of the patients participating in psycho-social rehabilitation programs (772) in Flanders were aged 65 years or older.<sup>97</sup> The percentage of patients aged 60 years or older treated in specialised rehabilitation centres for addictions (773) amounts to 0.3%, 2.1% and 3.5% in Flanders, Wallonia and Brussels, respectively. It should be noted, however, that these conventions may target younger age groups as one of their main objectives is to reintegrate persons in the community as well as to regain access to the labour market.<sup>98</sup>

#### **Access to the community mental healthcare centres seems to be hampered by different barriers.**

First, professionals working in community mental healthcare centres must accommodate to care demands for older persons in a challenging environment, with teams often facing a high workload related to the care demands of the general population. Second, older adults with physical decline may face limited out-of-home mobility and therefore the accessibility to treatment may depend on the professional's capacity and willingness to go to the person's home. Third, due to stigma and discrimination, older persons with mental health problems struggle to engage contact with mental health services. Finally, professionals do not always have the opportunity to follow adequate training allowing them to respond to the specific demands of these group that include the management of multiple actors (e.g. family, home care services) and the identification of the older person needs.

#### **Mental health intervention at home may be a key aspect to reach older persons with mental health problems.**

Data on the number or the frequency of mental health interventions for older adults in their home is scarce. It was not possible to assess the extent to which older persons benefit from mental health interventions at home, provided by psychiatric home care teams (PZT – SPAD) or mobile teams set up via the reform art 107. Both initiatives do not specifically target people aged 65 or older. Some professionals from community mental healthcare centres provide interventions in the home of the patients. The results of the evaluation of the 'pilot projects' and the reported experience from the 'specific initiatives for older persons' point out that reaching older persons in their home enhances substantially the accessibility to mental health intervention.

The experience gained via the 'therapeutic projects' opened the way for the introduction of a specific reimbursement for the 'consultation around the psychiatric patient at home' ('Overleg rond de psychiatrische patiënt in de thuissituatie' – 'Concertation autour du patient psychiatrique à domicile, since 1 April 2012). In 2016, 175 consultation plans for older persons (65+) (11.7% of the total (1502)) benefited from a reimbursement for consultation around the psychiatric patient at home'. This percentage of consultation plans for older persons (11.7%) is in line with the percentage of consultations of older persons with psychiatrists (11.8%).



### Box 3 – Professionals working in the field of mental healthcare

In Belgium, there is no specialised title or further accreditation criteria in 'old-age' psychiatry. Doctors can specialise in psychiatry and obtain a further accreditation in adult psychiatry and in child and adolescent psychiatry. In a separate specialisation branch, doctors can obtain further accreditation as specialist in geriatric care.

In a similar way, nurses can obtain a professional nursing accreditation in specialised mental healthcare and psychiatry or in geriatric care.

#### **Older persons have fewer consultations with mental healthcare specialists ...but have more frequent contacts with their general physician**

Stigma associated with having a mental illness has a negative influence on the help seeking behaviour of older adults and their families.

In Belgium, the total number of acts performed by psychiatrists (consultations and psychotherapies) decreases over the years for the whole population (reduction of 10% for the psychotherapies between 2008 and 2015 and a reduction of 3% for the consultations). In 2015, the number of consultations with a psychiatrist per 100 000 population was found to be 3 125, 2 843 and 1 477 for persons aged 64 years or less, 65 to 74 years and 75 years or older, respectively. A similar trend in the number of psychotherapies was also observed (i.e. fewer cases among older adults). There is, however, an increase of 40% in the number of psychotherapies (from 64 380 to 89 940) between 2008 and 2015 for the population aged 65 years or older.

It has been pointed out that GPs play a central role in the detection of psychosocial problems that involve 'medical or somatic problems as well as poor functioning in the daily life of the patient'.<sup>99</sup> For older persons, their role may be even more important as they often have a close and long lasting relationship with their general physicians and have frequent contacts with them.<sup>100</sup> Belgian data show, as expected, that the number of GP's consultations per patient increases with the age. Recently it has been proposed that the GP actively participates in the construction of a first line psychological care.<sup>12</sup> In 2018, the mental health commission of the FAMGB

(Fédération des Associations de Médecins Généralistes de Bruxelles) published recommendations to improve the quality of mental healthcare in primary care in Brussels. It notably highlights the added-value of the integration inside GPs office of specialised mental health professionals as clinical psychologist and of a helpdesk or a direct helpline to ease contacts with psychiatrists and hospital wards.<sup>101</sup>

While it is widely acknowledged in Belgium that the GP can play an important role in the mental healthcare systems, several barriers still need to be outpaced<sup>102</sup>:

- Communication between the different lines of care is too fragmented, and as such GPs are not always informed about the type of support they can get from other health and care professionals (e.g. allowing them to refer the patient to other care settings or ask for advice).
- Enhancing the access to continuous training and education is required in order to allow GPs to better tackle mental health problems.

#### **Home care services can play a role in detection and surveillance... but this role needs to be clarified and improved**

Home care services for people living at home are key actors to allow older persons to stay at home as long as possible.<sup>103, 104</sup> Nurses and family aids provide physical and cognitive assistance and are confronted on a daily basis with questions on how to manage mental health problems. In 2014, 7.5% of adults aged 65 years or older and living at home received a lump sum for nursing care at home. It is, however, not possible to know the share of these persons that combined physical and mental problems.

In order to help home care professionals to manage older patients with mental health problems, training courses are developed by multiple actors (nursing professionals organisations, psychiatric home care teams (PZT – SPAD), etc.).



#### 6.4. Provision of care in the least complex environment: an overarching principle that guides the provision of services for older patients

Over the past decades, reflections of and changes in the Belgian healthcare landscape aimed to provide high-quality and integrated care in the least complex environment that is clinically appropriate to the patient's situation.<sup>102</sup> In line with this overarching aim, the mental healthcare sector has been remodelled according to five core principles defined as follows:<sup>12</sup>

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

The long-term care system in Belgium that supports older persons with a decline in physical and mental capacity has also been restructured to enhance care provision in the natural environment of the patient, i.e. their home. To a certain extent, the changes in the long-term care sector can be described using some of the core principles of the mental healthcare reform. On the one hand, protocol agreements between the federal and federated authorities aimed to progressively replace lower-intensity care to higher-intensity care beds in residential care facilities. This can be seen as an 'intensification' of care delivery. On the other hand, since 2005 there has been a clear movement towards the development of home care services as well as alternative forms of care that can allow older persons to stay as long as possible in their home. The latter recalls the principle of '*desinstitutionalisation*' that has been widely pursued in the mental healthcare sector.

#### Box 4 – Five functions to set up the mental healthcare model in Belgium

The global and integrated vision of the mental healthcare reform calls for pooling resources from all actors (also including those not providing mental healthcare services) to create strategies that meet the mental health needs of the population residing in the catchment area. The model of care delivery is based on a 'stepped care approach' and is constructed around five functions:<sup>12</sup>

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



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

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

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

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

## 6.5. Lessons from innovative projects for older adults with mental health problems ('therapeutic projects' and 'Protocol 3' projects)

In the first decade of the year 2000, the so-called 'therapeutic projects' were launched in order to provide 'integrated mental health services' in clearly defined coverage areas. Twelve out of the 76 therapeutic projects (about one out of six projects) concerned older adults with mental health problems.

The creation of care networks in the beginning of 2010, the so-called 'article 107' networks, further targeted a qualitative integration of resources from hospitals and community services in order to adapt the supply of mental health services. The networks encompassed to a large extent the 'therapeutic projects' but mainly focused on the financing of networks for adults (including adolescents aged 16 years or older).

Some therapeutic projects for older persons found a second opportunity to continue their activities via the 'Protocol 3' initiative, launched in 2010.<sup>105</sup> Protocol 3 provides funding for innovative projects aiming at delaying institutionalisation in residential care facilities whilst improving/maintaining quality of life of persons aged 60 years or older. All projects have a **strong case management component** but can provide other specific interventions. Among the 66 projects selected in the first wave, thirteen had a 'psychological or psychosocial support'-component. Eight out of the thirteen projects were considered as having a focus on 'psychological or psychosocial support or therapy'.

Scientific independent evaluators assessed the work of the 'therapeutic projects' and 'Protocol 3' projects.<sup>105-108</sup> The findings of both evaluation highlight similar issues<sup>c</sup>:

- **The target population** included persons aged 60 years or older suffering from different severity levels of psychiatric disorders. However, most projects focused on persons with non-complex psychosocial problems (most often common early stage of dementia problems, depression, mourning, loneliness and fear). The projects did

<sup>c</sup> While there is an overlap between some projects included in the two initiatives the evaluation were carried out separately



not target patients with a specific diagnostic. The evaluation of the therapeutic projects pointed out that it remained uncertain whether the projects targeted and reached older persons with severe mental disorders.

- **The mental healthcare intervention** of the projects varied substantially from psychological consultations, psychotherapy to social support (e.g. information on availability of services, support in transition between different services). Psychological consultations were often organised at the patient's home. The duration of the treatment and the regularity of the consultations varied between the projects.
- **The involvement of the patient and the family** in the care plan (e.g. decisions regarding the transfer of patients) was perceived as an essential tool to optimise care.
- **Stigmatisation of mental illness** inhibits patients and their families to seek help from specialised healthcare professionals (e.g. psychiatrist). Older persons seem to better accept psychological interventions when they take place at home.
- **Support for healthcare professionals** via specific training was perceived as a key aspect to improve the care provided to older persons. It increased the awareness of healthcare professionals for undetected psychosocial problems (e.g. depressed older persons (even suicidal)) and resulted in faster mobilisation of specialised care providers. Clinical expertise and stability of staff were considered as key success factors for these initiatives.
- **Shortage of psychiatric services** that target older patients was considered as an important concern.

Within the scope of this project, four projects financed via 'Protocol 3' were contacted in order to obtain additional details on their current activities. Three projects provide home interventions and one project is set up as a small alternative (sheltered) living environment linked to a nursing home. The following points were mentioned by the participants:

- **Strengths of the projects** include that patients are not subject to additional out-of-pocket payments and that the approach is dynamic and tailored to their needs (e.g. pace and content of therapy, intervention based on the patients' needs). The projects are built to enhance and improve collaboration with the different lines of care. This allows to enhance the recognition of their work within the mental health sector. Continuous appraisal of their activities (evaluations) is also perceived as a positive aspect. One project reported that they are able to intervene in case of a crisis.
- **The weakness of the projects** include possible low patient's compliance with the therapy. The projects reported that limited and short-term funding for 'pilot initiatives' with an experience of more than 15 years hampers the possibility of further extending their work.

In 2014, a second wave of protocol 3 projects were launched through a convention with INAMI – RIZIV. Two characteristics of those new projects were, amongst others, the enlargement of the psychological support and the use of the BelRAI instrument.<sup>109</sup>





## 7. DISCUSSION

In the last decades of the twentieth century, an important step in the reorganisation of mental healthcare (MHC) in Belgium was taken, as federal and federated authorities agreed to reorganise the mental healthcare landscape according to the principles of target groups and networks in order to provide tailored, patient centered and integrated care, directed to the patient in his personal living environment.

Pilot projects which targeted three groups of patients (i.e. children and adolescents, adults, and older persons) were set up. This pilot projects initiative was followed in 2010 by the creation of 'care networks' or 'care circuits' for persons aged 16 to 65 years.<sup>12</sup> More recently, the principles of this reform were put into practice in order to build networks for children and adolescent.<sup>13</sup> In this context, a program aiming to enhance the mental health of older adults has not been organised yet.

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

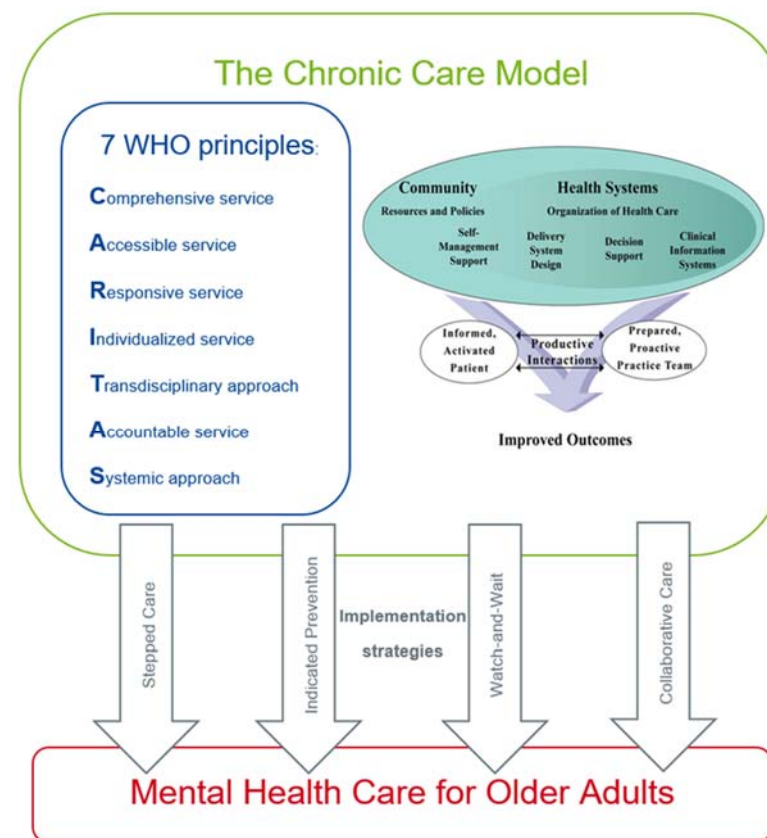
- A specific organisational model that encounters the needs for mental healthcare for older people exists and would be applicable in Belgium, and;
- The current system of MHC for adults might be in line with the model identified.

### 7.1. C.A.R.I.T.A.S. principles as a good approach for the organisation of mental healthcare for older adults

The rising number of older people and the fact that external factors (e.g. stigmatisation of mental illness) hamper professional help seeking are a major matter of concern. In 1997, WHO suggested that good mental healthcare services for older persons should follow the C.A.R.I.T.A.S. principles: comprehensiveness, accessibility, responsiveness, individualisation and accountability, with a transdisciplinary and systemic approach of care. The Chronic Care Model (CCM), as a general overarching model of comprehensive care, seems to provide the building blocks to reach these principles. To implement this theoretical model, four operational core elements were identified through the literature: the Stepped Care strategy,

the Indicated Prevention strategy, the Watch-and-Wait strategy and the Collaborative Care strategy. These strategies can be used alone or in combination (see Figure 1).

**Figure 1 – C.A.R.I.T.A.S. principles, Chronic Care Model and implementation strategies**





The literature review showed that a strategy based on a combination of the stepped-care approach with other implementation core elements (collaborative care, watch-and-wait and indicated prevention) allows to build an effective care model for the older adults with mental health problems (i.e. depression, anxiety, suicidal ideation and behavioural symptoms in Alzheimer patients).

The international comparison points in the same direction. The principles of stepped-care, collaborative care and indicated prevention strategies are also applied to organise services in France, the Netherlands, England and Canada. The last two countries<sup>83,84</sup> have also developed comprehensive guidelines to improve the systems that closely follow the C.A.R.I.T.A.S. principles.

A number of Belgian stakeholders participating in a survey on organisation of mental healthcare in Belgium did not perceive the C.A.R.I.T.A.S. principles to be met in our current system. The overview of the Belgian situation shows that some on-going initiatives belonging to the long-term and mental health sector already apply these principles. For instance, Protocol 3 projects and the 'old age' teams from the community mental healthcare centres (CGG – SSM) enhance the availability of services adapted to their needs, include follow-up meetings at home and provide support to their informal caregivers. These initiatives work towards facilitating the collaboration between families, health and social care services.

## 7.2. Requirements of a system with mental healthcare services adapted to the needs of older persons

### 7.2.1. *Services must be commissioned on the basis of need, frailty and not only age*

Most developed countries accept the age of 65 years as a definition of older people. But this might be misleading as older people are a very heterogeneous group. Indeed, the decrease in functional reserves with higher levels of comorbidities leads to increased vulnerability often described as 'frailty'. But some very old persons remain vigorous while others, even younger and without any apparent disease, fail to rebound following illness or hospitalization. Physiologically and pharmacologically, frail older people may react differently to sickness and (psychotropic) drugs than more robust adults.<sup>3</sup>

Older adults with mental health problems often have comorbid somatic illnesses, which might influenced their mental health status. This imply that mental health professionals need to offer to older adults specific attention for side effects of drugs, end-of-life care, frailty and polypharmacy. The somatic health of older adults might in turn be influenced by their mental health status.

In parallel to functional mental disorders (e.g. depression, anxiety,...), organic mental health diseases (e.g. dementia) are also frequent in the older population. Services therefore need to encounter both types of mental diseases and in particular psychological and behavioural symptoms related to dementia.

Another point of concern is that older people may be prevented from accessing psychological therapies because mental health problems may be perceived as a reaction to physical health problems or as a normal ageing process, and therefore remain underdiagnosed and undertreated although psychotherapies are as effective in older persons as in younger.

Belgian stakeholders partly agreed that the current mental healthcare system in Belgium does not sufficiently targets basic social problems like social isolation, disability and maltreatment.



**Key message 1:** Older adults with mental health problems are a heterogeneous group with specific needs according to their frailty and pathologic profile.

*7.2.2. Comprehensive care for older persons can only be reached by a strong collaboration between services dedicated to somatic, mental and social care.*

As pointed out in the Canadian and English guidelines, a comprehensive and integrated care model for older persons can only be reached if mental health for older adults is embedded in the general health service delivery (social, somatic and mental aspects). Services with expertise in mental and geriatric care have a double role in the system: they can support the care needs of patients with more complex problems and, they must work in close collaboration with primary care and social care services and support it.

A MHC system based on the C.A.R.I.T.A.S. principles and the Chronic Care Model depends not only on the availability of services but also on the collaboration and alignment between all involved actors and on the good coordination of care (case management). A coordinated exchange of data between the social and medical sector, as well as between first and second line, is essential.

The literature review shows that the mental healthcare system for older persons suffers from fragmentation, lack of communication (data sharing) and inflexibility. In Belgium, GPs often perceive a lack of access to psycho-geriatric specialists for consultation and referral, and also a lack of support from these specialists. Stakeholders indicated that problems of collaboration between GPs and psychiatrists remain a barrier to provide high-quality and effective mental healthcare.

Our study however identified several examples of good inter-professional communication:

- Some nursing homes<sup>d</sup> in Belgium cope with the specific needs of residents with mental health problems through a close collaboration with psychiatric hospitals, GPs and centres of expertise for dementia.
- Large inter-sectoral networks were created abroad, such as in the Netherlands (Nederlands Kenniscentrum Ouderen Psychiatrie) or in France (Centre régional de référence en psychiatrie du sujet âgé). Evidence from abroad highlights the creation of partnerships between geriatric medicine, emergency medicine, family practice and mental health specialists which increases awareness of the needs of older adults (addition of a geriatric nurse in the emergency department, close collaboration between psychologists and GPs in first line, involvement of a geriatrician in community mental health centres, old age psychiatry liaison in general hospitals).
- Protocol 3 projects foster the use of a case manager, the BelRAI tool, a shared patient folder, an integrated IT system, clinical protocols, and continuous evaluations.

Belgian stakeholders agreed that it is required to foster a multidisciplinary and collaborative approach with clear definition of role and tasks, a better communication among professionals and the avoidance of competition between care providers.

**Key message 2:** Close collaboration between mental health specialists, first line practice, geriatric services, emergency departments, and professionals from the social sector will increase the quality of the mental healthcare to older adults. The use of the BelRAI tool and the presence of a case manager allow to contribute to it.

<sup>d</sup> Nursing home encompass here homes for the elderly and nursing homes



### *7.2.3. Mental healthcare expertise for older people must be present in multiple settings*

#### **Clarify and boost the role of primary care in order to better target mental health problems.**

WHO recommendations<sup>110</sup> and international guidelines acknowledge that general physicians often are the first health professionals to be contacted when a mental health problem occurs. This is particularly relevant for older persons as they have more frequent contacts with their GP compared to the younger population. In a model following a 'stepped-care strategy', general physicians can play a central role as they can identify mental health problems and provide initial non-intensive treatment. They are also well-placed to treat somatic symptoms, which are often co-morbid for these patients' subgroup.

In Belgium, the GP could play a more central role in the mental health systems. GPs are widely involved in the treatment of patients in initiatives for older persons. The role of home care services may also be more prominent in the management of these patients. Home care staff may be well-placed to support the early identification of mental health problems. Case managers from home care services can not only coordinate and organise the care plan but can also alert healthcare professionals in an early stage of any changes in the health status of the patient.

In order to allow general physicians and home care providers to play this key role, the results of this report highlight the need to enhance collaboration with specialized professionals (e.g. psychologist and geriatrics/psychiatrics nurses) and institutions; and to develop and facilitate specific training for primary caregivers (GPs, nursing home staff, home care nurses, informal caregivers,...). Several Belgian actors (nursing professionals organisation, psychiatric home care teams (PZT – SPAD), etc.) already provide trainings and courses with the aim to allow home care providers to fulfil this challenging role.

**Key message 3:** Primary caregivers should be entitled and be able to play a key role in the detection and the management of the mental health problems of older adults. There is however a strong need for close collaboration and specific training.

#### **Facilitate access of elderly to low-threshold community mental healthcare services**

Several stakeholders indicated that availability of and access to mental health services must be enhanced for the elderly. Abroad, community mental healthcare centres have specialised professionals in the diagnosis and treatment of MHC problems in older people. These professionals have skills and competencies to assess whether patient's symptoms are related to a mental health problem, a somatic or a psycho-organic disease (or a combination). The work is done by multidisciplinary teams and can encompass physicians with a specialisation in geriatrics, psychiatry or both. Teams may provide interventions in the patient's home environment or in a nursing home.

The evidence from the international comparison and from Belgian initiatives showed that healthcare professionals who provide interventions at home may be able to overcome two existing access barriers to services. First, stigma related to mental illness negatively influences help seeking behaviour of older adults and their families. They are found, however, to have a much more positive attitude when mental health interventions are provided at the patient's home. Second, older adults with physical decline may face limited mobility hampering access to treatment, which may depend on the professional's capacity and willingness to go to the person's home. English guidelines point out that interventions at the patient's home lead to better scope for accurate assessment and clinical management of these patients.

Community mental healthcare centres in Belgium aim to provide services adapted to older adults but struggle to target this group. Federated authorities already have supported some effective programs in community mental healthcare services that proved to be able to reach an increasing number of older patients. A key aspect of these initiatives is the possibility to treat the patient at home.



**Key message 4:** 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).

#### **Extend psychiatric mobile teams (article 107, PZT-SPAD) to overcome barriers in the access to mental health services**

Foreign best practices show that old-age mobile teams can be an added value through their skills and competencies in mental and geriatric care. The scope of their work is broad as they provide diagnosis, treatment and counselling services for psychological and psychiatric problems as well as for psycho-organic diseases. In addition, they can provide support, information and education to primary care professionals as well as to informal caregivers. Old-age teams and general physicians can build strategies to ensure the continuity and coordination of care between home, hospital and nursing homes.

The creation of sufficient resources and trained staff for old-age MHC teams to tackle the needs of older adults in the community remains a matter of concern. Abroad, there is sufficient evidence that care for this population can be delivered by 'adult' teams in close collaboration with 'old-age' teams, even in case of a crisis situation (24h/24 and 7d/7).

The idea of mobile teams is certainly not new in Belgium but the scope of the psychiatric home care teams (PZT – SPAD) or the mobile teams (article 107) at present does not encompass older adults. There is, however, a large consensus that more efforts to develop 'old-age' mobile teams are needed. The National Council for Hospital Facilities (NRZV – CNEH) as well as interviewed stakeholders emphasized the specific need to set up 'old-age' mobile teams as a new service or as an extension of existing mobile teams.

**Key message 5:** Specialised old-age mobile teams can be an added value to support the present (general) adult teams, as they can improve the assessment and the management of the complex mental health problems of older adults.

#### **An ageing population calls for fine-tuned policies to overcome the shortage of beds in residential settings**

Abroad, psycho-geriatric services or wards are preferred for in-hospital care, as care provided in these wards is based on a multidisciplinary approach, allowing psychiatrists to work in close collaboration with geriatricians and neurologists. The need for these services and for staff with expertise in psychiatry and geriatrics will increase due to the ageing population.

There is some evidence from abroad that a part of older patients with mental health problems are referred to hospital wards with insufficient specialised resources to treat them. In order to cope with the needs of these patients, two different strategies were applied. First, geriatric liaison teams can provide support to healthcare professionals working in adult psychiatric wards. Second, old-age psychiatry liaison teams can provide support in geriatric wards.

The Belgian MHC system already faces similar challenges. The results of the stakeholder survey as well as the experiences of the innovative projects suggest that the demand for old-age psychiatric services already exceeds the current supply. Belgian geriatric liaison teams already can provide support to healthcare professionals working in adult psychiatric wards while old-age psychiatry liaison teams might be an added value as a support in non-psychiatric wards.

In addition, a part of the in-hospital psycho-geriatric care capacity in Belgium is used to accommodate patients who no longer need acute hospital care but who cannot return to their home environment and/or for whom an alternative form of residential care cannot be found.

**Key message 6:** To cope with acute needs of patients with mental health problems which cannot be managed in the community, adapted hospitalization in general psychiatry, psycho-geriatric or geriatric wards (according to patients' profile) should be available.



**Key message 7:** In general hospitals, geriatric/"somatic" liaison teams can provide support to healthcare professionals working in adult psychiatric wards while old-age psychiatry liaison teams might be an added value as a support in non-psychiatric wards.

### **Alternative housing adapted to older persons resides in the boundaries between the mental health and long-term care sector**

A significant difference for the care of older people, compared to adults of working age, is related to the access to adapted housing alternatives. For dependent older persons, it is unclear whether they should be admitted to a residential facility in the mental health sector or the long-term care sector. In Belgium as well as in other countries, nursing homes frequently face people suffering of mental health problems. In some regions of Canada, given the high percentage of older persons with mental health problems living in nursing homes, they are perceived de facto as (longer-term) mental health facilities.

In Belgium, the share of admissions for older adults in psychiatric care homes and sheltered accommodations tends to decrease over the last ten years. This might be due to older patients being more rapidly referred to a nursing home. Moreover, those adapted housing alternatives are more focused on working rehabilitation and reintegration of younger adults.

An issue of concern mentioned in the online survey are the needs (skills, competencies, staffing and, architectural constrains) of nursing homes to deal with mental health problems of their residents. The international comparison shows that it might be helpful when nursing homes can rely on mobile 'old-age' teams for further support. In addition, in France and Canada, psycho-geriatric units inside nursing homes (mostly for elderly with behavioural problems related to dementia) was perceived as an added value. They can benefit from the occasional supervision of psychiatrists.

**Key message 8:** In nursing homes, MHC mobile teams can be of added value to support treatment of elderly as well as to inform and to train staff. Specific units for older adults with behavioural troubles offer the opportunity to improve their care.

### **7.3. Further considerations for the system**

#### **Sensitisation and early detection**

In addition to the stigma of mental illness, the stigma of being older was identified as an issue of concern in all countries. In Belgium, initiatives providing specific care to these patients highlighted that stigma has a negative influence on the help seeking behaviour of older adults and their families. Some stakeholders of the online survey as well as the evaluation report of old age mental health initiatives in Belgium indicate that mental healthcare for older persons is still not known well in the community and more information campaigns are needed.

Some reflections are emerging from best practices abroad. The Canadian guidelines recommend that mental healthcare services for older people should develop and apply anti-stigma public strategies, and create awareness on recovery and well-being for older persons. In England, there have been many information campaigns aiming to reduce stigma in the healthcare system and society. Community oriented mental healthcare helps to avoid or decrease stigma, wrong beliefs and intercultural barriers but, above all, a huge work of sensitisation and information provision is essential.

Awareness about and vigilance for of mental health problems among older adults might also require to screen high-risk groups. The literature review highlighted that screening for mental health problems in older persons should be systematic in nursing homes. Canadian guidelines recommend that mental healthcare services for older people should implement early identification of mental health symptoms and should develop public prevention and detection strategies. Some stakeholders of the online survey suggested that a specific approach for elderly must be developed and includes screening and detection of mental healthcare problems.



**Key message 9:** More information campaigns are needed to sensitise lay people and healthcare professionals for old age mental health problems. Systematic screening for mental health problems in older persons in nursing homes should be considered.

### Patients and caregivers as active partners in care

The C.A.R.I.T.A.S. principles and international guidelines highlight that informal caregivers have to be recognised as long-term carers and integrated in the multidisciplinary collaboration around the older adult with mental health problems. Care planning should be discussed with and accepted by the patient and his family, to ensure a tailored and individualized service.<sup>102, 103</sup>

In Belgium, stakeholders and initiatives for older persons suggest involving patient and their informal caregivers in the planning and provision of care to enhance the quality of the mental health interventions.

**Key message 10:** The older adult with mental health problems and his (her) informal caregivers have to be involved in the planning and provision of care. Support and recognition of informal caregivers should be strengthened.

### Skills and education of health and care professionals

The literature review and the international analysis draw attention to the fact that health professionals (GPs, professionals in community mental health centres, etc.) struggle to detect, diagnose and treat mental health problems in older adults. They often lack knowledge, skills and confidence to work with these group. A survey conducted by the geriatrics committee at the University of Montreal highlighted that, while more than 50% of non-paediatric patients are aged 65 or older, at the best 10% of healthcare professionals time of training had focused on older persons care.<sup>111</sup>

Mental healthcare for older adults evolves at the frontier between psychiatry and geriatric care. In order to provide physicians with knowledge in both areas, specialisations in old age mental healthcare have been developed abroad. Their final objective is to allow physicians to deal with the mix of mental and somatic symptoms. In addition to this, education in old-age

psychology/psychiatry is organised abroad for physicians and nurses, and include a training to detect somatic issue in older adults with mental health problems.

Respondents of the online survey emphasized the need for training for health and social care professionals in old age mental healthcare, as a lack of knowledge hinders the quality of care provided. At present, there are ongoing initiatives to provide training to professionals working in the primary line of care.

Evidence from abroad and from the evaluation of pilot projects in Belgium suggest that clinical expertise and retention of staff are key factors to ensure care continuity. Training of healthcare providers in old age mental healthcare changes their view on elderly, increases their awareness and their knowledge and even increases their confidence.

**Key message 11:** Specific skills and competencies in old age mental healthcare are needed to ensure good quality of care. This implies that specific training must be organized.

### Development and dissemination of evidence based clinical practices

The Canadian and English government have developed national guidelines and assessment tools to better organise mental health services for older persons. In the online survey performed in this report, some stakeholders stated that evidence-based approaches need to be promoted to align provision of care. The quality of mental health home care and the assessment of the older adults' mental health needs must be improved. International analysis also revealed that by adopting best practices and educational tools, a more scientific approach of MHC to older adults could be of use to fight stigma.

**Key message 12:** Awareness of and care for older adults' needs can be improved through development and dissemination of evidence-based knowledge.



### Improved data collection in ambulatory settings

Stakeholders participating in the survey pointed out that collection of data regarding MHC for the elderly is incomplete, especially for ambulatory and at home mental healthcare services. The current reform of the mental healthcare system provides a good opportunity to improve data collection and to deliver feedback to healthcare providers and policy makers.

Although data from the Health Interview Survey (HIS) is important to get a clear overview of the mental status of the population, the answers to the HIS questions do not give any proof of mental illness diagnostic. So, more accurate data on mental health disorders is therefore welcome.

Sharing patient information in electronic health records may also facilitate the collaboration between different health and social care professionals<sup>112</sup>.

**Key message 13:** Data collection regarding mental healthcare for older adults needs to be optimized.

### Joined-up or separate system of mental healthcare for older adults

For two decades, the Belgian mental healthcare landscape has been restructured in order to implement 'care networks' or 'care circuits' for specific target groups. Networks for children and adolescents (0-18) and for adults aged 64 years or younger exist today (with different levels of maturity). The remaining age group, the 'older adults' have up till now not been included in the reform art.107. It is therefore relevant to reflect upon the place of this (heterogeneous) group within the framework of the reform.

The reorganisation of the MHC sector aims to provide mental healthcare following the principles of the stepped-care approach<sup>12, 87</sup>. This approach is one of the implementation strategies for the Chronic Care Model and the C.A.R.I.T.A.S. principles (see figure 1). An open question is whether the place of older adults in the reform requires to be integrated to the overall context for adults or to be set as a separate framework as is the case for children and adolescents.

### *Arguments for and against*

Building a '**customized**' network for older adults can maximise the quality of care to older people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems. There are, however, at least three main risks and barriers that need to be overcome in order to build such a network.

Highly specialized networks require a significant number of trained and experienced medical and paramedical healthcare professionals in old-age mental healthcare. Abroad, as well as in Belgium, there is already a shortage of specialised healthcare professionals dedicated to the needs of an ever increasing ageing population. Without sufficient human resources in old-age psychiatry, a highly specialised network for a designated group of patients may create further delay in detection and treatment of the elderly.

The diversity in the group of adults aged 65 years and older makes it difficult, if not impossible, to delimit a network based on clear-cut age criteria. While frailty is associated with age, not all older persons can be considered as being frail. Adults above 70 often remain vigorous while others, in their 50s or 60s may experience a decrease in functional reserves with higher levels of comorbidities. A system based on age may also put at risk the continuity of care for patients once they reach the required age limit. Moreover, in a vision fostering the principle of recovery it may be the case that after an acute episode that can only be treated by highly specialised professionals, the person may be stabilised and further directed towards 'general' adult services. The transition between systems may be considered as a point of concern for this group.

Stigma associated with having a mental illness along with ageism could be fostered in a clearly separated network.

Building a **joint and comprehensive ageless 'adult' network** may help to overcome these barriers, but at the same time poses multiple challenges.





A comprehensive and integrated care model for older persons can only be reached if mental healthcare for older adults is embedded in general health service delivery (social, somatic and mental aspects) and is aligned with the long-term care system for the elderly. Coordination between different sectors (health, long-term and social care) remains an issue of concern abroad and in Belgium.

To encounter the specific needs of older adults and to prevent neglect of problems, an ageless network should include multidisciplinary teams with expertise in old age mental healthcare. Certainly, shortage of staff may remain an issue of concern. However, good collaboration between specialised teams and 'general' teams may reduce the pressure of the limited resources. These specialised teams can play a double role. Specialized teams should work in close collaboration with general teams in order to identify the most complex cases where their additional expertise is an added value. At the same time, they may be required to provide support (including training) to non-specialised teams in order to allow them to cope with specific needs of these population.

Ensuring sufficient resources to tackle the needs of older persons may also be an issue of concern. The challenge resides on being able to direct limited resources towards the smaller group of frail patients. To overcome this limitation, clear procedures and guidelines, and transparency in resource managements is a must.

Better knowledge and boundless collaboration between different professionals may also reduce stigmatisation of older persons. In an ageless system, older patients might not be excluded from accessing services provided for "adults of working age", where it can appropriately meet their needs and cure them.

**Key message 14:** Since 2010, older adults have not been included in the on-going reform. A separate mental healthcare system seems to present barriers. An ageless adult network may help to overcome these barriers, but at the same time poses multiple challenges.

### **Moving towards community care requires reinforcing actors to set new roles and attitudes**

The principle of deinstitutionalisation of the on-going reform that is also present in the long-term care sector is also pursued abroad. Countries have moved away from an institutionalized approach for mental healthcare in older people (and in general for all persons) in favour of providing care in their home.

The evidence in this report suggests that reinforcing and clarifying the role of primary care (*in line with the first function of the reform*) together with easing the access to acute and chronic mental healthcare services at home (*in line with the second function of the reform*) are both necessary steps to construct a system aligned to the needs of older patients.

Primary care providers are well placed to deal with prevention, screening and diagnosis of mental health problems. For older persons, their role is even more central as general physicians have regular contacts with them. Home care services having a direct access to the person's home are also well- placed to early identify signs of multiple health problems.

To ensure their missions, professionals in the first line of care must be able to furnish an adapted response to mental health problems and to ensure the continuity of care. As pointed out in this report, the latter comes with multiple challenges that can only be overcome by enhancing collaboration with other lines of care and developing accessible training courses focusing on how to detect, diagnose, treat, and monitor these group of patients.

Ambulatory intensive and non-intensive treatment provided in the patients' natural environment facilitates the acceptability and access to treatment. This is widely supported by the international and national experiences. An extension of the mobile teams (article 107) and of the initiatives allowing professionals from community mental healthcare centres to reach out patients at home would be an adequate response for the needs of older adults, a requesting and responsive target group. Combining both types of home care approaches may effectively target patients with severe mental disorders as well as those facing other problems (e.g. social isolation, bereavement) that can lead to poor mental health. In order to allow those teams to fulfil their role, expertise in old-age mental healthcare is needed. However, an extensive development of mobile teams remains conditioned by sufficient human and financial resources.



It should be noted that the ageing population brings challenges for residential settings. Shortage of staff with specific training in geriatrics and psychiatry is an issue of concern in nursing homes and hospitals. Due to the ageing of the population, both institutions also face shortage in the number of beds. For older persons with mental health problems who are no longer able to live in their home, the 'logical' step is often to enter a nursing home. This can be a challenge, as the management of severe psychiatric cases may exceed the resources available in a nursing home.

**Key message 15:** The evidence in this report suggests that reinforcing and clarifying the role of primary care (in line with the first function of the reform) and towards easing the access to services at home (in line with the second function of the reform) are all necessary steps to construct a system aligned to the needs of older patients.

#### **Changing established patterns remains the biggest challenge**

The shift of mental healthcare provision towards the community has been pleaded for since the late 1970s in Belgium as well as in many European countries. The changes are on-going but seem to require patience, continuous discussion and collaboration between different levels of government and levels of care, and new attitudes in the society. For older adults, it also calls to fight stereotypes, stigma and ageist attitudes.

The old age wellbeing paradox appears as a good counter-example of those attitudes. It highlights the contrast between loss in biological, physiological, and cognitive capacity occurring with ageing and the relatively high levels of emotional wellbeing in older adults (except in case of prolonged and unavoidable stress). This can shed light on resilience towards an acceptable quality of life (recovery concept) for people (including younger) with mental health problems.

The way to mental health recovery for older adults calls for a societal debate on how to integrate them in the society that goes beyond the provision of rehabilitation services. It should not be forgotten that mental health is a key aspect of promoting healthy ageing. International guidelines specify that older people's mental health services benefit from an integrated approach with social care services and have to promote social inclusion and independence (autonomy) of older people with mental health difficulties.

**Key message 16:** 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).

#### **7.4. Limitations of the study**

##### **Scope**

Mental health is a broad concept. As such, the definition and understanding of what is a mental healthcare intervention is often blurred. Elderly patients most often have multiple needs (bio-psycho-social)<sup>107</sup> that go beyond those relating to their mental health status, and therefore mental health interventions seemed to be both encompassed by the mental health and the long-term sector.

This study focused on the organisation of the mental healthcare services for older patients. The description of specific initiatives for older persons suffering from memory problems or young dependent persons was out of the scope for this report. The report does not explore how to rehabilitate and integrate older persons in the society, neither the use of scales to assess frailty and autonomy. Diseases, drugs management; determinants of mental health problems; primary prevention; accessibility according to financial means; and detailed implementation processes (e.g. practical care pathway) are also not taken into account.

##### **Literature review**

The scope of the literature regarding models of healthcare delivery is extremely broad and often not specific for mental healthcare interventions. Evaluation of the effectiveness of healthcare interventions in complex delivery settings such as the mental healthcare sector is most often hindered by numerous methodological problems. The models include multiple and



complex components not always clearly defined in the studies. As such it is rarely possible to determine whether a single or a combination of elements are responsible for the intervention's outcome. Boundaries between different models of care provision are not always clear cut and therefore it does not allow to determine whether a model is better adapted to a specific setting or population.

Little to no studies were identified on the (cost-) effectiveness of the general models and implantation strategies on the outcomes for severe psychiatric disorders and minorities of refugee populations. Therefore we cannot generalise the findings of this study to these populations. The field of research on mental healthcare is continuously expanding. However, given the time constraints of the project, evidence published after May 2016 was not included.

### **International comparison**

Evidence gathering for the international comparison relies on a narrative review of available reports and ad-hoc searches for the mental health for older patients. This approach allowed us to have a global perspective of the situation in the different countries. The choice of case studies was not the result of a systematic screening but was based on the potential added-value for the Belgian organisation of care.

An analysis of payment mechanism in selected foreign countries was not included as these depend on organisational and financing models that are not directly transferable to the Belgian situation.

### **Belgian data analysis and survey to stakeholders**

The analysis of the Belgian situation aims at providing an overview of the use of mental health services by older adults. We focused on the use of services that aim at providing treatment for mental health problems. The biggest limitation of this perspective is that we did neither assess the step-by-step process leading to use different types of services (e.g. different types of hospital beds or combination of hospital and community services), the evolution of services used according to the severity of the psychiatric disorders nor the impact of psychosocial interventions (e.g. provision of social support by care workers). Given these limitations, we could not measure the performance of the system giving the lack of information of patients' outcomes.

Recent data on prevalence of mental health disorders is lacking for the Belgian population. Data from ESEMeD (European Study on the Epidemiology of Mental Disorders) was presented for older adults but should be analysed with caution. First, the sample of older adults was small and did not include institutionalised persons or those with severe mental health disorders. In addition, given the large reform of the mental health landscape in the last 20 years, it is likely that services use has evolved. Data from the Health Interview Survey (2013) allows us to only approximate the prevalence of the mental health problems among the Belgian population. Moreover, the blurred definition of mental health problems needing intervention and the lack of precise/standardized time frame to study specific psychologic and psychiatric problems lead to difficulties to compare prevalence data between different countries and times, and prevent to make trustable extrapolations.

We acknowledge that data analyses mainly rely on administrative data gathered in in-hospital settings because data for community and at home/nursing home settings is mostly not available.

Information on innovative projects in the community was collected via existing evaluations and an online survey filled by a limited number of projects. The information retrieved does not allow to have a global and exhaustive view of the reality in the field. It did, however, provide important elements to identify gaps and solutions to improve the current working of the system.

The survey sent to stakeholders on the current organisation of the mental health system, reflects their views and opinions, not factual data. As such, results aim to generate assumptions about the gaps and improvements and how to improve the current system but does not rely on statistical significant analysis of quantitative data. Therefore, these findings must be considered as qualitative input



## 8. CONCLUSION

This report explored ways to optimise the organisation of mental healthcare for older adults. The study was based on a mixed method process encompassing a systematic review of the literature about models of care in mental healthcare for older adults, an online survey on stakeholders' opinions, an international comparison of services organisation between four western countries and a description of the Belgian supply.

Thanks to the knowledges gathered in the scientific report (separated document available on the same webpage) and based on the key messages highlighted in this short report, recommendations (see below) were drawn up with the help of Belgian experts in mental healthcare for older adults (see appendix 7 in a separated document available on the same webpage)

In short, mental healthcare is a broad concept and older adults with mental health problems often have multiple needs. To cover those, primary care must be the key stone of the care and informal caregivers have to be included in the process of care. In addition; mental healthcare services in the community and at home (mobile teams), must be supported by healthcare professionals adequately trained in old age psychology/psychiatry. The care has to be evidence-based and adapted to the patient's needs and not based on the patient's age.



## ■ RECOMMENDATIONS<sup>e</sup>

In the context of the ageing population, it is essential to ensure to older adults a coherent and coordinated mental health care offer, with particular attention to care integration; quality of life and geographical accessibility. This provision of care must be a political priority.

***Recommendation 1 to the attention 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***

- Mental healthcare to older adults could be integrated in the existing mental healthcare services organisation only if several conditions are fulfilled
  - 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;
  - The role of primary care is reinforced and clarified;
  - Sufficient experts trained in old age psychology/psychiatry are present in all settings of care;
  - The access to mental healthcare at home and in nursing home is facilitated.

***Recommendation 2 to the attention 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 ensure quality and continuity of care:
  - The GPs have to be supported by mental healthcare professionals including experts in old age psychology/psychiatry (third line);
  - 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;

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<sup>e</sup> The KCE has sole responsibility for the recommendations.



- Old-age psychiatry liaison teams should be created to support mental health professionals in non-psychiatric wards;
- 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.

***Recommendation 3 to the attention to the Federal Minister of Social Affairs and Public Health, to the Federal Public Service Health, Food chain safety and Environment and to the Ministers of Higher Education***

- Specific training in old age psychology/psychiatry must be developed
  - All healthcare professionals have to be sensitized for specificities of old age mental health problems during their basic training;
  - Specific training in psychogeriatric care should be considered for healthcare professionals who frequently encounter older adults;
  - Specific training in psychogeriatric care has to be reinforced for all mental healthcare professionals;
  - A specific competency in old age psychiatry has to be created.

***Recommendation 4 to the attention to the Federated entities responsible for the healthcare and their respective governments and administrations***

- 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).

***Recommendation 5 to the attention to the Federal Minister of Social Affairs and Public Health and to the Federal Public Service Health, Food chain safety and 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.



***Recommendation 6 to the attention to the Federal Minister of Social Affairs and Public Health, to the Federal Public Service Health, Food chain safety and Environment and to the General Council of the RIZIV – INAMI***

- Mobile teams specialized in old-age psychiatry (third line) should be created
  - To provide care to older adults with complex mental health problems;
  - To share their expertise with other health professionals (eventually by means of new communication techniques).

***Recommendation 7 to the attention to the Federated entities responsible for the healthcare and the care of the elderly and the disabled and their respective governments and administrations***

- 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.

***Recommendation 8 to the attention 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***

- It is necessary to plan 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.

***Recommendation 9 to the attention to the Federal Minister of Social Affairs and Public Health, to the Federated entities responsible for the healthcare and their respective governments and administrations and to the Federal Public Service Health, Food chain safety and Environment***

- Specific campaigns are needed to sensitise healthcare professionals as well as lay people about
  - The specificity of old age mental health problems;
  - The importance to recognize, include and support informal caregivers in the planning and provision of care;
  - 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).

***Recommendation 10 to the attention 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 and to all services taking care of older adults with mental health problems***

- Data collection regarding mental health (care) for older adults needs to be optimised, especially in ambulatory settings and nursing homes (e.g. BelRAI tools).

***Recommendation 11 to the attention to research institutions***

- 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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'All experts consulted within this report were selected because of their involvement in the topic of "Mental healthcare elderly". Therefore, by definition, each of them might have a certain degree of conflict of interest to the main topic of this report'

Membership of a stakeholder group on which the results of this report could have an impact: Gérald Deschietere (Target population in consultation), An Haekens (VVP), Christophe Lafosse (Belgische Vereniging van Geriatrie en Gerontologie), Chantal Mathy (Nomenclature change - financial impact (INAMI – RIZIV)), Mary Quentin (SSMG, FAMGB – GGNO), Véronique Tellier (Mental healthcare services), Petra Thewes (Specific initiatives for the elderly of SSM), Rik Thys (Board member centre GGZ, about law Flanders), Robert Van Buggenhout (Vlaamse Vereniging voor psychiatrie, sector elderly psychiatrie), Patrick Vanneste (AVIQ), Sylvie Veyt (Influence on the SSM study)

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