

# Addiction & Mental Health and Seniors

Perspectives and Context

## Who we are?

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### Sandy (and Gloria) – Complex Needs Initiative

- a joint initiative between Alberta Health Services and Government of Alberta, Persons with Developmental Disabilities (PDD) to improve practice and outcomes for individuals receiving supports and services from both PDD and Alberta Health Services, mental health care.

# Complex Needs

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## Complex Service Needs:

*Eligible for services from PDD, pose a significant risk and/or are destructive to themselves, others or property. These individuals require intensive services **and** have, or have had a history of one or more of the following diagnosis or life experiences:*

- *A Mental health disorder*
- *Termination from services*
- *Specialized treatment for psychiatric and/or behavioral issues*
- *Multi-system involvement (i.e. Dementia related)*
- *Incarceration(s) or criminal justice involvement;*
- *Chronic substance abuse/dependency problems*

## Who we are

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Mollie Cole – Seniors Health - Strategic  
Clinical Network, AHS

Collaborate with clinicians/physicians, leaders,  
researchers across Alberta

Partnering with AH to develop and implement a  
**Dementia Strategy** for Alberta

Goal: Good Dementia Care

## Seniors Health – SCN – AUA project

GOAL: reduce antipsychotics in older residents with dementia in LTC

Intervention:

- Developed resources for care teams - **AUA Toolkit**
- Education to LTC teams – medication reviews; non-pharmacologic approaches
- measures of success

OUTCOME: Alberta has the lowest provincial average (18.8%)

SUSTAINABILITY: What is needed to keep 'low use' into future?  
Who will support teams to use non-pharmacologic approaches?  
How? What do we expect of leaders?

**What tools are needed to hire, mentor and provide feedback to staff?**

# What we share

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## Common Interactional Strategies

Individuals working with anyone with responsive behaviors ... we are more alike than different

Overlapping workforce

Similar client or patient presentations

# Best Case Scenario

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I am living where I want to live



I can go out and choose where I want to go



I have friends and family over to socialize at times of my choosing



I engage in meaningful and engaging daily activities

# The struggle

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The competence of front line staff is not as high as would be ideal (not to be confused with staff capabilities)

Caregiving skills and tasks are well defined yet do not provide competency to manage challenging/responsive behaviours

Unregulated and ungoverned workforce is the norm of staff members supporting clients living in community

Individualized wellness plans challenge even the most capable staff/staff teams



# The struggle

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“We only know what we know”

“My client/patients need me to do it for them”

“Anyone can do this job”

“If you’ve seen one, you’ve seen them all”

# What pajamas can teach us

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Imagine this...

- being in a foreign place and not being able to communicate
- eating something you don't like
- interacting with people who have different customs
- not knowing the language
- possibilities

Who am I?

# What pajamas can teach us

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Imagine this...

-having in front of you a patient who  
cannot

-a patient who  
importance  
decreases

-responsiveness and pacing, never asleep,  
even at night

Who am I?

# What pajamas can teach us

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Imagine this...

-connections are made – enduring,

some

-a c

you

hos

-you

feeling sad, what more should I or could I  
have done

Who am I?

# Best Case Scenario

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I am living where I want to live



I can go out and choose where I want to go



I have friends and family over to socialize at times of my choosing



I engage in meaningful and engaging daily activities

**Some competencies will allow staff to support these outcomes**

- Effective Communication
- Enhanced clinical skills related to my practice area
- Cultural Values and Diversity
- Client Centered care practices
- Leisure and Recreational practice skills

## Opportunities to work together

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- Individualized/unique care crosses our practice areas
- strength in working together across sectors, each group can build on similar strategies
- Sharing dementia and other competencies
- What practice area does this address?
- Fun exercise – demonstrate our thesis
- Good Work and productive problem solving



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## BSO Capacity Building The Right Tool at the Right Time

**Capacity Building Roadmap** helps plan the first 6 months of orientation for new staff. It is a framework to organize what staff need to know, when they need to know it and how they can learn it.

Capacity Building Roadmap Video



You need to **develop an individual learning plan.**

You need to **plan an orientation.**

**The Road Ahead** helps inform your decisions at any career point, supporting continuous learning for yourself or your staff.

The Road Ahead Video



### YOU ARE HERE.

You are likely interested in building capacity for an individual, team or organization to support person-centred care and enable system change for older adults with, or at risk for, responsive behaviours associated with complex mental health, addictions, dementia and other neurological conditions, and their caregivers.

The BSO project offers tools that support core competencies development, workforce learning and development programs, and better care at the bedside.

### HOW DO YOU KNOW WHICH TOOL IS RIGHT FOR YOU?

You need to **invest in education and training.**

You need to **develop an organizational education strategy.**

You need to **plan a**

You need to **continue with the next phase of training for your recent hire.**

You need a **conceptual framework for team-based**

# BSO Core competencies

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1 Knowledge	2 Personal-centered Care Delivery	3 Clinical Skills (including assessment, care planning & intervention)	4 Field-based Quality Improvement and Knowledge Transfer
5 Change Management Skills	6 Leadership, Facilitation, Coaching and Mentoring	7 Cultural Values and Diversity	8 Prevention and Self-Management
9 Resiliency and Adaptability	10 Collaboration and Communication	11 Technology Skills	12 Professional and Work Ethics



Competency	Awareness	Skill
Effective Communication		
Enhanced clinical skills related to my practice area		
Client Centered care practices		
Leisure and Recreational practice skills		
Cultural Values and Diversity		

<b>Competency</b>	<b>Awareness</b>	<b>Skill</b>
Effective Communication	Cognitive deficits are an outcome of advancing dementia	Speaking clearly and slowly with someone with a cognitive deficit
Enhanced clinical skills related to my practice area	Anti-psychotic medications have many side effects	Identify known, newly occurring or unexpected side effects
Client Centered practices	Person Centered planning has substantially better outcomes	Clearly document important preferences – i.e. If it is known that interrupting 6:00 news is a trigger, respect that wish and plan around it.
Leisure and Recreational practice skills	Client work and personal history and interests are known and documented	Introduce activities to match what is known about the client
Cultural Values and Diversity	Determine and document important cultural and known or possible sensitivities	Enhance planning to integrate known information

# What we share

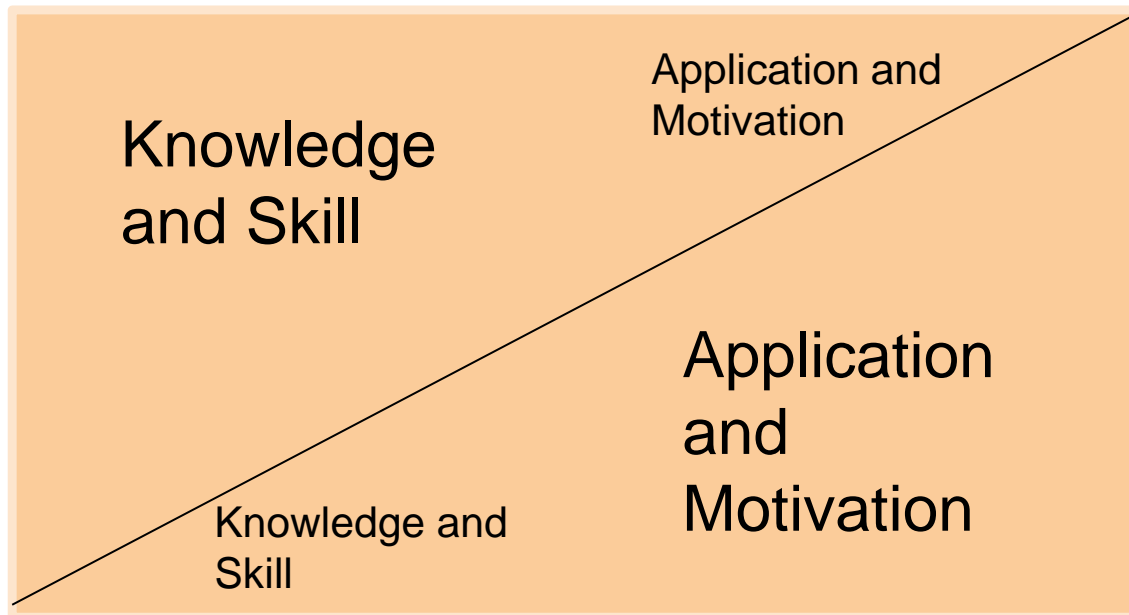
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Individual competence and the link:

- 1) What is needed to support staff to **know** and **do** the 'right thing' in practice
- 2) WHEN: hiring, mentoring, providing feedback

# Working together: educators/leaders

Educator (basic and continuing)



Manager/Leader

# Individuals work in teams

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How well do individuals work in to teams?

Address: “team” competencies

Manager/Leaders role and knowing what should be expected.... Of teams