

Mental health service delivery to older people in New South Wales: perceptions of aged care, adult mental health and mental health services for older people

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Objective: To compare the perceptions of aged care services, adult mental health services and mental health services for older people regarding aspects of mental health service delivery for older people in New South Wales, Australia.

Method: The NSW Branch of the Faculty of Psychiatry of Old Age in association with the NSW Centre for Mental Health, sent a postal survey to all aged care services, adult mental health services and mental health services for older people in NSW. The survey canvassed issues ranging across service profiles, regional variations, availability of resources, processes of care, views on working relationships between services, difficulties and gaps experienced, and ways to improve co-ordination and service delivery. Clinical issues such as the management and practice of psychiatric disorders of old age, educational/training requirements and skill and experience in working with older people were explored.

Results: An overall response rate of 86% was achieved, including 95% from aged care services (n = 58), 74% from adult mental health services (n = 62) and 90% from mental health services for older people (n = 20). Only 59% of aged care services and adult mental health services considered that their local mental health services for older people provided an adequate service; resource and budget limitations were portrayed as the main constraint. Mental health services for older people varied widely in structure, settings and activities undertaken. Access to mental health beds for older people was also variable, and alongside staffing levels was considered problematic. Lack of staff training and/or inexperience in psychogeriatrics posed a challenge for aged care services and adult mental health services.

Conclusion: Relationships between aged care services, adult mental health services and mental health services for older people are affected by lack of access to psychogeriatric staff, resource limitations of mental health services for older people, and inadequate liaison and support between the service types. Joint case conferences, education, increased funding of mental health services for older people, and cross referrals were considered ways to address these issues.

Key words: aged care, mental health, service delivery.

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The provision of public mental health services to older people is complex. Physical ill health, functional impairment, social isolation and organic mental disorders are common and contribute to a range of psychiatric presentations. The ageing process itself may colour both new and longstanding mental disorders. Hence older people with mental disorders are regularly seen in various health care settings including aged care, adult mental health and old age mental health.

The World Psychiatric Association (WPA) consensus statement on mental health service delivery for older people recognizes this diversity of entry points into mental health care and stresses the importance of co-ordination of services and partnerships between service providers [1]. Australia's Second National Mental Health Plan has echoed a similar theme [2]. Yet there has been relatively little research examining the way in which aged care, adult mental health and old age mental health services interact in service delivery. There have been anecdotal reports about how unilateral changes made by one type of service can adversely impact on another [3] and how resource deficiencies in one service can affect other services [4]. However, no detailed investigations or studies exploring the relationships between these types of services were found in the published literature.

In 1999, the NSW Government funded the NSW Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists to undertake a survey of mental health service delivery to older people in NSW. The main aim of the survey was to compare the perceptions of aged care, adult mental health and old age mental health services regarding delivery of services, available resources, processes of care, training requirements and directions for future service development in NSW. A secondary aim was to identify whether there were any regional variations in service delivery in NSW and whether there were any particular models of service delivery that worked well.

Method

All community-based aged care services (ACS), community-based adult mental health services (AMHS) and mental health services dedicated to older people (MHSOP) in NSW were identified. Permission was obtained from the Directors of Mental Health and Aged Care in each Area Health Service in NSW to conduct the research. At a late date the mental health services of one Area Health Service wanted the surveys to be subjected to a lengthy local ethics committee approval that would have delayed the entire project so we decided to exclude that service.

A questionnaire of current practice in mental health services to older people was developed. Information about the demography of each service area and the profile of each service and team was obtained. This included examination of the working relationships between ACS,

AMHS and MHSOP and covered areas such as access, level of support and co-ordination between services. Views were obtained on current challenges, constraints and gaps in service delivery and ways of improving and enhancing co-ordination, linkages and service delivery. The degree of access to private psychiatric services was also noted.

The questionnaire also canvassed the use of protocols, policies and routine practices for assessment and treatment of mood disorders, behavioural disturbance and suicide risk. The educational requirements of each service were explored.

Separate versions of the survey were developed to accommodate the different aspects of service provision by each of the three service types. It was revised following a pilot study in July 2000. Pilot results have been incorporated in the final analysis, except where questions were substantially changed or rating scales were altered. No substantial service structure changes occurred in this period. For questions where only post-pilot results were included due to the changes made to the questionnaire, the pilot cases were considered as missing data and the valid percentages were used to account for this.

The main survey was conducted in October 2001 through a mailed questionnaire. The service director or equivalent completed the majority of surveys.

Results

An overall response rate of 86% was achieved, with a 95% response from ACS (n = 58), a 74% response from AMHS (n = 62) and a 90% response rate from MSHOP (n = 20). Some AMHS non-responders indicated that they did not provide services to the over 65 years age group, but other AMHS that did respond also reported that they did not officially provide services to older people. Some AMHS had formed, or were in the process of forming, a small old age mental health subteam within their AMHS. For the purposes of this study, these services remained classified as AMHS and not MHSOP.

Regional distribution of services

Of MHSOP, 60% were located in the inner metropolitan area (n = 12), 30% in the outer metropolitan area (n = 6), and only 10% (n = 2) in rural areas. By contrast, 26% of ACS (n = 15) and 27% of AMHS (n = 17) were located in the inner metropolitan area, 23% of ACS (n = 13) and 18% of AMHS (n = 11) were in the outer metropolitan area, and 52% of ACS (n = 30) and 55% of AMHS (n = 34) in rural areas. Many of the rural ACS and AMHS teams were very small, often consisting of only one or two workers.

MHSOP service types

Sixty percent of MHSOP were integrated inpatient/community services, 20% were community services only, 10% were inpatient services only, one was a community consultation-liaison service, and one with limited inpatient beds for dementia was combined with community nurses located in three adult mental health teams. Few MHSOP were stand-alone services. Most were collocated with AMHS and ACS, with one service collocated with a palliative care and rehabilitation unit.

MHSOP activities

The activities undertaken by the MHSOP are shown in Table 1. A wide range of 'other' activities mentioned by respondents included

community development, health promotion, public policy consultancy, research drug trials and a 'shared care program'. One third of MHSOP ran memory clinics, and ECT clinics, dementia day care and depression clinics were also mentioned.

MHSOP beds

A range of 0–22 acute inpatient beds was available to MHSOP with a median of 10, while the number of long stay beds available to them ranged from 0 to 65, with a median of 0. For those MHSOP with an inpatient component, 60% had dedicated MHSOP beds, 40% had beds in AMHS, 13% had beds in CADE units 7% had beds in geriatric medical wards and 7% in residential care facilities.

Community MHSOP staffing

Community MHSOP had varying levels of staffing with 75% of services having a psychogeriatrician and a further 10% having general

psychiatrists. Registered nurses were present in 75% of services. Other health professionals included social workers (40%), psychologists (35%), occupational therapists (15%) and medical officers (15%), with all services having at least one allied health professional on the team, though often this was only part-time.

Challenges, difficulties and constraints facing ACS, AMHS and MHSOP

Viewpoints of ACS, AMHS and MHSOP were elicited and compared on various aspects of mental health service delivery to older people in the Area Health Services where MHSOP were present (Table 2). As the catchment areas of the teams varied, the number of services represented in each Area Health Service differed. While there was general conformity between the three types of services about the main issues, a much higher proportion of MHSOP identified staff shortages and budgetary constraints as a problem. Aged Care services and

Table 1. Type of activities undertaken by the MHSOP

Activities undertaken by MHSOP	Percentage (n = 20)
Consultation and liaison in hospitals	100
Patient and family education	100
Training for health professionals	95
Community based assessment	90
Inpatient assessment	90
Assessment in institutional and residential care	90
Prescribing and monitoring medication	90
Inpatient treatment and management	80
Community based treatment and management	75
Treatment and management in institutional or residential care	75
Counseling	75
Arrange community supports	75
Outpatient clinics	70
Assist with placement	70
Crisis intervention	60
Research	55
Provide residential respite care	30
Provide specialized day programs/clinics	20
Other activities	25

MHSOP, mental health services dedicated to older people.

Table 2. Challenges, difficulties and constraints facing ACS, AMHS and MHSOP in providing services to older people with mental health problems

Challenges, difficulties and constraints	ACS % (n = 34)	AMHS % (n = 38)	MHSOP % (n = 20)
Limited access to psychogeriatric service/psychogeriatrician	44	26	20
Staff shortages including recruitment problems	24	24	60
Budget/resource shortages and constraints	35	32	70
Staff inadequately trained or inexperienced in psychogeriatrics	21	29	10
Psychogeriatric bed shortages (acute and assessment beds)	21	13	25
Shortages of long stay beds or nursing home beds	9	18	10
Poor liaison between aged care and mental health	15	16	15
Lack of clear guidelines	18	11	0

ACS, aged care services; AMHS, adult mental health services; MHSOP, mental health services dedicated to older people.

AMHS more often identified lack of staff training and/or inexperience in the field of psychogeriatrics as issues.

Opinions on gaps in services were also obtained. The issues identified were similar to those listed in Table 2, though the lack of community/integrated services was particularly noted by MHSOP (40%) and AMHS (24%) but was not of major concern to ACS (9%). Mental health services dedicated to older people were also more perturbed about the lack of acute beds (40%) than were ACS (32%) or AMHS (16%).

Fifty percent of ACS and MHSOP believed that a larger budget was required for psychogeriatrics, whilst a considerably smaller percentage of AMHS held this view. There was general agreement between services about the need for improved access to staff specializing in psychogeriatrics (Table 3).

Mental health services dedicated to older people were particularly keen for liaison between services to be improved. Both MHSOP and AMHS were more eager than ACS to achieve this through a model involving joint assessment/management and closer networking/planning than ACS. Aged care services preferred site visits or rotations which was not favoured as much by MHSOP or AMHS. However, MHSOP and ACS tended to have similar views on collocation of services and a more appropriate budget as opposed to AMHS. Protocols were not strongly favoured.

Working relationship of ACS and AMHS with the MHSOP

Aged care services and AMHS that had a local MHSOP were asked about their working relationship with the MHSOP (Table 4). Aged care services reported that they were collocated with the MHSOP in 57% of cases, while AMHS reported collocation in 37%. On most parameters, ACS recounted greater use of, and contact with, their local MHSOP than the AMHS. While ACS described that they received much more support from the MHSOP than the AMHS, a similar high proportion of each (ACS 85%, AMHS 91%) desired extra support in all categories covered in Table 4.

Difficulties experienced by ACS and AMHS in relation to the local MHSOP

Sixty-seven percent of ACS and 58% of AMHS reported difficulties in referring older people to the MHSOP. Over 50% of both services

reported that referral difficulties related to staff shortages and constraints in the MHSOP. In some cases the MHSOP was a sole worker with only a monthly visit from a psychogeriatrician. Limited inpatient facilities were another problem, particularly for ACS but less so for AMHS. This often became an issue for ACS when there were patients in residential care with behavioural disturbances that were regarded by residential care staff as being unsuitable for the residential care setting. For rural services, distance commonly posed difficulties for referral. Some AMHS encountered disputes regarding age and appropriateness of referrals, for example 'graduate' patients with chronic mental illness with onset before age 65 years. Overall, 59% of both types of services believed that MHSOP provided an adequate response.

Two-thirds of ACS and 43% of AMHS felt that their relationship with the MHSOP could be improved by better access to MHSOP staff. Substantially more AMHS than ACS felt that better liaison with MHSOP was the way to improve their relationship. Both types of services felt that joint educational sessions would be helpful.

Mental health services dedicated to older people also had some difficulties in their working relationships with AMHS and ACS (Table 5). These were more pronounced with AMHS than ACS, with 83% of MHSOP wanting more support from AMHS and 72% from ACS. Joint case assessment and management, after hours and crisis support were felt to be needed.

Difficulties experienced by MHSOP in relation to their local ACS and AMHS

Mental health services dedicated to older people described more difficulties in their relationship with AMHS than with ACS. Almost 75% of MHSOP reported difficulties referring older people to their AMHS. This mainly involved patients with dementia, delirium and challenging behaviours, to an inpatient setting. Some services commented that their AMHS refused to provide any crisis services to older people. There were also disputes over 'graduate' patients with chronic mental illness. In contrast, only 37% of MHSOP reported difficulties in referrals to ACS, mainly in situations when the patient was psychotic, a suicide risk or had particularly aggressive behaviour. Staff shortages were also mentioned as problematic.

More liaison and case discussions and better access to AMHS and ACS staff were ways most frequently mentioned by MHSOP to improve the relationship with their AMHS and ACS. While collocation

Table 3. Changes or improvements advocated for mental health service delivery for older people by all service types

	ACS % (n = 34)	AMHS % (n = 38)	MHSOP % (n = 20)
Bigger budget dedicated to psychogeriatrics	50	24	50
Access/more access to dedicated psychogeriatric staff/psychogeriatrician	38	37	25
Dedicated psychogeriatric community team	9	21	20
More access to acute/assessment psychogeriatric beds	15	13	25
Long-term psychogeriatric beds or a special psychogeriatric nursing home	18	8	25
Need for increased/improved liaison with other services	18	8	35
More in-service training/education	12	16	10
Integration of aged care and mental health services	12	13	5

Table 4. Percentage use of MHSOP by ACS (n = 34) and AMHS (n = 38)

	Service	Often	Sometimes	Rarely	Never
Extent to which MHSOP is used	ACS	72	24	3	0
	AMHS	24	59	15	3
Acceptance of referrals by MHSOP	ACS	88	6	6	0
	AMHS	54	39	7	0
Crisis Intervention/After hours service by MHSOP	ACS	8	31	23	39
	AMHS	12	15	19	54
Routine discussions, scheduled network meetings	ACS	79	7	14	0
	AMHS	15	26	37	22
Joint assessments	ACS	75	13	6	6
	AMHS	15	41	37	7
Joint case management	ACS	53	27	7	13
	AMHS	11	37	26	26
Case conferences	ACS	56	25	13	6
	AMHS	15	26	41	19
Joint training sessions	ACS	33	33	13	20
	AMHS	12	8	48	32
Consultation and/or MHSOP support	ACS	81	13	6	0
	AMHS	31	42	19	7

ACS, aged care services; AMHS, adult mental health services; MHSOP, mental health services dedicated to older people.

Table 5. Percentage response of AMHS and ACS to MHSOP (n = 20) requests

	Service	Often	Sometimes	Rarely	Never
Acceptance of referrals	ACS	90	9	0	0
	AMHS	8	67	17	8
Crisis Intervention/After hours service	ACS	27	36	0	36
	AMHS	33	58	8	0
Routine discussions, scheduled network meetings	ACS	64	18	18	0
	AMHS	0	33	33	33
Joint assessments	ACS	46	46	0	9
	AMHS	0	25	58	17
Joint case management	ACS	36	36	18	9
	AMHS	0	58	42	0
Case conferences	ACS	36	9	27	27
	AMHS	0	17	50	33
Joint training sessions	ACS	45	27	27	0
	AMHS	8	25	25	42
Consultation and/or support	ACS	82	9	9	0
	AMHS	9	42	33	17

ACS, aged care services; AMHS, adult mental health services; MHSOP, mental health services dedicated to older people.

was mentioned as a way to improve relationships with ACS, this was less frequently mentioned with regard to AMHS. Joint educational sessions were mentioned for both services.

Accessibility of private psychiatrists was a problem for all services, particularly in rural NSW where 40% of services reported they were not at all accessible as compared with 17% of metropolitan services. Thus 33% of rural services never referred and 32% rarely referred to private psychiatrists, as compared with 7% metropolitan services never referring and 47% rarely referring.

Discussion

The results of these surveys emphasize the complexities of mental health service delivery to older people in NSW. In part this appears to be due to the marked variability in size and distribution of MHSOP in NSW. Aged care services and AMHS rated only 59% of MHSOP as providing an adequate service, with the main

reason cited for service inadequacy being resource limitations and budgetary constraints. These result in inadequate staffing of community MHSOP where few have multidisciplinary teams. Community work is often bi-disciplinary, being undertaken mainly by a psychiatrist and/or nurse. Case management is often not feasible and many services operate in a consultative model.

This is not surprising given the low budgetary allocation for NSW mental health services in general, and MHSOP in particular, as compared with other states and territories of Australia. In 1997–1998, per capita expenditure on aged care psychiatry services in NSW was \$76.21 as compared with the national average of \$102.91 [5]. We believe that increased resource allocation to MHSOP is necessary to address these concerns. Multidisciplinary teams with sufficient resources for case management in the community and more dedicated inpatient beds are needed.

As a consequence, it is essential that ACS, AMHS and MHSOP establish good working relationships in order to fill the inevitable gaps that exist. While the surveys indicate that efforts are being made to achieve this, they also highlighted some areas of concern. The relationships that exist between MHSOP and ACS seem to be smoother than those experienced between MHSOP and AMHS. This may be partially due to the more frequent collocation of MHSOP and ACS, but also probably reflects the closer functional relationships of the services. Joint assessments, case conferences and management procedures are more likely to occur between MHSOP and ACS. Mental health services dedicated to older people report that ACS are more responsive to their needs than AMHS. Where resource deficiencies exist for MHSOP, particularly for inpatient beds and crisis services, the response of AMHS is perceived at times as being unsupportive.

Unfortunately, the private sector does not appear to be able to fill the gaps, with very poor access especially in rural areas and relatively few referrals being made, in both metropolitan and rural areas. This is confirmed by recent findings that private psychiatric service provision to older people in NSW is well below the national average [6].

The survey results indicated that services appear to be keen to improve their working relationships. Better liaison between services, easier access to staff, joint assessment and management, and joint educational and training sessions were most frequently mentioned as ways to achieve this. Mental health services dedicated to older people were more likely to believe that collocation

could improve relationships with ACS than with AMHS, probably reflecting their mostly functional relationships. Protocols and guidelines were not favoured by many services as an effective approach for cultivating enhanced working relationships. This might be because NSW Health has inundated services with protocols and guidelines in recent years without necessarily providing the resources to implement them. Hence they are viewed with scepticism. Despite expressing what they would desire from the working relationship, it was not clear from the surveys whether any specific action was being taken by services to actually enhance or improve these relationships.

A limitation of these surveys is that they were addressed to service managers. In many cases we know clinical service directors completed them and are likely to be reasonably reflective of actual clinical practice but this may not be the case for others. This may have impacted on the uniformity of the data gathered. Although the survey was piloted in rural and urban services, the reliability of the survey responses is unknown.

In conclusion, the relationships between MHSOP, AMHS and ACS in NSW are complex and periodically strained though there appears to be an underlying goodwill and desire to improve them. Systemic deficiencies are apparent, underpinned by a lack of resources.

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References

1. Wertheimer J. Psychiatry of the elderly: a consensus statement. *International Journal of Geriatric Psychiatry* 1997; 12:430–435.
2. Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.
3. Baker AA, Byrne RJF. Another style of psychogeriatric service. *British Journal of Psychiatry* 1979; 130:123–126.
4. Draper B. The elderly admitted to a general hospital psychiatry ward. *Australian and New Zealand Journal of Psychiatry* 1994; 28:288–297.
5. Commonwealth Department of Health and Aged Care. *National mental health report 2000: sixth annual report. Changes in Australia's mental health services under the First National Mental Health Plan of the National Mental Health Strategy*. Canberra: Department of Health and Aged Care, 2000.
6. Draper B, Koschera A. Do older people receive equitable private psychiatric service provision under Medicare? *Australian and New Zealand Journal of Psychiatry* 2001; 35:626–630.