Chapter 4

MODELS OF MENTAL HEALTHCARE AND ORGANISATIONAL ISSUES

INTRODUCTION

Although there is evidence for the effectiveness of older persons' mental health services (OPMHS) (Draper 2000), the most effective components of such services have not yet been clearly identified. There are many different ways to deliver community mental health services to older people. This chapter covers models of care delivery and associated organisational issues. It assumes the presence of a national health service with universal access.

AREA-BASED SERVICES

In countries with national health systems, such as Australia, New Zealand and the United Kingdom, most public sector mental health services are organised and delivered within a defined geographical area or district. Inpatient beds and mental health teams are generally provided on an historical basis with forward planning of both bed numbers and community teams determined by population data. Subspecialty mental health services such as OPMHS teams are a more recent phenomenon and in many places have been grafted on to adult mental health services.

The OPMHS is likely to see people with a wide variety of mental health problems. However, in comparison with adult mental health services, the older persons' service is likely to see a higher proportion of women and more people with mood disorders and cognitive disorders.

In more fortunate districts, acute inpatient mental health facilities for older people have been purpose-built and are co-located with geriatric medical services. More commonly, however, older people with mental health problems are admitted to general adult inpatient wards. This is often a rather unsatisfactory situation because the needs of younger people with, for example, acute psychosis are quite different from the needs of older people with, for example, severe depression. Because of their physical frailty, older people are vulnerable to falls. Some older people with cognitive impairment are prone to wander into other people's rooms, precipitating retaliatory assaults. In addition, older inpatients often require substantially more physical nursing care and more medical interventions, mandating a quite different staffing mix. Wards with mixed groups of younger and older people often have difficulty providing for the needs of each group.

Because community mental health services for older people are a relatively new phenomenon in most places, their implementation has generally been planned. However, some districts have autonomous community-based services and others have integrated hospital and community services. This particular issue is dealt with in more detail in Chapter 5.

While larger provincial towns often have their own OPMHS, in rural and remote regions, mental health services for older people are generally provided by a lone mental health worker who must cover a vast geographic area, usually in an off-road vehicle. In some rural locations, there are fly-in fly-out mental health teams that augment the work of the local worker.

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INTEGRATED HOSPITAL AND COMMUNITY SERVICES

An integrated model of hospital and community care is useful for the management of complex problems in older people with serious mental health problems such as major depression with psychotic features, bipolar disorder with comorbid physical problems such as Parkinson's disease, and very late onset schizophrenia-like psychoses complicated by dementia. In each example, the combination of complexity and severity mandates access to hospital beds, but chronicity mandates assertive community follow-up. In such cases, the integrated hospital and community model allows essential continuity of care.

In integrated hospital and community care, the inpatient and community parts of the service share personnel, have common team meetings and share case notes. In an integrated service, the hospital team knows well the strengths and limitations of the community team and can better judge when it is appropriate to discharge a person. Similarly, the community team knows well the strengths and limitations of the inpatient team and can better judge which people are likely to benefit from inpatient care. The community team might also be better able to judge when an illness has reached the stage where inpatient care is needed. In addition, access to certain types of treatment, including electroconvulsive therapy (ECT), is often restricted to inpatient units.

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For practical reasons, not all personnel can be shared. For instance, the requirement of shiftwork for most inpatient nursing personnel means that they are less likely to be able to participate much in community care. However, most allied health workers such as social workers, occupational therapists and clinical psychologists are able to work across the inpatient and community parts of the service. Similarly, most medical personnel, including psychiatrists and trainee psychiatrists (registrars), are able to work across both sectors. It is also often feasible to rotate nursing and junior medical staff between community and inpatient roles so that they are familiar with both.

In integrated services, team meetings (including ward rounds) are attended by representatives from the inpatient unit and from the community team. In some services, completely integrated meetings are held in which inpatients and those people in the community are discussed, although these can be rather lengthy. In other integrated services, separate team meetings are held with the inpatient and community teams, with representatives from the other team in attendance. There are great advantages in having cross-representation at team meetings or ward rounds. These include both teams having advance notice of impending admissions and discharges, and a larger group of health workers to share the responsibility of providing care for challenging people.

One major advantage of integrated services is the early involvement of community case managers in the care of inpatients who have not previously been case managed and

the continuing involvement of community case managers where the person has been admitted from their care. Early engagement of case managers during the inpatient phase of clinical care can greatly facilitate discharge planning and allow this to begin at the time of admission.

Community case managers bring with them a wealth of knowledge about individuals and this can be used to facilitate an early commencement of inpatient treatment, as work-up time can be minimised. Community case managers can often introduce the person to the inpatient unit and the inpatient staff. They can also introduce the person's family to the inpatient team. Each of these steps has the potential to make the transition to inpatient care less traumatic for the person and their family. It might also make the whole inpatient treatment phase more efficient, with reduced length of stay.

There is nothing more irritating to busy mental health workers than missing clinical files. These are a common occurrence when hospital and community mental health services within the same geographical area insist on having separate and independent clinical files. One essential feature of an integrated hospital and community mental health service for older people is a single integrated clinical file. Ideally, this would be an electronic file but, at the time of writing, in most jurisdictions this will still be a physical chart. Preferably, this clinical file should be the same file used by district medical and surgical services, so that a holistic approach can be taken to mental and general healthcare.

One perennial question is: Who covers the after-hours roster? In many mental health services, the OPMHS team is too small to cover nights and weekends in its own right, so this task is covered by a shared roster to which all teams contribute.

Australian experts (Snowdon 1993, Snowdon et al 1995) have recommended the provision of eight acute inpatient beds per 100,000 of the total population for older people with mental health problems, and British experts (Royal College of Physicians and Royal College of Psychiatrists 1989) have recommended the provision of 15 beds per 100,000 total population. However, planning documents in Australia generally specify the provision of approximately four acute inpatient beds per 100,000 of the total population for older people with functional mental health problems. They usually make no allowance for inpatient mental health beds for older people with dementia associated with severe behavioural and psychological symptoms. The net effect is that districts often have too few acute inpatient beds for older people with mental health problems, including dementia. Similarly, planning documents often specify approximately four full-time equivalent (FTE) older persons' community mental health staff per 100,000 of the total population, rather than a number based on the number of older people and the likely prevalence of mental health problems.

PRIVATE SECTOR SERVICES

In most countries with well-developed public mental health systems, there are also private practitioners providing fee-for-service mental healthcare. In Australia, there is a flourishing private sector involving mainly psychiatrists and clinical psychologists, with smaller numbers of social workers and occupational therapists in independent private practice. There is also a relatively large number of private psychiatric hospitals, many of which are now providing community outreach services to people with private health insurance. Public sector and private sector services often need to work together to provide optimal care for people. In Australia, people with private health insurance

cover have the option to be admitted to a private psychiatric hospital and have private community follow-up or to be admitted to a public hospital and have public or private community follow-up.

Contemporary private psychiatric hospitals generally have a multidisciplinary staff consisting of mental health nurses, clinical psychologists and occupational therapists. Although some private hospitals employ psychiatrists or psychiatric registrars (trainee psychiatrists), others rely on visiting psychiatrists for their medical input. Many also have visiting general practitioners and general physicians. Care arrangements can sometimes be complex and it is important for mental health services to avoid a silo mentality in which it is difficult for people to move between public and private healthcare providers.

WHO CARES FOR THE 'GRADUATES'?

The term 'graduates' has been used to describe those people with early-onset psychotic disorders, particularly chronic schizophrenia, who make it into old age. Because of higher mortality rates among young and middle-aged people with chronic psychoses, it is a select group who live through to later life. These individuals often have complex care needs and longstanding relationships with adult mental health teams. Thus, the question which arises is whether they should continue to be cared for by their adult mental health team or transfer to the care of an OPMHS team when they reach 65 years, or whatever age of transition is used locally.

The principle of continuity of care would argue in favour of their staying with their adult team, as they are likely to know them well. However, older people with early-onset psychotic disorders often have significant general medical problems due to risk factors such as smoking and obesity, and poor access to general practitioners. OPMHS are often more used to addressing the physical health needs of older people and often have better links with general practitioners and geriatricians. As the older person with an early-onset psychotic disorder ages, they may develop increasing frailty associated with gait disorder and dementia. They may need to have access to community aged care services, including home-delivered meals, home help and in-home respite services. Some will ultimately need residential care. All of these services are likely to be very familiar to the older persons' team, and so this is an argument in favour of transferring the care of the older person with an early-onset psychotic disorder to an OPMHS team.

WHO CARES FOR PEOPLE WITH DEMENTIA?

As the population ages, the number of people with dementia will increase significantly. Some of these people will have clinically significant problems with their mental state or behaviour. These problems are known collectively as the behavioural and psychological symptoms of dementia (BPSD) (see Ch 28). An important issue for any OPMHS is the extent to which it will be responsible for the assessment of older people with BPSD. Most OPMHS take the view that BPSD is core business for their service and spend much of their time on the assessment and management of such people. However, many people with dementia do not have clinically significant BPSD and it is debatable whether those with uncomplicated dementia should be dealt with by mental health services. There is a good argument for people with uncomplicated dementia to be managed by their general practitioners with the assistance of a memory clinic. Specialised driving

assessment clinics, often run by occupational therapists, are generally beyond the scope of the OPMHS.

Younger people with dementia should be assessed by clinicians with specialised knowledge of this area. If there is a local memory clinic or some other type of specialised dementia assessment service, then this should be used to undertake the work-up and confirm the diagnosis. Later on in the clinical course of early-onset dementia, there are often issues with BPSD, and the OPMHS is likely to be in a good position to offer advice and support.

TRANSCULTURAL ISSUES

In larger OPMHS teams it may be possible to employ some workers with a similar ethnic or language background to the main minority groups in the local community. However, in smaller teams this is often not possible. In such cases, it is essential to have access to transcultural mental health workers who can conduct specialised mental health assessments in the person's own language. If such transcultural mental health workers are not available, it is useful to have access to professional interpreter services, either in person or on the telephone.

SOURCES OF REFERRALS

From whom should community OPMHS teams accept referrals? Although specialist medical services traditionally accept referrals only from other doctors, this model is not appropriate for OPMHS. Legitimate referrals may come from a host of different sources, including the older person themselves, their family members, their local doctor, a community health worker, staff from an adult mental health service, nursing personnel from a local residential aged care facility (RACF), and the local police station. Many OPMHS require that the person's general practitioner is aware of the referral to minimise frivolous referrals and to allow for easy handover to the general practitioner when the OPMHS has completed their episode of care.

DOMICILIARY OR CLINIC-BASED CONSULTATIONS

Although many adult mental health teams conduct most of their consultations in hospital outpatient departments or centralised clinics, domiciliary consultations (home visits) seem to come naturally to OPMHS community teams. In most instances, more clinically relevant information is obtained from a home visit than from a clinic visit. On home visits, the person's partner or adult child is often present and able to provide collateral information. On home visits, the OPMHS clinician can observe the living environment and see if any delusion-based modifications have been made (e.g. to exclude poison gas from getting in through the cracks around the front door). The kitchen can be checked for the adequacy of food supplies and the back veranda can be checked for empty alcohol bottles. On a home visit, the older person should have ready access to their spectacles and hearing aids. The clinician should be able to directly examine the Webster Pak® or Dosette® box, or look at the medication containers. The clinician can also look for hazards in the home, such as loose runner carpets or dangers in the kitchen.

Occasionally, the clinician will not be able to enter the house or apartment because of the extent of hoarding or because the person has frank persecutory delusions. However,

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clinic or hospital visits should generally be reserved for those, usually younger, older people who are particularly concerned about their privacy or have serious dependency issues.

CASE MANAGEMENT MODEL

The traditional case management model involves the use of mental health workers (usually registered nurses, social workers, occupational therapists and clinical psychologists) to conduct community-based assessments, devise management plans and implement time-limited case management. In this model, most contact with the person is made by the case manager, who obtains the assistance of other personnel as needed. Under such a model, the medical staff is used in the initial work-up of the person and in regular reviews at 3-month intervals. The case manager visits the person at home and makes regular telephone contact between home visits. The case manager reports back at regular intervals to team meetings about the person's progress. In OPMHS teams, the case managers also provide education and support to carers and family members of the person.

CONSULTATION–LIAISON MODEL

In the community-based consultation–liaison model, mental health workers are consulted by general practitioners, by community health workers or by RACF personnel to assess a person under their care and make recommendations for future management. In some places, particularly where no inpatient mental health service exists, a community mental health service might provide consultation–liaison services to hospital medical and surgical wards. Occasionally, an OPMHS would be engaged in this role. In all of these versions of the consultation–liaison model, the person remains under the care of the referrer. Quite often, the problems raised by consultative requests are common to more than one of the people referred by an individual referrer and allow the possibility of providing more general clinical advice to the referrer. This might take the form of impromptu educational sessions or planned training workshops for staff.

THE DAY HOSPITAL

Day hospitals were once widely used in mental health services, although they are no longer considered to be an essential component of adult mental health services. Day hospitals are still used by geriatric medicine services, as they allow older people access to a wide range of nursing and allied health interventions without requiring a hospital admission. Although still popular in the United Kingdom (Hoe et al 2005), there is limited evidence for the efficacy of day hospitals in the OPMHS context. In Australia, community mental health teams have largely replaced day hospitals for the ongoing management of people with functional mental health problems. Similarly, various forms of respite care, including centre-based day respite, have replaced day hospitals for the care of people with dementia.

THE MEMORY CLINIC

Memory clinics assess and manage people with cognitive complaints, including people with subjective memory complaints, mild cognitive impairment and dementia. Older people attending memory clinics tend to be a little younger (mid-70s) than older

people seen by an OPMHS (late 70s). Memory clinics are generally run on a multidisciplinary and multispecialty basis. They are often staffed by geriatricians, psychogeriatricians, neurologists, neuropsychologists, nurses and social wokers. The availability of a local memory clinic is likely to reduce the workload of geriatric medical services and OPMHS. However, the memory clinic will be a source of referrals to the OPMHS, as some people with dementia will go on to develop clinically significant BPSD. Similarly, when older people with uncomplicated dementia are referred to the OPMHS, they can be referred on to the memory clinic, which is likely to have better resources for the assessment and management of such people.

RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities (RACFs) provide care for older people with dementia and other chronic disabilities. In the Australian setting, they may provide either high care (nursing home care) or low care (hostel care), or both. They are often locked to prevent the egress of confused older people. Community mental health teams work closely with the staff of RACFs, as many older people with challenging behaviours and other mental health problems reside in aged care facilities. Residents of aged care facilities commonly have mental health problems (McSweeney & O'Connor 2008) and are often prescribed psychotropic medications (Snowdon et al 2006). In some places, specialised psychogeriatric RACFs are managed by the OPMHS. This arrangement has the potential to allow greater flexibility in managing acute inpatient beds and the longer term management of older people with severe mental health problems, including BPSD.

INVOLUNTARY CARE IN THE COMMUNITY

Involuntary care in the community is a well-established part of community mental healthcare and at first glance seems to be a sensible practice. It is designed to maintain a least restrictive approach to involuntary treatment and to minimise frequent readmissions to hospital of people with serious mental health problems. However, the available evidence suggests that it actually reduces neither admissions nor bed days (Kisely et al 2007). Nevertheless, involuntary treatment in the community is a normal part of the role of the OPMHS team. Thus, the model of care adopted by OPMHS teams needs to take into account the requirements of the local Mental Health Act in relation to involuntary care in the community. In practice, this means that all clinical staff will need to understand the involuntary provisions of the Mental Health Act and sufficient staff will need to be authorised under the Act to carry out the procedures required by the Act. Similarly, many people being cared for by the OPMHS team are likely to be under guardianship and administration orders. Such orders may dictate where they can live and their access to money. Thus, OPMHS personnel will need to develop good working relationships with personnel from the local office of the Adult Guardian (or equivalent).

THE POLICE SERVICE

The police service comes into frequent contact with older people with mental health problems. The police are asked to assist when older people are found wandering in the street and when older people assault others. Older people often call the police to complain about their neighbours and many of these complaints turn out to be due to

persecutory delusions. OPMHS teams often need to call the police for assistance in transporting people who are being taken involuntarily to hospital and in gaining entry to houses and apartments when it is suspected that an older person may have come to harm.

SOCIAL AND COMMUNITY SERVICES

The well-functioning OPMHS will need to have collaborative relationships with income support services and with accommodation services. The latter might include providers of private hostel accommodation, providers of emergency accommodation as well as the local public housing provider. Similarly, the OPMHS will have collaborations with community health providers, including those providing domiciliary nursing care, and providers of respite care. Thus, it is clear that the health and welfare milieu in which the OPMHS team operates is a complex one.

SUMMARY

Older people with mental health problems are seen in a wide variety of clinical and non-clinical settings, each with its own model of care. The complexity of these arrangements is magnified by differences in funding models between the public and private sectors. In the ideal situation, a district will have a public sector, integrated hospital and community mental health service for older people. In some locations, there will also be private sector mental health services.

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FURTHER READING

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