Accessibility and effectiveness of mental health care for older adults

Summary
Chapter 1 is the general introduction of this thesis. In older adults (65 years and older) mental disorders are highly prevalent. The presence of mental disorders in older adults has serious negative consequences for the older adults themselves and their environment. This marks the importance of treatment of these disorders in this population. However, there are several factors that can prevent older adults from receiving the appropriate care, such as: older adults themselves do not acknowledge that they have mental health problems, general practitioners (GP) do not recognize the presence of mental health problems, or older adults are not referred to specialized mental health care when needed.

Over the years, several initiatives have taken place to improve mental health care in general and to older adults specifically. For instance, guidelines have been developed for professionals in general practice and specialized mental health care to improve the diagnosis and treatment of mental disorders. In addition, several measures were taken by the Dutch government to influence the accessibility and quality of mental health care. Amongst these were measures to promote treatment in primary care instead of specialized mental health care and an agreement with relevant parties in the field to increase transparency of the effectiveness of the care provided with a nationwide Routine Outcome Monitoring (ROM).

This thesis aims to add to the improvement of the accessibility and effectiveness of specialized mental health care for older adults. With regard to the accessibility is studied which developments took place in the identification and treatment of mental health problems in older adults by GPs (chapter 2) and which developments took place in the number of older adults who used specialized mental health care and the type of care they received (chapter 3). To improve our understanding of the effectiveness of the specialized mental health care provided, we developed our own ROM-system, called the MEntal health care Monitor Older adults (MEMO). Chapter 4 describes the design of MEMO and which clients are monitored. Clinicians’ perspectives on the procedures of MEMO are also studied (chapter 5), as are the psychometric properties of the primary outcome measure of MEMO, the Health of the Nation Outcome Scales for Older Adults (HoNOS 65+; chapter 6). In the next chapters is studied whether older adults profit from the mental health care they received and which factors predict outcome (chapter 7) and treatment duration (chapter 8).

Chapter 2 describes developments between 2002 and 2010 in the identification and treatment of mental health problems by GPs. For this purpose data from the NIVEL Primary Care Database were used. The study showed that overall there was no change in the prevalence of mental health problems as registered by GPs. The prevalence of
some specific diagnoses increased (dementia and alcohol abuse), while others decreased (anxiety and emotional distress). The former could be related to an actual increase of these problems among older adults due to a cohort effect (alcohol abuse) and population ageing (dementia). The latter could be related to decreased prescribing of benzodiazepines for anxiety and emotional distress, since these medications were no longer reimbursed by the basic health insurance. This could have made registration of these diagnoses by the GP less urgent. Furthermore, the study showed that referral rates of older adults with mental health problems to specialized mental health care increased, while referral rates to other primary care providers remained consistently low. This was a remarkable finding, since the Dutch government was already promoting the treatment of mental health problems in primary care instead of specialized mental health care at the time the data for this study were collected. However, considering that the referral rates to specialized mental health care were lower compared to younger age groups, despite the high prevalence rates of mental disorders in later life, this increase was considered to be in the use of resources.

Chapter 3 describes developments in the number of older adults who used specialized mental health care and the type of care they received in the period 1990–2004. This study was based on data from the Psychiatric Case Registers (PCRs) and showed an increase in the numbers of older adults treated in specialized mental health care. This increase could not be fully ascribed to an ageing society, since the proportion of older adults receiving specialized mental health care had also risen. Possible explanations for this finding are a decline in the availability of informal care, a cohort effect, or the introduction of new interventions for people who had previously gone untreated. Finally, better recognition of mental disorders by older adults themselves and GPs may also have contributed to this phenomenon. Furthermore, the study showed that until 2002, deinstitutionalization of mental health care for older adults took place, with the result that older adults received more outpatient care instead of inpatient care. As a consequence, treatment could be provided to a larger group without a rise in costs.

Chapter 4 shifts to measuring effectiveness of outpatient mental health care for older adults, since the study in chapter 3 showed that the majority of older adults in specialized mental health care received outpatient care. Since no data were available to shed light on whether older adults benefit from this care, we developed MEMO. Fifteen mental health care organisations throughout the Netherlands participated in MEMO. Clients with gerontopsychiatric disorders (i.e. no dementia or other cognitive disorders as a primary diagnosis) referred to the department of old age psychiatry in the participating mental health care organizations were included. They were assessed at baseline and
monitored at 4, 8 and 12-month follow-up, so called ROM. For all clients, mental and social functioning were measured with HoNOS 65+. Clients with a depressive disorder were additionally monitored with the 15-item version of the Geriatric Depression Scale (GDS-15). Data collection was supported by a web-based system for clinicians, which enabled direct feedback to the clinicians to monitor clients throughout treatment. Data from MEMO showed that older adults who entered outpatient specialized mental health care were relatively more often female, single and older compared to the general population (chapter 4). Somatic comorbidity was highly prevalent among clients who entered specialized mental health care, which adds to the complexity of pharmacological treatment. It was found that older immigrants were not sufficiently reached, which is most likely explained by cultural barriers, such as stigma and denial.

Chapter 5 evaluates clinicians’ perspectives on the procedures of MEMO. A survey showed that they found the procedures workable, but they hardly used the graphical feedback from the web-based system. Integration of the direct feedback into the electronic patient records and more training on the interpretation and use of feedback in daily practice were seen as primary issues for further improvement. Furthermore, many clinicians appreciated the support of a research assistant who reminded them to collect the data and entered the scores into the web-based system when they preferred pen and paper versions.

Chapter 6 explores the psychometric properties of HoNOS 65+, the primary outcome measure in MEMO, in more detail. The study showed that the use of individual items of HoNOS 65+ is preferable for evaluating care outcomes. Given its internal consistency, the total score still remained acceptable as a more general measure of impairment. Nonetheless, the study found no support for the use of subscales, in which individual items of HoNOS 65+ are combined, to evaluate care outcomes. Interestingly, rating outcomes differed between professionals according to educational background (nurses/social workers versus physicians/psychologists) for some of the most prevalent gerontopsychiatric disorders, despite training in the use of the instrument. This calls for HoNOS 65+ to be filled out by professionals in the same discipline when evaluating the progression of a client in daily practice.

Chapter 7 shifts to effectiveness of mental health care for older adults. The functioning of two thirds of the clients largely improved after treatment. HoNOS 65+ yielded effect sizes of 1.08 and 1.23 for the total group and the subgroup of depressed clients, respectively. On GDS-15, filled out by clients with a diagnosis of depression, an effect size of .92 was found. This indicates that clients rated their degree of improvement somewhat lower than the attending clinician, but still a large average effect size was found.
Furthermore, better functioning at baseline, comorbid personality disorder, somatic comorbidity and the experience of negative life events during treatment predicted poorer outcomes in both the total group and clients with depression on HoNOS 65+, explaining 16% of variance. An explanation for the finding of better functioning at baseline predicting poorer outcome could be that there is less room for improvement. The finding of the influence of comorbid personality and somatic disorders argues for specific treatment strategies in which these are taken into account. On GDS-15 the same predictors minus comorbid personality disorder were found, probably due to low prevalence rates in this subgroup.

Chapter 8 examines which factors predicted treatment completion within one year of referral to specialized mental health care in clients with affective disorders (i.e. any mood disorder, any anxiety disorder or any adjustment disorder). It appeared that mainly organizational culture rather than client characteristics and clinical functioning predicted treatment completion. In ‘type 1’ organizations, the treatment of two-thirds of newly referred clients was completed within one year, and only higher symptom severity of the affective disorders predicted long-term care. In ‘type 2’ organizations, the treatment of one-third of clients was concluded within one year, which was in contrast to type 1 organizations, independent of the severity of the affective disorder. Remarkably, less severity of ‘other’ symptoms predicted long-term care. The most likely explanation seems to be difference in culture between organizations. In-depth interviews should be conducted to shed more light on these differences in culture.

Chapter 9 is the general discussion of this thesis. The main results of the studies are summarized and connected with each other. In addition, the limitations of the registers used in this thesis are discussed, since these should be taken into consideration when interpreting the results concerning the accessibility and effectiveness of specialized mental health care for older adults. For instance, NIVEL Primary Care Database does not provide information on the type of psychosocial or psychological intervention, nor on the severity of the mental health problems.

Also, the representativeness of the data on referral of older adults to other mental health care providers might be limited. Within the PCRs some forms of mental health care, such as care provided in residential homes, nursing homes or private practices, are not included. Also, PCRs cannot show whether a client benefits from the care, nor can they give insight into the number of older adults who have a mental health problem and should have received care. Amongst the limitations of MEMO are a selection bias of included clients, exclusion of clients with a primary diagnosis of dementia or other cognitive disorders and the lack of a control group.
The chapter ends with some implications for research and clinical practice, including the following recommendations:

• Conduct a population-based study to determine the number of older adults in the community who suffer from any type of mental disorder, how many of them receive mental health care and from which provider, and whether this matches the preferences of the clients themselves and their symptom severity.

• Obtain more information on the effectiveness of specific treatments in the daily practice of mental health care.

• Provide support for clinicians in generalized mental health care in the treatment of older adults with mental health problems.

• Improve the implementation of ROM in general.

• Improve the use of ROM-data by clinicians in daily practice.

• Improve ROM for benchmarking.

• Study the influence of organizational culture on care outcomes.