1 General introduction
**Introduction**

The treatment of mental health disorders in older adults, as for all age groups, is important because of the negative consequences of these disorders. Several (policy) measures have been taken to optimize mental health care, but it is not self-evident that older adults with mental disorders will receive this care; nor is it known whether older adults really benefit from the mental health care they actually receive.

This chapter examines the prevalence of mental disorders in older adults, factors hampering the accessibility of mental health care, measures taken to optimize the quality of mental health care, and policy measures taken in the past decade that influence the accessibility and quality of mental health care for older adults. The chapter ends with the specific research questions explored in this thesis on the accessibility and effectiveness of mental health care for older adults.

**Background**

**The need for mental health care among older adults**

In older adults (65 years and older), estimates of the 12-month prevalence of mental disorders range from 5% to 17%.

Recent prevalence rates are not available for the Netherlands. Nonetheless, the Longitudinal Aging Study Amsterdam that started in 1992, enables us to estimate some prevalence rates for specific mental disorders. These are anxiety disorders (10.2%), attention-deficit hyperactivity disorder (2.8%), major depressive disorder (2.0%) and posttraumatic stress disorder (0.9%).

The prevalence of anxiety disorders may have been inflated by the use of the older DSM-III definition.

The presence of mental disorders in older adults has serious negative consequences for quality of life, physical functioning, disability, mortality and health care expenditure.

This highlights the importance of treatment for these disorders in this population.

**Filters that hamper the accessibility of mental health care for older adults**

There are several ‘filters’ that can prevent older adults who experience an episode of mental ill-health from receiving the appropriate care (Figure 1.1). First, older adults themselves must perceive the need for care and decide to seek help because they feel their health and functioning are impaired. Previous research has shown that older adults with a mental health problem are less likely to perceive the need for (professional) care than younger adults.
Second, their general practitioner (GP) must be able to detect the presence of a mental health problem. Research has shown that identification of mental disorders in older adults by GPs is suboptimal. For instance, GPs were less likely to recognize the presence of a mental disorder in older adults compared to younger adults. Both GP-related factors, such as lack of knowledge about treatment options and ageism (the perception that these problems are a natural part of the aging process), and patient-related factors, such as the presence of somatic illness, stigma surrounding psychological problems or patients’ lack of knowledge about treatment options, may play a part in this.

Third, if treatment given by the general practitioner is not sufficient, older adults should be referred to mental health care professionals in primary care or to specialized mental health care services. Research has shown that older patients are less likely to be referred to specialized mental health care by their GP compared to younger patients. Perceived stigma and a preference for being treated in general practice may prevent older adults from continuing treatment in specialized mental health care.

Measures taken to optimize quality of mental health care for older adults

Over the years, professionals have been encouraged to work according guidelines to optimize treatment, although implementation of these guidelines seems to be far from easy. For both general practice and specialized mental health care, guidelines are developed for the treatment of mental disorders. These guidelines are based on the latest scientific evidence on the screening, diagnosis and treatment of the particular mental disorder. If evidence from the literature is lacking, consensus between clinicians on
best practice is incorporated in the guidelines. In the Netherlands, specific guidelines for general practice are called ‘standards’ and currently, such ‘standards’ are available for psychological problems such as anxiety, depression and problematic alcohol use\[1\]. Although these guidelines are not age-specific, they contain observations throughout, regarding what to look out for in the diagnosis and treatment of older patients. Examples are co-morbidity of somatic illnesses and interaction with other medication. Standards have also been developed for dementia and delirium in older adults specifically.

Besides these standards, Multidisciplinary Guidelines (MG) have been developed over the years for the treatment of several psychiatric disorders, ranging from anxiety and depression to personality disorder\[2\]. These guidelines go beyond the different levels of care and apply to all professionals who are involved in the treatment of a particular disorder. Addenda to the MG anxiety and depression have been developed for older adults, focusing on where the diagnosis and treatment of these disorders in this age group deviate from younger adults.\[33-34\]

Both standards and MG place emphasis on stepped care treatment. This means that care starts with the least intensive treatment possible (such as watchful waiting, psycho-education or a self-help course), while more intensive treatment (such as psychotherapy or psychotropic medication) is offered only if necessary.\[35\]

Policy measures taken that influence accessibility and quality of mental health care

Because of a growing demand for mental health care, which has resulted in increasing costs and longer waiting lists for specialized mental health care, the Dutch government has promoted the treatment of mental health problems in primary care over the last 15 years.\[36-40\] An important measure taken in the period 1999–2007 was to strengthen mental health care in general practice by introducing social psychiatric nurses in general practice and fostering collaboration between primary and secondary mental health care. A further incentive was to provide national associations of GPs, primary care psychologists (PCPs) and social workers with funding to enhance the quality of mental health care, expertise and collaboration.\[38-40\] From 2008, more permanent measures were taken under the Health Insurance Act to promote the deployment of nurses and psychologists in primary care.\[41\]

Despite these incentives to treat mental health problems in primary care, there was a further increase in the costs of specialized mental health care in the period 2008–2011, mainly caused by a large rise in the number of new providers (especially self-employed)

\[1\] https://www.nhg.org/nhg-standaarden
\[2\] http://www.ggzrichtlijnen.nl
in specialized mental health care.\[^3\]\ To further improve the affordability of mental health care while ensuring high quality, the government and relevant parties in the field (such as representatives of mental health care organizations, professional associations, health insurance companies, patient organizations) have recently come to an agreement for the period 2013–2017\[^4\]. As a part of this agreement, a fundamental reorganization of mental health care has taken place since January 1, 2014. Instead of a division between primary and secondary mental health care, there is now a division between 1) general practice, focusing on the treatment of psychiatric symptoms, 2) generalized mental health care, focusing on the treatment of mild psychiatric disorders or chronic psychiatric disorders requiring low-intensity monitoring and 3) specialized mental health care, focusing on the treatment of patients with complex psychiatric disorders. It is intended that clinical capacity in specialized mental health care be reduced, and care transferred from specialized to generalized mental health care and from generalized mental health care to general practice.

Another part of this agreement is to increase transparency of the effectiveness of the care provided. For this purpose, a nationwide Routine Outcome Monitoring (ROM) by providers in generalized and specialized mental health care is currently under development, since until now no information is available on outcome of the care provided. ROM means that during treatment, questionnaires about the functioning of the patient are filled out regularly.\[^4\] This provides updates on changes in symptom level and general functioning of a client during treatment. This information can be used by a clinician in the treatment of an individual client. When aggregated, the information can be used for teams or organizations for research purposes, accountability can be provided to health insurance companies about the care provided and interventions can be studied in daily practice.\[^4\]

**Aim of this thesis and research questions**

The current thesis aims to add to the ongoing discussion on mental health care policy issues, including the accessibility and effectiveness of specialized mental health care for older adults, by exploring the following research questions:

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Chapter 1 | General introduction

Accessibility of mental health care for older adults

Based on the order of the level of care:

- Which developments took place in the recognition and treatment of mental health problems in older adults by GPs in the period 2002–2010? (chapter 2)
- Which developments took place in the number of older adults who used specialized mental health care and the type of care they received in the period 1990–2004? (chapter 3)

Measuring the effectiveness of specialized mental health care for older adults

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). The following questions are addressed:

- How is MEMO designed, and which clients are monitored? (chapter 4)
- What are clinicians’ perspectives on the procedures of MEMO? (chapter 5)
- What are the psychometric properties in daily practice of the Health of the Nation Outcome Scales for Older Adults (HoNOS 65+), the primary outcome measure used in MEMO? (chapter 6)

Effectiveness of specialized mental health care for older adults

- What is the effectiveness of specialized mental health care for older adults and which factors predict outcomes? (chapter 7)
- Which factors are related to duration of treatment in clinical practice? (chapter 8)

In the final chapter of this thesis, chapter 9, the main findings of all the individual studies are summarized and discussed.

Registers

To answer the research questions outlined above, data from three registers were used. These are described below.
NIVEL Primary Care Database

To gain insight into the identification and referral of older adults with mental health problems in general practice, registration data were used from the NIVEL Primary Care Database\(^5\). This registration system extracts patient data anonymously from routinely kept electronic medical records (EMRs). The database holds information on diagnoses, prescriptions and referrals from approximately 84 general practices covering care for over 335,000 patients. Participating GPs are considered representative of Dutch general practitioners in terms of age, gender and duration of business.

Dutch Psychiatric Case Registers

In order to gain knowledge of the use of specialized mental health care by older adults, registration data were used from the Dutch Psychiatric Case Registers (PCRs).\(^4\) The PCRs collect data about the use of mental health services for the population in a geographically defined area. Contacts with all mental health care providers are recorded and collected at one central point. In this way, the patients’ history of mental health care can be retrieved.

MEntal health care Monitor Older adults

At the start of our project, no registration system was available that could give insight in the effectiveness of treatment in specialized mental health care for older adults on a national level. Existing registrations were too global. For example, the DBC Information System (DIS) in which data from mental health care organizations is collected, the Global Assessment of Functioning (GAF) score was the only measure available as indication for the severity of problems of a client. Furthermore, reliability of the GAF score is questionable.\(^4\)-\(^7\) To gain insight in effectiveness of treatment in day-to-day outpatient mental health care for older adults, we therefore developed our own nationwide registration, called the MEntal health care Monitor Older adults (MEMO). Data collection took place in the period 2008–2011. Over the years, fifteen mental health care organizations throughout the country participated in MEMO. They had to assess all newly referred clients at baseline and routinely monitor their functioning and symptoms every four month up to end of treatment or till twelve month in case of continued treatment.

\(^5\) http://www.nivel.nl/NZR/zorgregistraties-eerstelijn (cited 2014 June 20)
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