DOWNLOAD PDF EVALUATING MENTAL HEALTH SERVICES FOR OLDER PEOPLE

Chapter 1 : Wellbeing and participation - theinnatdunvilla.com

To evaluate mental health services for older people can be challenging as the contextual details might be vital. Hence, the qualitative research helps us to explore statistical analyses by.

This chapter describes the constellation of barriers deterring use of mental health treatment by people who are either suicidal or who have major risk factors for suicidality: A close examination of barriers to treatment is warranted by several striking findings: Nearly 20 percent make contact with primary care providers in the week before suicide, nearly 40 percent make contact within the month before suicide Pirkis and Burgess, , and nearly 75 percent see a medical professional within their last year Miller and Druss, Among older people, the rates are higher, with about 70 percent making contact within the month before 1 Page Share Cite Suggested Citation: The National Academies Press. However, suicide victims are three times more likely to have difficulties accessing health care than people who died from other causes Miller and Druss, These findings underscore the importance of sifting through reasons why people escape detection or fail to receive adequate diagnosis and treatment for risk factors and suicidality. They also underscore the importance of taking a broad view of barriersâ€"focusing on suicidality, as well as on risk factorsâ€"because their treatment is so intertwined. The barriers discussed in this chapter collectively weigh against treatment. Each barrier is unlikely to act in isolation, but likely interacts with and reinforces the others. The complex relationship of various precipitative, exacerbative, and maintenance effects of barriers is unique in each clinical case. Deeper and more nuanced understanding of the multiple barriers to treatment is essential for design, development, and implementation of preventive interventions. Prospective longitudinal studies can help to elucidate relationships among barriers as they change across the life-span and across the development of suicidality. The chapter works its way from general to more specific barriers. It first looks broadly at barriers to treatmentâ€"such as stigma, cost, and the fragmented organization of mental health services. It then covers barriers raised within a range of therapeutic settingsâ€"by both clinician and patient. Finally, the chapter focuses on barriers for groups at greatest risk for suicide: About two-thirds of people with diagnosable mental disorders do not receive treatment Kessler et al. Stigma toward mental illness is pervasive in the United States and many other nations Bhugra, ; Brockington et al. Stigma refers to stereotypes and prejudicial attitudes held by the public. These pejorative attitudes induce them to fear, reject, and distance themselves from people with mental illness Corrigan and Penn, ; Hinshaw and Cicchetti, ; Penn and Martin, The stigma of mental illness is distinct from the stigma surrounding the act of suicide itself. The stigma of mental illness deters people from seeking treatment for mental illness, and thereby creates greater risk for suicide. The stigma surrounding suicide is thought to act in the opposite directionâ€"to deter Page Share Cite Suggested Citation: In some situations, however, the stigma of suicide acts to increase suicide risk because it may prevent people from disclosing to clinicians their suicidal thoughts or plans. Studies cited later in this chapter clearly indicate that patients often do not discuss their suicidal plans with their clinician. This, in turn, leads to their under-treatment and thus increases their likelihood of suicide. The existence of stigma surrounding mental illness is best supported by nationally representative studies of public attitudes. Studies find that about 45â€"60 percent of Americans want to distance themselves from people with depression and schizophrenia. The figures are even greater for substance use disorders Link et al. Stigma leads the public to discriminate against people with mental illness in housing and employment Corrigan and Penn, It also discourages the public from paying for treatment through health insurance premiums Hanson, Public attitudes toward mental health treatment are somewhat contradictory: For people with mental illness, the consequences of societal stigma can be severe: The National Comorbidity Survey, one of the only nationally representative studies to investigate why individuals with mental illnesses do not seek treatment, found that almost 1 in 4 males and 1 in 5 females with Posttraumatic Stress Disorder cite stigma as their reason Kessler, While the majority with mental illness do not seek treatment, there is wide demographic variability: If they make contact with primary

care providers, stigma inhibits them from bringing up their mental health concern. Patients may instead report more somatic symptoms of 2 Both stigmas can feed into the emotional burden in the wake of a suicide attempt by someone with mental illness. They may experience the stigma of mental illness, as well as the stigma of having tried to die by suicide. Page Share Cite Suggested Citation: Even if patients begin treatment for mental illness, stigma can deter them from staying in treatment. These problems are especially relevant for older people Sirey et al. These groups are discussed later in the chapter because they are at high risk for suicide. Stigma also extends to family members. Family members of people with mental illness have lowered self-esteem and more troubled relationships with the affected family member Wahl and Harman, Families of suicidal people tend to conceal the suicidal behavior to avoid the shame or embarrassment, or to avoid the societal perception that they are to blame especially with a child or adolescent suicide. After suicide, family members suffer grief as well as pain and isolation from the community PHS, Financial Barriers The cost of care is among the most frequently cited barriers to mental health treatment. About 60â€”70 percent of respondents in large, community-based surveys say they are worried about cost Sturm and Sherbourne, ; Sussman et al. Economic analyses of patterns of use of mental health services clearly indicate that use is sensitive to price: Rises in co-payments of mental health services are associated with lower access Simon et al. The demand for mental health services is more responsive to price than is demand for other types of health services Taube et al. Having health insurance, through the private or public sector, is a major determinant of access to health services Newhouse, People without health coverage experience greater barriers to care, delay seeking care, and have greater unmet needs Ayanian et al. Overall, about 16 percent of Americans are uninsured, but rates are higher in racial and ethnic minorities Brown et al. Having health insurance, however, does not guarantee receipt of mental health services because insurance typically carries greater restrictions for mental illness than for other health conditions US DHHS, Over the past decade, during the growth of managed care, disparities in coverage have led to a 50 percent decrease in the mental health portion of total health care costs paid by employer-based insurance Hay Group, Not surprisingly, insured people with mental disorders in a large United States household survey in were twice as likely as those without disorders to have reported delays in seeking care and to have reported being unable to obtain needed care Druss and Rosenheck, The consequences of the disparities in insurance coverage for mental illness have led to legislative proposals at the state and federal level for parityâ€”coverage for mental illness equivalent to that for other health conditions US DHHS, While there do not appear to be any studies directly examining cost as a barrier to treatment for suicidal people, most researchers believe that cost does play a role. The vision, beginning in , of the community support reform movementâ€”an integrated, seamless service system that brings mental health services directly to the communityâ€”has not fully materialized. People with mental illness frequently report their frustrations and waiting times as they navigate through a maze of disorganized services Sturm and Sherbourne, ; Sussman et al. The disorganization is a product of historical reform movements, separate funding streams, varying eligibility rules, and disparate administrative sourcesâ€”all of which have created artificial boundaries between treatment settings and sectors Ridgely et al. Among the hardest hit are people with co-occurring substance abuse and mental health problems, a group at higher risk of suicidality. Co-occurring disorders are the rule rather than the exception in mental health and substance abuse treatment US DHHS, Linkages between different settings are critical for detection and treatment of mental disorders and suicidality Mechanic, They include linkages between primary care and specialty mental health care; emergency department care and mental health care; substance abuse and mental health care; and, for adolescents, school-based programs with mental health or substance abuse care. The transition from inpatient care to community-based care is an especially critical period for suicidality in light of studies finding that a large proportion of completed suicides come after recent inpatient discharge, often before the first outpatient appointment Appleby et al. In addition to improved linkages between different settings, many new programs strive to integrate mental health and primary care, through a variety of service configurations e. Its utility for suicidality is being studied through ongoing trials Mulsant et al. Services research has focused for the past

decades in developing better models of care that bridge these different sectors of care to deliver more integrated mental health care. Several successful models have been developed, most notably wraparound services including multisystemic treatment, for children and adolescents with serious emotional problems and assertive community treatment, a form of intensive case management for people with serious mental illness, combined services for people with mental and substance abuse disorders, and management programs for late life depression in primary care settings US DHHS, One major problem, however, is lack of availability to these state-of-the-art services. Many communities simply do not provide them, and, when they do, there are often waiting times for treatment US DHHS, Low availability of mental health services of any kind is a major problem in rural areas Beeson et al. People in rural areas report significantly more suicide attempts than their urban counterparts, partly as a result of lower access to mental health services Rost et al. Another major problem is adapting model services to the unique needs of different communities or populations. Programs found successful for some populations may not translate into other settings. For example, a new primary care program for veterans designed to expand access to specialty mental health failed to do so Rosenheck, , despite the success of similarly designed gateway programs for other populations. Tailoring programs to the needs of distinct populations, including minority groups, is essential, given that they are less likely to access mental health treatment than are whites US DHHS, Its promise has been to improve access to health care by lowering its cost, reducing inappropriate utilization, relying on clinical practice guidelines to standardize care, promoting organizational linkages, and by emphasizing prevention and primary care. The impact of managed care on mental health services has been profound in terms of costs: The study cited above by the Hay Group indicated that during the growth of managed care, there was a 50 percent reduction in the mental health portion of total health care costs paid by employer-based insurance. Whether these cost reductions have lowered access to, and quality of, mental health services for people who need them is a critical topic for research, but one for which answers have been elusive. Research has been stymied by the dramatic pace of change in the health care marketplace, the difficulty of obtaining proprietary claims data, and the lack of information systems tracking mental health quality or outcome measures Fraser, ; US DHHS, Most concerns center on potentially poorer quality and outcomes of care from limited access to mental health specialists, reduced length of inpatient care, and reductions in intensity of outpatient mental health services Mechanic, ; Mechanic, The impact of managed care expressly on detection or treatment of suicide has been largely unstudied. The limited body of relevant research has focused on depression treatment, spotlighting problems in quality of care and outcomes. The first major studies of prepaid managed care versus traditional fee-for-service care found generally no overall differences in outcome, but poorer outcomes for patients with the most severe mental illness Lurie et al. Later studies, focusing exclusively on primary care, found that less than 50 percent of depressed patients in staff-model health maintenance organizations received antidepressant medication that met practice guidelines Katon et al. One of few managed care studies to have addressed suicide, at least tangentially, was of outpatients with depression receiving care from seven managed care organizations of varying organizational structures Wells et al. Using patient questionnaires, the study found that about 48â€”60 percent of patients with depressive disorder received some sort of mental health care. Two findings of the study are particularly relevant to suicide prevention: A largely unstudied question is whether reductions in intensity of outpatient services, or in length of stay in inpatient care, contribute to suicide risk. Reduction in care was defined by the study as one or more of the following: While this study was not of managed care per se, it raises questions about cost containment strategies used by managed care to reduce intensity or frequency of services for people at risk of suicide. In related findings, initial results from a study of all hospital discharges in Pennsylvania found a 25 percent reduction in length of stay during a 3-year period for inpatient treatment of depression. Preliminary results suggest that the reduction in length of stay was accompanied by an increase in readmission rates, a finding that the study investigators interpreted as suggesting that caution should be used when implementing practice guidelines for length of stay personal communication, J. Quality improvement guidelines have been demonstrated to be successful at improving

productivity and outcomes of depression in managed care, according to a randomized controlled trial Wells et al.

Chapter 2 : Health-care of Elderly: Determinants, Needs and Services

Finch, an expert in British social care policy, offers physicians and professionals concerned with health and social care this account of the developments in mental health care for the elderly in the UK, Europe, the US, Canada, and Australia, and offers a model for evaluating and improving these services.

Assessing the mental health needs of older people SCIE Guide 3 About this guide Context Mental health and emotional well-being are as important in older age as at any other time of life. Most older people have good mental health, but older people are more likely to experience events that affect emotional well-being, such as bereavement or disability. The Department of Health estimates that perhaps 40 per cent of older people seeing their GP, 50 per cent of older people in general hospitals, and 60 per cent of care home residents, have a mental health problem. Assessing the mental health needs of older people requires an understanding of the complex interaction between specific medical conditions and social circumstances. To be able to offer effective support, practitioners need to keep up-to-date with the latest research methods and legislation. This guide, which was first published in , has recently been updated. Purpose The guide describes some of the specific mental health problems that older people may experience. It aims to help practitioners in mainstream, non-specialist settings to develop their knowledge and skills and to think creatively about their work. The guide does explore a number of areas though and you will see these listed on the left hand menu. The guide looks at: Audience The guide is primarily for the use of front-line social work practitioners working with older people in non-specialist settings, who are often the first professional in contact with an older person and their family and friends, and who may have limited knowledge and experience of mental health issues. If you are an older person If you are an older person reading this guide, you may be worried about your own health or that of a family member or friend. If you are in contact with health and social care professionals you should have a general assessment of your needs carried out. This might include assessing your health, your ability to manage at home and discussing with you and your family about what help you may need. Your mental health needs may also be assessed as part of a general assessment. If there is a problem, it is important for you and your doctors to understand what that problem is and how it might be approached. The following organisations produce helpful advice leaflets and fact sheets especially for older people: Help the Aged External link: Age Concern If you look after an older person Looking after someone else brings with it particular features which professionals should take into account. You may encounter particular problems, and Section 5 discusses these. As a carer you are entitled to a separate assessment of your own needs, so, if the person you care for is having their needs assessed, make sure that you are also offered your own assessment. The following organisations provide information on caring and services available: Carers UK External link: The topics that are covered in this guide are listed in the left hand column. Click on these to access the topics. Within each topic there are several pages of information, which you can skip to using the navigation in the middle column. All of the links are in blue. The right hand column also has links to either to a PDF of the guide so that you can print it out or to other relevant information. Your feedback SCIE welcomes comments on any aspect of the guide, which will inform future updates. We are also very interested in collecting examples of good practice. Please send us your Feedback.

Chapter 3 : Evaluation of the Specialist Mental Health Services for Older People

Pt. I. Mental health services for older people in the United Kingdom --Ch. 1. Development of services -- Ch. 2. An integrated approach to services -- Pt. II. Old age psychiatry as a discipline worldwide -- Ch. 3.

To examine, using the published literature and local service experience, the contributions that carers can make to the development and evaluation of specialist mental health services for the elderly. MEDLINE search for relevant papers about carers and the elderly, especially with mental disorders; review of recent experience of service planning, implementation and evaluation in the Cambridge area. These issues are discussed, along with possible future developments, such as the need for a standardized assessment of carer satisfaction. Carers health care, not just mental health, on increasing are well motivated, as demonstrated by their the participation and input of service users. This article ment of Health, b. There is mention of carers in the above achieved. Accepted 24 July T. LAWTON old age psychiatry but also in other areas of mental are usually relatives of patients, who may or may health. For example, guidance is available for not live with them, but may include others, such as users and carers on how to evaluate services for friends or good neighbours. Most discussion about people with learning disabilities Whittaker, carers refers to relatives: First and foremost, it environmental niche which the individual occupies, seems inappropriate to design and instigate services usually though not exclusively with a view to without involving recipients, and this obviously keeping them there if possible. Assessing carer includes carers as well as patients. Many patients will intervention was made worked out and what the have dementia and in all but mild cases it may be patient and those around them made of it. Similarly, other factors such as physical illness or In this sense, therefore, mental health services sensory impairment may limit their capacity or for older people have always involved carers in the motivation. It is therefore logical to use carers as evaluation of care and continue to do so. The proxies for frail patients. There still remains, however, they are likely to be well motivated and committed no satisfactory legal basis for carers or others to to the person for whom they care; and they are act as advocates on behalf of patients Killeen, often supported by other family members. They may become stressed by problems faced by patients and carers and to the burden they carry and they may have their own delivering appropriate assistance. Also needed is a perspective, which is not necessarily identical with more critical approach to practice, including clini- that of the person who receives their care. The evidence Carers may be suitable persons to act as advo- base for interventions in dementia has recently cates on behalf of those in their care, in order been reviewed Melzer et al. Carers may also we go beyond this basic level of carer involvement become increasingly important in taking decisions and feedback. An inter- services to seek the views and input of carers, there esting new development is the Caregiver Activity are some issues which may present problems or Survey Davis et al. In addition, it anti-dementia drugs. They and to conduct discussions with them in as open a need help, not questionnaires. So it is ex-carers or style as possible. Fourth, there is also great example service-planning meetings. Some live with the patient, but others may and allowing one or two individuals to dominate visit from a distance and only see the patient at the carer input. In situations where there is certain selected times. They may be less prepared to take in Table 1. Each of these is discussed below, but risks than the patient would be, for example in with most emphasis on the provision of services. Carer organizations wider perspective, and their views may be domi- In the UK, these include such bodies as the nated by their own experiences. It may be impractical for them to represent the views of other carers or unfair to expect them to weigh competing responsibilities within the service. Carer organizations the evaluations that are conducted. Carer input into purchasing and policy Seventh, professionals should try to consider 3. Carer input into planning service provision the perspective of users, not only in the individual 4. Carer input into existing services case but in proposed major changes in service a Initiatives for carers: LAWTON have an impact at a number of levels, ranging from carers is largely via organizations, rather than the individual case, where they may act to provide on an individual basis. In practice, the local information, support and advocacy, through

local community health council acts as the main service provision and planning to the national level, lobby group for carers, and disagreements with where they constitute a powerful lobby in the HA plans are raised via the CHC. Carer input into planning service provision 2. UK are health authorities and social service Our own experience has been in developing our departments. There is variable consultation with local strategy for older people with mental illness. Moen and Forest have argued in respite care, and the closure of two continuing that health and social policy for elderly people care wards for dementia and their replacement with should be based on a family perspective. A major group which was set up to coordinate the process of problem for carers is that they need to feel that communication regarding the changes. These meetings include formal reduce the numbers of hospital beds; they were representation of voluntary organizations consulted more as to how this would happen. The question as to whether the health Carer education programmes have become authority would make better decisions if it were widespread and numerous examples have now obliged to involve carers in its decisions is an been described. The best and most convincing empirical one and could be evaluated. How- larly the shift from state NHS to personal ever, both of these programmes involved quite means-tested funding of continuing care pro- intensive input, so it is then important to identify vision. Experience from family education programmes in 4. These are not really a direct way of using of links between carers which persist after the end carers to evaluate the services, but inevitably in of the formal programme Berkowitz et al. So, in this indirect 3 days. One of the features is that all the partici- way, service providers will be listening out and pants are visited prior to the sessions, and the taking the opportunity provided by this feedback content of the sessions can be adjusted to address on their performance. Several future develop- since the patient population is relatively stable. As mentioned above, groups being galvanised by the proposed changes this happens to some extent in routine practice, but and the planned ward closures. The presence of the various recent initiatives provide particular oppor- group complemented, but did not replace, the tunities for carers to feed back their views of process of communication with individual relatives. For example, in the UK, packages of care From our point of view as providers, it was possible are allocated on the basis of needs-led assessments, to encourage the group to represent their views which should encourage carers to say how their independently and critically when required, partic- needs have been met or how they might be met in ularly in relation to the health authority. They found The study examined primary care rather than that most discharged patients did well and, in mental health. Caregivers placed particular psychiatry setting was performed in Cambridge, value upon good relationships, especially access UK Bedford et al. The and continuity, with primary care physicians. Their particular interest was including carer stress levels measured using the in the implications of this for case managers. Outcomes health and levels of functioning. The second part of the study Melzer et al. Thirty patients were the service recipient and the ethnic origin of the female and most were over At 6 months, 24 of carer. Some other studies, such as those evaluating the patients were still in the community, with three- individual services, have mentioned the importance quarters of them receiving home care services of of involving carers, but have not been explicit various kinds. This study found a high level of unmet need among There are various reasons why this might have the dementia group, even though they were already occurred. Just over half the sample regarded the in receipt of more domiciliary and day care. As must also then be available to inform the manage- regards residential care, the main problems were rial and planning processes. In the UK, the Government white levels. Secretary of State for Health, In the light The strengths of this study are that the data of the above discussion, this would be a valuable ascertainment was reasonably good as the research source of information and a welcome development. The level of data collection and Carers are a valuable source of feedback regarding analysis was only modestly above that used in services and can be used in service evaluation. It own experience with local services in Cambridge, would appear that the sole use of a question- and it is consistent with the increased emphasis on naire measure of carer stress GHQ would be carer and user involvement in health services. From both the objective data and the in mind. Research studies involving These issues have been fundamental in the strategy carers can cast valuable light on how services are that we are currently implementing. As mentioned earlier, there is no

validated This article includes material presented to the RSAS measure for rating satisfaction with services. At present, the best way to obtain valid Two referees also made helpful comments. There are two important issues: Do relatives want family Berkowitz, R. A randomized controlled trial. Alzheimer Scotland, Moen, P. NHS executive Patient Partnership: Department of Health, ment and validation of a new measure for caregivers of London. Department of Health a Carers Recognition and J. Policy Guidance and Practice Philp, I. Department of Health, London. Age Ageing 24, Gold, D. The burden of the illness in England. Health Trends Tarrier, N. Confessions of a guarded optimist.

Chapter 4 : Older people in hospital - theinnatdunvilla.com

Despite a consensus on the need to expand and improve mental health care for older people, evidence on models of service development is limited. Objective Referring to two case studies, this paper considers how evaluation of service innovations can inform policy and practice.

Chapter 5 : Older Adults | Healthy People

The challenge of evaluating mental health services for older people. Niall McCrae (), The challenge of evaluating mental health services for older people. Int.

Chapter 6 : Assessing the mental health needs of older people - A framework for well-being

A NSW Health model of care was released in January to help guide good practice in specialist community older people's mental health services (available here).An external evaluation of this model of care is now underway.

Chapter 7 : Assessing the mental health needs of older people

The Health of the Nation Outcome Scales (HoNOS) family of measures is routinely used in mental health services in the New Zealand, Australia, and the United Kingdom. However, the psychometric properties of the HoNOS65+ for elderly people have not been extensively evaluated. The aim of the present.

Chapter 8 : Formats and Editions of Evaluating mental health services for older people [theinnatdunvilla.co

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Chapter 9 : Mental Health and Mental Disorders | Healthy People

Assessing the mental health needs of older people. SCIE Guide 3. Published April About this guide Context. Mental health and emotional well-being are as important in older age as at any other time of life.