Primary mental health care for the elderly

This issues guide is linked to the vignette ‘Mental health needs of the elderly’.

From a system perspective the elderly represent another ‘invisible population’ as far as the management of common mental disorders is concerned. There are many similarities in the presentation and appropriate management of common mental disorders between the elderly and the younger adult population.

Notable differences however include the higher prevalence of co-morbid chronic physical disease and the presence of dementia in older adult populations. The organisation of primary care must therefore have systems for assessing cognitive impairment. There needs to be the capacity to detect and manage increased prevalence of depression found alongside common diseases of the elderly, such as diabetes. There may well be conditions in this age group which are currently under diagnosed such as elder abuse.

Mental disorders have a lower overall prevalence among the younger elderly than in those over 75 years. In those over 65 years the prevalence of any common mental disorder in those attending their GP was 7.6 % for men and 12.1% for women.\(^1\) Overall, the 12-month prevalence of depressive disorders among community-dwelling older adults aged 65 years and over in New Zealand primary care is about 2% for men and 5% for women. Older adults in residential care are at much higher risk of depression, with a prevalence of about 18% in low-level care residential facilities.

Service delivery

The following points are important to consider from a service delivery perspective.

- The psychosocial wellbeing of older adults can be assessed using the same approach as for other adults.

Guides to specific issues

- Targeted screening for common mental disorders is indicated for older adults in groups with high prevalence rates, such as; older people in residential care, or those with a recent significant loss. Among older adults living in residential care, routine psychosocial assessment including screening for depression, anxiety and substance abuse should be conducted annually.

- Older Māori living away from their birthplace sometimes describe feelings of *moke moke*, a sense of loneliness or physical and mental displacement that may resolve when they return to their home environment.

- In many localities there is fragmentation between primary care and adult psychiatric and psychogeriatric services. It is important that there is sufficient clarity in terms of the specialist roles of psychogeriatricians and their teams, and that referral pathways are clear.

- Communication between primary care services and social services for the elderly is often not well developed and coordinated care between health and social services lacking. Relationship building in this area should be a priority.

- Services for dementia are increasingly important and largely fall within the broader remit of primary care. Caring for a person with dementia is stressful, and carers' needs are being increasingly recognised, particularly since carer interventions in people with dementia have been shown to be effective.
Questions to consider

1. In each locality you must decide whether the current configuration of services is appropriate for older populations.
2. How are mental health services for the elderly configured in your area? Where does primary care fit in?
3. Are there regular opportunities for skill sharing and training between the relevant primary and secondary care clinicians?
4. What relationships does your organisation have with NGO’s involved in the mental health care of the elderly?
‘Mental health needs of the elderly’

Winifred B is 71 years old and retired last year from her job as a cleaner. She lives with Jonas, her partner for the last 15 years. Jonas recently went to their GP, concerned that Winifred was becoming ‘a bit forgetful’ and seemed more inclined to ‘fly off the handle’. This is distressing Jonas, who had been looking forward to his retirement as an opportunity for them to take a more relaxed view of life. Simon, her GP, notes that Winifred has several long term health problems and uses her next review visit to explore her mental health. At interview Winifred is more withdrawn and irritable than Simon remembers her, and when with some reluctance she completes a mental health state assessment her borderline score makes Simon consider both depression and early dementia. Given current secondary care workload Simon knows Winifred would not get to see the psychogeriatric team for eight weeks. Because of their low income Simon discusses the situation with Jacqui, the primary mental health initiative (PMHI) coordinator to see whether Winifred might qualify for free assessment and therapy.

Jacqui would like to help, but the current PMHI initiative is only for adult patients up to the age of 65 years. Simon is concerned at this as he feels that Winifred would benefit from intervention and spends that evening ‘Googling’ the internet.

He finds out that international studies (e.g. IMPACT study on depressed elderly patients) demonstrate collaborative care involving a psychiatrist, primary care doctor and nurse (the latter as the depression case manager) achieve better outcomes and that patients react better to treatment provided in primary care settings. Simon is also impressed that evidence suggests that this kind of approach encourages a large component of self management.

He relays his information to Jacqui who agrees to discuss this at the next PHO/DHB planning forum. She also points out that there is little expertise in mental health

---

Guides to specific issues

problems in the elderly among the present primary mental health team and there would need to be significant up-skilling if they were to take on a lot of work with the elderly. Simon replies that the elderly seem to yet another ‘invisible group’ when it comes to primary mental health care.

At the DHB / PHO planning meeting there is overall support for the view that older adults would benefit by being able to access to primary care based programmes. It is also felt however that there is a resource issue both in terms of DHB funding (increased volumes) and general practice resourcing. The psychogeriatrician present points out older adults often present with physical problems and often have complex drug regimes, and it can be difficult to separate disorders such as depression or anxiety from reduced cognitive functioning.

Jacqui agrees saying that the complexity of these issues in older people is a very good reason for increasing service provision. She also feels that considerable linkage could be made with other long term condition management programmes supported by the DHB, such as Careplus.

The planning group meeting recommends that PMHI programme is extended to include older adults i.e. everyone aged 65 and over. It also agrees to support some additional training for general practice teams. The training would include how to identify mental health issues separate to cognitive functioning; polypharmacy; greater focus on self management and peer-support groups.

The DHB also requests some modelling of expected increase in workload volumes. Initial modelling on prevalence rates for 65+ year olds suggests there might be minimal impact on depression volumes. Data from Te Rau Hinengaro shows the 12-month prevalence rates for >65 years old as 1.7% for depression, 6% for anxiety, 2% for both anxiety and depression and 7.1% with any mental health disorder. Rates for rest homes are higher at 18%.

Modelling cost increases for a large DHB suggests that extending the entry criteria to include everyone over 65 years would require an additional 750 volumes per annum.
Using the current costs of $400 per enrolee, this equates to an additional $300,000 per annum. However, there is an argument that because the elderly are largely ‘forgotten’ in terms of utilisation data analysis, there is a risk that this estimation is based on suppressed demand rather than need.³

Jacqui reports back to Simon who is pleased that some recognition is being given to the topic.

Winifred is referred to the local psychogeriatric services. In the meantime she is found to have mild hypothyroidism and started on thyroxine and an antidepressant.

Questions to consider

1. How are the primary mental health care needs of the elderly addressed from the perspective of your organization?
2. How ‘invisible’ are the mental health needs of the elderly in your area? What sources of information do you have available and how accurate are they?
3. How could you improve the primary mental health services for the elderly in your district?

³ Figures courtesy of Counties Manakau DHB