

# AUSTRALIA

## Integrated mental health care for older people in general practices of inner-city Sydney

### Case summary

This Australian example demonstrates how primary care for mental health can be provided seamlessly to older adults. General practitioner physicians provide primary care for mental health, and community psychogeriatric nurses, psychologists, and geriatric psychiatrists give advice and support as required. The key to the model is supported, collaborative, and shared care between primary care, community services, and specialist services, which include community-aged care, geriatric medicine, and old age psychiatry. Over time, general practitioners have required less advice and support, and achieved better outcomes in terms of maintaining continuity of care.

### 1. National context

Australia's national context is summarized in Table 2.4. Its population consists mainly of descendants of colonial-era settlers, and post-Federation immigrants with around 90% of European descent. The indigenous population – Aborigines and Torres Strait Islanders – represents only 2.2% of the Australian population.<sup>1</sup> They are one of the most disadvantaged groups in Australia.<sup>2</sup> English is the national language. Australia has a mixed economy whose main sector of employment and revenue is services. Although extreme poverty (living on less than US\$ 1 per day) is virtually nonexistent in Australia, 14% of the Australian population live below the nationally-established poverty line.<sup>3</sup>

**Table 2.4 Australia: national context at a glance**

Population: 20.2 million (88% urban) <sup>a</sup>
Annual population growth rate: 1.2% <sup>a</sup>
Fertility rate: 1.7 per woman <sup>a</sup>
Adult literacy rate: 99% <sup>a</sup>
Gross national income per capita: Purchasing Power Parity International \$: 30 610 <sup>a</sup>
Population living on less than US\$ 1 per day: data not available or not applicable <sup>a</sup>
World Bank income group: high-income economy <sup>b</sup>
Human Development Index: 0.962; rank 3/177 countries <sup>c</sup>

**Sources:**

- <sup>a</sup> World Health Statistics 2007, World Health Organization (<http://www.who.int/whosis/whostat2007/en/index.html>, accessed 9 April 2008).
- <sup>b</sup> Country groups (<http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html>, accessed 9 April 2008).
- <sup>c</sup> The Human Development Index (HDI) is an indicator, developed by the United Nations Development Programme, combining three dimensions of development: a long and healthy life, knowledge, and a decent standard of living. See Statistics of the Human Development report. United Nations Development Programme (<http://hdr.undp.org/en/statistics/>, accessed 9 April 2008).

## 2. Health context

The Australian population has a generally good health status (see Table 2.5), with the notable exceptions of Aboriginal and Torres Strait Islander populations. Otherwise, the pattern of disease is similar to that of other developed countries, with high rates of heart disease, stroke, and cancer.<sup>4,5</sup>

**Table 2.5 Australia: health context at a glance**

Life expectancy at birth: 79 years for males/84 years for females
Total expenditure on health per capita (International \$, 2004): 3123
Total expenditure on health as a percentage of GDP (2004): 9.6%

**Source:** World Health Statistics 2007, World Health Organization (<http://www.who.int/whosis/whostat2007/en/index.html>, accessed 9 April 2008).

Health care is provided and funded through a mix of federal, state and private contributions. General practitioner physicians provide the majority of primary care. Payment is made through reimbursements from government through “bulk billing”, private health insurance, out of pocket payment, or a combination of these. Medicines or pharmaceuticals prescribed by physicians and dispensed in the community by independent private sector pharmacies are subsidized directly by the Commonwealth Pharmaceutical Benefits Scheme. Public hospitals (funded by state governments) provide medicines to inpatients free of charge.

### Mental health

In 1992, an important mental health policy was passed that changed the approach of mental health care from an institutional to a community-oriented service.<sup>6</sup> The mental health policy established a framework for the protection of the rights and civil liberties of people with

mental disorders, consistent with that established in the Australian Health Ministers' mental health statement of rights and responsibilities, and in the United Nations Resolution on the protection of rights of people with a mental illness. The policy also advanced the position that mental health services should be part of the mainstream health system, including primary care. As such, it necessitated a new relationship between mental health services and the wider health sector.

### **3. Primary care and integration of mental health**

Primary care is the point of first contact with the formal health service and occurs through general practice, community health services, and pharmacies. General practice is now regarded as a medical speciality equivalent to other specialities. There is an emphasis on continuing relationships between service providers and consumers over extended periods of time, and on early detection, disorder prevention, and population health programmes including health promotion. Primary care is funded mainly through Medicare, a government-funded health financing system. Eligible people are provided with free-of-charge access to a general practitioner, and can enhance their choices through private health insurance designed for their needs.

The mental health policy establishes the need for an identifiable, integrated mental health programme within the mainstream health service. It recognizes that general practitioners are often the first point of contact for people with mental disorders, and that they need to be able to recognize, manage and, where appropriate, refer to specialist mental health services. The policy also recognizes the need for educational programmes for general practitioners to prepare them adequately for this role.

In addition to the mental health policy, an implementation plan was formulated for the period up to 2008. Some of the key strategies of the plan included:

- ongoing support for existing programmes in which general practitioners and other primary care workers (including, for example, community nurses, psychologists, social workers, occupational therapists, and other allied health providers) provide mental health care to the community;
- the development of primary care programmes in which general practitioners and mental health professionals provide shared mental health care;
- strengthening linkages between general practitioners and mental health specialists (both public and private) to improve clinical support from and access to private psychiatrists, and shared care protocols;
- the ongoing development of strategies to enhance the role of general practitioners and other primary care workers in delivering mental health care, particularly in rural and remote areas.

Currently, all general practitioners in Australia undertake mental health training at both undergraduate and postgraduate levels, and practitioners are expected to be able to deal with uncomplicated mental health problems in the same way as they deal with physical problems.

## 4. Best practice

### Local context

This example describes an older people's mental health service in the St. Vincent's District in inner city, Sydney. Around 13 000 people aged 65 and older live in the district, including people who are homeless, or in government housing, hostels, or nursing home accommodation; of Aboriginal and Torres Strait Islander origin; from non-English-speaking backgrounds; with HIV/AIDS; and holocaust survivors – many of whom are at increased risk of having mental health problems.

A significant number of older people in the district have comorbid mental and physical health problems, disability, disadvantage and mortality. Ischaemic heart disease, stroke, diabetes, hypertension, renal failure, obesity, cardiac failure and arthritis are prevalent in this population.

The majority of mental health care in the district is either self-managed or delivered through informal agencies, including faith-based nongovernmental organizations. A few non-health related, government-funded agencies operate under the auspices of local councils and/or the state government. There are also individuals who provide informal older adult mental health care, including priests, ministers, rabbis, police, and other community leaders.

Beyond this informal network, formal older adult mental health service delivery starts with general health services. This is where the majority of people seek help, most commonly from their general practitioner. Because their choice of general practitioner is their responsibility and is not dictated by where they live, a level of autonomy and trust alleviates some of the traditional barriers to seeking mental health care. Less than 1% of all those with mental health problems present directly to hospitals.

### Description of services offered

The major aim of the programme established in the district is to identify older people with mental health problems and mental disorders, as early as possible, and to deliver appropriate, well-coordinated, evidence-based treatment, rehabilitation and relapse prevention within primary care and in collaboration with other agencies. Primary care for the mental health of older adults is provided mainly by general practitioners, who are assisted by community psychogeriatric nurses and psychologists and supported by old age psychiatrists as required. The key to the model is supported, collaborative and/or shared care between primary care, community services and specialist services, including community-aged care, geriatric medicine and old age psychiatry.

General practitioners play a major role in the initial identification of older people's mental disorders. Their assessment forms the basis for the management of the identified mental health issues within a biopsychosocial model of care, now taught in all medical schools in Australia.

A number of options exist if the issues are beyond the expertise of the general practitioner. An older adult mental health specialist may be contacted for advice. Alternatively, the general practitioner might make a referral to the older adult mental health community team for practical assistance. This might involve specific needs such as neuropsychological assessment, occupational therapy or rehabilitation services, or more general requirements such as shared

care and case management. Alternatively, the general practitioner might make a request for further specialist assessment by an old age psychiatrist, which can occur through a home visit, a consultation at the general practitioner's rooms, an outpatient appointment at a community centre or the hospital, or through admission to hospital if required, depending on the needs of the patient and the most appropriate approach identified by the general practitioner.

To maximize the patient's experience of continuity of care, the psychogeriatric nurse, psychologist and psychiatrist aim to keep their involvement with the patient as minimal as possible, within the bounds of the assessment and management required to facilitate the best outcome for the patient. This is achieved by providing focused and time-limited services that are usually defined by the request of the general practitioner, and agreed upon by the general practitioner, the psychogeriatric team member and the patient, as early as possible in the assessment and management planning phase.

Practically, this means that the general practitioner has primary responsibility for arranging investigations, prescribing medication, monitoring progress, and identifying the need for alterations to the management plan. In Australia, few general practitioners make home visits, so patients are usually seen at the clinic. The psychogeriatric nurse may make home visits between general practitioner consultations, and the two liaise regularly by telephone. In addition, the psychogeriatric nurse commonly accompanies patients to the general practitioner's clinic, particularly in the early and acute stages of community-based management.

If the old age psychiatrist is involved, the psychogeriatric nurse and the psychiatrist will almost always see the patient together, whatever the setting. The advantages of this approach are that it:

- facilitates the development of rapport;
- further enhances the continuity of care;
- reduces the stigma of seeing a psychiatrist;
- helps the process of gathering and exchanging accurate information;
- distributes the burden of care to some degree;
- assists with teaching and supervision.

Following patient contact, the psychiatrist typically contacts the general practitioner, often by telephone, and always in writing. The communication with the general practitioner contains all information that would be relevant and useful in providing mental health care for the older person. It also describes clearly the step-by-step details of the management plan, so that it can be initiated, monitored and adjusted appropriately by the general practitioner. And lastly, the communication contains clear parameters for when the general practitioner should consider alternative management strategies, and the details of those alternatives.

## **The process of integration**

### **Planning the older adult mental health service**

The model was established based on the principle that older adult mental health care should be integrated into primary care as a means of improving access and reducing stigma. The shared care and case management model was promoted mainly on the basis of its accessibility, cost effectiveness, and the comprehensiveness and continuity of care that would be provided.

Central stakeholders were engaged. An area committee was established by the chief psychiatrist to develop a strategic plan. The plan defined specialist mental health services for older people as multidisciplinary, community-focused, secondary referral services for people aged 65 years and over, with a strong commitment to integration with primary care. General practitioners were then contacted and informed that they would receive additional training in an area where a substantial number of their patients needed assistance, but where they as practitioners were not well-trained. They were also advised that they would be able to contact specialized practitioners to assist them with complex cases, and they would be able to refer patients who needed more specialized attention. Payment to the general practitioners would be on the same basis as for treating any other health condition. All these reasons made the model appealing to most general practitioners.

The finalization of the plan was overseen by a committee comprising representatives from the hospital and community services in the area, and a report was submitted for approval to the area's chief administrative board.

The relevant specialist clinicians and administrators met to discuss options for funding the recommendations of the plan by using existing resources and identifying ways of securing new funds. Discussions with funders were facilitated because the national and state mental health policy and plan called for the integration of mental health services into general health care. The funding that was requested for staffing was relatively small. For the catchment population of 13 000 people, the request was for a consultant psychiatrist (0.5 full time equivalent; FTE), a clinical psychologist (1.0 FTE), a clinical nurse consultant (1.0 FTE), and a psychiatry trainee (0.5 FTE).

### **Implementation of the service**

Despite the enthusiasm of the health professionals who would provide the service, as well as the commitment from administrators and funders, it took almost five years from the establishment of the area committee to the first staff appointment.

Following appointment of the first psychiatrist, a new series of meetings were held to create the implementation plan. These included consultations with the director of the division of general practice and the division's liaison officer for mental health, the director of the catchment community health services, the director of the community aged care assessment team, the director of the community dementia nurses team, the director and deputy director of mental health services, the director and clinical staff of the geriatric medical services, the area coordinator of older adult mental health services, the mental health consumer consultative committee, the director of the adult mental health crisis and case management team, the director of mental health rehabilitation services, and the director of mental health inpatient services. In addition, meetings were held with general practitioners in the area.

A strategic plan for the development of older adult mental health services was developed and circulated for comment. This document was vital to both inform key people of the intended direction of the service's development, and to enlist support for this process. Three months after the appointment of the consultant psychiatrist, a psychiatry trainee (0.5 FTE) and a clinical nurse specialist (1.0 FTE) were appointed. One year later, a second clinical nurse specialist (1.0 FTE) was appointed. One year after that, a psychologist (0.8 FTE) was appointed.

It is important to note that the five-year time frame was not the result of an idle committee or resistance from government. Rather, it reflects the reality that planning and implementation take time. While there were times when the architects of the plan became somewhat despondent and thought that the new service may never be realized, their patience and perseverance were rewarded eventually.

### **Training for integrated older people's mental health care in primary care**

Most training of general practitioners occurs through verbal and written advice and informal supervision that they receive from the older adult mental health specialists. General practitioners are involved closely in every assessment and treatment in which the specialist service is engaged. In more complicated cases, the psychiatrist describes the step-by-step details of the management plan, which is then initiated, monitored and adjusted by the general practitioner. Often the patient will also be seen by both the general practitioner and the more specialized practitioner in a single session. In this way, the general practitioner gains skills and experience that are useful not only for the treatment of that particular patient, but also for future mental health care of older people. Of course where referral is required, the specialist service is available to assume responsibility, but only as required until the patient can be back-referred to the primary care level.

General practitioners also benefit from the expertise of older adult mental health specialists through joint monthly meetings, which take a variety of forms including a journal club, a case presentation, or a seminar. The principle responsibility for organizing and selecting the meeting content is taken by the general practitioners themselves.

## **5. Evaluation/outcomes**

As a result of this model, general practitioners and other primary care workers have developed skills in the assessment and management of older adults with mental health problems. Over time, they have required less advice and support, and achieved better outcomes in terms of maintaining continuity of care.

The older age adult mental health specialists have noted a substantial reduction in “revolving door” patients since the general practitioners have taken greater responsibility for older people's mental health care.

## **6. Conclusion**

This example shows how a specialized service for older people supports and empowers general practitioners to fulfil their general health care function more effectively. This is not only a good use of scarce resources, but is also best for patients. They are treated holistically and they do not need to waste their time and resources to go to specialist mental health care unless it is absolutely necessary.

## Key lessons learnt

Lessons from this example are listed below.

- It is a myth that specialized services are “better” services. On the contrary, holistic care that is accessible to older people is “better” care – provided the primary care workers are adequately trained and supervised.
- Where mental health specialists do get involved, it is crucial that they work closely with primary care workers, which facilitates continuity of care and allows primary care workers to develop relevant skills.
- Even in a high-income country, establishing an integrated mental health service can be highly time-consuming. Perseverance and patience is needed to persuade authorities and secure necessary resources.
- Training occurs not only through formal courses where people get degrees or diplomas, but also through ongoing informal interaction with health specialists.

### References – Australia

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