Psychiatry of Old Age

AUSTRALASIAN PSYCHIATRY

An evaluation of the aged mental health and primary care partnership program

Australasian Psychiatry
2023, Vol. 31(1) 47–52

DOI: 10.1177/10398562221141337
journals.sagepub.com/home/apy
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Abstract

Objective: To evaluate the Mental Health and Primary Care Partnership (MaP) pilot program which operated in a metropolitan Melbourne setting in 2020.
Method: Data collection included: surveys, interviews, file audits, and an evaluation of routinely collected data, with MaP consumers, their carers, GPs, Practice Managers and Nurses located in Boroondara, and MaP and Aged Person's Mental Health Service staff.
Results: Thirty-five consumers aged between 66 and 101 years old (of whom 63% were female) received support from the MaP program throughout its 12-month operation. Statistically significant improvements in outcome measures assessing for psychological distress and symptoms of mental illness were observed. Strengths of the program included the single referral pathway and the provision of services for those not meeting criteria to access tertiary mental health support. Consumers and clinicians made recommendations for service improvement including provision of a longer duration of care to consumers and greater integration of community and primary care.
Conclusions: It is hoped that the learnings from the MaP pilot program can be used to guide future program development.

Keywords: older adults' mental health, primary health network, program evaluation, community mental health

Although Victoria has robust public aged persons mental health services (APMHS), they only have capacity to help the most severely ill.[1] People with low severity mental health problems generally cannot access public mental health care options. Further, many experience barriers in accessing private mental health care, particularly financial cost and affordability.[2] There is also a lack of outreach to consumers living in residential aged care facilities (RACFs).[3,4] It is therefore left to General Practitioners (GPs) to manage the bulk of mental health care in the community and in RACFs.[1] Subsequently, the Australian government tasked Primary Health Networks (PHNs) with implementing new models of mental health service provision.

In 2020, the Eastern Melbourne Primary Health Network (EMPHN) partnered with St Vincent's Hospital Melbourne (SVHM) APMHS to develop a pilot mental health support program called the Mental Health and Primary Care Partnership (MaP). The MaP program was tasked with improving the quality of life and mental health of persons aged over 65 (or over 55 for Aboriginal and/or Torres Strait Islander peoples) with mental health concerns residing in the Boroondara local government area. It involved the development of a new program working in collaboration

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with existing local mental health services and primary care.

The MaP program (in operation from January 2020 for 12 months), provided free, brief, mental health intervention support, to consumers living in the community or RACFs. Support was provided by a multidisciplinary team that included a mental health nurse, psychologist, and psychiatrist. Brief intervention consisted of mental health assessments, case management, GP liaison, psychological intervention, and development of personalized care plans. The MaP program also offered capacity building education sessions and secondary consultations to GPs seeking advice about their consumer's mental health or psychotropic medications. The consumer's GP remained their primary care provider and prescriber throughout the consumer's engagement with MaP.

Despite the Commonwealth's investment in implementing mental health programs through the PHNs, little is known about the outcomes of these models in supporting the mental health concerns of older adults. This project therefore aimed to evaluate the model of care delivered by the MaP program to better understand the experiences and outcomes of those involved and identify future ideas for better supporting mental health needs of older adults.

Methods

MaP consumers, their carers, and GPs, Practice Managers and Nurses, MaP Clinicians and foundational staff, and APMHS Aged Psychiatry Assessment and Treatment Team (APATT) clinicians were invited to participate in the program evaluation. Data collection involved a combination of surveys, interviews, file audits, and an evaluation of routinely collected data reported in "FIXUS" (EMPHN's data collection platform). Table 1 shows the different data sources for each participant group. The surveys and interviews collected participants' feedback of the MaP program, opinions around facilitators and barriers to mental health service provision for older adults, and preferences for service delivery.

As part of their engagement with the MaP program, consumers were also administered several outcome measures at intake and discharge (see Table 2).

Data were imported into the Statistical Package for Social Sciences (SPSS V26) and Microsoft Excel for quantitative data analysis, with statistical significance set at $p < 0.05$. Qualitative data were collected using audio-recorded semi-structured interviews. The interviews were transcribed and imported into NVivo. Deductive thematic analysis was employed to analyze the data.[10] A coding framework was generated by the authors based on the project's evaluation framework. A sample of interviews were reviewed independently and discussed by two authors (not involved in delivery of the MaP program) until consensus was reached. Two main themes were coded to, with four subthemes identified:

1. Service set up and implementation. Subthemes: COVID-19 impact; MaP program outcomes.
2. Service improvements and future directions. Subthemes: Learnings, future ideas, and gaps; Improving GP support and engagement.

Saturation was not reached due to the small number of participants interviewed.

Results

Referrals

A total of 35 consumers were seen by the MaP program. Referrals to the MaP program were predominantly via a health professional, with the consumer's GP being the most common referrer (37.1% of all referrals). Other referral sources included: mental health nurses, RACFs, and self-referrals.

Consumer demographics

Consumer ages ranged from 66 to 101 years old, and 63% of consumers were female. Age distributions between sexes were not significantly different ($U = 140$, $p = 0.92$). The most common mental health diagnosis for

Table 1. Sources of evaluation data

	Survey	Interview	File audit	FIXUS
Consumers	X	X	X	X
Carers	X	X		X
General practitioners	X	X		
Practice nurses	X			
Practice managers	X			
MaP clinicians	X			
MaP foundational staff		X		

Note: MaP, Mental Health and Primary Care Partnership.

Table 2. Consumer and caregiver outcome measures

Outcome measure	Measures
Kessler 10 (K10)[5]	Psychological distress
The health of the nation outcome scales 65+ (HoNOS 65+)[6]	Psychiatric symptoms and functioning
Life skills profile (LSP)[7]	Function and disability in the context of mental health symptoms
Behaviour and symptom identification scale (BASIS-32)[8]	Mental health treatment outcomes
Zarit carer burden interview (Zarit)[9]	Caregiving burden

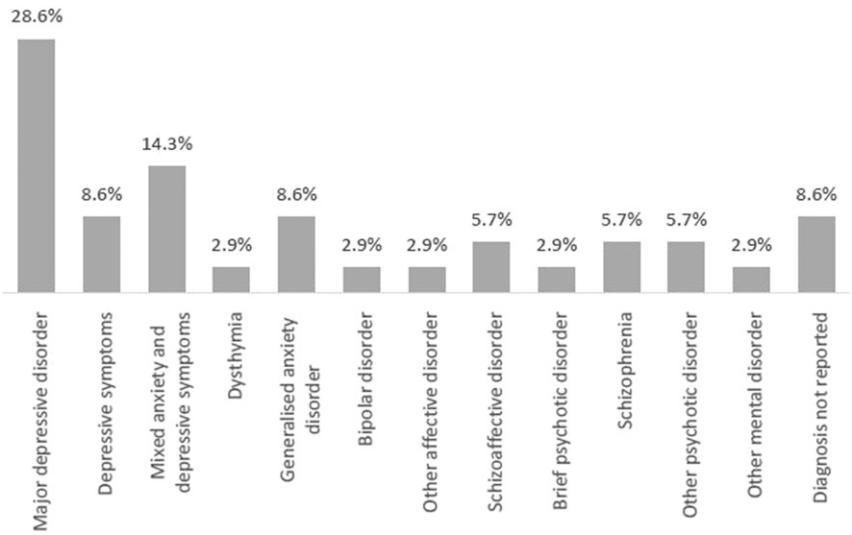

Figure 1. Mental health diagnoses for MaP consumers. Note: Map, Mental Health and Primary Care Partnership.

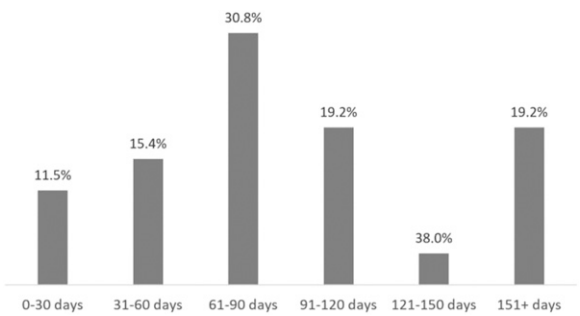

Figure 2. Length of episode of care with the MaP program. Note: Map, Mental Health and Primary Care Partnership.

MaP consumers was Major Depressive Disorder, followed by mixed anxiety and depressive symptoms (Figure 1).

Interventions provided

File audits and FIXUS data indicated that the MaP program delivered 507 contacts over its 12-month operation. The majority of contacts were with individual consumers (53.1%). Almost a quarter (24.3%) were with the consumer's family/client support network, and 22.3% were with another health professional. Almost 60% of participants had an episode of care that was up to 90 days (see Figure 2).

Services provided included: mental health assessments, case management, medication reviews, and clinical care coordination and liaison. More than half of MaP contacts (54.04%) were focused on psychological interventions which included Cognitive Behavioral Therapy and Acceptance and Commitment Therapy. MaP services were primarily (76.9%) provided by the program leader (mental health nurse).

Consumer outcomes

Consumers interviewed ($n = 3$) endorsed improvements in their mental health post discharge from the program, reporting they felt a noticeable difference in their mental state, psychological symptoms, and capacity to self-manage their distress. Significant reductions in psychological distress and symptoms as measured by the K10 and HoNOS 65+ were observed at discharge (see Figure 3).

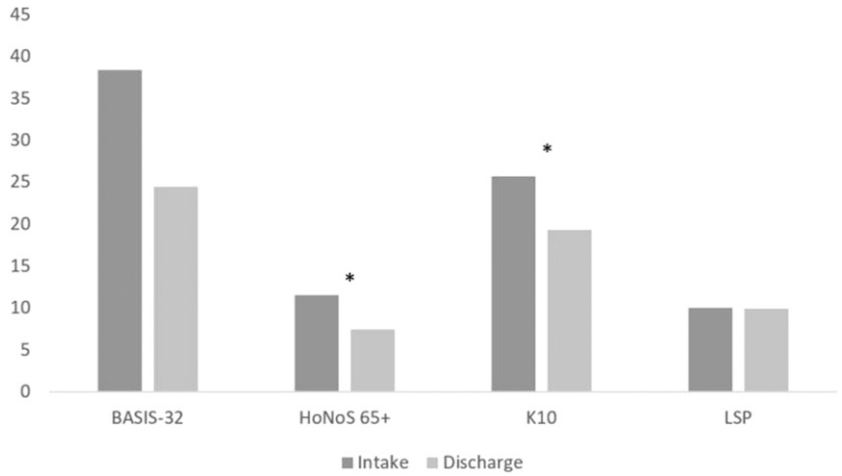

Figure 3. Outcome measure scores for consumers at intake and discharge.

Table 3. Feedback from interviewed consumers relating to the service set up and implementation theme

Feedback from interviewed consumers
• Consumers reported that the program enabled them to overcome a difficult time in their lives and/or past issues that continued to impact their mental health. "It certainly got me through a difficult hump, and even this year"
• All consumers reported that they felt the psychosocial intervention approaches were beneficial, with one consumer endorsing that they preferred this approach to psychopharmacological interventions. "I don't think it was the medication. I think it was that human contact."
• All consumers endorsed a preference for face-to-face services. "The best was, you know, the face-to-face meeting with them.". Consumers described telehealth as "impersonal"
• Two of the consumers reported they would have preferred more frequent or longer duration of contact with the MaP program: "I would have liked ... More sessions with them, which would help my mental health"
• Consumers reported that once they had engaged with the service, they felt comfortable accessing it again (via self-referral): "Well he [GP] didn't actually navigate it this time. He didn't even know that I was considering it. This time, I did it myself"
• Consumers interviewed endorsed improvements in their mental health post discharge from MaP, reporting they felt a noticeable difference in their mental state, psychological symptoms, and capacity to self-manage their distress. "I'm less anxious and, you know, I am, you know, yeah, I don't think too much about the past, I take one day at a time…I can feel the difference in myself now"
• All consumers endorsed that during their intervention period with MaP they learned skills that supported their capacity to cope with distress and self-manage their mental health. A consumer reported still using written strategies provided by their MaP clinician. "I get all stressed and, you know, with worries, so she gave me some notes, you know, how to manage those…when I feel overwhelmed with anxiety I go to the notes"

Note: MaP, Mental Health and Primary Care Partnership.

Feedback from interviewed consumers is summarized in Table 3.

Carer outcomes

The average Zarit score was 26 (n = 5, range: 9–46), indicating that majority of carers were experiencing high levels of carer burden (defined as a score of ≥17).[9]

Carers surveyed reported feeling welcome, respected, safe, and included in their loved one's care and treatment. On average, carers endorsed the program as having an "excellent" impact on their hopefulness for the future, capacity to manage day to day life, and overall wellbeing.

Service provision

Surveyed GPs (n = 2) indicated a preference for primary consultations to support the clinical care of their patients. Decisions to use secondary consultation appeared to be driven by concern about whether secondary consultation is appropriate, as well as the urgency of the consumer's needs and their willingness to be referred to mental health services. MaP also provided four capacity building

education webinars attended by 394 clinicians who provided positive feedback.

Feedback from APMHS staff indicated that having a single point of entry for referrals was a strength of the program, as this placed fewer demands on busy GPs, and made the self-referral process easy for consumers: "A single point of entry…worked out the details of best suited agency to support the referred consumer." Additionally, it was reported that the MaP program filled a gap which allowed for provision of mental health support for consumers who did not meet APATT criteria: "So I think the kind of target cohort for MaP are…the missing middle. So people who need more than primary care treatment but may not necessarily meet the criteria for a tertiary or acute public mental health service."

Barriers and challenges

The MaP staff surveyed endorsed a significant negative impact of COVID-19 on service provision. Implementing telehealth with the older adult cohort was reported to be difficult: "…There were issues with the technology, bandwidth, user knowledge, as well as the availability of hardware…". Additionally, other COVID-related responses were prioritized over mental health, which added a further barrier for GPs engaging with a new mental health program.

Other challenges identified included: MaP was not equipped to support consumers with cognitive problems and that consumers with complex mental health concerns did not benefit from the brief nature of the program.

Suggestions for improving service delivery

Surveyed and interviewed participants' feedback and themes included their recommendations for service improvement, which have been summarized in Table 4.

Discussion

This evaluation yielded important findings regarding the implementation and efficacy of the MaP program. It

Table 4. Recommendations for improving service delivery as reported by study participants

Participant group	Recommendations
Consumers	• Longer episodes of care • More frequent contact with service
MaP staff	• Support to implement telehealth as a modality for service delivery • Improving access to psychological interventions for older adults in RACFs
APATT clinicians	• Ensure the service has established strong links with primary care, aged care, and local APMHS to enable consumers to transition seamlessly through different services as their needs change • Provide a longer duration of support to consumers. "Increase the number of brief intervention sessions available to consumers." • Ensure the service is multidisciplinary and includes at a minimum: Psychiatrists, mental health nurses, and allied health clinicians (psychologists, occupational therapists and social workers) • Inclusion of more brief intervention psychotherapy options, for example, CBT, ACT, psychodynamic psychotherapy, grief counseling or family therapy, pet therapy • Provision of psychosocial groups, step-down wellbeing groups, and day programs. "It would be better if we had some other services such as day programs that are targeted for people with mental illness, not just accessing mainstream day programs" • Adopt a recovery-focused framework • Ongoing upskilling of clinicians in brief interventions, mental health diagnostics • Further integration and collaboration with RACFs/GPs • Inclusion of services for older adults experiencing substance abuse. "So I do think maybe drug and alcohol services more broadly, more targeted for older adults" • Involvement of GPs in advanced care planning. "We're seeing more older, sicker, frailer people over time, and certainly sometimes we're managing those people together with the GPs when they're in aged care facilities" • Involving consumers in service co-design. "We need to find out from people what they think they want" and "involve consumers in the conceptualization stages/quality improvement"

Note: MaP, Mental Health and Primary Care Partnership.

demonstrated the feasibility and effectiveness of the MaP program in meeting the needs of older adult mental health consumers, as evidenced by objective improvements in mental health outcome measures for consumers. These results were supported by the qualitative findings, whereby consumers endorsed the program as contributing to an improvement in their mental health.

Several strengths of the program were identified, including the single referral pathway which minimized barriers to entry, with the ability to step up or step down with the level of mental health support within the same service minimizing confusion for consumers and referrers. Additionally, MaP addressed a gap in the current local APMHS, which excludes consumers presenting with psychological symptoms that are mild to moderate in severity.

Feedback from participants highlights recommendations for improvements including: longer service provision to consumers, greater integration of mental health services, and provision of a broader range of intervention programs.

Limitations of this study were that GPs, Practice Nurses, and Practice Managers did not respond to invitations to participate in interviews and survey responses were minimal, resulting in limited feedback from Primary Care. Further, only a small number of consumers and no carers were interviewed. Additionally, the COVID-19 pandemic impacted service provision and uptake. We are therefore unable to generalize the impact of the program more broadly.

Conclusion

Overall the MaP program was feasible to implement and effective in improving consumer mental health outcomes. It is hoped that the learnings from the MaP pilot program can be used to guide future program development, particularly in the context of the COVID-19 pandemic which will see an increased demand on the mental health system for years to come.

Acknowledgments

The authors wish to acknowledge the Eastern Melbourne Primary Health Network for their support in the development and implementation of the MaP service and evaluation study, Dr Sarah Berriman for her contribution to the operations of the MaP service as the program's psychiatrist, Dr Francine Moss for her support and leadership as the St Vincent's Hospital Melbourne APMHS Director of Clinical Services, and the study participants and people with lived experience of mental health concerns, as well as their carers.

Declaration of conflicting interests

T Cottrell, C Harrison, and T Chong were clinicians and/or foundational staff responsible for the implementation and operation of the MaP service throughout 2020. No other conflicts of interest to disclose. The authors alone are responsible for the content and writing of this paper.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Eastern Melbourne Primary Health Network.

Ethics approval

Ethics and governance approval for the purpose of this evaluation study was received from the St Vincent's Hospital Human Research Ethics Committee and Research Governance Unit. Participation in the evaluation study was voluntary and informed consent was sought from all participants in the study.

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