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Older persons' perspectives on satisfaction with a mental health service and its impact on their recovery

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Abstract

Consumer satisfaction with mental health services plays an important part in recovery from mental illness. Older consumers in particular need access to appropriate care and assistance, due to their often-compromised health status. It has been extensively reported that well-organised care enables a larger number of older consumers to return to the community as active members. To date, however, there has been little research in the area relating to older consumer satisfaction with mental health services in Australia. This small qualitative study reports the personal experiences of five older consumers residing in a rehabilitation-focused older persons' mental health service. The consumer participants revealed that whilst they rated the service quality as satisfactory in general, when more specifically probed they did not find it suitable in meeting their individual recovery goals. Their main areas of concern were: inability to move freely, finances being managed by a public trustee, repetitiveness of meals, and those meals were not cooked on site. This narrative study revealed a need for the mental health service to focus more on individualised and consumer-centred services; in particular a higher degree of flexibility, encouraging independence, increasing freedom of choice and allowing consumers to have a say in their care, recovery planning and social inclusion.

Key words: older age care, quality, mental health, recovery

Introduction

There is mounting evidence that the quality of mental health service and consumer satisfaction with those services can have a major impact on recovery from mental illness (Hungwe, 2010; McCrae & Banerjee, 2011; Ruggeri, 1994). With mental illness prevalent in up to 10% of the older population (Hall, Waldock, & Harvey, 2006), the elderly are becoming a significant consumer group of mental health services in Australia. Consequently there is an increasing need to deliver, at the very least, good quality care through older persons' mental health services and in primary care.

Consumer satisfaction is one of the key indicators of successful mental health care and is associated with better quality of life (Ruggeri, 1994; Ruggeri, Biggeri, Rucci, & Tansella, 1998). A study of older primary care patients revealed that close to 90% were generally satisfied with their mental health care but only 73% said that the services met their needs (Chen et al., 2006). This suggests that despite high satisfaction overall, individual consumers' needs were unmet at the same time.

While personal recovery may have a different meaning to different people, the models of care focus on strengths, and emphasise the active role of people. Deegan (1996) describes recovery as a personal journey, and an ongoing process, which involves individual effort, hope, courage, meaning, direction, adaptation, equality, respect, personal empowerment, confidence, social inclusion and connectedness with others. This includes both physical and psychological aspects of health, and economic and interpersonal well-being. In order to support personal recovery, services need to move beyond preoccupation with risk avoidance and a narrow interpretation of evidence-based approaches. They need to move towards working with creative risk-taking, and to shift focus onto what is meaningful to the individual and their family (Care Services Improvement Partnership [CSIP], Royal College of Psychiatrists [RCPsych], Social Care Institute for Excellence [SCIE], 2007). Recovery-based services support the process of regaining consumers' active

lifestyles, and encouraging them to learn, grow, and gain independence as well as confidence.

All consumers should have a recovery care plan, which would include the principles of recovery, interventions to promote their quality of life, and outline appropriate links to agencies and resources connecting them to activities, assistance with finances and other requirements based on their identified needs. A review of mental health services that cater specifically for older consumers concluded that they should provide support in returning them to their community, living as independently as possible and preventing relapse (Kaskie, Gregory, & Van Glider, 2009). In addition to promoting psychological well-being, services need to focus on reducing rates of mental illness by addressing negative factors such as social isolation, chronic physical illness, poverty and poor housing etc. (Lippens & Mackenzie, 2011; McCrae & Banerjee, 2011). Mental health services need to focus on these factors in both the acute setting and also when consumers return to the community, as the presence of these factors could result in relapse.

Other variables that have been found to influence older consumer's psychological well-being and satisfaction with mental health services include nutrition, physical activity, learning and financial and social assistance (Benbow, 2009; Bottomley, McKeown, & Berry, 2008; Boyle, Buchman, Wilson, Bienias, & Bennett, 2007; Hughes, Prohaska, Rimmer, & Heller, 2005; Lippens & Mackenzie, 2011). Quality, variety and satisfaction with food plays an important role in older consumer's well-being (Harmer, 2007). Neglecting nutritional needs can have a detrimental effect on both physical and psychological health, and can make the recovery process slower (Ryrie, Cornah, & Van de Weyer, 2006). However, currently, the quality of nutritional services for older people particularly in residential care situations is generally given a low priority (Murray, 2006). Research with older people has also shown significant benefit from physical activity in terms of gaining independence and reducing symptoms of mental illness (Boyle, et al., 2007; Hughes, et al., 2005). Social supports have also been significantly associated with effective treatment and satisfaction with care (Lippens & Mackenzie, 2011). This includes mental health professionals who may also become part of a person's support structure especially those providing psychological therapy (Ten Have, Vollenburgh, Bijl, & Ormel, 2002).

A study of satisfaction with inpatient mental health services found that providing education in illness management and life skills contributed to positive health outcomes as well as overall satisfaction with the service (Hackman et al., 2007). Benbow (2009) identified 'learning' as having a positive role in the maintenance of mental and physical good health for older people, and argued that learning assists with maintaining life skills, reducing isolation, engaging with the community, improving self-confidence, and pursuing interests. Therefore, it is important that opportunities for 'learning' are a strong focus of activities provided to older consumers of a mental health service.

Very little research has focussed specifically on older consumer satisfaction with mental health services in Australia. In response to this, the aim of this small study was to explore satisfaction with an older persons' mental health service. In particular, consumer views on whether the care they received helped them progress towards recovery, and had a positive impact on their well-being. The study also explored the service provider's attention to the nutritional and day-to-day financial assistance needs of the consumer, and the appropriateness of the services provided.

Method

Design and setting

This qualitative study was undertaken to explore the experiences of residents with an older person's mental health care service and the findings are therefore descriptive in nature (Buetow, 2007; Kairuz, Crump, & O'Brien, 2007). The service aims to provide a home-like environment with a number of leisure and lifestyle activities to persons over 65 years of age, who have been diagnosed with a mental illness, (and also have an underlying disorder that is related to aging), as well as consumers who experience serious behaviour disturbance that complicates a late onset psychiatric disorder.

The service opened in 2000 in an urban area of Australia, funded by both the State and Commonwealth governments and run under the provision of the Aged Care Act and Mental Health Act. This service provides 22 beds to male and female residents with a median length of stay of 1.7 years. The service primarily provides beds for its own catchment population (80%), and the remaining 20% is for older people from the surrounds of the catchment area. The residents come from diverse

cultural backgrounds. At the time of the study, finances were managed by a public trustee for 19 residents, while the remainder either self-managed or had assistance from a family member. The health care team was composed of nursing staff, psychiatrists, an occupational therapist, a social worker, and a number of other therapists. The service's philosophy was to provide its residents with quality extended care, as well as support while preparing them for their return to their own home, to their families, or to an aged care facility.

Data collection for this study was completed by a mental health professional, who had previously been part of the older person's care team but who was no longer employed in this service. In order to avoid exploiting the vulnerability of the participants being interviewed, their written informed consent was obtained, after they were assessed as being able to take part in the interview, and had the capacity to freely provide their consent to participate (Stenbock-Hult & Sarvimaki, 2011). The participants were given the opportunity to have a support person (such as a carer or family member) during the interview with them if they wished.

The study formed part of a postgraduate mental health practice qualification for a student at an Australian university in 2011. The study was approved by the Health Service District Human Research Ethics Committee (HREC/11/QPAH/438-SSA/11/QPAH/439).

The interviews were 45 to 60 minutes in length. The sampling method employed was the convenience method, as all of the participants were invited from the one mental health service, and had to be present at the time of the interviews being undertaken (Buetow, 2007). The participants for this study were invited to participate on a given day, employing the technique of identifying suitable people, and asking for their consent to take part in the study. The first five eligible consumers who agreed became the participants of the study. A number of potential participants who were able to provide informed consent, declined to sign the consent form in fear of being identified, and consequently did not form part of this study. Some participants were not willing to give particular answers to certain questions, for privacy reasons, or to avoid providing potentially identifiable information. In such cases, no further follow up questions were asked on the topic, in order to ensure their comfort in completing the rest of the interview (Warren & Williams, 2008).

Data Collection

The interview guide was developed to be non-intrusive, while at the same time allowing the participants to provide as much information as they felt comfortable discussing (Clarke, 2006; Kairuz, Crump, & O'Brien, 2007). Topics included their progress towards recovery, self-oriented recovery goals, nutrition, financial assistance and activities that they engaged in as part of their stay in service (see Table 1). Hand-written notes were taken during each interview and additional notes made upon its completion. Interview excerpts quoted in the results are not verbatim; rather they are the researchers' best approximations of what was said by interviewees.

Table 1

Interview Guide

Services

Recovery and goals

1. What does recovery mean to you and what do you expect to do when you recover?
2. How are your goals and plans for recovery supported by the service and how satisfied are you with this level of support?
3. What could the service do differently to make your journey to recovery more satisfying, quicker, or otherwise improved?

Nutrition

4. What would you say about the diet and nutrition provided to you in the service?
5. Are there any changes you would make to the food/catering service that would make you more satisfied?

Finance

6. What is your financial situation, and is it adequate to your daily needs?
7. Do you understand who manages your finances, and are you satisfied with such arrangements?

Activities

8. What activities does the service provide that make you happy?
9. What activities could the service provide to enable you to become more independent in the community?
10. What are some kinds of activities that the service does not currently offer, but which would assist you in becoming increasingly happy and independent?
11. How are you socially involved with other residents and the community? How does this make you feel?
12. What else would assist you in becoming completely or partly independent in the community, with regards to social involvement in the community, finance, and living alone?

Overall

13. How does the service offer you freedom of choice?
 14. If you had a choice in the future, would you choose to reside here again? Why/Why not?
-

Data analysis

Data analysis was undertaken through common-theme identification from the narratives. After identification of major themes that became apparent, these were separated, with corresponding responses entered into Microsoft Excel® software, and then further analysed in conjunction with current literature on the topic.

Results

Study participants

A total of 23% ($n=5$) of the residents consented to participate in the study; three men and two women. Four of these consumers were receiving treatment under an involuntary treatment order (ITO) of the Mental Health Act. Under an ITO consumers have restricted leave from the facility which is authorised by the treating psychiatrist and they are escorted by a staff or family member.

Recovery and goals

When asked about their recovery goals, the participants aspired to live independently in the community in the future with only limited assistance, such as meals-on-wheels, and cleaning agencies. For instance, one consumer responded:

“I have a physical disability, and want to do it mostly by myself. I don’t expect anything and certainly don’t need be locked up. Being locked up means to be curtailed.”

From some participants, it appeared that the service had failed to make a contribution towards their long term goals. For example, one respondent stated:

“I receive no help from the service with the realisation of my personal goals.”

The participants also raised several issues, which they described as preventing their progress towards recovery and wellness. Most frequently, they emphasised the inability to come and go as they wanted from the building, and they felt that this restricted their freedom. One participant stated:

“It’s good here but I don’t need to be here anymore. I only get leave with supervision. I feel that I am losing friends outside of the service

due to my placement here. I have no access to people in the community where I used to live since I was locked up here. They [my friends] are good people.”

Another participant pointed out how the shortage of staff at the service could have a negative impact on their ability to attend to their activities of daily living:

“There is not enough staff here and I was told that I could not go out by myself and there is no one who could take me out. I like shopping; I would like to go to my own hairdresser. I don’t like the one they always take me to...but they don’t let me go... I can only go out once a month for 2 hours, and that’s not good enough.”

Another participant concurred:

“Freedom of choice in our life living here is very important for us. The limitation in what we can or can’t do does not help us in the slightest.”

Nutrition

The nutrition area concerned a number of the participants, as they responded to questions about the service's food. One respondent was satisfied in general, but saw areas for improvement:

“Today was a good meal but not always. We do get fruit but would like more choice of fruit, not only apples and bananas.”

This satisfaction was not, however, shared by all. Others responded negatively and expressed dissatisfaction with the fact that their food was prepared off-site, and reheated at their building. For instance:

“The food is ordinary and far from fresh. I take no joy from the food and have lost lots of weight.”

The cyclical nature of the menu also resulted in negative feedback about the repetitiveness of the food provided. One participant stated:

“I like the food but I would like something from the outside. One day every week we would like to have a special day, maybe Saturday or Sunday, we could choose food, meals for all day and include some ice cream, sweets and more.”

Another participant had hoped to get some support in learning to prepare food, and prepare her own meals while in the care of the service.

“I would appreciate more variety in the food. Why don't we have our own kitchen where we could cook what we like? I would like to cook for myself every now and then, and have cooking classes. A visit to a nice restaurant is long overdue as well.”

Finance

Whilst discussing their experience, the participants commented that they received a substantial pension but had no access to it while residing within the service. Most said that they did not receive any allowance, or received only a very small allowance every week, which they did not perceive to meet their needs. A public trustee managed the funds of the participants interviewed, and they were dissatisfied with the fact that the trustee did not contact them, and they could not access statements or information about their finances regularly:

“We definitely need more flexibility and easier access to our money. I would like to have some money at least one day per month to spend on some special items, clothes... And I want to be able to contact the public trustee, and know what is happening with my finances.”

Several participants expressed frustration with the public trustee and this service which they were charged for. They felt they could manage their finances themselves with some help and knowledge about the movement of their money. However, they said that they had not been able to do this since their admission into the mental health service. For instance:

“I used to manage everything myself till mental health stood in it. I ran my house myself, fed my dog, paid rates, electricity, and all other expenses. I still could do it myself with a bit of help.”

“I am not satisfied. I don’t like to see my money managed by a public trustee. I don’t get statements; my sister gets [them].”

Another participant perceived this as a feeling of being controlled because she had no money available and was dependent on other people:

“[My family] has been very generous to me, helped me a lot with things, but there is some danger here, such as them controlling people doing things.”

Activities

A number of the participants said that they were satisfied with the activities that the service offered, including singing, exercise, cooking and dancing. However, one participant commented on the state of relationships between residents as follows:

“There are a number of activities available, but I hardly ever get involved. I do not mix well with other residents or the staff as we don’t have much in common.”

Another participant was keen to join in the activities but was unable to due to most activities not taking individual disabilities into consideration:

“I used to go the movies, museum, art gallery but this is not happening here. Sometimes they do things like exercise with a ball but these activities are not suitable for my physical disability.”

Overall

Overall, most consumers were generally satisfied with the service but felt that a number of improvements would allow for a better road to recovery. They considered that overall the mental health service met its consumers’ needs:

“I would like (for) some professional people to come here and help me, tell me how to manage things, and fix up my money and pension.”

There were differences in opinion about whether they would have stayed in this particular facility had they been given the choice. One respondent said:

“If I had to, yes. I like the staff, they are good to me. This place is ok.”

Others made negative comments about the service, emphasising would not choose to stay in the service again, if they had a choice:

“It doesn’t matter what I’m trying to do, or what I think is right, I get blocked by the staff. Living in [the service] is like having a ball and chain around my neck. I would like to live independently while I can still do it. They force me to have injections. I’m still sore after that.”

Discussion

Focus on recovery is an essential part of mental health practice. Mental health professionals provide care and support for older consumers, and attempt to engage them in activities that will assist their progress towards recovery, making subsequent living in the community easier and more manageable. In order for recovery-focused practice to take place, health professionals who work with older people with mental health problems need to take this approach. They need to assist consumers with learning about their illness and establishing an individual management plan so that they can take back control of their own lives, plan for the future, and work with the support agencies available to them (Reynolds & O’Hanlon, 2011).

In the process of recovery from mental illness, a holistic approach is suggested, rather than treating the mental illness in isolation (Reynolds & O’Hanlon, 2011). To provide appropriate care to older adults, mental health services should not only focus on the clinical aspects such as provision of medication and ensuring safety, but also explore and provide access to supports for activities of daily-living and social support. Older adults may require help with their finances and diet, for example, and while these are not directly connected to ‘symptom recovery’, they assist consumers in becoming self-sufficient and increasing independence as they re-transition to their community environment. Being treated with respect, feeling safe, and receiving appropriate and timely assistance from staff when required are also well known contributing factors to satisfaction with a mental health service (Howard, Rayens, El-Mallakh, & Clark, 2007).

Overall the consumer participants in this study revealed that whilst they rated the service quality as satisfactory in general, when more specifically probed in the interview they did not find it suitable in meeting their individual recovery goals. This apparent mismatch has been reported in older people by others (Chen, et al., 2006) and Lippens and McKenzie (2011) suggest that with increasing age there may be less impact of need factors on treatment satisfaction. This issue is not unique to mental or physical healthcare consumers rather studies of consumer complaint behaviour in general have observed that many mature consumers react passively to questionable services, products and behaviours and are less likely to complain than younger consumers. It has been proposed that learned helplessness may be an explanation for elderly consumers reluctance to complain about dissatisfaction and consequently consumer education is important to assist mature consumers to express their legitimate concerns (LaForge, 1989; Oumlil & Williams, 2000).

The most prevalent issue or need that was identified during the course of this study was independence. Every participant recognised independence and freedom of choice as their ultimate goal, and this was also included in their definition of recovery alongside improving their overall psychological and physical health. Many of the respondents aspired to gain or regain control of their own housing. However, they pointed out that residing in the mental health service was preventing them from doing so. It was their belief that they were mostly self-sufficient and could manage their day-to-day tasks with little support. The issue of independence raises a tension between the service's delivery of care and the wishes of the people residing in the service. While the older consumers want to be able to come and go more freely as, the service does not allow this level of independence. It may be that the service needs to consider renegotiating the relationship with their residents in a more flexible and individualised way rather than a 'blanket approach' to recovery. A service policy that allowed for individualised plans is more likely to meet consumer needs, increase satisfaction and facilitate long-term positive recovery outcomes (Chen, et al., 2006).

In the case of nutrition, it is apparent that participants had a number of concerns about the food service provided to them. While their nutritional needs may be met with the current provision of meals, their dissatisfaction with the quality of the food and the cyclical repetition may have a negative impact on their recovery. Over the duration of a long-stay it may also reduce their confidence and skills in preparing their own meals when they return to the community. Again, a more flexible approach

from the service around consumer input into menus and sharing and contributing to some meal preparation is likely to have positive outcomes in terms of satisfaction and recovery.

While it may be necessary for a third party to assist with consumer finances during the time they are with the mental health service, access to regular information in a transparent fashion from the service agency such as the public trust could significantly reduce the concerns raised by the participants in this study. Providing the consumers with a choice about whom or which agency assists them with financial management may also be a positive move towards improving satisfaction with the service. Despite the fact that up to 85% of the older persons' disability pension goes towards fixed costs at the service such as accommodation, food, toiletries and medication (leaving only 15% for personal use), the residents should have some input into the way their finances are managed, and have access to competent and professional financial managers that can meet their individual needs. Overall, there is a need for consumers to have more say in the management of their finances, and have options.

Older consumers, who are in the care of a mental health service, may need to encouraged engage in activities that improve their mental health, and be discouraged from engaging in those activities that are detrimental to their mental health. An issue that became apparent in this study was that not all the participants did mix well and socialise with other residents and staff within the service. Mixed responses about satisfaction with the activities raises questions about whether the activities were being tailored to the individual needs of the consumers. The service may need to engage the residents in some choice about the activities they provide and explore individual consumer interests as part of their recovery plan. By doing this, consumers may find unexplored interests, and form relationships with others that they had previously not met, or otherwise had contact with.

In the study, participants described their personal goals and activities that they wanted to participate in; to learn to cook, to go outside to interact with the general community, to make regular trips to shopping centres and leisure destinations. They also desired to have the freedom to come and go and objected to not having the ability to exit the service when they wanted. Whilst the treating team may have some safety and risk based concerns that need to be considered, the plan should be discussed and negotiated with the consumer so that they are actively

contributing to their recovery. Wherever possible consumers should be making lifestyle decisions, managing as much of their own care as appropriate. The service can facilitate this by linking consumers with other agencies, leisure therapists or volunteers who could support individualised activities which meet the consumer's personal recovery goals and choices. Examples of agencies providing such services include Richmond Fellowship, Open Minds and Blue Care, whose community workers can assist with taking residents shopping, organising leisure activities and outings such as gardening, bowls, and theatre etc.

To improve social relationships, the service could consider operating various social clubs such as reading, painting, walking, yoga or exercising (both on and off the premises) with an emphasis on reducing social isolation. These groups may also facilitate two-way communication between the service and residents, by allowing the consumers to voice feedback and suggestions.

Limitations

As with any qualitative research there are a number of limitations that need to be considered. The participants were all residing in one mental health service, and therefore, the results may not be generalised to other older persons' mental health services. Additionally, the number of consumers involved was small ($n=5$) and a larger sample of consumers may have provided a broader perspective of issues. The aim of the small-scale approach was to gain a deeper understanding of consumer perceptions. Further, this study only explored the perceptions and experiences of one group of participants and in order to fully explore the issues around service satisfaction, quality and outcomes it would be important to include other groups such as family members, carers and health professionals who work with the service. Future research could investigate these issues more quantitatively in a survey format from a larger number of older consumers residing in a number of different mental health services and include a more diverse range of participants (e.g. carers and family members).

Conclusion

Overall, during the course of gathering the personal narratives of these five older people, the participants expressed general satisfaction with the quality of the service but were dissatisfied with the restrictions placed on their freedom and independence.

The participants had divided views on whether they would reside at the facility if they were given a choice. They identified the need for more person-centred-care, and a higher degree of flexibility. Increased freedom of choice, personal goal setting, and encouraging their contribution to planning in a meaningful manner, would facilitate recovery and wellness for these older persons living in a mental health service. Further research on a larger scale is required to investigate and provide recommendations to improve the recovery journey of older consumers living in long-stay mental health rehabilitation services.

References

- Benbow, S. (2009). Older people, mental health and learning. *International Psychogeriatrics*, 21(5), 799.
- Bottomley, A., McKeown, J., & Berry, L. (2008). Promoting nutrition for people with mental health problems. *Nursing Standard*, 22(49), 48-56.
- Boyle, P., Buchman, A., Wilson, R., Bienias, J., & Bennett, D. (2007). Physical activity is associated with incident disability in community-based older persons. *Journal of the American Geriatrics Society*, 55(2), 195-201.
- Buetow, S. (2007). *Health research methods: A tabular presentation*. South Carolina, U.S.A: Nova Biomedical Books.
- Care Services Improvement Partnership [CSIP], Royal College of Psychiatrists [RCPsych], Social Care Institute for Excellence [SCIE]. (2007). *A common purpose: recovery in future mental health services* (Joint Position Paper 08). Retrieved 29 October, 2011, from <http://www.scie.org.uk/publications/positionpapers/pp08.pdf>
- Chen, H., Coakley, E., Cheal, K., Maxwell, J., Costantino, G., Krahn, D. D., . . . Levkoff, S. E. (2006). Satisfaction with mental health services in older primary care patients. *The American Journal of Geriatric Psychiatry*, 14(4), 371-379.
- Clarke, A. (2006). Qualitative interviewing: Encountering ethical issues and challenges. *Nurse Researcher*, 13(4), 19-29.
- Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 91-97.
- Hackman, A., Brown, C., Yang, Y., Goldberg, R., Kreyenbuhl, J., Lucksted, A., . . . Dixon, L. (2007). Consumer satisfaction with inpatient psychiatric treatment among persons with severe mental illness. *Community Mental Health Journal*, 43(6), 551-564.
- Hall, J, Waldock, H, & Harvey, C. (2006). Improving mental health services for older people. *The Mental Health Review*, 11(4), 7-13.
- Harmer, J. (2007). Stimulating older appetites. *Caterer & Hotelkeeper*, 197, 53-54.
- Howard, P., Rayens, M., El-Mallakh, P., & Clark, J. (2007). Predictors of satisfaction among adult recipients of Medicaid mental health services. *Archives of Psychiatric Nursing*, 21(5), 257-269.
- Hughes, S., Prohaska, T., Rimmer, J., & Heller, T. (2005). Promoting physical activity among older people. *Generations*, 29(2), 54-59.
- Hungwe, C. (2010). Evaluating older persons' perceptions on their quality of life in an old people's institution. *Journal of Applied Gerontology*, 29(3), 333-351.

- Kairuz, T., Crump, K., & O'Brien, A. (2007). An overview of qualitative research. *The Pharmaceutical Journal, 277*, 312-314.
- Kairuz, T., Crump, K., & O'Brien, A. (2007). Tools for data collection and analysis. *The Pharmaceutical Journal, 278*, 371-377.
- Kaskie, B., Gregory, D., & Van Glider, R. (2009). Community mental health service use by older adults with dementia. *Psychological Services, 6(1)*, 56-67.
- LaForge, M. C. (1989). Learned helplessness as an explanation of elderly consumer complaint behaviour. *Journal of Business Ethics, 8*, 359-366.
- Lippens, T., & Mackenzie, C. S. (2011). Treatment satisfaction, perceived treatment effectiveness, and dropout among older users of mental health services. *Journal of Clinical Psychology, 67(12)*, 1197-1209. doi: <http://dx.doi.org/10.1002/jclp.20842>
- McCrae, N., & Banerjee, S. (2011). The challenge of evaluating mental health services for older people. *International Journal of Geriatric Psychiatry, 26(6)*, 551-557.
- Murray, C. (2006). Improving nutrition for older people. *Nursing Older People, 18(6)*, 18-22.
- Oumlil, A. B., & Williams, A. J. (2000). Consumer education programs for mature consumers. *Journal of Services Marketing, 14(3)*, 232-243.
- Reynolds, T., & O'Hanlon, L. (2011). Recovery-focused practice in mental health services. *Mental Health Practice, 14(7)*, 25-26.
- Ruggeri, M. (1994). Patients' and relatives' satisfaction with psychiatric services: the state of the art of its measurement. *Social Psychiatry & Psychiatric Epidemiology, 29(5)*, 212-227.
- Ruggeri, M., Biggeri, A., Rucci, P., & Tansella, M. (1998). Multivariate analysis of outcome of mental health care using graphical chain models. The South-Verona Outcome Project 1. *Psychological Medicine, 28(6)*, 1421-1431.
- Ryrie, I., Cornah, D., & Van de Weyer, C. (2006). Food, mood and mental health. *Mental Health Today, 6(1)*, 23-26.
- Stenbock-Hult, B., & Sarvimaki, A. (2011). The meaning of vulnerability to nurses caring for older people. *Nursing Ethics, 18(1)*, 31-41.
- Ten Have, M., Vollenburgh, R., Bijl, R., & Ormel, J. (2002). Combined effect of mental disorder and low social support in care service use for mental health problems in the Dutch general population. *Psychological Medicine, 32(2)*, 311-323.
- Warren, C., & Williams, K. (2008). Interviewing elderly residents in assisted living. *Qualitative Sociology, 31(4)*, 407-424.

Biographical Notes

Sonya Ojala trained as a general nurse in the Czech Republic, and completed a Master of Education at the University of South Bohemia. She then worked as a primary school teacher and as a registered nurse in various positions throughout the Czech Republic and Australia. Recently, Sonya completed Mental Health Nursing Clinical Assessment at The College of Nursing in Sydney (2006), and Master of Mental Health Practice (2011) at Griffith University (Australia). Sonya is passionate

about mental health nursing, and has worked in a variety of mental health areas, including acute mental health, older persons' mental health and community mental health services. Currently, Sonya works as a Clinical Nurse in the Wynnum Continuing Care Team. Sonya has conducted research into the delivery of mental health services to older people with the objective to share her experience with others and promote implementation of effective methods for recovery and wellbeing in mental health care.

Professor Amanda Wheeler took up an appointment in Mental Health at Griffith University in late 2010. Amanda's key focuses are on translational research and quality improvement in healthcare particularly in the management of mental illness and addictions. She has been successful in obtaining funding grants from various sources and completed many health services and clinical research projects both investigator-initiated and contracted projects. Amanda has published widely and frequently leads workshops and presentations on issues related to mental health and psychopharmacology. She has a strong focus in training of new researchers and practitioners and one of her primary goals is to bring research into the clinical and community workplace.