Submission to the Senate Select Committee on Mental Health

Submitted by Dr Roderick George McKay
On behalf of the New South Wales Branch of the Faculty Of Psychiatry of Old Age within the Royal Australian and New Zealand College Of Psychiatrists.

As NSW Chair of the above Faculty I wish to bring the following concerns regarding the mental health of older Australians to the attention of the committee

Although members of the Faculty have, as do any group of professionals, a variety of motivations for working with older Australians with mental illness, there is one reward they all share. That is the reward of seeing individuals with mental illness being relieved of the dreadful distress they can suffer. This is often accompanied by significant improvements in quality of life for those in close contact with these individuals. Unfortunately this reward is tempered by the knowledge that only a minority of older Australians with mental illness are able to access professionals trained and resourced to provide optimal evidence based treatments. Our hope is that this situation can, with integrated planning and improved funding, be progressively improved.

In summary we submit that:

- the National Mental Health Strategy has had limited effect in improving mental health services to older people
- specialist mental health services for older people in all settings are markedly under-resourced, and significantly less developed than mental health services for the remainder of the population. This is clearly evident in NSW.
- lack of clarity regarding responsibility for funding between different levels of government, and within each level, is a significant ongoing barrier to improvements in mental health care for older Australians.
- older Australians in Residential Aged Care Facilities are at particular risk of mental illness, and of lack of access to services
- evidence based models of care do exist for mental health disorders in older people, but current resources severely limit the access of older Australians to such care.

The National Mental Health Strategy has had limited effect in improving the mental health care of older Australians in NSW. Although there has been a reduction in patients managed in long term mental health beds there has been no co-ordinated system developed across the State to optimally manage older people with mental health disorders in the community. There is a marked shortage of inpatient resources of all types. There is an even greater, severe, shortage of resources to manage older people with mental illness in the community in all areas of NSW. Some areas have no access to specialist mental health services for older people. As a consequence of this older people with mental illness do not have access to a comprehensive range of mental health interventions. Furthermore older people have less access to private psychiatric services in Australia. An analysis of 1998 Medicare data revealed that per capita the proportion of Medicare

expenditure allocated to adults aged less than 65 years was 4.1 times that for adults over 64 years. This was a decline since 1985–1986 (Draper and Koschera 1).

The NSW Branch of the Faculty of Psychiatry of Old Age, in association with the NSW Centre for Mental Health, sent a postal survey to all aged care services, adult mental health services and mental health services for older people in NSW. The results of this were published in 2003 (Draper et al 2003). This concluded "Only 59% of aged care services and adult mental health services considered that their local mental health services for older people provided an adequate service; resource and budget limitations were portrayed as the main constraint. Mental health services for older people varied widely in structure, settings and activities undertaken. Access to mental health beds for older people was also variable, and alongside staffing levels was considered problematic. Lack of staff training and/or inexperience in psychogeriatrics posed a challenge for aged care services and adult mental health services". As with other areas of mental health, mental health services for older people face major challenges in workforce development that require a co-ordinated, resourced, approach linking service development to staff recruitment, training and retention.

NSWHealth is currently developing a service plan for older persons mental health services. In it's current state of development this appears a promising framework for improving the delivery of mental health care to older people. However the Faculty has significant concerns regarding the likelihood of funding being allocated to effectively implement such a plan. NSWHealth has a model to estimate the number of beds and staff required for the care of the mentally ill, broken down into child and adolescent, adult, and older people. Whilst elements of this model could be questioned; such as largely excluding those with dementia and comorbid mental illness from calculations; it does provide a benchmark to guide planning. Despite Older Persons' Mental Health Services clearly being **very** poorly resourced against these benchmarks compared with services to other age groups, there has been no evidence to date that this deficit is being considered a priority with regards to funding services. The NSW Government's Plan for Mental Health Services released in March 2005 to guide planning over the next four years included funding for opening one older persons mental health inpatient unit in the Illawarra. No other planning for older persons' mental health services was included in this plan.

Whilst engagement with NGOs is a reasonable way of delivering some aspects of care for older people with mental illness there appears to be a significant risk that moves across the NSW Mental Health systems to do this more may actually disadvantage the elderly. This appears particularly the case for accommodation support services for the mentally ill. It is our perception that the elderly have always had difficulty accessing such services. Recent moves towards contracting such service provision to NGOs have resulted in contracts that define the population to be served as being no older that 65 years.

There is a pressing need for clear policy responsibility at a national level for older Australians with mental illness.

Ongoing disagreement regarding responsibility for funding at both National and State levels appears a significant factor in the lack of development of mental health services for older people. There appears to be disagreement at National, State and Area Health Service levels regarding the respective responsibilities of Mental Health versus Aged Care departments. This is then further exacerbated by disagreement regarding the respective responsibilities of different levels of government. The consequence of this is that, even when the need for such services is acknowledged, at all levels the funding of mental health services to older people appears to always be something that should be sought 'from someone else'. This problem is particularly evident in attempting to develop services for people with mental health disorders in Residential Aged Care Facilities; or who have Behavioural and Psychological Symptoms of Dementia (BPSD). BPSD is a term that has been developed to describe those people with dementia who develop associated mental health and behavioural disorders.

A further result of this funding confusion is that if an older Australian develops mental illness this becomes an impediment to obtaining access to appropriate support services (ongoing or respite) in the community or within Residential Aged Care. This can be because services consider (officially or unofficially) that the presence of a mental illness makes the person 'outside their scope'; fear that the presence of mental illness (even depression) may make the person dangerous or inappropriate for the service; or because no services have been developed for those who do require services with able to refocus upon people with ongoing mental illness. Currently there are few such services within the community or residential aged care within NSW. With an increasing focus upon non-'Health' 'Case Management' of the elderly with complex care needs, there is an urgent need for such services to be developed in a manner that is inclusive of, and has the capability to serve, those with mental illness.

Residents of Residential Aged Care Facilities (RACFs) are at particularly high risk of mental illness. Elderly males have significantly higher rates of suicide than the general Australian population. Estimates of rates of depression within high level residential care are in the order of 20% with diagnosable disorders and 30 to 75% with significant depressive symptoms (Llewellyn-Jones et al 2001). Estimates of rates of BPSD in nursing homes vary from 29%-90% (Brodaty et al 2003); with estimates of over 90% in a recent Australian study (Brodaty et al 2001). These rates are far higher than rates of psychiatric illness in other areas of our community and should be seen as unacceptable. There are no current estimates of the rates of schizophrenia or Bipolar Disorder within RACFs in NSW. However the absence of alternate long-term inpatient care options and very limited community care options would appear to increase the likelihood of older people with such disorders being managed within RACFs. Mental illness not only affect the individuals whom directly have them, but also impact markedly upon other residents, staff and families. There are significant associated costs in terms of staff and resident injuries and increased care needs.

These problems are exacerbated by staffing issues within RACFs. The majority of 'hands-on care' within RACFs is provided by low-skilled staffing positions, with high

rates of people with English not as their primary language. Mental health issues in the elderly in RACFs are most commonly associated with significant medical problems, with significant interactions between these. Access to GPs appears to becoming increasingly difficult within residential aged care, and the ability of GPs to address mental illness related issues in these settings appears very variable. It is known that depression is under diagnosed within RACFs. Access to specialist medical services, including geriatricians, also often appears impeded by entering residential aged care. The result of this is that older Australians with the highest degrees of medical and mental health morbidity have the most restricted access to appropriate health care. Even when facilities have access to advice regarding appropriate management of mental health disorders they often have great difficulty implementing this advice.

Despite these issues, only one area in NSW (Illawarra) has been funded for a Psychogeriatric Unit to support RACFs in managing patients with BPSD. This team has no funding for psychiatric input and is not integrated with mental health services. We propose that there is an urgent need for funding for mental health care within RACFs across NSW. There has been a Severe and Challenging Behaviours project developed in partnership between NSWHealth and this Faculty, with involvement of other interested parties including the Commonwealth Government and Residential Aged Care Provider organizations. The recommendations of this report could be utilized to guide such funding.

The Commonwealth funded the 'Challenge Depression' package to provide a guide for facilities to reduce rates of depression amongst residents utilizing a largely preventative approach. This package has many excellent elements to it and addresses a major problem. Unfortunately, however, there appears to be no plans to fund implementation of the package beyond it's production. Subsequently it is very unlikely it will be effectively implemented. It is vital that when funding is put into developing resources that an effective implementation plan, linked to funding, is integral to the project. Otherwise the resources will not be effectively utilized. Other Australian research confirms that proactive and preventative action can reduce rates of psychological distress in residential aged care facilities (Llewellyn Jones et al 2001). Such action should become part of routine care in residential aged care, supported by adequately funded older persons' mental health community teams for those identified as requiring clinical treatment.

Providing appropriate management for older people with BPSD is particularly challenging. Optimally this requires an integrated approach from prevention through to acute inpatient care when required (Brodaty et al 2003 outlines this model in detail). The fragmentation of delivery of services relevant to this in the community makes this such an integrated approach uncommon. Instead patients and their family's must negotiate through a series of services (private, NGO, Health and doctors) to try to obtain services in the community. There is marked variability from place to place in what services are provided by whom, and in no area of NSW is there appropriate access to services with adequate resources to manage these issues. BPSD should be optimally managed initially through non-pharmacological interventions. These require to co-ordinated multidisciplinary teams to assess patients and provide at least initial training of families

or staff, and sometimes, ongoing involvement for a period. This then requires supplementary use of medications for some patients. In the absence of such teams excessive reliance must be placed upon medications. This is expensive, less effective and increases the risk of adverse events for patients. The presence of ongoing BPSD is a predictor of earlier admission into residential aged care, and a predictor of increased costs within residential aged care. There is an urgent need for the funding and development of multidisciplinary teams to manage these problems once primary level services cannot, and to provide training for primary level services to enhance their capabilities. Such teams must provided a service that is integrated with community older persons mental health, and community geriatric, services. Such integration is hindered by current funding structures.

Current funding structures also result in major problems in data collection. The importance of being able to effectively measure the resource put into services, and the outcomes for individuals receiving such services, is essential for effective service delivery and policy development. However currently services providing mental health related services to the elderly have multiple potential data sets they may have to complete. These include the Mental Health National Outcomes and Casemix measures, Mental Health Minimum Data set, Aged Care Minimum Data set, HACC minimum data set, the AN-SNAP Outcome measures and minimum data set and the residential aged care data sets. There are also differing, duplicate, accreditation systems that (usually small) services must comply with. This results in either duplicate data entry of fragmented sets of data that cannot be effectively utilized. At present clinicians are very disillusioned with such activity. There must be rationalization of these data sets and systems if such activities are to improve service delivery or allow rational planning.

Older Australians with drug and alcohol problems, especially of comorbid with mental illness, have extremely poor access to drug and alcohol services. The national drug and alcohol plan has only two brief mentions of the elderly and no policy initiatives with regards to the elderly. Older Australians with drug (most commonly prescribed) and alcohol problems have increased rates of mental illness and may have co-morbid cognitive impairment. This may be due to the substances or due to dementing processes. Current drug and alcohol services are focused on the problems of younger Australians and so there appears to be no services clearly accepting responsibility for managing these issues.

It is worthwhile noting that older Australians with mental illness, and their carers, also have had very little involvement in the increasingly important consumer and carer movements within Mental Health. This appears due to multiple factors including their functional capacities, lack of respite care options, at times cognitive impairment, and differing views upon consumer involvement and stigma. Also the ‘mainstream’ mental health (and dementia) consumer/carer movements are probably focused upon issues at variance from the main concerns of older mental health consumers and their carers. This is balanced, to a degree, by a traditionally more co-operative approach taken by mental health services for older people. However it means that there is reduced consumer and carer involvement in guiding service planning, and in lobbying for services.

As service delivery to older Australians with mental health disorders has been poorly served compared with younger Australians, this also applies to research. Pharmaceutical trials often exclude older people in the larger trials, and then reliance must be placed upon smaller, later trials in older people. There is a general lack of funding for research relevant to older persons' mental health, but particularly relevant to the development of services is the lack of funding for research into successful implementation of non-pharmacological management of BPSD and non-pharmacological management of depression in the elderly.

WHO Regional Office for Europe's Health Evidence Network (HEN) commissioned a report 'What is the effectiveness of old-age mental health services?' in 2004 (Draper and Low 2004). This report provides an excellent analysis of the evidence supporting the implementation of older persons' mental health services. In part they concluded "The strongest evidence supports the development of community multidisciplinary teams as a major service-delivery component, and this should be encouraged in all European countries, as should partnerships with consumers, non-governmental organizations, primary care providers, social services, long-term residential care providers and other medical services."

In summary, despite the increasing concern in the broader community regarding the impact of an ageing population upon our health system, the delivery of services to improve the mental health of older Australians has received very limited resources, and development is hindered by lack of clear responsibility for planning or funding of services. This situation is exacerbated by the reality that older Australians with mental illness and their carers are not as vocal, nor as likely to be in the media, as their younger counterparts. There are known effective systems for improving the mental health of older people, but they require adequate resourcing. We believe that nation has a responsibility to offer equivalent access to mental health care to older Australians as it does to younger Australians. We do not believe this is currently the situation.

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