FACULTY OF PSYCHIATRY OF OLD AGE

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

Submission to the Senate Select Committee on Mental Health

Introduction

The Faculty of Psychiatry of Old Age (FPOA) represents the members of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) with a special interest and expertise in the care of older people who suffer from mental illness.

The Faculty trains young psychiatrists in this area of work; supports its members by means of conferences and other teaching activities, and advocates for better services for older people and their carers.

Mental disorder in later life

Old age psychiatrists treat three broad types of disorder – mood disorders, psychosis and dementia. I list examples here from my own service in a Melbourne public hospital to give Committee members an impression of our work:

- Mrs A, a 76 year old married woman, became depressed six months ago following surgery. She is now so anxious and agitated that she cannot eat or sleep and she has stopped cooking and shopping. She has withdrawn from all social contacts. Her husband must encourage her to shower and dress. We prescribed antidepressant medication and provide twice-weekly psychological and practical supports. She is likely to make a full recovery.

- Mr B, an 83 year old single man, has suffered from schizophrenia for six decades. He was admitted to psychiatric hospitals on innumerable occasions when his delusions and hallucinations became too frightening but he is now generally settled and lives in an aged care hostel. He has fewer side-effects on new anti-psychotic treatments but the dose of medication must be titrated frequently because of fluctuations in his physical health. He remains isolative and odd in his demeanour and speech. Staff avoided him at first but, with education and encouragement, they now involve him in activities which he enjoys.

- Mrs C, a 72 year old married woman, suffers from Alzheimer's disease. She is confused, disoriented, persistently restless, verbally abusive towards her husband and resistive to efforts to help her dress and shower. Her disturbed behaviour is immensely distressing to her husband despite support from his children, neighbours and GP. She also experiences delusions and hallucinations. The treatments we prescribed to slow the progression of her dementia and to calm her agitation have stabilised her condition and Mr C values the opportunity to ventilate his fears and frustration. We have also linked him to the local carer support service and the Alzheimer's Society.

These patients have different conditions and prognoses but all were helped greatly by a multi-disciplinary aged psychiatry team. Such teams have a special role to play in the case of:

- Older people who cannot access private psychiatrists or private psychiatric hospitals because of poverty, physical frailty, confusion, type of residence, or area of residence in Australia.
- Those who require involuntary admission to a public mental health facility.
- Those with complex combinations of mental and physical disorders who require speedy input from psychiatrists, geriatricians, nurses and allied health professionals.
- Those whose treatment requires linkages between mental health workers, GPs, general hospitals, Aged Care Assessment Services, local councils, Community Aged Care Package providers and residential care staff.

The numbers of people in all these categories are growing quickly.

Demographic and social changes

The Australian population is ageing rapidly. As a result, by 2050 the total numbers of people with dementia will exceed 700,000, a fourfold increase since 2000 (1).

At the same time, community expectations of aged care services are rising. In aged residential facilities, for example, the Commonwealth Department of Health and Ageing stipulates that care must be as home-like and dignified as possible. This can be difficult since 60% of nursing home residents have moderate or severe dementia and many show the sorts of disturbed and disruptive behaviours described above. Such behaviours threaten the well-being and safety of staff and co-residents whose levels of tolerance are declining. The demand for special residential units, and specialist clinical input, is likely to grow.

Severe anxiety and depressive disorders are commonest in old people with chronically painful physical disabilities. Their numbers will grow in line with population ageing. Anxiety and depression are complicated in many cases by physical illness and dementia. Special expertise is required to distinguish these conditions and to deliver effective, safe treatments that restore quality of life, promote independence and relieve strain on carers.

The Mental Health Strategy

The Mental Health Strategy focuses on community care, consumer and carer participation, and service coordination. FPOA supports all these initiatives. We have always worked closely with families, GPs and aged care services. This is what we do. It is perfectly routine.

We know from experience that we must base ourselves in the community to engage frail, old people with severe mental and behavioural disorders; to support families and residential facilities, and to help people remain in their own homes if they wish.

Models of Care

FPOA supports a fully integrated model of aged mental health care that comprises:

- Community outreach to old people with severe mental illness and/or behavioural disturbance, whether in the community or residential care, whose needs exceed the capacity of GPs, geriatricians and private psychiatrists.
- Acute inpatient units that provide intensive assessment and short-term treatment, typically for 3-4 weeks, to older people whose mental and/or behavioural conditions cannot be managed safely in the community. It is anticipated that most will improve and return home.

- Small numbers of specialist residential beds for people with dementia and severe, persistent behavioural problems who cannot be cared for safely in mainstream facilities. These beds can be auspiced by a range of service providers with support from aged psychiatry teams.

This community-focused, integrated model of care is expressed most fully in Victoria where stand-alone psychiatric hospitals were closed in the early 1990s (using funds from the Commonwealth Government's *Better Cities* program) and replaced by child and adolescent, adult and aged psychiatry services in all parts of the State. "Ring fenced" mental health funding is allocated centrally using a weighted, population-based formula. Service components are described in a *Framework* document which Regions are required to implement. The model is straightforward and ensures equity of access to services to people of all ages and in regional and rural areas (2).

Old age psychiatry services are developing in other States too but the process is slow and lacks coherence. According to a survey conducted by FPOA in 2003, the number of services per 100,000 people aged 65+ years ranged from 0.9 in South Australia to 7.4 in Western Australia. Similarly, the numbers of State-funded aged mental health beds ranged from 36.6 per 100,000 people aged 65+ years in New South Wales to 130.3 in Victoria. Services in New South Wales, the State with the largest aged population, were especially poorly resourced (3). This situation is highly inequitable, particularly for people in regional and rural areas.

Funding and service coordination

Older people benefit greatly from the Commonwealth Government's community and residential support programs. People with mental disorders including dementia can access home-based domestic support, carer support and respite programs that greatly enhance their quality of life.

For those in residential care, the Aged Care Standards and Accreditation Agency has overseen the closure of derelict nursing homes and their replacement with modern facilities that offer personalised care to physically and mentally disabled residents. Staff must now conduct detailed assessments of new residents' physical and mental states and deliver individualised care plans that accord with residents' and carers' values. This is a wonderful initiative.

In Victoria, elderly residents of long-stay mental hospital wards were moved in the early 1990s to new Commonwealth-subsidised psychogeriatric nursing homes as part of the *Better Cities* program described above. The State Government's "top-up" funding ensures higher than average staffing levels. These homes are now part of local aged mental health services and provide care, usually for one to two years, to people with the most severe mental and behavioural disturbances whether due to dementia or other mental disorders. They work very well and provide an example of how Commonwealth and State Governments can pool resources to good effect. FPOA supports the development of similar cooperative arrangements in other States.

The Commonwealth Government also funds small numbers of high quality programs that support mainstream residential facilities to care better for residents with dementia and challenging behaviours. Examples include the *Psychogeriatric Unit Program* that supports one specialist team per State and the *Dementia Behavioural Assessment and Management Service Program* that is being trialled at present in some States.

Many more such programs will be required in the future. It seems wasteful, however, to have Commonwealth dementia-specific residential programs (where they exist) working alongside State-funded aged psychiatry teams (where they exist) that work in both community and residential settings. To complicate matters, these programs are usually run through different State Government branches (e.g. aged care and mental health) with little communication between the two. This doesn't make sense. Both types of programs care for older people who

are anxious, frightened, agitated and subject to behavioural disturbances and psychotic symptoms. Such duplication cannot be helpful and should be remedied.

Private and non-government sector

The kind of multi-disciplinary, community-focused care espoused by old age psychiatrists generally works best in publicly-funded settings. While private psychiatrists see large numbers of older people, and a few private psychiatric hospitals in capital cities have dedicated psychogeriatric units, older adults receive only a quarter of the Medicare-rebated psychiatric consultations provided on a *per capita* basis to younger people (4).

Frail, confused, multiply handicapped elderly people cannot easily visit psychiatrists. Psychiatrists and other clinicians must visit them instead. This reinforces the need for public aged psychiatry services in metropolitan and regional areas in all parts of Australia.

GPs provide the bulk of care to older people with mild to moderate mental disorders (and severe disorders too in isolated areas). The new Medicare-rebated annual health checks of older patients generally include questions about mood and memory and will alert GPs to new cases of depression and dementia. This is a major advance in primary care.

It is imperative to strengthen GPs' skills, especially in regional and rural areas, by means of targeted rebates (e.g. annual health checks) and access to dementia/mental health multi-disciplinary teams. Given the size of some States, and the large number of regional centres, Tele-psychiatry has an obvious role to play.

Summary

- The rapid ageing of Australia's population necessitates stronger, better coordinated systems to care for older people with serious mental disorders including dementia. Key players include GPs, State Government's mental health and aged care programs, and the Commonwealth's aged care programs.

- The current rigid division of responsibility for aged and mental health services is rooted in history and makes no sense in today's society. Community-resident old people with depression, schizophrenia and dementia all benefit from Commonwealth programs. Equally, residents of Commonwealth-subsidised aged care facilities benefit from the broad-based aged psychiatry services provided by in some areas by some States.

- While dementia and mental disorder take many forms, both can precipitate anxiety, depression, psychosis, confusion and disturbed behaviours. Medical, nursing and psychological treatments often overlap. Aged psychiatry services therefore meet a broader demand than dementia-specific residential services.

- The neediest, most disabled old people cannot easily access private psychiatrists or private psychiatric hospitals. State-funded services pick up most of this load – but to varying degrees. Victoria, for example, does a much better job than New South Wales. This is unfair.

- Victoria has led the way in developing equitably distributed aged mental health programs that care for older people with dementia and other mental conditions. It works closely with the Commonwealth Government to run its psychogeriatric nursing homes which form a model for other States.

Recommendations

- There is huge demand for mental health services in Commonwealth aged residential facilities where rates of dementia and depression are high. The current division of responsibility between Commonwealth dementia services and State aged psychiatry services is unhelpful. The Commonwealth as the larger partner must take the lead in linking these different service models.

- Aged psychiatry services vary greatly from one State to another. Services to people in regional and rural areas are especially poor, even in States as large as New South Wales. Incentives and sanctions should be applied by the Commonwealth to remedy this inequity.
- Commonwealth and State Governments have worked together to good effect in Victoria to fund psychogeriatric nursing homes that provide medium-term care to older people with severely disturbed behaviours. In larger States, alternative arrangements will be required, e.g. State "top-up" funding to beds in selected generic facilities.
- Commonwealth initiatives to help GPs better identify and manage mental and behavioural disorders are immensely helpful. These initiatives include annual checks, locally-based aged psychiatry services and tele-psychiatry services to regional and rural areas.

Concluding comments

This submission was approved by the FPOA Executive. I and other senior members of the Faculty would be delighted to amplify this evidence and to respond to Committee member's questions at a public hearing.

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References

Access Economics (2005). *Dementia Estimates and Projections: Australian States and Territories.* Melbourne, Alzheimer's Australia, p6.

Victorian Government Department of Health and Community Services (1996). *Victoria's Mental Health Service: The Framework for Service Delivery: Aged Persons Services.* Melbourne: Psychiatric Services Division.

O'Connor DW, Melding P (submitted for publication). A survey of publicly-funded aged psychiatry services in Australia and New Zealand.

Draper BM, Koschera A (2001). Do older people receive equitable private psychiatric service provision under Medicare? *Australian and New Zealand Journal of Psychiatry* 35: 626-630.