Submission to the Royal Commission into Aged Care Quality and Safety.

October 2019

MentalHealth Victoria

Collaboration • Knowledge • Leadership

Contents

About us

Mental Health Victoria is the peak body for organisations that work within or intersect with the mental health system in Victoria. We advocate for reforming the mental health system to ensure that people living with mental health issues can access the care they need, when they need it.

Reflecting the composition of the mental health system itself, our members come from a mix of clinical and non-clinical, acute and community-based, and public and private organisations. In addition, we work closely with stakeholders from a broad range of intersecting systems including aged care, disability, housing, public safety and legal services.

Our collective vision is for a mental health system where people can access safe, effective and appropriate treatment and community supports to enable them to participate fully in society. Our purpose is to drive system reform to ensure people receive the mental healthcare they need, when they need it, regardless of their age, gender, disability, level of need, or any other factor.

This submission was produced with the assistance of:

- Aged Care Guild
- Australian College of Mental Health Nurses
- Carers Victoria
- Council on the Ageing, Victoria
- EACH
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- Mentis Assist
- Merri Health
- Mind Australia
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- VincentCare

Executive summary

While stigma and stereotypes may tell us otherwise, mental ill health is not a normal part of ageing.

The evidence tells us that 10–15% of older Australians have symptoms of depression. More worrying and relevant to the Royal Commission's investigations is that the rate of depression increases to 45% for those entering residential aged care facilities and more than 50% for those residing therein.

Mental illness is the single largest contributor to years lived in ill health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians so it is of critical importance to aged care.

Many older Australians experience mental illness, either continuing from earlier years or arising in later life. Few are getting the support they need.

Older people are much more likely to be given medication over other treatment and support services. In residential aged care facilities, this may lead to what is known as 'chemical restraint' which is, of course, not only unacceptable as a care response but may even increase vulnerability to unsafe practices and abuse.

This submission calls on the Royal Commission to ensure that mental healthcare is central to its investigations, including through an overarching recommendation to hold a special hearing focussed on mental health service provision for older people with a particular focus on residential aged care facilities.

It also urges reform to address barriers to mental healthcare, including location, cost, and equity of access. At the top of the list are the need to address age eligibility frameworks and access to mental health programs in residential aged care.

The submission also looks closely at the design of services and highlights workforce issues, urging better remuneration and training in aged care.

Summary of recommendations

Mental Health Victoria urges the Royal Commission to:

Hold a special hearing that focuses on mental health services in the aged care sector with a particular focus on residential aged care facilities.

Access to mental health services:

2. Investigate why older people have such high PBS mental health-related medication rates and low MBS service rates relative to the rest of the population.
3. Investigate access to the MBS and specialist health services in RACFs, including barriers and mechanisms to increase access.
4. Investigate the mental health competencies of My Aged Care assessment teams, the use of appropriate screening tools, and streamlined referral pathways into the system to ensure that aged care assessment processes cater for the mental health needs of older people.
5. Investigate access to coordination/ navigation services for older Australians with mental health issues, both living in RACFs and the broader community, including a focus on key population groups.
6. Investigate the appropriateness of age eligibility requirements for access into specialist adult and older persons' mental health services.
7. Investigate access barriers for key population groups in aged care, including culturally and linguistically diverse, LGBTIQ+ and Aboriginal and Torres Strait Islander peoples, and people in rural and remote locations.
8. Investigate the use of advance care planning supports and mechanisms in relation to mental health and aged care services.

Design of mental health services:

9. Investigate the availability of healthy ageing programs that intervene early and prevent the symptoms of depression among older people.
10. Investigate the care of people with long-term mental health conditions in RACFs.
11. Investigate how to achieve the best balance between promoting information-sharing across systems while guaranteeing human rights and privacy.
12. Investigate access to carer-specific services including peer support, respite, information and navigation of available supports.
13. Investigate access to culturally appropriate services for Aboriginal and Torres Strait Islander, LGBTIQ+ and culturally and linguistically diverse communities.
14. Implement the recommendations in the Australian Law Reform Commission Report 131 on Elder Abuse, including the establishment of an independent oversight body to investigate incidents of elder abuse.

Workforce support & development:

15. Investigate how the workforce can be better supported to act as a key enabler of system reform.
16. Investigate how mental health capabilities and systems for learning can be improved within the workforce.

Introduction

Better responding to the mental health needs of older Australians should be an integral part of aged care reform.

Mental illness is the single largest contributor to years lived in ill health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians.[1]

Many older Australians experience mental illness, either arising in their later life or continuing from their earlier years. As the population continues to grow and age, the costs associated with mental illness in later life will continue to rise.[2]

Dementia is having an increasing impact on the mental health of older Australians. Though strictly a neurological condition, the majority of people living with dementia will experience distressing associated behavioural / psychological symptoms. This may drive or exacerbate mental health symptoms and illnesses and present challenges to service delivery.

Despite these growing issues, our mental health and aged care systems cannot meet the current and future needs of Australians. This is due to many interconnected and reinforcing factors, including:

- ineffective system governance – compounded by commonwealth, state and territory service silos, a multitude of commissioning bodies, ineffective planning, and a lack of real targets and outcome measures
- a history of under-resourcing across all systems, resulting in rationing of services, ageing infrastructure and failure to meet growing demand
- insufficient focus on prevention, early intervention and recovery in the community.

In this environment of scarcity, Australians struggling with mental illness and their unpaid family and friend carers are too often unable to access mental health treatment and support. Barriers to accessing quality services relate to geography, government policy, and the inability of the various parts of the system to work together to provide integrated care.

For many older Australians, these issues are compounded when their access to mental health services is arbitrarily restricted according to their age group and whether or not they are living in a residential aged care facility (RACF).

Those aged 65 years and over – an arbitrary bureaucratic dividing line between being an adult and an 'older person' – face significant disadvantages in terms their ability to access medical, allied health and other support services, particularly if they enter residential aged care.

While access to mental health services is low for older Australians, medication rates are high. Medication is often an appropriate response to mental health issues such as dementia but there is concern that prescriptions occur at such high rates and are not routinely provided with concurrent non-pharmacological treatments. At worst, this can constitute a form of 'chemical restraint' which may increase an older person's vulnerability to unsafe practices and abuse.

1. Australian Institute of Health and Welfare 2016, Impact and causes of illness and death in Australia 2011, Australian Burden of Disease Study series no. 3, Canberra.
2. Australian Institute of Health and Welfare 2015, Australia's welfare 2015, Australia's welfare series no. 12.

An overarching recommendation

This submission was developed with the advice and input of a large number of organisations from across the mental health, aged care, seniors rights, local government and primary health sectors. It is intended to draw the Royal Commission's attention to the experiences of older Australians who either have a pre-existing mental illness or who develop a mental illness in later life. It focusses on three key areas:

1. Access to mental health services
2. Design of mental health services
3. Workforce support and development.

Each section of the submission contains a number of recommended focus areas for the Royal Commission to consider.

Given the scale of the difficulties in accessing appropriate mental healthcare experienced by older people in RACFs, our overarching recommendation is that the Royal Commission hold a special hearing on mental health with a focus on RACFs.

While a focus on mental healthcare in RACFs is vital, ensuring that people in receipt of aged care services in the community can also access appropriate mental healthcare is important too. Wherever possible, services should intervene early in the course of mental illness and prevent mental illness from occurring later down the track.

Recommendation 1

Hold a special hearing that focuses on mental health services in the aged care sector with a particular focus on residential aged care facilities.

Key facts

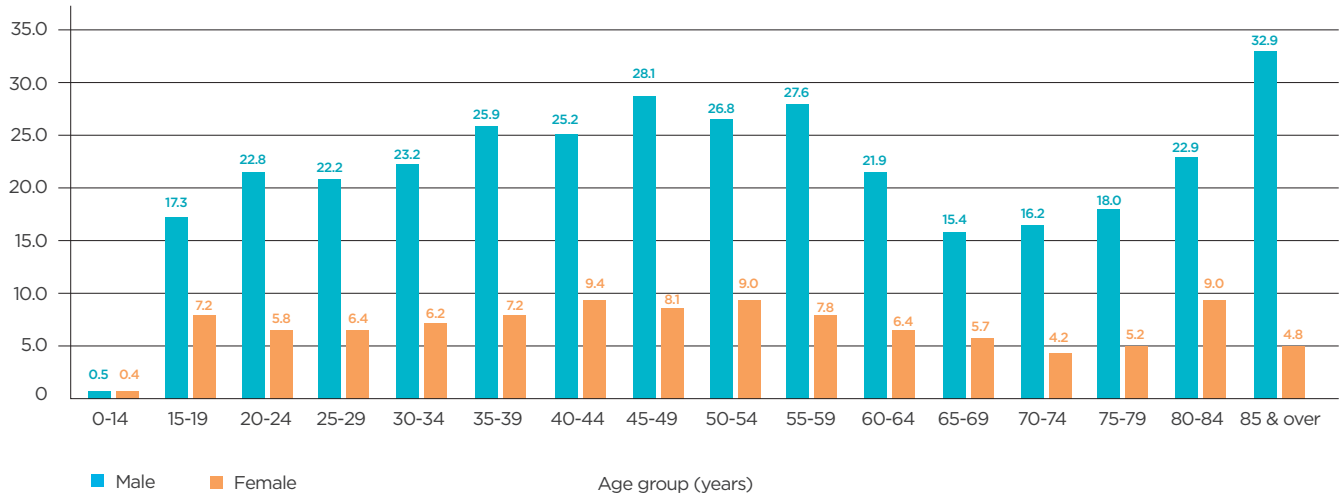
Rates of depression among general practice patients are trending upward;[5] however GPs are often unable to refer older people to specialist services because of service shortages.[6]

10–15% of older Australians have symptoms of depression and this rate increases to 45% for those entering RACFs and more than 50% for those residing therein.[3 4]

One in 10 older Australians are living with dementia; by 2058, it is expected that more than 1 million Australians will have dementia.[8]

Men aged 85 and over have the highest age-specific suicide death rate in Australia.[7]

Suicide deaths per 100,000 by age and gender, 2018

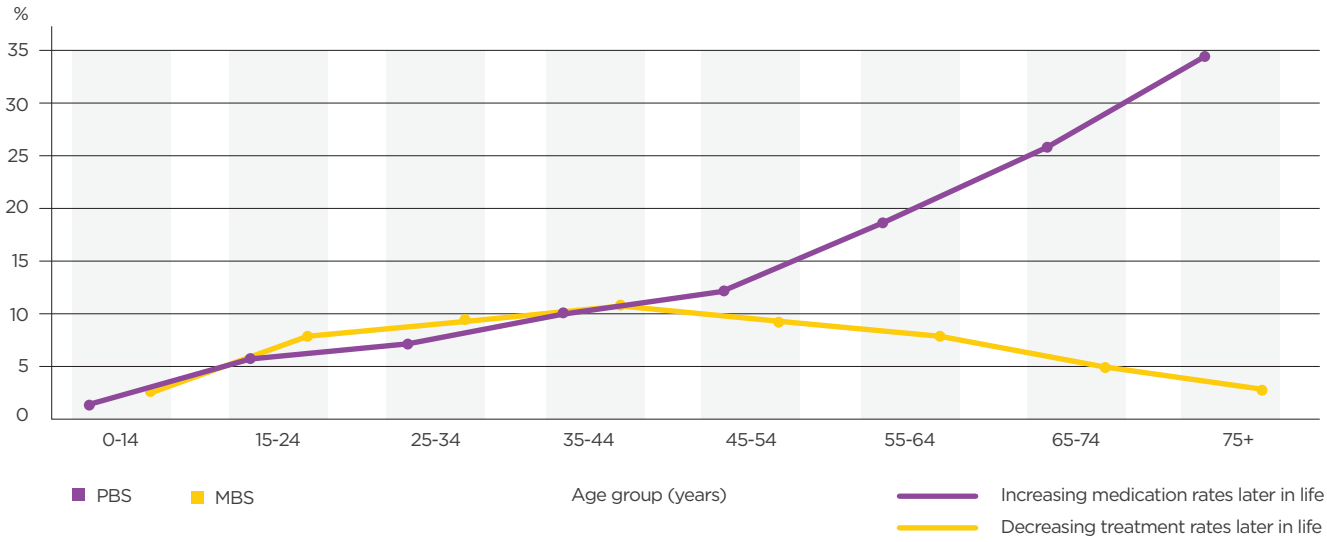


3. National Ageing Research Institute 2009, Depression in older age: a scoping study, Final Report, Melbourne: beyondblue.
4. Australian Institute of Health and Welfare 2013, Depression in residential aged care 2008–2012, Aged care statistics series No. 39. Canberra.
5. Pfaff JJ, Draper BM, Pirkis JE, et al. , 2009. 'Medical morbidity and severity of depression in a large primary care sample of older Australians: the DEPS-GP project.', Medical Journal of Australia 190(7): S75–S80.
6. McKay R 2012, 'Is it too late to prevent a decline in mental health care for older Australians?' Medical Journal of Australia 197(2): 87–8.
7. Australian Bureau of Statistics 2019, Intentional self-harm, key characteristics, ABS cat. no. 3303.0, Canberra: ABS.
8. Dementia Australia 2018, Dementia Prevalence Data 2018-2058, commissioned research undertaken by NATSEM, University of Canberra.

1. Access to mental health services

Older people access mental health services at much lower rates than the general population and many only do so in a crisis. Australian Bureau of Statistics (ABS) data show that access to mental health-related medications via the Pharmaceutical Benefits Scheme (PBS) increases with age, while access to mental health-related services via the Medicare Benefits Schedule (MBS) decreases after the age of 44.

Proportion of Australian population who accessed subsidised mental health-related MBS services and PBS medication 2011, by age



This disparity is greatest among those aged 75 years or older: more than 30% receive subsidised medications but less than 5% access subsidised mental health-related services.[9]

This suggests that almost one third of older Australians are being prescribed mental health-related medications without appropriate specialist consultations.[10]

Australian RACF residents are even more likely to be given medication over other treatment and support services.

Older people prefer non-pharmacological approaches to care and these should be equally available to medications wherever indicated.

Recommendation 2

Investigate why older people have such high PBS mental health-related medication rates and low MBS service rates relative to the rest of the population.

9. Australian Bureau of Statistics 2016, Characteristics of people using mental health services and prescription medication, 2011. ABS cat. no. 4329.0, Canberra: ABS.
10. Royal Australian and New Zealand College of Psychiatrists 2017, Submission to the Senate Standing Committee on Community Affairs Inquiry on the Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised, Available at: https://www.ranzcp.org/files/resources/submissions/13060-president-to-senate-aged-care-assessment-sen.aspx.

1.1 Barriers to accessing mental healthcare

Access to mental health services in residential aged care facilities

Older people in RACFs face significant barriers accessing mental health services.

MBS services including GP Mental Health Treatment Plans under the Better Access Scheme have specifically excluded people in residential care.[11] A range of other infrastructural barriers and financial disincentives also impede visits to RACF residents by mental health and medical specialists such as GPs, psychologists and private psychiatrists.[12]

Like their counterparts living in the community, aged care residents should have unrestricted access to the MBS and more specialist service visits to provide the appropriate diagnosis, treatment and ongoing care.

The Federal Government has taken welcome action on a number of fronts over the past year, but these initiatives do not yet go far enough. For example, the *Better Ageing – mental health support for older Australians* program provides $82.5 million over four years in psychological services for older people in RACFs. It is a very welcome initiative considering the elevated incidence of mental illness amongst residents, but these funds are spread very thinly across 31 Primary Health Networks, over 180,000 RACF residents, and over 4 years. More will be required to meet the demand.

Aged care residents should have equal access to the MBS and specialist health services.

Recommendation 3

Investigate access to the MBS and specialist health services in RACFs, including barriers and mechanisms to increase access.

11. Royal Australian and New Zealand College of Psychiatrists 2018, Medical Benefits Schedule (MBS) Review Taskforce – supplementary submission. Available at: https://www.ranzcp.org/files/resources/submissions/ranzcp-sub-to-supplementary-mbs-review-taskforce.aspx.
12. Royal Australian College of General Practitioners 2019, RACGP submission to the Royal Commission into Aged Care Quality and Safety. Available at: https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Royal-Commission-into-Aged-Care-Quality-and-Safety.pdf.

Needs identification and assessment

Ageism and low mental health literacy among older people often hinder identification of mental health needs when they arise.

People living in RACFs often rely on aged care staff and unpaid family and friend carers to identify the need for mental healthcare. As discussed in Section 3, most aged care staff are not equipped to respond to mental health needs and do not have even the most basic mental health awareness training in their qualifications. It is left to overworked nursing staff who are managing very high staff ratios to take on this responsibility. Without mandatory staff ratios, these pressures are unlikely to abate.

In the community, older people have access to screening and assessment services via the My Aged Care system which may be requested by individuals or referring health professionals. After an initial screening process, individuals may be provided with information, referrals to multidisciplinary Aged Care Assessment Teams and Regional Assessment Services for face-to-face assessments, or direct referrals to services.

Problems in My Aged Care screening and assessment processes include:

- inconsistencies in the quality of assessment processes, including in relation to mental health competencies of assessment teams[13]
- ageist attitudes that mean symptoms of mental distress in older people are wrongly dismissed as natural outcomes of the ageing process
- inefficiencies and duplications in screening and assessment processes
- ineffective needs assessments across diverse population groups due to inflexible use of standardised assessment tools
- lack of opportunities for consumer-driven identification of needs.[14]

Smooth referral pathways into My Aged Care screening, such as from GPs and prison facilities, are crucial to prevent people with mental health support needs falling through the gaps between systems. Where consumers consent, family and friends should be involved, particularly for Aboriginal and Torres Strait Islander peoples.

Recommendation 4

Investigate the mental health competencies of My Aged Care assessment teams, the use of appropriate screening tools, and streamlined referral pathways into the system to ensure that aged care assessment processes cater for the mental health needs of older people.

13. Warburton J, Cowan S, Savy P, MacPhee F 2015, 'Moving towards integrated aged care assessment: A comparison of assessment tools across three regional Victorian services', Australasian Journal on Ageing 34(3): 177–82.
14. Tune D 2017, Legislated review of aged care 2017, Canberra: Department of Health, Commonwealth of Australia.

1.1 Barriers to accessing mental healthcare

Navigation of service systems

Finding appropriate mental health services can be difficult for individuals, unpaid family and friend carers, and health professionals.

Trouble navigating the system can prevent timely access to services, create crises at key transition points (such as retirement, loss of a loved one, loss of capacity or transition into residential care) and worsen ill health. This is true both in the community, where navigation supports are in short supply, and in RACFs where staff lack the requisite training, knowledge and access to service pathways to perform this role.

Older people with mental health issues often have complex needs, including:

- cognitive deficits
- emotional and environmental stressors
- temporal fluctuations in capacity and functional impairment
- mobility and sensory difficulties associated with their mental as well as physical health
- other disadvantages including health comorbidities.

For these reasons, people with mental illness will benefit from services to assist them to find appropriate services, including clinical, community and social supports. However, coordination/navigation and case management services for older Australians with mental health issues are in limited supply.

Coordination/navigation services should be provided through an individualised model with the capacity to provide person-centred support which is flexible and comprehensive and can include in-home/in-facility visits and peer support, as needed.

A successful coordination/navigation model must accommodate the crucial input and support of family and friend carers who often end up performing the unpaid role of care coordinator for their loved one. This can put significant financial and emotional stress on carers and strain their relationship with the person receiving care, particularly if they are forced to step back from paid work or other family and caring responsibilities.

Access to coordination/navigation services is also a key consideration for older people from key population groups including Aboriginal and Torres Strait Islander peoples, LGBTIQ+ people, people from culturally and linguistically diverse communities, people in rural and remote areas, and people from low socioeconomic backgrounds.

Recommendation 5

Investigate access to coordination/navigation services for older Australians with mental health issues, both living in RACFs and the broader community, including a focus on key population groups.

Age eligibility barriers

Age eligibility restrictions present a particular barrier to accessing appropriate mental health services.

Age criteria determine a person's eligibility for specialist adult or older persons' mental health services. As a result, people under 65 years of age who are experiencing premature ageing are excluded from the aged care system, while healthy people over 65 years of age who are not in need of older persons' services are excluded from adult mental health services.

Such arbitrary restrictions can present problems, including:

- preventing access to services which are appropriate for developmental and functional needs
- delaying access to services and preventing early intervention, including by:
  - requiring additional negotiations to occur on behalf of the older person to enter a developmentally appropriate service
  - forcing older people to restart the navigation process upon entry refusal
- enforcing ageism and increasing social isolation by quarantining people according to age rather than health or functional needs.

There is already precedent for some variation in age eligibility criteria: Aboriginal and Torres Strait Islander people are able to access older persons' mental health services from 50 years of age.

Recommendation 6

Investigate the appropriateness of age eligibility requirements for access into specialist adult and older persons' mental health services.

1.1 Barriers to accessing mental healthcare

Barriers for key population groups

There are a number of further barriers to particular cohorts of older adults seeking an appropriate mental health service, including:

- **Location:** particularly in rural and remote locations where fewer services exist and long distances need to be travelled.
- **Cost:** especially out-of-pocket costs associated with GP Mental Health Plans and payments for services not covered by GP Mental Health Plans, including clinical, community and social services. There are also significant associated opportunity costs where people may forego paying bills or accessing social activities that provide preventative benefits in order to pay for mental health services.
- **Models of care:** particularly for key social and cultural groups:
  - People from culturally and linguistically diverse (CALD) backgrounds require culturally appropriate communications to facilitate their approach to relevant services, including the provision of same-language information through face-to-face and telephone interpreters. A significant proportion of people from CALD communities revert to their first language as they age and may have varying skills in English.[15] Unpaid family and friend carers should not be relied upon to provide interpreting services and should themselves be able to access those services when required.
  - Aboriginal and Torres Strait Islander peoples require culturally appropriate services in line with the principle of self-determination. This means increased support for community-controlled aged care and health organisations, and ensuring that mainstream aged care services are sensitive to the needs of the Stolen Generations.[16]
  - Progress made under the National LGBTI Ageing and Aged Care Strategy should be built on, particularly as many people from LGBTIQ+ communities, and people living with HIV, delay entering RACFs due to fear of stigma and discrimination. This is particularly so in light of ongoing exemptions for religious organisations against anti-discrimination laws.[17]

Recommendation 7

Investigate access barriers for key population groups in aged care, including culturally and linguistically diverse, LGBTIQ+ and Aboriginal and Torres Strait Islander peoples, and people in rural and remote locations.

15. Ethnic Communities Council of Victoria 2019, 'Consultation on access of older migrants to language services', Golden Years 119. Available at: https://eccv.org.au/wp-content/uploads/2019/05/Gab-ECCV-position-paper.pdf.
16. Healing Foundation, 'Stolen Generations want a commitment on aged care', Media release, 13 February 2019. Available at: https://healingfoundation.org.au/app/uploads/2019/02/Apology-11-FINAL-Media-Release.pdf
17. Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013, ss 23 & 37.

1.2 Involuntary admissions

Advance care planning is essential to safeguard the rights of older people who are admitted to services involuntarily.

In rare cases, older people may require involuntary admissions into mental health and other relevant services. Their rights are better safeguarded when plans for such an event have been made, such as through the development of an Advance Care Plan (ACP) or a Mental Health Advance Care Directive. However, advance care planning in the community remains low with most older people entering aged care services without one.[18]

ACPs state a consumer's preference regarding health and other relevant outcomes, ensuring that their wishes can be respected in the event of a significant deterioration in their communication ability or mental state. They are recognised by legislation in some states and territories but not nationally.[19]

Advance care plans and directives can provide essential tools to ensure a person's wishes are met in such situations, thus providing important safeguards for a person's dignity and human rights. On the other hand, consumers who do not have an ACP or directive, or whose plans are not properly followed, may be (re)traumatised during an involuntary admissions process and/or have their dignity and human rights violated.

Plans that support a holistic and relational recovery approach can place less stress on consumers and their family bonds. Family and friend carers can otherwise be put under immense stress when they are forced to make decisions about the care of their loved ones which may have a lasting impact on their relationship as well as their own wellbeing.

To maximise the benefits associated with ACPs and directives, three things are required:

- accessible information and supports for people to undertake advance care planning
- a process of regular review to ensure a plan or directive constitutes a present and accurate account of a person's wishes
- appropriate communication to relevant staff to ensure a plan or directive is respected in the event of an involuntary admission.

Recommendation 8

Investigate the use of advance care planning supports and mechanisms in relation to mental health and aged care services.

18. National Ageing Research Institute 2018, Advance care planning in aged care: A guide to support implementation in community and residential settings. Available at: https://www.advancecareplanning.org.au/docs/default-source/acpa-resource-library/acpa-publications/advance-care-planning-in-aged-care-implementation-guide.pdf?sfvrsn=12.
19. Ibid.

2. Design of mental health services

Older people experience a range of mental health and mental health-related care needs. The services which cater to these needs and prevent them from arising must be appropriately funded and designed.

There are certain essential foundations of mental healthcare provision which all services must provide. While there are numerous examples of services providing high-quality and best-practice interventions across Australia, they remain constrained by system silos and resourcing limits.

Services should be:

- **Flexible** – including that they can go into RACFs and/or provide telephone or electronic supports.
- **Recovery-oriented** – as an approach to mental health treatment focussed on hope and recovery is fundamental to best practice.
- **Inclusive** – for consumers and unpaid family and friend carers, taking into account diverse population groups whose needs and perspectives may differ from the majority (for example, LGBTIQ+ people who may have non-biological families of choice).
- **Consumer-focused** – within a human rights framework.
- **Evidence-based.**
- **Culturally appropriate** – to cater for all diverse groups, including Aboriginal and Torres Strait Islander peoples, and for the one in 20 Australians who speak a language other than English at home.[20]
- **Integrated** – bringing together mental health interventions along the entire spectrum of care, through the design of more integrated governance structures, sectors, organisations and work practices, and including other health, welfare and social services.
- **Person-centred** – to address the silos operating between mental health and aged care service providers that are barriers to the provision of holistic care, including restrictions on sharing information when this is done with the consumer's consent.
- **Safe** – ensuring that people's dignity and human rights are respected.
- **Targeted** – across the spectrum of need (including early intervention) and the course of mental illness (from prevention to recovery and relapse prevention).

20. Australian Bureau of Statistics 2018, Cultural diversity in Australia: 2016 Census Data Summary. ABS cat.no. 2071.0, Canberra: ABS.

2.1 Preventative and early intervention services

Mental health support provided before a person experiences mental health crisis can significantly reduce distress and harm, while also reducing costly hospital presentations and costs associated with other healthcare services.

As outlined in the Introduction, the onset of depression among older people is particularly concerning. Some studies have shown 10–15% of older Australians have symptoms of depression and this rate increases to 45% for those entering RACFs and more than 50% for those residing therein. Rates of depression among general practice patients are also trending upward in the face of significant service shortages.[21] [22]

Certain changes or significant life events can place older people at risk of developing depression, which is often a response to declining health and functional impairment, and social isolation.[23] The loss of professional identity, physical mobility and the inevitable loss of family and friends as people age can affect a person's ability to maintain relationships and independence, which in turn may lead to a higher incidence of depressive symptoms.[24]

Some interventions are known to reduce the risk of older people becoming depressed, including psychotherapy and social activities.[25] [26] [27] The 'Pleasant Activities to Enhance Well-being in Care' research project run by the National Ageing Research Institute also found behavioural activation techniques significantly reduced depressive symptoms.[28]

Social inequities are generally associated with increased risks of many common mental diagnoses.[29] Thus broader health and social policies, political and economic systems, physical environments and cultural norms also play an important role in the mental health of older people.

Recommendation 9

Investigate the availability of healthy ageing programs that intervene early and prevent the symptoms of depression among older people.

2.2 Continuity of care for people with ongoing mental health support needs

Services delivered to older people experiencing mental illness must facilitate smooth transitions between different mental health services as well as between other (state and federally funded) service sectors they are likely to be involved with. In particular, it is important that people with long-term mental health conditions are able to maintain continuity of care in their transition into RACFs.

Recommendation 10

Investigate the care of people with long-term mental health conditions in RACFs.

21. Pfaff JJ et al. 2009.
21. McKay R 2012.
22. Ibid.
23. Alpass F and Neville S 2003, 'Loneliness, health and depression in older males', Aging and Mental Health, 7(3): 212–6.
24. Ibid.
25. Forsman A, Schierenbeckf I and Wahlbeck K 2011, 'Psychosocial Interventions for the Prevention of Depression in Older Adults: Systematic Review and Meta-Analysis', Journal of Ageing and Health, 23(3): 387–416.
26. Lee S, Franchetti M, Imanbayev A, Gallo, J, Spira A. and Lee H 2012, "Non-pharmacological prevention of major depression among community-dwelling older adults: A systematic review of the efficacy of psychotherapy interventions", Archives of Gerontology and Geriatrics, 55, 522-529.
27. Forsman AK, Nordmyr J & Wahlbeck K 2011, 'Psychosocial interventions for the promotion of mental health and the prevention of depression among older adults', Health Promotion International, 26(1): 85–107.
28. National Ageing Research Institute, Pleasant activities to enhance wellbeing in care. Available at: https://www.nari.net.au/news-and-events/news-from-nari/pleasant-activities-enhance-wellbeing-care-paw.
29. WHO and the Calouste Gulbenkian Foundation, Social Determinants of Health, 2014. Available at: https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/

2.3 Privacy and information sharing

Mechanisms which respect the privacy and human rights of consumers while facilitating appropriate information-sharing between the aged care and mental health systems is important to reduce duplication of work and provide coherence of care for consumers.

Where consumers consent, it is important that services share information and communicate with family and friend carers so that they can continue to support their loved one. This is particularly important during the transition from adult to older persons' mental health services.

Recommendation 11

Investigate how to achieve the best balance between promoting information-sharing across systems while guaranteeing human rights and privacy.

2.4 Unpaid family and friend carer-specific services

Unpaid family and friend carers are a fundamental but often underappreciated pillar of the mental health system.

There are at least 240,000 mental health carers in Australia, providing an estimated 208 million hours of informal care per year, valued at around $14.3 billion in 2015. This unpaid work comes at considerable cost to the economy in lower workforce participation rates.[30]

Providing long-term unpaid mental healthcare can have a significant impact on a person's own health and wellbeing as well as their financial, vocational and educational security. As a result, unpaid family and friend carers may require a broad range of supports related to their caring including respite, peer support, counselling, education, system navigation services and financial supports. Unfortunately, services and supports for unpaid family and friend carers are often inadequate, inaccessible, underfunded or simply unavailable, particularly in regional areas.

This poses a serious risk for the mental health system and the broader economy. Unpaid family and friend carers with unmet needs may develop their own mental health issues, and when they are no longer able to provide care, the person receiving care may be at greater risk of relapse, hospitalisation, suicide and other negative outcomes, putting additional pressures on health, housing and other government support systems.

There are at least 240,000 mental health carers in Australia, providing an estimated 208 million hours of informal care per year, valued at around $14.3 billion in 2015. This unpaid work comes at considerable cost to the economy in lower workforce participation rates.[30]

Recommendation 12

Investigate access to carer-specific services including peer support, respite, information and navigation of available supports.

30. Mind Australia 2017, The economic value of informal mental health caring in Australia. Available at: http://caringfairly.org.au/sites/default/files/pdf/The_economic_value_of_informal_care_full_report.pdf

2.5 Culturally appropriate services

Culturally appropriate programs are required for people from Aboriginal and Torres Strait Islander, LGBTIQ+ and CALD communities whose needs may not be adequately met by mainstream services, both in the community and in RACFs.

Services must be adequately resourced to cover costs associated with, for example, past trauma, interpreting, dietary requirements, and cultural/religious/social activities.

Recommendation 13

Investigate access to culturally appropriate services for Aboriginal and Torres Strait Islander, LGBTIQ+ and culturally and linguistically diverse communities.

2.6 Elder abuse and human rights

Safety and dignity are fundamental to the provision of high-quality and best-practice care.

In 2017, the Australian Law Reform Commission released a report into elder abuse with a range of recommendations for law reform and regulatory oversight which provide a comprehensive overview of the reforms required, including the establishment of an independent oversight body to investigate incidents of elder abuse.

Recommendation 14

Implement the recommendations in the Australian Law Reform Commission Report 131 on Elder Abuse, including the establishment of an independent oversight body to investigate incidents of elder abuse.

3. Workforce support and development

A suitably skilled and well-supported aged care and older person's mental health workforce is essential to improve mental health service delivery to older Australians.

In 2018, the Aged Care Workforce Strategy Taskforce delivered a report which outlined 14 strategic actions to better support the aged care workforce, along with two key acknowledgements, that:

- mental health was a key competency gap in the aged care workforce
- career pathways were essential to attracting and retaining suitable workers.[31]

Aged care can be a challenging environment for workers, particularly in light of long-term under-resourcing, poor workplace pay and conditions, and limited career pathways. As a result, there is high staff turnover compromising quality and continuity of care, particularly in RACFs. There is significant potential for various segments of the workforce, particularly personal care workers, health and leisure staff, nurses, peer workers, family/carer workers and volunteers, to support mental health, but this is going largely untapped.

Issues with the lack of mental health training for the aged care workforce include:

- Aged care workers without basic training and competencies are unable to adequately respond to the needs of residents with mental health challenges and likely unable to pick up on the early signs of distress. This limits the opportunity for early intervention.

31. Aged Care Workforce Strategy Taskforce 2018, A matter of care: Australia's Aged Care Workforce Strategy.

- Opportunities for workers to more effectively promote positive mental health are undermined by the absence of basic mental health capabilities across the workforce.
- Stigma-based beliefs regarding a correlation between ageing and poor mental health, particularly with reference to depression, go unchallenged.

The workforce needs to be recognised as a key driver of successful change. For example, the success of changes to improve access to services for RACF residents will rely to a great extent on whether staff understand and can engage with each resident about new service opportunities.

3.1 Worker supports

Strategies to improve workplace conditions and support the financial and emotional health and wellbeing of workers are required in RACFs to increase retention and to enable the delivery of higher quality mental health interventions.

This should include:

- appropriate remuneration for work and other financial supports
- self-care and mentoring/apprenticeship programs
- support for workers with lived experience of mental illness, including both peer and family/carer workers, and those from key population groups, such as Aboriginal and Torres Strait Islander, CALD and LGBTIQ+ communities.

Recommendation 15

Investigate how the workforce can be better supported to act as a key enabler of system reform.

3.2 Training and development

Mental healthcare is best provided by multidisciplinary teams to ensure that complex needs can be met in an individualised and holistic way.

Each segment of the workforce requires appropriate training and development opportunities to provide them with the requisite skills and knowledge, and the ability to maintain them, as our understandings of mental health evolve.

Currently, there are significant gaps in the competencies of the aged care and mental health workforces in relation to older people's mental health. This is partly attributable to the lack of adequate pre-vocational training and credentialing in National Training Packages and their failure to provide ongoing upskilling.

The Aged Care Workforce Strategy Taskforce has recommended the Aged Services Industry Reference Committee undertake work to map skills and identify and fill competency gaps in the aged care workforce. The recommended focus on personal care workers and nurses is appropriate considering the important but undervalued and undersupported roles these workers perform.

However, considering the multidisciplinary nature of mental health and the effects of ageism on the recognition and management of mental health issues among older people, it is important that this work also consider the broader workforce responsible for providing care to older persons. This may be best achieved through a subcommittee with aged care and mental health expertise to sit beneath the Aged Services Industry Reference Committee.

Improving workforce capability for older persons' must take place in an integrated fashion across the various workforce segments. Early steps would include:

- Pay specific attention to mental health competencies and implement mandatory skillsets for each profession to ensure that suitable training and ongoing professional development is available for all segments of the workforce, across metropolitan, rural and remote areas.
- Consider various opportunities for training and development including vocational and tertiary qualifications and training placements and rotations.
- Ensure that resources (funding) and workplace systems (supervision, coaching and mentoring) are in place to support ongoing reflective practice, skill building and practice improvement.

Competencies should be developmentally specific and should broadly cover:

- strategies related to the promotion of positive mental health
- mental health risk factors including grief, loneliness, chronic pain, loss of mobility and key transition points, such as retirement, and moving into an RACF
- mental health symptoms and disorders, particularly dementia, depression and suicidality
- management of conditions and symptoms which may have physical and mental health components such as chronic pain and substance use disorders
- differentiation of physical and mental health conditions and symptoms, for example depressive symptoms which are often misunderstood within a dementia framework
- mental health interventions, including mental health first aid and suicide prevention
- approaches to care which are person-centred, recovery-oriented, trauma-informed, carer-inclusive and relationship-based
- culturally appropriate care (including, for example, trauma-informed care, language competencies and HIV training)
- multidisciplinary care and the roles of different specialisations.

This should be appropriate for and delivered to all workforce segments, including:

- aged care workers including personal care workers, health and leisure staff, and support workers across the community and residential sectors
- specialist mental health workers including mental health nurses, community mental health workers, psychologists and psychiatrists
- other health workers including general practitioners, geriatricians, allied health workers and other medical specialists
- other relevant workers including social workers, housing support workers, legal aid providers, disability service providers and first responders
- community streams within and across workforce segments including peer workers, family/carer workers and volunteers.

Supporting the mental health and wellbeing of older Australians requires the effective functioning of a complex array of systems and services. Only strong leadership and sustainable accountability practices can provide such a complex system with the foundation it needs to function safely, efficiently and effectively.

Recommendation 16

Investigate how mental health capabilities and systems for learning can be improved within the workforce.

MentalHealth Victoria

Collaboration • Knowledge • Leadership

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