

# Submission to Productivity Commission Final Review into the National Mental Health and Suicide Prevention Agreement

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**This submission focuses on the mental health and wellbeing needs of the priority group within the National Mental Health and Suicide Prevention Agreement (NMHSPA), “Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)”**

This submission proposes that the NMHSPA has failed to stimulate actions to meet the needs of older Australians with mental ill-health or risk of suicide; and that there is increasing evidence of the costs and adverse impacts related to this. It concludes with discussion of factors that may contribute to the current state of mental health care for older people, and proposed actions for consideration in the development of future agreements.

## Evidence of failure to stimulate actions to meet the needs of older Australians

1. Despite being listed as a priority population, no actions are focused on improving services to older Australians in any Commonwealth-State Agreements beyond continuation of existing state mental health services for this population
2. Descriptive analysis of changes in access by people aged over 65 has been published(1), looking at changes since the introduction of Better Access in 2006. There is no evidence of recent change in the trends described.

The analysis showed

- *access to all forms of mental health care is lower for those aged over 65; with the greatest gap in Medicare funded mental health services.*
    - People aged 65-74 were found to have 56% the rate of access to Medicare funded services as the general population, those aged 75-84years 36%, and those aged 85years old older 21%.
    - Population access for Medicare-funded psychologists and clinical psychologists access for those aged 85 and over has to rise above 1%
  - *There has also been progressive reduction in rates of access to specialist inpatient and community mental healthcare since the introduction of Better Access for those aged 75 years and older.*
    - The reduction is greatest for those aged 85 and over; with a 21% fall in community care access, 54% fall in inpatient access.
3. Findings of the Royal Commission into Aged Care Quality and Safety in Australia(2) of significant deficits and variability in the provision of mental health care.
    - a. Recommendation 59 specifically focused on improvement to older persons mental health care
    - b. At 2024 review this recommendation was found to be “ ‘under further consideration’ and ‘not commenced’ with the commentary “activities do not in themselves constitute any meaningful or measurable steps towards implementation”(3)
  4. There is very limited information available regarding the access to e-mental health interventions by older people, but room for concern; with the needs for adaptations being explored in Australia (4) and internationally(5) in light of inequitable access to digital technologies to date, and limited research focused on their needs(5).
  5. No public data is available regarding the access to the Psychological Treatment Services for People with Mental Illness in Residential Aged Care Facilities initiative, but initial evaluation found a number of barriers to implementation that required addressing to enable significant uptake(6). There is no public information indicating the response to these recommendations.

## Evidence of costs related to poor access of Older Australians to mental health services

Poor access of Older Australians is associated with the currently unquantifiable costs related to reduced quality of life of individuals; and costs related to their care by family or others. These costs relate to delayed or unavailable treatment, as well as provision of treatments with potential for significant side effects.

There is also increasing evidence that poor access is associated **with increased costs on sections of health and aged care sectors beyond mental health services.**

- Analysis of AIHW data since 2006(1) identified
  - rates of admissions to hospital for mental health conditions without specialised mental healthcare (that is to non mental health hospital beds) by those 85 and older increased by 92% since 2007-08;
  - rates of emergency department presentations by those 85 and older with mental health problems increased by 33% since 2014–2015
  - the above increases were substantially greater for older people than for other age group
- Despite estimates of very high rates of depression or mental illness on entry to residential aged care (in the order of 50%, and at assessment for aged care services in the order of 20 to 30% ( <https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/what-is-available-in-existing-national-aged-care-d> ), with numerous published studies internationally); finding of persisting suicidal ideation in residents following entry (7) (in the US where data sets enable such analysis), and a significant rates of death from suicide in these contexts(7)
- Assessment at admission to residential aged care using the Cornell Scale for Depression in Dementia in the Aged Care Funding Instrument ceased in October 2022( <https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/what-is-available-in-existing-national-aged-care-d> )
  - Rates of screening for psychological distress at aged care eligibility assessment of approximately 5% ( <https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/what-is-available-in-existing-national-aged-care-d> )
  - There is no regular screening for suicide at entry to aged care care, f
- psychotropic medication use increases markedly across older age, and even more so after entry to residential aged care(8).
  - Innapropriate prescribing is associated with adverse outcomes, and the focus on concern by the Australian Commission on Safety and Quality in Healthcare (<https://www.safetyandquality.gov.au/standards/clinical-care-standards/psychotropic-medicines-cognitive-disability-or-impairment-clinical-care-standard> )
- Whilst the long term trend to reducing death from suicide in older people (<https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-and-self-harm-among-older-australians> ) is welcomed; men over 85 are consistently over-represented in deaths through suicide

([https://www.suicidepreventionaustralia.org/wp-content/uploads/2022/12/Older-People\\_policy-position.pdf](https://www.suicidepreventionaustralia.org/wp-content/uploads/2022/12/Older-People_policy-position.pdf))

- The prevalence of serious mental illness other than Major Depression in aged care is poorly studied, but appears to be increasing (9), <https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/mental-health-conditions-in-aged-care-service-user> Figure 2
  - This has not been accompanied by changes in training, care standards or stigma(10) towards people with related diagnoses
- Poor access to mental healthcare for older people is also likely(11) to be associated with
  - avoidable early entry to residential aged care
  - avoidable medical morbidity and mortality
  - avoidable workplace stress upon residential aged care staff(12)

## Factors that may contribute to the current state of mental health care for older people

### Misconceptions about the prevalence of mental illness in later life

Past concerns related to poor mental healthcare access by older people have in part been minimised by statements mental illness is less common in older people.

- Mental illness does appear to reduce in prevalence at around 65 to 70 years of age. Without a focus on the age groups after this age, the age profile of samples means that this dominates many estimates of mental illness in later life.
- There is increasing evidence of increasing prevalence of mental ill-health with increasing age over age 65; contrary to the National Surveys of Mental Health and Wellbeing finding very low prevalence rates, declining further with age over 65 years
- This has been further strongly challenged with Australian data (14) with the conclusion “the prevalence of depressive and anxiety disorders increases with age, particularly among the older old. We conclude that the NSMHW should not be relied upon to guide planning or policies to address the mental health needs of older Australians”
- In terms of service planning, it is important to note these figures are not inclusive of the role of mental health services with regards to people or mental illness in the presence of dementia; whether categorised as such, or as having behavioural and psychological symptoms of dementia; as they are effectively excluded from such studies.

### Differing mental illness profiles and presentations across later life

- Older people who may die from suicide have distinctive needs and service use compared with younger people(15-17) and are underrepresented in pathways designed for younger people(13, 14)
- The prevalence of mental illness in older people represents a combination of people with long standing mental illness, those with new mental illness (most commonly associated with medical or social problems) or mental illness associated with dementia.

- The first cohort is most similar to people general mental health services (Medicare or public) are used to working with; and around which many systems that determine access, treatment or remaining in care are based around
- Difference are best characterised in the diagnostic profile and needs of people seen by mental health services change significantly with age within public services <https://www.aihw.gov.au/mental-health/monitoring/performance-indicators> has age stratifications of diagnostic data and data from the Health of the Nations Outcome Scales
  - In brief these show patterns of clinical issues present varies with age, but the, the overall severity of mental health problems is not clearly different to younger people; but there is additional complexity of greater presence of cognitive, physical health and disability related factors.
  - Diagnostic profile in this data, and other data sets show depressive disorders and dementia (with related mental health problems) become more dominant with age, and schizophrenia less common.
  - In combination this means that state run community mental health services for older people see people with both ‘Severe Mental Illness’ and moderate but complex mental illness.
    - These differences may represent potential points that impede access when intake systems, across-age acute care mental health teams, and potential referrer expectations may be shaped by the profile of younger adults. With regards to Medicare funded services,

## Structure of Medicare funded and other services

Whilst single practitioner Medicare funded services may meet the needs of the ‘younger old’ there are structural reasons that may impede their ability to meet the needs of older people with mental illness (and comorbidities. These include

- The time required to effective therapy in older people is longer, and requires age specific adaptations when comorbidity is present(15), making the economics of delivery more difficult
  - Multimorbidity requires coordinated multidisciplinary input
  - The reduced access to available funds reduces the financial ability to pay gap fees
  - Impaired mobility reduces access to facilities.; especially in the presence of comorbid problems
  - The combination of fee for service practitioners, and waiting times for services, may reduce timely ‘stepping’ of care when initial interventions are not working.

## Siloing of services impeding effective early, effective, interventions

Effective interventions for older people are more likely to be effective if implemented prior to the development of complications (mental illness, social or physical) from prolonged illness(16)

They are also most likely to be effective if service coordination occurs between relevant services at local health service levels to minimise siloing of care(16) ,<https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/relationships-between-old-age-psychiatry-and-geriatric-medicine> , and <https://www.ranzcp.org/clinical-guidelines->

[publications/clinical-guidelines-publications-library/psychiatry-services-for-older-people](https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/old-age-jcp-for-mental-health.pdf?sfvrsn=8242f3c2_4) and [https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/old-age-jcp-for-mental-health.pdf?sfvrsn=8242f3c2\\_4](https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/old-age-jcp-for-mental-health.pdf?sfvrsn=8242f3c2_4)

Mental health care in Australia for older people is particularly prone to siloing due to a division between dementia and mental health services that is atypical internationally; and inconsistent in large part with the National Mental Health Service Planning Framework

<https://www.aihw.gov.au/nmhspf>

The full details of factors causing siloing appear beyond the scope of this review. However central to the review appears that clauses in the current NMHSPA appear prone to both either increasing these silos, or exacerbating their impacts.

These are the clauses relating to Commonwealth and State responsibilities with regards to people living in residential aged care facilities

- “.....the Commonwealth agrees to be primarily responsible for:”
  - “Planning, funding, policy, management and delivery of the national aged care system, including mental health and suicide prevention services in Commonwealth-funded residential aged care facilities”.
- ...”the states agree to primarily be responsible for:”....
  - “Providing mental health and suicide prevention services to state funded aged care residential settings, where they exist, and specialist tertiary mental health services to older people with complex needs in residential aged care settings, including people with behavioural and psychosocial symptoms of dementia” ....
  - “Providing specialist mental health community and bed-based services.”

The current wording encourages a ‘treatment gap’, and potentially encourages withdrawal (or at least failure to enhance) of state community mental health care outreach into residential aged care; given ‘tertiary care’ is usually considered care that follows after attempts at specialist care: which is rarely available in residential aged care. This also potentially creates additional barriers to residents in residents in aged care; and people living with dementia avoiding being disadvantaged.

This is in the context that

- There is evidence of significant variation in the presence of cognitive impairment in older people accessing state mental health services(17)
- And evidence that people with dementia and self harm have distinctive features, use greater health resources, and significant psychiatric comorbidity (18)
  - With reduced mortality with involvement of ambulatory mental health services(19) (20)

## Workforce

An additional factor that may impact on decisions related to the agreement review is consideration that in Australia, the only mental health profession with specific training in working with older people is psychiatry, and even this is limited except for those choosing to do this as a subspecialty. There is no subspecialty training in psychology, unlike in the United States (where it has very small uptake(21)). In this context state run mental health

services for older people are effectively the main workforce development mechanism, with a very limited range of Higher Education support such as <https://heti.edu.au/our-courses/applied-mental-health-studies/older-persons-mental-health> )

## Proposed actions

It is essential to recognise that there are not clear answers to reverse the long standing neglect of mental healthcare for older people in Australia. It must be acknowledged that this is occurring in the context of multiple factors impeding action. However, it is also essential that action occurs, or the balance of barriers to opportunities will continue to grow within and ageing population; as will the personal and societal costs of inaction. It is also essential mental health services access is to be a realistic opportunity for older people considering suicide

In such discussions and considerations it appears essential to consider the impacts of

- The likely benefits of actions, or costs of inactions, by services focused on mental health care for older people often not being directly evident to those services.
  - o That is the benefits are likely to be most seen through reduced activity in emergency departments, general hospital beds, aged care admissions and primary care services; rather than inpatient mental health services. Unfortunately this also applies to interventions related to suicide prevention as older people rarely repeatedly self harm (and so represent to mental health services) , but rather are more likely to die from suicide after an attempt.
- effective interventions for older people most at risk of mental illness or suicide require integrated responses across traditional silos.
- Complex adaptive systems conceptualisations of health and mental health systems, and actions to improve them emphasising the importance of partnerships and relationships(22)

Actions should consider factors impeding and facilitating potential actions

## Barriers include

- Significant attitudinal barriers related to ageing within health workforces(23)
- Major limitations in overall mental health workforce (<https://www.health.gov.au/resources/collections/national-mental-health-workforce-strategy-2022-2032> )
- Even greater limitations in mental health workforce with specific training or specialisation in working with older people.
- The very early development of the most appropriate application of the lived experience workforce with older people; or recruitment and training of appropriate lived experience workforces for this purpose
- The significant co-morbidity of older people with mental ill-health; and differing services that may be involved in addressing these compared with younger people. The age barriers related to NDIS or Aged Care eligibility are particularly important.



- Delays in accessing home care packages to meet the needs of older people living at home (and address potential underlying vulnerability pathways to suicide).(24)
- Limitations ‘across age’ mental health services meeting needs older people /[https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2) , and <https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/psychiatry-services-for-older-people> .

### Facilitators include

- Existing investments, most notably public older persons mental health teams, some limited psychological services into residential aged care, some aging work looking at core competencies for the OPMH workforce (<https://www.health.nsw.gov.au/mentalhealth/resources/Documents/core-competencies-smhsop.pdf> ) and the passion of professionals in teams and Medicare funded who are providing services to older people
- Older people who have died from suicide have much more frequently seen health services prior to death(25) (26)
- Identification and actions by other services older people who may be at increased risk of mental ill health or suicide who older people see, notable aged care, primary care and hospital services.(27) (28)

### I would propose that in that context there are

- both specific actions worth immediate consideration; and
- that it is desirable to consider if the degree of access gap to mental health services for very old Australians, and barriers to progress within current arrangements, requires consideration of a more comprehensive, collaborative Commonwealth-State/territory approach as the most viable way forward

### Specific actions

1. Revision of wording of the clauses cited above to ensure residents in residential aged care, or with dementia, are not disadvantaged through misinterpretation.
2. Commission research into key gaps related to effective interventions, potentially implementable within the Australian context, to guide mental health support and/or interventions related to critical transitions for older people such as entry to residential aged care(29)

### More comprehensive reform

A commitment to specific consultation and development of a future desired vision of a system able to meet the mental health needs of older people with features such as the following.

- Focus on PHN/LHD integration
- Public reporting at PHD/LHD level of progress
- With flexible joint funding



- This would enable both.
  - integration of multidisciplinary input (including lived experience workers) as required and desires; and
  - training, development, and supervision of individuals working within such services to build sustainable workforces.

as well as

  - development of suicide prevention pathways specific to older people in those areas
  - better integration of mental health and dementia care
- removal of barriers to mental health care in residential aged care facilities through both enablement of staff capacities within residential aged care facilities and access to appropriate direct clinical mental healthcare equivalent to that available in the community

Such models could be integrated with exiting state older persons mental health services, or developed in close conjunction with them and other relevant services already accessed by older people such as Urgent Care Centres

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