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Mental Health Program
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Caring for Older Australians

The rapidly increasing numbers and proportions of the older population in Australia are well documented. Accompanying the greying of Australia are aged associated diseases, such as dementia which will quadruple over the next 40 years. Key issues are listed below:

1. ***Residential Care*** - to meet the projected growth it estimated that to maintain current levels of residential care, a thousand new beds will have to be built each month through to 2050. Clearly this will be a major financial impost – Access Economics estimated that the costs of dementia will rise from 0.8% to over 3% of GDP by 2050. Alternative models of care need to be developed.
    - The major alternative is home care this requires more supports for families and an increase in community services.
    - There are also other models of residential care which do not involve institutions such as having small group homes or having a team of carers servicing a cluster of home units.

2. ***Supports for families*** pay dividends. Nationally, the true costs of dementia care would more than double if families were recompensed for their efforts. Family supports and training programs have been demonstrated to save their costs very quickly (Brodaty & Gresham, 1989; Brodaty et al, 1991; Brodaty et al, 1997; Mittelman et al, 1995, 1996, 2004). Counselling and education with ongoing support can reap long lasting dividends in enabling family carers to support people with dementia at home longer.

3. People with ***dementia and severe behavioural problems*** cause havoc in nursing homes (and in private homes as well). People with severe behavioural problems require a lot more nursing care and are therefore more expensive.

   Milder behavioural problems can be easily managed with adequate training for nursing staff (and for families) resulting in less escalation of severity.
    - A study of person centred care in nursing homes demonstrated that a two day training program supplemented by shorter visits once a month resulting in lower levels of agitation in nursing home residents (Chenoweth L et al, 2009). The cost per reduction in agitation was about $6.00 per point on a well recognised scale of measurement. It is recommended that a national program of training all staff in residential care and hospitals in person centred principals would pay dividends.
    - Even with the best training there will be a small proportioned estimated at about 10% (Brodaty et al, 2003) who have severely disruptive behaviours that cannot be managed in mainstream facilities. A national system of ***specialised nursing homes*** to accommodate such residents on an interim basis (say three to six months) before returning them to mainstream facilities would result in improved efficiency within nursing homes. A subsidy for nursing homes willing to take on this responsibility means the system could be implemented on top of the existing RACF system. Support from State Health Services would be required.

4. A major issue is **early diagnosis and continuing management in general practice**. In a series of consultations that we conducted as a prelude to writing the NSW Department of Health Dementia Services Plan was the difficulty in obtaining a diagnosis from general practitioners and issues with long term management, particularly when residents enter nursing homes. The following model is proposed:
    - That practice nurses be trained in assessments of people with cognitive impairment and supported to work with the GPs and that Clinical Nurse Consultants work towards making a diagnosis and arranging referral for a plan of management.
    - That special training courses for GPs in aged care be offered, analogous to what was done with mental health). Incentives for GPs could be an added rebate for GPs qualified in aged care, special rights for prescribing some medications for Alzheimer's disease which are currently restricted and require a specialist confirmation of diagnosis. and additional rebates for nursing home care.
    - The current arrangement where each resident of a nursing home is allowed to have his or her own GP may mean that there could be dozens of GPs attending one home; this is understandable but not ideal. There should be incentive for nursing home approved (or aged care trained) GPs who would be dedicated and have an interest in elder care within RACFs. A model such as this applies in the Netherlands.

5. ***Continuity of Care***. The commonest issue raised by consumers and service providers was the lack of continuity in care. Health and Aged Care in the community is mainly devoted to assessment and episodic care. A key worker could be a guide, build up a longstanding relationship and provide continuing care which would enhance the ability of people with dementia to stay at home and their families to cope for longer. Rough calculations are about 1200 key worker would be required around Australia.

6. ***Acute Hospital Care*** of people with dementia is a pressing and growing issue. People with dementia do badly in hospital. They have a greater length of stay which is costly, they have more falls, they become delirious and require sedation and specialling and their outcomes are poorer. In summary, people with dementia are costly for the hospital system and hospitals are not set up to deal with people with dementia.

   The solutions to this are training (see above), better design and a realisation from health that Aged Care is now core business. Over 50% of most teaching hospitals have their beds occupied by older people. For people aged over 75 there is a higher rate of cognitive impairment much of which is dementia and this is often complicated by an acute confusional state, i.e. delirium.

   The solutions to this, apart from those already outlined, are to prevent hospitalisation by providing better care in the community. As the acuity of residents is increasing a medical model of reviews, combine with a person centred care nursing model would reduce these costs. Specialist teams visiting RACFs on a regular, say monthly, basis could review residents of concern to prevent them being admitted to hospital.

7. Ideally, we would all like to ***prevent cognitive decline and dementia***. Nothing is yet proven to achieve this. However adoption of several lifestyle factors would lead to multiple health benefits such as potential delay in developing dementia, improved gait and less propensity to falls, better cardiovascular health and improved well being. Community based physical mental activity/exercise programs should be developed nationally and this would pay widespread dividends.

8. ***Access*** is an issue for a number of groups:
    - ***Young People with Dementia*** - younger onset dementia is diagnosed later, leads to different issues as regards management and is not well catered for. The National Hospital and Health Reform process will place younger people with dementia within Disability Services and exclude them from Aged Care Services. This is a problem. Services for people with dementia are organised within the Aged Care Setting and although they are not always appropriate with people with younger onset dementia, there is very little on the disability side to assist them. Exception should be made for younger onset dementia to be eligible for generic dementia services.

- ***Intellectual Disability and Dementia*** – we are now seeing for the first time significant numbers of people with intellectual disability to an older age. They have a higher proportion of dementia but services are not yet equipped to care for them.
- ***CALD*** – people from culturally and linguistically diverse backgrounds receive a diagnosis later, a less likely to access services and maybe place in residential care where no one else speaks the language. Clustering of services is one solution for this as well as encouraging dual language health practitioners.
- ***Indigenous People*** – Aboriginals and Torres Strait Torres Islanders have a higher rate of dementia. They are less likely to receive a diagnosis or access services. Trust and a special relationship needs to be established within each community before indigenous people will avail themselves of such services.
- ***Rural and Remote*** – the special issues of people living in rural and remote areas are well known. The use of flexible services and telehealth will be one way to overcome their barriers to access.

9. ***Mental Health Needs of Older People*** (other than dementia) – other mental health problems that older people face are depression, anxiety, psychosis and senile squalor. Older people are less likely to receive a diagnosis of their mental illness and if they do, are less likely to be treated or referred for specialist care. In an analysis of Medicare item data, (Draper and Koschera 2001) demonstrated that per capita compared to younger adults, older people were about $^{1}/_{3}$ as likely to see a private psychiatrist and when they did their consultations were for a much briefer time indicating that they were more likely to receive medication and less likely to receive talking treatments. There is a need to bolster recognition of the treatability of older people with mental health problems and appropriateness of referrals.

10. ***Stigma*** – is a huge issue. Not only is there a stigma about ageing, there is stigma about mental health and about dementia. An older person with two or three of these conditions faces a great deal of stigma. A national awareness campaign would be helpful in reducing this, would lead to earlier diagnosis and earlier treatment.

Yours,

Henry Brodaty

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