The Royal Australian & New Zealand College of Psychiatrists

Caring for Older Australians

Submission to the Productivity Commission public inquiry into Australia's aged care system
July 2010

working with the community

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Executive Summary

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to have the opportunity to make a submission to the Productivity Commission Inquiry into Caring for Older Australians, aimed at delivering significant reform to the aged care system to meet the challenges of an older and increasingly diverse population. The RANZCP is committed to improving health outcomes of older people and commends the Australian Government for commissioning this Inquiry.

Projections suggest that mental health related disease burden will grow markedly as a proportion of overall disease burden [1]. It is therefore inevitable that, as the population ages, an increasing number of older people will suffer mental illness and require aged care mental health services specific to their needs. Groups that particularly require attention are those with behavioural and psychological symptoms of dementia (BPSD), those vulnerable to depression and suicide in later life, and those growing older with a mental illness that they have suffered throughout life.

All older Australians must have adequate access to specialty mental health and dementia care services. Mental health funding and services should be integral to planning and reforming the aged care system to achieve equal access to quality care between physical and mental health. Greater investment in older people's mental health services, and better access to services currently denied to older people, will be essential ingredients for delivering equality.

Development of an effective system of care for older people requires:

- Implementation of broad and progressive aged care reform that delivers an adequately funded, comprehensive, simpler, and evidence-based system, that functionally integrates aged care facilities and community aged care support services with aged health care and maintains provision of specialist mental health services for older people.
- The use of evidence-based models of care for the planning of mental health services for older people and for psychogeriatric service delivery.
- Increased research to deliver evidence-based models of service delivery, treatments and diagnostic tools for older people suffering mental illness, guided by consumer and carer involvement.
- Specific support for the most vulnerable groups.
- Improved recruitment and retention of the aged care and mental health workforce.

This submission focuses on the needs of all older people who are affected by a mental illness, and recommends strategies to improve care to this group.

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Table of Contents

Summary of recommendations

The need for interaction between aged care and mental health care

1. Implementation of broad and progressive aged care reform that delivers an adequately funded, comprehensive, simpler, and evidence-based health system, that functionally integrates aged care facilities and community aged care support services with aged health care and maintains specialist mental health services for older people

2. Continuity of mental health services for those growing old should be maintained, and explicit provision of mental health services for older people should be included as part of the national service planning framework proposed under the Fourth Mental Health Plan.

3. Collaboration across governments to develop a strategy that ensures adequate access to specialty mental health and dementia care services for older Australians, including those persons living in residential aged care facilities.

4. Development and maintenance of effective partnerships between key service providers including the integration of, and formal agreements between, aged care, mental health services, private psychiatrists and GPs.

5. Services developed within a quality improvement framework and include measurable indicators that are collected consistently to allow service accountability to meet the needs of an ageing population.

6. Resources for aged care and mental health care distributed based on the basis of a population health framework and allocated according to burden of disease.

7. Consumer and carer involvement in design and delivery of aged care system to ensure effective implementation.

8. The use of evidence-based models of care for psychogeriatric service delivery in the planning of mental health services for older people is essential.

9. Investment in prevention to reduce the burden of mental illness across the community and prevent individuals requiring higher levels of care; this includes improving the skills of those providing care to people in dementia care, better facility design, more carer support and community services.

10. Detailed research into service models that deliver long-term outcomes and enhance the quality of life for older people and their families. It is strongly recommended that increased focus is given not only to researching evidence-based models and care, but also commitment to implementing these properly.

Who should pay and what should they pay for?

11. The financial situation of people ageing with mental illness must be considered when redeveloping the aged care health system.

12. Care for those with severe BPSD should be funded and provided for as part of the national universal health care system.

Addressing the needs of the most vulnerable

13. Urgent support and investment for those in aged care facilities that are socially excluded and have limited opportunity to access specialty mental health and dementia care services.

14. An increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islanders that are proficient in recognising mental health issues in older people.

15. Culturally appropriate and gender appropriate services to be provided for older people both within the general health and mental health systems.

16. Increased support and strategies for prevention of suicide in older men.

17. Increased mental health support for carers of older people.

18. Increased provision of appropriately supported and funded residential places for younger people (particularly males) with mental disorders, brain diseases, and brain injuries.

Workforce considerations

19. More training must be provided for GPs and other health professionals to assist them in identifying potentially high risk individuals and understanding how to better treat mental illness in those individuals identified.

20. Recruitment and retention of the workforce providing care to older people is crucial; there is a need to identify incentives and barriers to recruitment, training and retention throughout career stages for all disciplines involved in old age psychiatry services including, but not limited to, nurses, psychologists, social workers and occupational therapists.

21. Each geographical region of the country should have equitable access to old age psychiatrists, preferably in association with comprehensive multidisciplinary old age psychiatry service

22. Greater incentives to be provided for mental health practitioners to live and practice in rural areas, including access to peer support and continuing professional development opportunities.

Anticipating the future – the impact for service planning

23. Specific strategies, service and care plans to be developed for people suffering early onset dementia

24. Increased research to deliver evidence-based models of service delivery, treatments and diagnostic tools for older people suffering mental illness, guided by consumer and carer involvement

25. Introduction a Healthy Ageing Health Promotion Strategy that is evidence-based to enhance prevention and early intervention of mental illness in older people.

1. About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 3000 Fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, the RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

The RANZCP is a leader amongst Australasian medical colleges in developing partnerships with consumers and family and other carers in respect to excellence of service provision. The Board of Practice and Partnerships includes consumer and carer representatives from a variety of backgrounds who contribute extensively to the development and management of RANZCP programs and activities, and works together with the community to promote mental health, reduce the impact of mental illness on families, improve care options and supports, and ensures that the rights of people with mental health concerns are heard by mental health professionals.

This submission has been developed by the RANZCP Faculty of Psychiatry of Old Age.

2. About ageing and mental illness

There has been a dramatic increase in the number of persons surviving to a late age. In Australia, the proportion of people aged 65 years and over will increase from 13% in 2004 to over 26% by 2051, while those aged 85 years and over will increase from 1.5% of the population in 2004 to 6-8% in 2051 [2]. As the so-called 'baby boomer' generation reaches the 65 years and over age group in 2011, the number of people in the demographic requiring aged care is anticipated to grow rapidly between 2011 – 2030. This requires specific consideration for the mental health of an ageing population.

Although many persons are reaching late life in better health than past generations, they are also living longer with disabilities. This will challenge health systems generally, and have specific implications regarding the provision of mental health services for older people. It is expected that these demographic changes will result in the incidence and prevalence of mental disorders in late life increasing. Mental health services for older people will need to prepare for a near doubling of possible demand based upon estimates of the increase in prevalence of mental disorders in this period in the developed world [3]. Old age mental health services and aged care services will need to work closely together to ensure the best treatment and care of older people, many of whom suffer from complex combinations of mental and physical health.

It is important to differentiate between the two main groups that will require mental health services as they grow older. The first group is those who develop a mental disorder for the first time in late life – for example those who develop dementia, late onset schizophrenia, or depression in later life. This includes those people with chronic medical disorder that may impact on their mental health. The second group is those who developed a mental illness earlier in life, and who are now growing older with it. Both these groups will have specific needs that require specialist old age mental health services for optimal care provision.

As an age-related disorder, and because of the absence of effective prevention or treatment strategies, a significant consequence of an ageing population will be the disproportionate increase in the population with dementia. The number of cases of dementia is expected to increase from 245,400 in 2009 to 1.13 million cases by 2050 in Australia [4]. The prevalence of dementia within the population is estimated at 5% in persons greater than 65 years old, 20% in persons greater than 80 years and 30% of persons greater than 90 years old [4]. There is also evidence to suggest that mental disorder predisposes to dementia [5]. It is therefore important that dementia is given further and serious consideration in the development of policy and system reform for aged care.

The management of dementia is complicated by behavioural and psychological symptoms of dementia (BPSD), such as psychosis, depression, agitation, aggression and disinhibition [6]. Rates of BPSD vary according to how symptoms are ascertained, thresholds of severity, and setting. For example, rates of BPSD have been estimated at 61% - 88% among people with dementia in a community setting, 29% - 90% in residents of Australian nursing homes, and 95% among hospitalised patients in long-term acute care [6]. The importance of BPSD in people with dementia is that it is the major clinical factor that causes stress in carers and often leads to the breakdown of community care and institutionalisation. Within institutions, BPSD is a significant challenge for staff and requires the right mix of facility design, staff skills and resources to be appropriately managed.

As a group, older people with a mental disorder are in the care of a broad range of services including: general practitioners; residential aged care facilities; community health care; acute hospitals; respite

care; old age mental health services; adult mental health services (particularly in rural Australia); Commonwealth-funded Dementia Behavioural Management Advisory Services; private psychiatrists and private psychiatric hospitals; and geriatric services including the Aged Care Program. In providing these services, primary care and mental health workers need to be aware of the special needs of older people. Older people are less likely than younger adults to be referred for specialist mental health treatment. Factors that might contribute to this include stigma, ageism, wrongly attributed symptoms, and lack of appropriate old age mental health services especially in rural and regional Australia. Ensuring effective treatment will improve the quality of life of significant numbers of people, and may reduce the need for more costly treatment. Inadequate care can have fatal consequences, including suicide as a potential outcome.

Old age psychiatry is the field of psychiatry that specialises in the mental health of older people. Although in many jurisdictions the age of 65 years is used to determine the boundary between adult psychiatry and old age psychiatry, there are circumstances where this age might vary. For example, a younger age might be appropriate for some cultural groups or persons with younger onset dementia while and older age might be appropriate for persons with chronic mental disorders being managed long term in an adult service. Psychiatrists have a critical role in overseeing the issues that surround advice on mental health and ageing; both in the education of other professions about mental illness and in monitoring and advocating for service responsibility and improvement.

The RANZCP has published two position statements on caring for older people: position statement 22, *Psychiatry services for older people*, and position statement 31, *Relationships between geriatric and psychogeriatric services.* These statements outline key principles for the optimal delivery of services to older people. In the context of national aged care reform, the RANZCP continues to promote and support these principles.

3. Caring for older Australians

The RANZCP has considered the terms of reference and briefing paper published by the Productivity Commission in regard to this inquiry. The RANZCP has responded to specific issues outlined by the commission only where it is deemed relevant to psychiatry or mental health. Particularly in regard to people who are ageing with a mental illness, or who develop mental illness as result of the ageing process, the RANZCP has focused on difficulties within the current system and set out what should be addressed with the introduction of a new system of aged care provision. Specific attention must be given to mental disorders in older people, including dementia. Older people with chronic medical conditions who are at increased risk of associated mental disorder also require consideration.

3.1 The need for interaction between aged care and mental health care

Mental health services should be integral to planning and reforming the aged care system; only this will achieve equal access to quality care between physical and mental health and wellbeing. Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that perpetuates service gaps, cost shifting pressures and ineffective commitment of resources. There is a need for greater collaboration between all levels of government, between services at each level of government, and within the community sector.

Responsibility for care can include state and federal governments, geriatric and psychogeriatric services, generic mental health services and specialist mental health services for older people, and both primary and secondary health services. Successful aged care for those with a mental illness requires a whole of sector and community approach. Diagnosis, treatment and community support services should be seamless for patients and their carers. Currently, in Australia, services for older people who require mental health care are *ad hoc* and fragmented, and service availability varies both between states and within states [7].

An improved system requires improved service availability, accessibility and navigability for older people and their carers who require support. This includes provision of a range of high quality services across all spectrums and severity of disorder. This requires a broad system of reform delivered by an adequately funded comprehensive, simpler, and evidence-based aged care system that includes provision of mental health services.

There is a need for the disability support aspects of aged care, including residential aged care facilities and community aged care support services, to be functionally integrated with aged health care - including GPs, specialist geriatric and old age mental health services. Improved linkage between the public and private sectors is also necessary to strengthen system effectiveness. Aged care should be a genuinely socially inclusive system whereby services work in collaboration with rehabilitation, housing, and disability services.

An effective way of delivering comprehensive services is to view residential aged care facilities as a hybrid of health and welfare. At present these facilities generally focus too heavily on welfare aspects of care. To improve primary health care in residential aged care facilities, one option would be to employ specially trained GPs based in nursing homes as Medical Directors, undertaking this role as their sole practice. This has been effectively introduced in the United States of America and the Netherlands [8].

Without adequate provision as part of system reform, those ageing with a mental illness are at risk of getting lost in the system. This group may have limited choice in terms of what aged care facilities are appropriate for them, and many may not be competent to make decisions about their own care. As part

of system reform, there is a need for appropriate regulation and monitoring to ensure that the needs of this group are being met. Legislative and funding support will be required to achieve this outcome as not all residential aged care providers recognise the special needs of the mentally ill older person.

To assist with the implementation of aged care reform, further research is necessary into best models of service delivery. This research should be undertaken to guide practice delivery and carer involvement, and include consumer engagement. It is strongly recommended that increased focus is given not only to researching evidence-based models of care, but also commitment to implementing these properly.

Proposed model of care for psychogeriatric service delivery

A new system of care for older people should allow for care to be delivered as effectively as physical health care, and remove the barriers that currently exist. A good service will be comprehensive, accessible, responsive, individualised, transdisciplinary, accountable, and systemic [9]. Services should not only provide comprehensive management, but also attempt to prevent mental disorders and offer early intervention. Services should be across a broad spectrum that range from prevention of mental disorder to the management of the most severely ill. Many older people with a mental disorder are currently systematically excluded from current mental health and general health services owing to lack of appropriate services designed specifically for older people.

In a paper by Draper, Brodaty and Low [10], a tiered model of service delivery is recommended for mental disorders in late life. Using an evidence-based approach, this model can be utilised in the planning of mental health services for older persons.

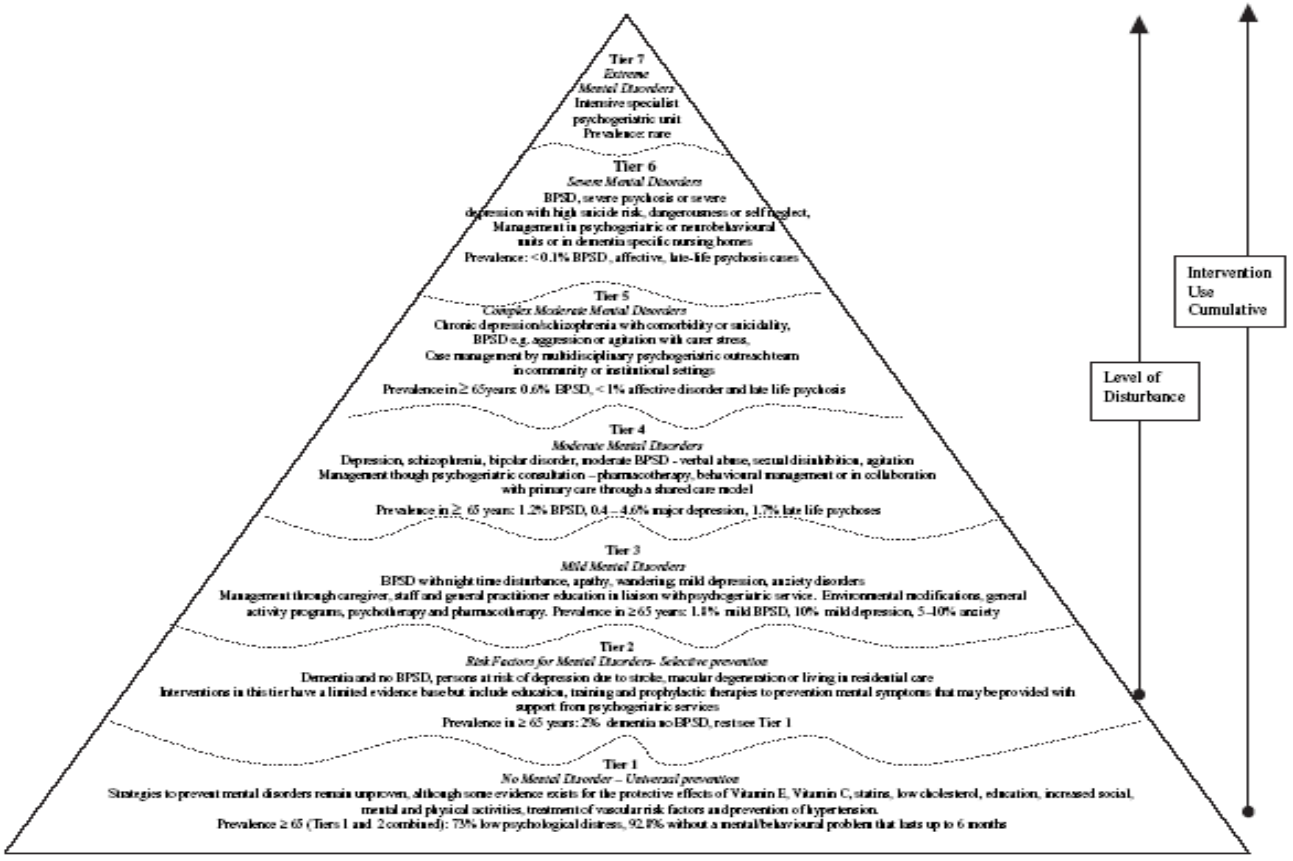


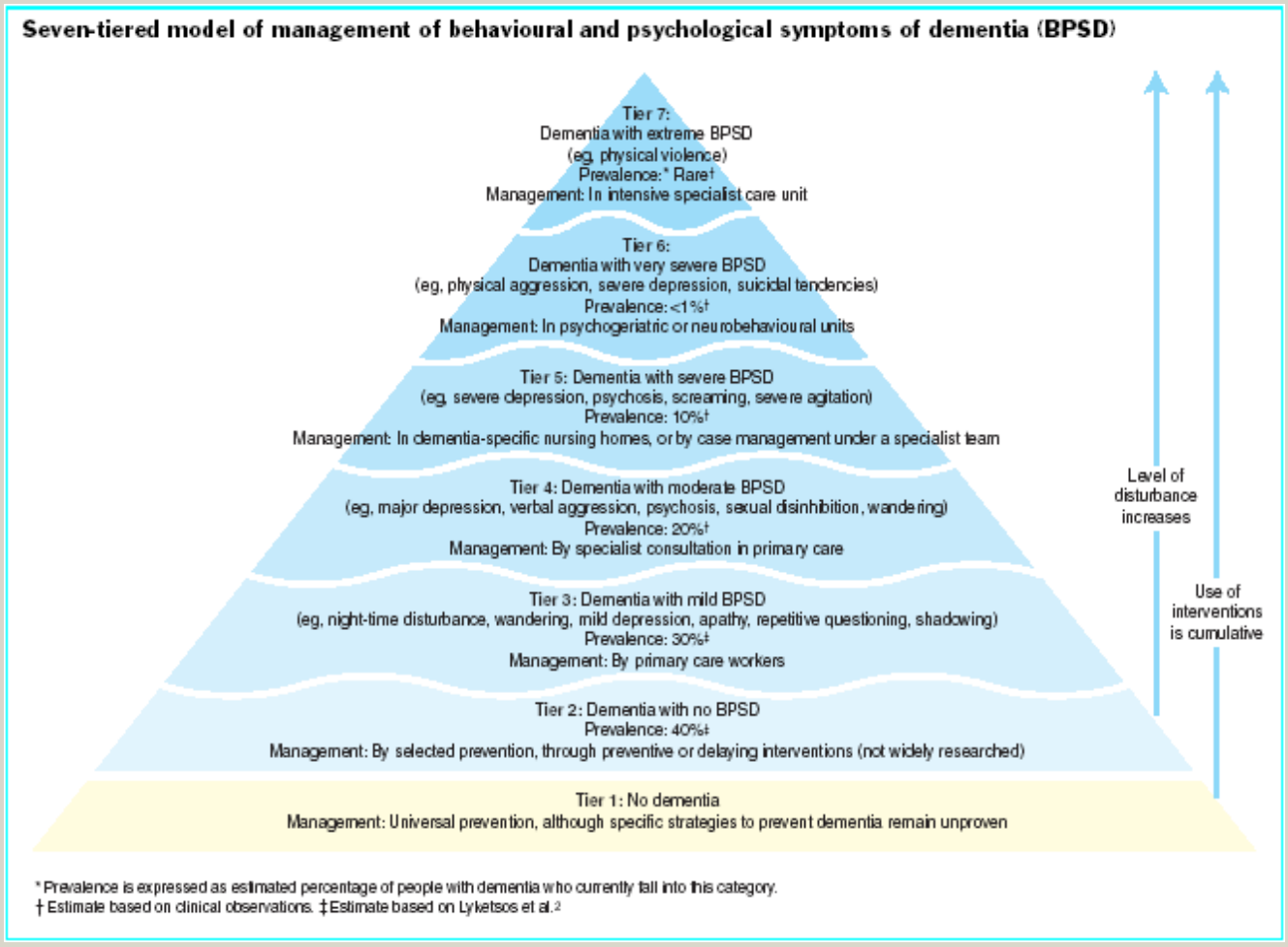
Figure 1. Tiered model of severity *vs* types of care of mental disorders in old age adapted from Brodaty H, Draper BM, Low LF. (2003). Reproduced with permission from The Medical Journal of Australia

The model depicts tiers in ascending order of severity and decreasing levels of prevalence, from the general population to the most severely mentally ill individuals. Interventions are cumulative from bottom up, with those on the bottom tier receiving the least intervention and those in the top tier receiving the most. In this plan, interventions aim both to stop individuals moving up tiers (prevention) and to move individuals down to lower levels (treatment/management).

One important aspect of this model is that it emphasises the importance of prevention strategies. At the base of the model this encompasses lifestyle, community attitudes, and inclusion of older people within broader society. Higher up, having the right services to allay the effects of disability, isolation, early identification of 'at risk' populations etc. is paramount. In terms of aged care reform it is important for the focus to be on further strengthening the base to reduce the numbers that move up tiers. This requires improving the basic skills of those providing dementia care, including enhancing skills of the primary health care workforce and providing more carer and community support.

It is also important to note that the model is broader than mental health services. Although in the upper tiers the role of old age mental health services is very important, the model does not specify that the services should be part of a mental health system. Indeed in most situations residential aged care facilities are designed and staffed to provide care with the input of old age mental health.

This model was adapted from a model originally designed for the management of BPSD [6] and is also supported by the RANZCP.



Facilities in Australia are often unable to adequately and humanely look after people with severe BPSD. Aged care reform needs an integrated system that does not discriminate against those individuals needing care. Accessibility and affordability are key issues along with simply having enough quality facilities available to meet the demand. In addition, in most parts of Australia, staffing ratios and skills are inadequate to manage these older people. Particularly for those requiring care at the top tiers, service provision will be a potential ongoing gap unless it is determined which service should have responsibility for this group (i.e. private, public or a mix). Similar to the tiered model for general mental health care, this outlines the importance of prevention. This requires greater emphasis on person centered approaches to care that prevent BPSD developing.

Recommendations

1. Implementation of broad and progressive aged care reform that delivers an adequately funded, comprehensive, simpler, and evidence-based health system, that functionally integrates aged care facilities and community aged care support services with aged health care and maintains provision of specialist mental health services for older people.

2. Continuity of mental health services for those growing old should be maintained, and explicit provision of mental health services for older people should be included as part of the national service planning framework proposed under the Fourth Mental Health Plan.

3. Collaboration across governments to develop a strategy that ensures adequate access to specialty mental health and dementia care services for older Australians, including those persons living in residential aged care facilities.

4. Development and maintenance of effective partnerships between key service providers including the integration of, and formal agreements between, aged care, mental health services, private psychiatrists and GPs.

5. Services developed within a quality improvement framework and include measurable indicators that are collected consistently to allow service accountability to meet the needs of an ageing population.

6. Resources for aged care and mental health care distributed based on the basis of a population health framework and allocated according to burden of disease.

7. Consumer and carer involvement in design and delivery of aged care system to ensure effective implementation.

8. The use of evidence-based models of care for psychogeriatric service delivery in the planning of mental health services for older people is essential.

9. Investment in prevention to reduce the burden of mental illness across the community and prevent individuals requiring higher levels of care; this includes improving the skills of those providing care to people in dementia care, better facility design, more carer support and community services.

10. Detailed research into service models that deliver long-term outcomes and enhance the quality of life for older people and their families. It is strongly recommended that increased focus is given not only to researching evidence-based models and care, but also commitment to implementing these properly.

3.2 Who should pay and what should they pay for?

The RANZCP does not intend to focus significantly on the issue of individual funding requirements for aged care services. However, it is necessary to note that, unlike the majority of the 'baby boomer' generation, those ageing with a chronic mental illness are likely to have limited financial means that will restrict their choice in terms of available options for aged care. Many people who have suffered a lifetime of mental illness are likely to have limited access to personal funds and superannuation and are not in a position to pay for treatment privately. The RANZCP strongly advocates that those financially disadvantaged by mental illness should not then be disadvantaged by a lesser standard or options of care.

A further matter that needs to recognised and considered is that the cost of appropriately looking after people with severe BPSD is much higher than standard care. Facilities for caring for those with BPSD need to be better designed, smaller, and employ more and better trained staff. This is an area where cost cutting inevitably worsens the quality of care. Indeed, in the current situation, many people with severe BPSD are contained, restrained and overmedicated in inappropriate facilities as this is often the only way facilities feel that they can cope with the situation and see no alternative.

Care for severe BPSD in aged care facilities cannot be simply driven by the ability to pay. Accessibility and affordability for all Australians is paramount to a well functioning system. Care for people with BPSD should be largely regarded as an arm of the universal health system much like Medicare.

Recommendations

11. The financial situation of people ageing with mental illness must be considered when redeveloping the aged care health system
12. Care for those with severe BPSD should be funded and provided for as part of the national universal health care system

3.3 Addressing the needs of the most vulnerable

As part of aged care service delivery, it is essential to ensure that services are developed to provide expert mental health interventions to special needs groups who may be at increased risk of developing mental health problems as they age. Particular groups to consider are: Aboriginal and Torres Strait Islander people; people from Culturally and Linguistically Diverse (CALD) backgrounds; people who live in rural and remote areas; people from low socioeconomic backgrounds; those who are homeless; and those who are within the justice health system.

All services, including aged care services, must accept their responsibility for taking steps to redress inequity and improve Aboriginal and Torres Strait Islander health and wellbeing. Enlisting existing Indigenous community services is an effective way to improve awareness and treatment acceptance in older people.

Owing to social isolation, older people in rural areas have a particularly high risk of mental illness such as depression, especially in circumstances where there is lack of a younger generation for support. Gaps in both aged care and mental health care service provision exist in rural and regional areas already and are likely to worsen with population increase and population ageing. It is imperative that additional support is provided to older people living in these areas, including through the use of telemedicine where appropriate.

Older migrants from some cultural backgrounds, where isolation is accentuated due to an absence of compatriots, are at higher risk of mental illness. Ongoing changes in the population profile and an increasing proportion of people from culturally and linguistically diverse (CALD) backgrounds requires an improved emphasis on culturally appropriate services. Enhanced availability of interpreter and other culturally sensitive services at point of service delivery is essential in meeting the emerging need. Early case finding and effective treatment by skilled mental health services will assist in reducing the long term morbidity and disability.

Despite reductions in suicide rates over the last few decades, the number of suicides among older age groups can be expected to rise, given that they constitute the fastest growing segment of the population. Contributing factors in old age suicide include physical or economic dependency, mental and/or physical health problems, chronic pain, grief, loneliness, lack of social support, alcoholism and carer stress. Late-life depression is known to frequently complicate medical illness (e.g. heart attack, stroke, Parkinson's disease) and is associated with poorer outcomes [11]. Patients with chronic medical conditions are therefore at particular risk of depression and should be given specific consideration. Suicide risk is particularly high in men with those in the 85+ age group having the second highest incidence of suicide rates (after the 40-44 age group) [12]. This indicates the need to focus on the special needs of older men who are isolated or disabled and need attention, with a particular focus on older men's psychological health (e.g. by using Men's Sheds and similar approaches). Late life suicide prevention should be about a 'whole of life' philosophy.

Gender specific services also need to be considered. This is particularly an issue in 'young old' males, often aged between 50 and 70, with early onset dementia. This can be due to a range of disorders including frontotemporal dementia, alcohol abuse and head injuries. These males can have a range of severe behavioural problems including aggression and sexually inappropriate behaviour. Additionally first-episode late-onset schizophrenia is more common in women than men [13, 14] requiring different treatment strategies to maximise outcomes. These individuals often need residential care, but the current aged care system is not designed or funded appropriately to meet their needs. Since the closure of asylums (long-stay mental hospitals) there are often no other residential care options apart from residential aged care facilities for this group.

Carers of older people are a further vulnerable group who are at risk of mental illness, and many of these people may form part of the older generation themselves (e.g. when the spouse is a carer). Carers undertake a significant level of care that can prolong the amount of time their relatives are able to be cared for at home. However, family caregivers themselves are at risk for mental disorders and should not be forgotten in the redesigning of the aged care system.

Recommendations

13. Urgent support and investment for those in aged care facilities that are socially excluded and have limited opportunity to access specialty mental health and dementia care services.
14. An increase in the number of community services that can provide holistic longer term care for Aboriginal and Torres Strait Islanders that are proficient in recognising mental health issues in older people
15. Culturally appropriate and gender appropriate services to be provided for older people both within the general health and mental health systems.
16. Increased support and strategies for prevention of suicide in older men
17. Increased mental health support for carers of older people

18. Increased provision of appropriately supported and funded residential places for younger people (particularly males) with mental disorders, brain diseases, and brain injuries.

3.4 Workforce considerations

A comprehensive system of care for older people can only be delivered by a comprehensively trained and adequately resourced workforce. Aged care workers are generally under resourced and there are far too few to meet the needs of an ageing population. There is a need for committed investment to increase and enhance the capacity of the mental health and aged care workforce and allow it to be distributed appropriately to meet community needs.

Of concern over the last decade is that the number of trainees completing advanced training in old age psychiatry in Australia and New Zealand has dropped from around 11 per year (2002 – 2005) to just over 6 per year (2006 – 2009) [15]. There is already evidence that older persons are in receipt of relatively few specialist psychiatric consultations. Medicare data from Australia indicates that persons aged 65 years and over have about a one-third chance of receiving a psychiatric consultation compared with younger adults [16]. This is a highly discriminatory situation.

It is critical to better understand incentives and barriers to recruitment, training and retention of old age health workers including psychiatrists, psychologists, nurses, social workers and occupational therapists. Many young health care professionals are usually not at the life stage where they want to work with older people and recruitment into aged care often happens in mid career. Hence there is a need to remove the barriers to training in mid-career such as the costs of training, length of training and opportunities for part time training. Incentives such as scholarships and training on the job need to be available. Without such action the RANZCP is concerned that there will be insufficient old age health workers and that the quality of mental health care for baby boomer elders will be compromised.

Most training places are funded by state and territory governments rather than by the Commonwealth. However, these governments have historically often neglected the provision of adequate training places for health workers of all types working with older mentally ill people.

In addition to increasing workforce capacity, enhanced education and training of workers in both general medicine and aged care is necessary to allow the identification of mental illness in older people. Improving people's knowledge of mental illness can lead to a greater recognition and understanding of mental health, increased help-seeking and support [17], and educating those who are most likely to come into contact with people with mental illness can increase community support and lead to early intervention and prevention. Although psychiatrists have a critical role and responsibility in leading the physical, psychological and social aspects of health care and wellbeing, the contributions of other members of the health workforce are vital to the effective model of multi-disciplinary delivery care. The coming demographic changes are such that it will not be possible for psychiatrists trained in old age psychiatry to see all older people with mental disorders including dementia. All workers should be adequately trained, informed, and resourced to enable them to assist in the identification and referral of older people with mental health problems and participate in their management.

Training primary care, hospital staff and even the general public will go some way to ensuring that early signals of dementia or late-onset mental illness is identified and appropriate treatment and support provided. GPs acknowledge that they have difficulty in detecting depression in late life, lack confidence in treating it, and that this is a training need that remains inadequately met [18]. Training of health professionals should emphasise the importance of communication with family and close friends and vice versa [19].

The health workforce is ageing and many health workers trained at a time when specialised approaches to the needs of mentally ill older people were not widely recognised. Thus, their training was often inadequate in this area.

As the mental health and aged care workforce expands it is essential that mechanisms are put in place to ensure sustainable networking, support and liaison.

Recommendations

19. More training must be provided for GPs and other health professionals to assist them in identifying potentially high risk individuals and understanding how to better treat mental illness in those individuals identified.

20. Recruitment and retention of the workforce providing care to older people is crucial; there is a need to identify incentives and barriers to recruitment, training and retention throughout career stages for all disciplines involved in old age psychiatry services including, but not limited to, nurses, psychologists, social workers and occupational therapists.

21. Each geographical region of the country should have equitable access to old age psychiatrists, preferably in association with comprehensive multidisciplinary old age psychiatry service

22. Greater incentives to be provided for mental health practitioners to live and practice in rural areas, including access to peer support and continuing professional development opportunities.

3.5 Anticipating the future – the impact for service planning

The changing demographic of the Australian population requires that attention be given to what may change in the future that will impact service planning. The changing family structure indicates that there will be fewer children to support ageing parents in the future, and that there will be an increased inter-generational gap. This raises some issues in terms of care for older people, much of which has traditionally been provided by their children. Baby boomers may have different expectations in terms of treatment or services, and their children may still have dependent children of their own to care for. Additionally, with the baby boomer generation reaching the 65 years and over age group, the resultant population increase in this age group is likely to increase the number of diagnoses of early onset dementia.

Developments in drug treatments continue for dementia, and there is an increasing move to implement prevention programs. Better treatment for BPSD may also reduce some of the psychological systems associated with dementia. However, on the whole, it is not clear whether new dementia drugs will reverse the effects of dementia, or keep those people with dementia living longer (the latter requiring need for more psychiatry services in old age). What is clear however is that there is unlikely to be a cure or significant treatment introduced in the foreseeable future and, therefore, service delivery must be shaped based on what is known and presently the situation points to the need to develop significantly enhanced aged care services.

Other ways to plan for the future include development of better ways to help families and people with dementia, and the introduction of better long term arrangements. There are also financial considerations to be taken into account, for example changes to superannuation legislation to ensure that people are able to financially sustain themselves to later life, and the introduction of long term care insurance are being considered.

Further research is imperative to meeting the needs of older people. This should include research into treatments and diagnostic tools, including those that are culturally specific.

Enhancing prevention and early intervention of mental illness in old age is crucial to reducing service need. In general any strategy that will improve the health of people in old age will be consistent with reducing mental illness and investment should be given to developing a healthy ageing health promotion strategy. Introduction of evidence-based prevention and early intervention strategies and campaigns can be effective; 'mind your mind' by Alzheimer's Australia is one such example.

Recommendations

23. Specific strategies, service and care plans to be developed for people suffering early onset dementia

24. Increased research to deliver evidence-based models of service delivery, treatments and diagnostic tools for older people suffering mental illness, guided by consumer and carer involvement

25. Introduction a Healthy Ageing Health Promotion Strategy that is evidence-based to enhance prevention and early intervention of mental illness in older people.

4. Conclusion

Reforming the aged care system to meet the challenges of an older and increasingly diverse population requires broad and progressive strategy that delivers an adequately funded, comprehensive, simpler, and evidence-based system. Essential to this reform is that the system functionally integrates aged care facilities and community aged care support services with aged health care to meet both the health and welfare needs of older people.

The dramatic increase in the number of persons surviving to a late age requires specific consideration in respect of mental health; it is expected that demographic changes will result in the incidence and prevalence of mental disorders in late life increasing. Mental health services for older people will need to prepare for a significant increase in demand, and this will require close interaction with aged care to ensure optimum service delivery. This requires committed implementation of models of psychogeriatric care, including an emphasis on effective prevention strategies.

The Royal Australian and New Zealand College of Psychiatrists thank the Productivity Commission for the opportunity to make a submission to this matter and looks forward to working with the Australian Government in the development and implementation of aged care reform in the future. The RANZCP would welcome the opportunity to address the Productivity Commission further on this matter.

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