



LASA
LEADING AGE SERVICES
AUSTRALIA
The voice of aged care

IMPROVED ACCESS TO PSYCHOLOGICAL SERVICES IN RESIDENTIAL CARE

LASA Members' observations

July 2018

*A strong voice and a helping hand
for all providers of age services*

Leading Age Services Australia

Leading Age Services Australia (LASA) is the national peak body representing and supporting providers of age services across residential care, home care and retirement living. Our purpose is to enable a high performing, respected and sustainable age services industry delivering affordable, accessible, quality care and services for older Australians. We represent our Members by advocating their views on issues of importance and we support our Members by providing information, services, training and events that enhance performance and sustainability.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 57% of our Members are not-for-profit, 33% are for-profit providers and 10% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

Introduction

The current lack of access to mental health care for people in residential aged care is an issue mattering greatly to LASA Members. LASA received many, passionate contributions from its Members to inform the consultation on *Improved Access to Psychological Services in Residential Care*:

- *You could write a thesis on this issue when you think that mental health is the 2nd highest prevalence disorder in this country.*
- *Many studies have indicated that 80% of the elderly residing in residential care have depression. Behaviours such as anxiety, demanding, yelling out, unmanageable pain are often a manifestation of depression*
- *Research from community and aged care settings has found that psychosocial interventions such as cognitive-behavioural therapy (CBT), behavioural activation (engaging in pleasant activities), and reminiscence therapy (reviewing one's life) are equally effective as medication in improving late-life depression, anxiety and suicide ideation¹. Despite the evidence for the effectiveness for such strategies, they are rarely utilized by aged care residents.*

When reading these reflections one can't help but consider whether the absence of mental health care results from ageism intersecting with a funding model that privileges physical and medical care over supporting residents to generate meaning and enjoyment in their lives. *Improved Access to Psychological Services in Residential Care* is a much needed initiative.

¹ Laidlaw, K, Davidson, K, Toner, H, et.al. A randomised controlled trial of cognitive behaviour therapy vs treatment as usual in the treatment of mild to moderate late life depression. *Int. J. Geriatr. Psychiatry*. 2008; 23 (8):843-850.

Cody, RA, Drysdale, K. The effects of psychotherapy on reducing depression in residential aged care: A meta-analytic review. *Clinical Gerontologist: The Journal of Ageing and Mental Health*; 2013; 36 (1): 46-69.

1. Any issues with how mental health supports work for clients in residential aged care now.

Mental health supports in residential aged care are largely absent and this generates many of the concerns in this setting, particularly as aged care staff tend to lack mental health skills.

Lack of services for mental health issues not related to dementia

A lack of in-reach services for aged care providers accommodating a resident with a serious and continuing mental illness² may cause providers not to accept a resident with such a history.

- *If residents' behaviours have been associated with a complex mental health diagnosis rather than dementia it has been very difficult to locate support services to assist in addressing the influencing factors within the residential aged care setting. Whilst some of the behaviours displayed by these residents were similar to those experienced by people with dementia, their mental health diagnosis meant they could not access services such as the Severe Behaviour Response Team.*

Psychogeriatric service provision lacks system wide approach

- *Psychogeriatric services are different from State to State hence the type of work and or support they give to residential aged care is different depending on the State you reside in. There needs to be a consistent approach.*

Care staff lack mental health training

- *In this sector the majority of staff are personal care workers hence they don't have the training to identify mental health issues let alone put in place interventions that will improve a person's quality of life. Most residential aged care facilities are run by general nurses, who do a great job, but often don't have the skills to identify mental health issues. Therefore, if you are unable to identify issues, how do they refer to the right agency to put in place the right intervention?*
- *Post assessment is often the issue. The mental health supports to date have been focussed on assessment. Some do recommend a behavioural/support plan but implementing this with staff not trained can be problematic and sometimes the plans are not contextualised and as such difficult to implement.*
- *Residential care staff are generally not skilled in understanding and responding to resident's mental illness/decline and as a result mental illness often goes unrecognised.*

Lack of support and follow-up services and support

- *Access to secondary consultation and support if need be for a specified time post assessment would be valuable as part of the offering.*

Primary health

- *Recently we've experienced some difficulties in getting mental health practitioners to provide support to elders living in residential aged care, even when this is specifically within their remit (e.g. Primary Health Network's Accessible Psychological Interventions (API) service specifically lists people living in residential aged care as one of their priority areas for the provision of free psychological services,) yet it takes a great deal of cajoling to get the*

² For example Bipolar disease or Schizophrenia

provider to agree to provide service here at the facility – not particularly feasible to expect an older person with limited mobility to attend for service outside the care facility.

- *Anecdotally, I have also heard from other staff members that GPs are often reluctant to undertake mental health assessments/care plans with elders in residential care.*

Specialist psychiatry assessment teams

- *Timeliness of assessments are problematic so additional resourcing will hopefully address this.*
- *In Victoria we have aged psychiatry assessment teams (APAT's) however these services only do assessments and expect untrained staff to put in place management interventions. Residential aged care require skilled psychogeriatric clinicians to provide education to staff working in this industry in the identification of mental health issues in the elderly but then most importantly work alongside residential care staff to ensure that this training is translated into practice.*

Lack of non-pharmacological therapy for mental health issues

- *There is a significant need for psychological and counselling support within the residential aged care setting. It is common for residents to receive medication for a mental illness but access to alternative therapies such as counselling is less common.*

Issues for rural providers

Mental health services in rural areas are difficult to access either because service delivery requires health professionals to travel or the access criteria exclude users in residential care. Service quality is lacking at times.

Access

- *Services are for people with a diagnosis only – getting access to specialists to obtain a diagnosis is problematic and older people experience inequitable access overall to mental health services.*
- *There is a lack of clarity about how to access funded services if there are funded services available.*
- *Access is also problematic in terms of timeliness and availability – with limited service providers who have expertise in older peoples' mental health. Facilities are reliant on public health systems, which in general are excellent but extremely limited in capacity as they prioritise people living in their own homes over those living in a residential aged care facility. Limited available private services are very expensive.*
- *My past experiences with mental health issues, is we miss the boat. Accessing services is very difficult and the excuses are cost, distance, time, only seeing one resident and every other excuse in between.*
- *Referrals to a service. GP's can make a referral but it is the service providers that decide if to respond or not. They have undertaken ph. consultations, to avoid traveling to the facility.*
- *The criteria that is set by the govt can also be a deterrent. For rural areas accessing mental health services, it has to be a realistic and achievable process. If the criteria is too restrictive, we are out of the ball park. The process has to be simple and the criteria has to be clearly set out, no mumbo jumbo advertising speak.*
- *NSW state-based Older People's Mental Health services are in an excellent position to support RACF's and have the infrastructure and expertise, especially in terms of the complexity of mental health conditions that present differently to younger adults. However,*

they do not necessarily have sufficient funding of positions to routinely support mental health/ provide short term interventions such as psychological support

Service quality at times inadequate

- *If and when you get them on site, they behave in a manner that is condescending i.e. try this or that and you let them know you have done all that. Generally the fact to face has been disappointing and not that helpful.*

2. Any issues due to the interface between Federal and State systems

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Accessing the small number of available mental services is so difficult as to constitute a hard to surmount barrier for providers seeking mental health care for their residents.

A confusing landscape of disconnected services

- *Navigating the complex and limited mental health services available is not only time consuming, but arduous in referral processes and often fruitless as services have such limited qualifying criteria. In many cases once a person has entered through the doors of RAC they no longer qualify for many services. Persons arrive with inherited ACAT or APAT teams involved but accessing their information is difficult and to make a single phone call can take upwards of an hour on-hold as their resources are limited. Staff in RAC are required to complete many assessments (psychological, Cornell, delirium screens etc) and have to forward all this before a decision is made to even accept a person. The Behavioural Assessment and Specialist Intervention Consultation Service (BASICS) or other localised mental health service referral processes are just as arduous as APAT or ACAT and in many cases falls to the RAC staff to complete as GPs do not have the knowledge nor time to make these referrals. Ultimately the GP is seen as the coordinator and gatekeeper for the care of their patients but GPs are time poor and often rely on RAC to perform this role.*

A combination of mental health services may be involved in a person's care but it is confusing to know who does what and how each can be contacted. When multiple services are involved they often do not speak directly to each other to coordinate a person's care. Once again this role falls to RAC to coordinate and facilitate.

There is no single point of reference nor one stop shop for RAC mental health service information, referral, triage and intervention. GPs are unable and/or unwilling to coordinate this for a number of reasons. GP mental health care plans are not claimable once a person is in RAC despite them being those potentially most in need of the services. Psychologist or even counselling service access is limited as many are static and do not visit RAC, and if they do the person will be billed privately at great and often restrictive cost. This could be related to federal/state issues but ultimately we are all the same under Medicare so not really sure where the roadblocks lie.

Anecdotally post-acute care is appalling for mental health care recipients. If RAC admission is arranged by service social workers; once the person arrives all follow-up and liaison stops. Once again the RAC must chase to coordinate mental health care service needs. At risk persons often arrive in RAC with no choice, nor advocacy for them. Community mental health supports aren't great and they don't communicate once a person has arrived. It's as though their duty of care stops once they are through our door.

We of course have access to Psychogeriatricians with a GP referral but access to psychologists is almost non-existent, often the RAC clinician and GP's only option is medication, often polypharmacy.

3. Whether the \$82.5 million over 4 years is an adequate level of funding – if this only helped 10% of residential aged care clients, this would only be around \$1000 per client per year.

Members are unanimous that the \$82.5million funding is a drop in the ocean of unmet mental health care need but they welcomed this funding as a start to addressing the issue.

- *\$82.5m over four years seems to be a “thin spread” allocation and I would strongly suggest it is not enough.*
- *\$82.5 Million is a drop in the ocean when you consider the magnitude of the issues.*
- *I would imagine the figure of assisting 10% will feel too low particularly for our services given the interplay of trauma and mental health issues. In the funding commitment consideration should once again be given to additional funds or brokerage being accessible to services supporting minority groups especially those who have experienced traumatic events.*
- *The AIHW Report on Depression in Residential Aged Care 2008-2012 indicated that just over half (52%) of all permanent aged care residents had a Cornell Scale for Depression score that indicated depression. Based on these figures the proposed budget for mental health in residential aged care does not seem adequate. However, inclusion of mental health in the budget at least gives this hidden/neglected issue some much need attention for the first time in years. Some funding is better than no funding.*
- *Will \$82.5 million over 4 years be an adequate level of funding? Absolutely not enough ... considering many psychologists services are \$150-200+ per hour of service ... well it won't stretch far at all.*
- *Regarding the suggested funding amount – estimates in email alert suggest \$1000 per year per resident – this would only enable 5 sessions (which is very conservatively estimated at \$200 per session for a psychologist) which is totally inadequate and would restrict access to effective interventions – there is significant evidence to support efficacy of mental health therapies in older adults but minimal implementation of this treatment.*

4. Whether there are any issues or ideas for roll-out of the initiative including the type of support required.

Members' identified priorities largely focus on the current major issues in mental health care in RACFs. Residents living in RACFs are not a homogeneous group; they are at different stages of their life and their life histories may affect their mental health in different ways. Thus mental health services delivered in the RACF setting need to also cater for special mental health care needs.

- *At a high level the question is essentially ‘what is the proposed model of intervention to be implemented and how will it be funded in the longer term’; as the need for well-resourced mental health interventions is only going to increase over time – not reduce.*

Strengthen capacity for mental health care delivery by RACFs

- *Funding for mental health champions/ specialists in RACF to triage mental health needs amongst resident population*
- *Incentives for RACFs to have staff attend the specific training in mental health first aid for older people (see <https://mhfa.com.au/courses/public/types/olderperson>)*
- *Development of protocols/ procedures at local RACFs for recognising deteriorating mental state in residents – aligned with protocols for deterioration in physical health.*

Training of care staff

- *Training of both paid staff and unpaid carers / families within the Residential Aged Care Facility will be an important part of an improved strategy.*
- *Staff knowledge and skills is an underlying issue for most of concerns raised regarding mental illness/ decline in residential aged care. Staff training on understanding, engaging supporting people living with mental illness/decline is essential.*
- *Staff require ongoing opportunities to learn to not only to better detect mental health conditions but also to implement evidence-based strategies.*

Ongoing clinical mental health input

- *Significant enhancement of existing state based teams with clear mandate to support RACFs – this would save the funding/ reimbursement issues directly to RACFs and would also support access to diagnostic services.*
- *Expand the scope of the Severe Behaviour Response Teams to include complex behaviours associated with mental illness.*
- *Attach a dedicated aged psychiatry clinician to every Aged Psychiatric Assessment and Treatment team (APATT) solely for residential care to provide education and support via a TRIP (Translating Research into Practice) model.*
- *Attach money to “flying squad”³ which is currently managed by Hammond Care to extend the scope of work they are undertaking but again using a TRIP model to implement.*
- *We need access to proactive and responsive Mental Health services within RAC. Staff need support to assist these persons and refer to suitably qualified services.*
- *Integration of intervention strategies with local (RACF) staff is a current issue but could be worsened with more providers/ systems made available. Funding model should include time to provide handover/ training to support ongoing intervention once mental health services/ specialists supports withdraw/ end.*

Non-pharmacologically therapeutic approaches to mental health issues

- *A greater promotion of programs designed to address loneliness – i.e. CVS and Telecross.*
- *More support for activities for residents that focus on mental health and wellbeing. Perhaps this could be achieved with further training or guidance for diversional therapists?*

Systematic and regular review of psychiatric medications

The Improved Access to Psychological Services in Residential Care initiative should provide residents with the opportunity to access psychological therapies in place of, or in addition to pharmacological

³ Also referred to as Severe Behaviour Response Teams. <https://ama.com.au/ausmed/dementia-‘flying-squads’>

treatments. Evidence suggests an overuse of pharmacological interventions in RACFs even though these are likely to cause serious side-effects if prescribed inappropriately.

For example, in 2014-15 Goodwin partnered with University of Tasmania to reduce the use of benzodiazepines and anti-psychotics in aged care. One facility was able to reduce the number of residents on these medications from 18 to 1. Further, Goodwin partnered in a research project into increasing non-pharmacological interventions to manage the Psychological and behavioural Symptoms of Dementia (BPSD)⁴.

The importance of reducing inappropriately prescribed psychiatric medications was raised by a LASA Member who offers medication reviews as a business.

- *When looking at appropriate mental health supports in aged care, **personalised proactive regular medication review** needs to be part of the picture.*

Based on a recent sample of our reports, almost a third of all of the medications we identify for review by a GP (27%) are psychiatric ones. The most common recommendation we make is that the GP cease medications (33%). Of those that we suggest be ceased, 19.7% are antipsychotic medications.

To put this in context, we look after over 25,000 people living in aged care. If we extrapolate the numbers, that would mean 8,250 recommendations would be to cease a medication and over 1,500 of those would be antipsychotics – that's a lot of people on medications we don't think they should necessarily be on...

In 2017, there were 580,000 subsidised prescriptions for risperidone at a Government cost of \$36.3 million. Surely there has to be a better way to invest those funds where the medication isn't needed and give people true quality of life...

Support for residents adjusting to life in the residential care facility⁵

- *Many people experience grief and loss when moving into residential aged care. This can often be associated with an unexpected transition into residential care following an acute care episode. In these instances, people may not have been offered the opportunity to prepare, process and grieve their previous lifestyle⁶.*
- *... almost all residents transition into RAC environments with an element of grief for their independence lost. Psychological support at this time would be wonderful for everyone in RAC, however there are little or no financial resources or available services to meet this need.*
- *There is a lack of early interventions to assist with adjustment – resulting in mental health decline and residents presenting with 'Adjustment disorder' which when untreated can lead to other mental illness such as depression and anxiety.*

⁴ Australian Ageing Agenda, May-June 2018 *A focus on pharmacy. Goodwin pioneers a new model.* pp.36-39.

⁵ Swinburne University of Technology developed the *Program to Enhance Adjustment to Residential Living (PEARL)* to meet these challenges and which is being trialled now. The PEARL team of trained mental health clinicians is currently accepting expressions of interest from RACFs in the Melbourne Metropolitan area who would like to participate in the trial. Contact: pearlproject@swin.edu.au

⁶ *Issues of loss and grief tend to be: Premature admission into residential care, the loss or separation from a partner, loss of the family home and adjustments moving into shared accommodation, loss of independence and an autonomous life, loss of social connections, appointment of a formal decision maker who may not engage the residents in decisions.*

- *Increased access to early interventions including psychological and counselling supports should be provided on initial entry to residential care to assist residents to process and adjust to significant life changes.*

Special needs groups

- *In the roll out it would be worth recommending that whilst access to generic mental health support is needed by all aged care facilities, there should be some targeting of supports to ethno-specific providers so that expertise can be built around the specific ethnic group.*
- *Of course for us it would be essential for the mental health team engaged with any of our services to have a sharper understanding of trauma and the ability to differentiate trauma based behaviour from a diagnosable mental illness or at least be sensitive to building this expertise. It is difficult to do this if teams are to use a centralised referral system meaning any professional team might respond to a request.*

Residents approaching their End-of-life are another special needs group that may require specialist mental health support. Palliative Care Australia states:

'The principles for Palliative and End-of-Life Care in Residential Aged Care call for mental health needs of consumers to be assessed, documented and met including treatment for anxiety or depression.....Grief, bereavement and spiritual support must be included in this initiative'⁷.

Elder abuse is a reason for early admittance to residential care⁸. Residents may have been subjected or may continue to be subjected to abuse, most commonly by family members. Victims of elder abuse may require mental health care to assist them to deal with the trauma of abuse.

⁷ http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf

⁸ <https://seniorsrights.org.au/wp-content/uploads/2018/05/Elder-Abuse-as-Family-Violence-FINAL.pdf>