



National Mental Health Commission's Preliminary Response to the Royal Commission into Aged Care Quality and Safety's Adelaide Hearing 5 - Draft propositions

The National Mental Health Commission (NMHC) is providing a preliminary response to the seven draft propositions related to mental health care that the Royal Commission staff have developed for consideration at the scheduled Adelaide Hearing 5 (the draft propositions). The NMHC will provide a further, more detailed response to the draft propositions once they have been finalised following the conclusion of the hearing. Also attached to this preliminary response are two public submissions by the NMHC to the Royal Commission – one submitted in October 2019 (**Attachment A**) and the other is the NMHC latest submission (**Attachment B**).

Introduction

As noted in the NMHC's second submission, the changes recommended by the Royal Commission following its hearing on the interface between the aged care system and the health system could be extended to incorporate changes to mental health.

Overall, the NMHC notes that the draft propositions have a strong *clinical* focus, and while this approach may be appropriate for those who are experiencing severe mental illness, most people would benefit from a more holistic approach to their mental health and wellbeing. The NMHC recommends an approach based on the integration of *A Contributing Life Framework* which provides a whole-of-person, whole-of-system, whole-of-life framework to mental health and wellbeing. This approach would include the expansion of programs, outside of clinical services, to contribute to the mental health and wellbeing of older people, such as 'befriending' programs and the enhanced role for peer workers in both a community and a residential aged care setting.¹

The NMHC notes that in 2015, the Medicare Benefits Schedule (MBS) Review Taskforce was established by the Australian Government to review how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The NMHC would like to underscore the importance of better information and evaluation upon which to assess the effectiveness of the MBS as a funding mechanism and of the services it subsidises. The NMHC welcomes that a number of the draft propositions address the lack of access to MBS items for mental health care by residents in residential aged care, a matter which has been raised in the NMHC's submissions to the MBS Review Taskforce. The NMHC does consider that there is a need to expand psychological services in RACFs beyond the *Improved Access to Psychological Services measure*, currently the only source of psychological services for some RACF residents, which may be achieved through the implementation of some of the draft propositions.

The NMHC considers that reform in relation to aged care and mental health needs to recognise that the mental health workforce is a multi-disciplinary team, yet the Royal Commission's draft propositions do not address enhanced roles for a number of the key professionals in this team, such as mental health nurses and peer workforce. The NMHC recognises that the expansion of mental

¹ NMHC (October 2019) *First Submission to the Royal Commission into Aged Care Quality and Safety*



health services as outlined in the Royal Commission's draft propositions will require increases to the mental health workforce, specifically psychiatrists (M2) and psychologists (M3), to provide these services. While this may not necessarily be a barrier to implementing the proposed measures, the NMHC acknowledges that the impact of such measures may be reduced without strategies to grow the workforce, especially in rural and remote areas and outer-metropolitan areas.

Proposition M1: Fund mental health treatment plans prepared by a general practitioner for Australians living in residential aged care

The NMHC supports the removal of barriers to the use of existing MBS items (both referral and treatment items) by people living in residential aged care facilities (RACFs), by allowing GPs to prepare mental health treatment plans for residents on the same basis as people living in the community.

This will ensure continuity of care for older people who have been accessing mental health MBS services prior to moving into a RACF, allowing them to continue to receive treatment from their existing practitioners and helping to facilitate smoother transitions to living in a RACF. The NMHC also note that it is important, where possible, that the resident is given the ability to choose their treating team, including their GP, psychiatrist and/or psychologist. This is consistent with the position put forward by Counsel Assisting in *Proposition CH4*.

The role of primary health practitioners, including GPs, in the provision of mental health treatment to residents of RACFs also needs greater clarity. There is also a need for better mechanisms to enable GPs to be more involved in the linkages between health care, personal care and broader mental wellbeing initiatives. While this proposition supports GPs to access MBS payments, other options include incentives and training for GPs specialising in aged care related services. Flexibility for GPs to visit older patients in residential care also needs to be developed. Innovative approaches such as developing memorandum of understandings between RACFs and local general practices support a more planned approach to ensuring access to GPs.

The NMHC supports the Royal Commission's consideration of varied payment models, as the fee for service is not always the most effective approach to providing mental health care, especially in settings such as RACFs. However, for as long as MBS remains the primary mechanism for creating service access, the NMHC continues to advocate for the expansion of the MBS items available to residents of RACFs. In addition, the NMHC supports, in principle (see response to M5 below), the Royal Commission's proposition that the mental health services to older people should be delivered via specialised outreach multidisciplinary teams based in Local Health Networks (as proposed in *Proposition CH7*).

Proposition M2: Fund mental health assessments and mental health treatment plans by a psychiatrist for Australians living in residential aged care

The NMHC is concerned that this proposition may lead to M1 being considered redundant as the NMHC considers that GPs have a central role in mental health care. The NMHC supports a timeframe to ensure the accessibility to prompt mental health assessment and treatment plan for a person entering an RACF. However, the evidence-base needs to be considered on an individual basis as to



who is best placed to perform such an assessment and provide treatment. Whether it is a psychiatrist or a GP may depend on the complexity of an individual's mental health needs, their acuity and functional impairment.

Early involvement of a psychiatrist may not be the most effective use of this professional group, unless the presence of an existing psychiatric diagnosis is known or there is a significant change in psychiatric presentation. In such cases then a psychiatric assessment may be of use, however, the NMHC question the utility of specifying time intervals around this given these will likely be dictated by the needs of the resident and severity of the mental health presentation.

The NMHC recognises that there are significant workforce implications for this measure due to the current geographical mal-distribution and shortage of psychiatrists especially in rural and remote locations.

Proposition M3: Increase funding for psychologists providing psychological services to people living in residential aged care

The NMHC notes that *Proposition M1* would increase access to psychological services (up to ten sessions annually) for residents in RACFs by introducing access to GP mental health treatment plans. While the NMHC supports increasing access to psychological services for older people living in RACFs, it is not clear there is strong evidence suggesting treatment should consist of 15 sessions per six month period as identified by M3.

The NMHC encourages any reform of the MBS to be based on best-practice approaches and a strong evidence base. There are many gaps in the information currently available about the outcomes being achieved through mental health services funded through the MBS, and clinical research generally focusses on specific disorders and/or population groups. As a result, there may be limited areas where there is sufficient evidence for introducing additional sessions at this time. MBS sessions have only been increased beyond the standard 10 sessions for severe eating disorders as this decision matched treatment protocols for the evidence-based treatment which dictate 20-40 sessions. Prior to decisions around changes in number of sessions, a thorough review of the evidence base to ensure evidence based policy is required.¹

As outlined above, there is also a need to expand psychological services in RACFs beyond the *Improved Access to Psychological Services measure*. The Royal Commission might also consider whether there would be merit in accelerating the rolling out of *Improved Access to Psychological Services measure* over two years rather than the current four year period, as this would help facilitate greater (and wider) access across RACFs to mental health services. In saying that, the NMHC notes that the Commonwealth Department of Health states that the focus for Primary Health Networks (PHNs) should be on addressing the gap in service associated with the lack of availability of *Better Access* services. As a result, PHNs could target residents with a diagnosis of mild to moderate mental illness, and not necessarily seek to cover the full spectrum of services for older people. The *Improved Access to Psychological Services measure* may not fully address current gaps in access to mental health services faced by RACF residents, particularly those with severe and complex mental illness.



Proposition M4: Incentivise psychiatrists and psychologists to attend residential aged care facilities

As stated above, the NMHC supports the creation of MBS items (based on evidence) and other mechanisms for improving mental health services. There is, however, a need for national and state and territory workforce strategies and planning to examine the workforce needs to ensure any new reforms can be successfully implemented. There is a paucity of psychologists, social workers and mental health nurses operating in the aged care industry. The NMHC believes that the National Mental Health Workforce Strategy will need to consider these issues.

The NMHC considers that there may be a need to introduce Medicare-subsidised psychiatric services for older people living in RACFs, as recommended in the NMHC's submission to the MBS Review Taskforce. An option is to expand MBS Item 291 to include settings other than consult rooms, to include residential aged care facilities.

The NMHC agree that additional incentives are also needed, however, questions the use of a Practice Incentive Program (PIP) program and directs the Royal Commission to multi-disciplinary outreach health services (M5) rather than the fee for service model for this vulnerable population.

Proposition M5: Increase outreach services by state and territory government older person's mental health services at the residences of Australians accessing aged care services

The NMHC support in-principle the development of multi-disciplinary outreach health services including the Older People's Mental Health Services as proposed under *Proposition CH7*. These teams would be the result of coordinated funding under the National Health Reform Agreement (NHRA) from Australian and state and territory governments for Local Health Network led outreach health services for older people in residential aged care services or receiving high-level home care. The NMHC acknowledges that all governments would need to agree to progress action under the NHRA.

The proposed approach to outreach services could assist in achieving more equitable access to services by involving multi-disciplinary teams and provide a 24 hour on call service to residents' homes and RACFs. These services could include a mental health team of generalist physicians, psychiatrists, psychologists and nurses to provide holistic health care, enhance multi-disciplinary communication, and offer salaried roles in order to provide a service that is free to older people. Additionally, a specialised service model such as this ensures clinical skillsets are fostered specific to older people.

Proposition M6: Increase mental health training for personal care workers

This recommendation is in line with the NMHC's recommendations in its first submission focussed on the importance of increasing mental health training for all staff working within the aged care sector to ensure that safe and high-quality care is provided.² The aged care workforce needs to understand: what normal ageing looks like; what the mental health needs of older people are;

² NMHC (October 2019) *First Submission to the Royal Commission into Aged Care Quality and Safety*



suicide prevention; and the behavioural and psychological symptoms of dementia from mild to severe. Having an aged care workforce skilled and trained in mental health literacy is essential and has been identified as a key issue in the NMHC's previous submissions to the Royal Commission.³

The NMHC considers that training in mental health literacy, such as Older Person's Mental Health First Aid course, should be a core competency for all residential aged care staff within the first year of employment.⁴ Given personal care workers often spend large portions of time with older people, they may be best placed, if trained appropriately, to identify early warning signs of deterioration in mental state. As a result of increasing mental health literacy among aged care staff, referral pathways and formal connections are expected to be enhanced.

Recent research has concluded that training should go beyond ensuring compliance, to ensure care workers have the relevant practice and relational skills to deliver high quality care.⁵ As with any training and professional development in a work environment, it is essential for providers to develop and put in place the necessary system changes to ensure staff are encouraged and supported to use and refresh the outcomes of their training.

Proposition M7: Greater clarity on the role and responsibilities of residential aged care providers to maintain the mental health of residents.

The NMHC supports the stated purpose of this proposition that all aged care instruments, such as the Quality of Care Principles 2014 (Cth), should include an explicit and measurable requirement to maintain the mental health of residents. This proposition is premised on the principle that mental health care is an integral part of aged care business, including residential aged care. This is a position that the NMHC advocated for in its initial submission to the Royal Commission. The NMHC welcomes changes that increase clarity around the expectations of aged care providers in mental health assessment and management, and increases accountability by measuring clinical outcomes and quality of care.

The NMHC supports the recommendations by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) that regulation of clinical and medical care be informed by the collection and evaluation of established operationalised indicators of compliance with best practice and any relevant guidelines⁶. To improve accountability the collection of mental health indicators under the National Aged Care Mandatory Quality Indicator Program should be actioned and publicly available.

The types of evidence aged care providers should be required to provide in order to demonstrate that they have the systems and workforce in place to provide access to quality mental health care include:

³ NMHC (October 2019) *First Submission to the Royal Commission into Aged Care Quality and Safety*

⁴ NMHC (October 2019) *First Submission to the Royal Commission into Aged Care Quality and Safety*

⁵ Meagher, G., Cortis, N. Charlesworth, S., Taylor, W. (2019). *Meeting the social and emotional support needs of older people using aged care services*. Sydney: Macquarie University, UNSW Sydney and RMIT University. <http://doi.org/10.26190/5da7d6ab7099a>

⁶ RANZCP (2019) *Submission to the Royal Commission into Aged Care Quality and Safety*



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- more attention to specific aged care mental wellbeing and suicide prevention programs, shifting beyond depression assessments and treatments (often medication based) as the responses to older person's mental health;
- quality service standards and reporting systems need to include direct reference to the social and emotional health of older people and provide for consumer and carer feedback as a quality improvement technique, such as aggregated reviews of the mental health and wellbeing of residents and clients of aged care providers (for example, periodic surveys of self-reported wellbeing);
- rates of inappropriate psychotropic use; and
- rates and reasons for hospital admissions and readmissions.

The NMHC also recommends that an independent body investigate the suitability of using or adapting existing validated mental health instruments such as the [HoNOS65+](#) or components of the [Living in the Community Questionnaire](#) (such as the 'social activities' 'Having your say' 'overall' sections) for ongoing and regular use in RACFs..

The HoNOS65+ is one of the data sources for existing mental health indicators, including the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) indicator '*Change in mental health consumers' clinical outcomes*'. Whereas the Living in the Community Questionnaire was intended to be used for the Fifth Plan indicator '*Connectedness and meaning in life*'. These Fifth Plan indicators could be used as a starting point for the development of mental health indicators for the National Aged Care Mandatory Quality Indicator Program. These instruments could also be utilised to assess the mental health of all residents through the collection of measurements every six months

ⁱ [https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/\\$File/Eating-Disorders-Working-Group.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbs-review-2018-taskforce-reports-cp/$File/Eating-Disorders-Working-Group.pdf)