National Secretariat
PO Box 542 Marden SA 5070
Phone 1300 620 042
admin@LivedExperienceAustralia.com.au
ABN 44 613 210 889
Patrons: Professor Alan Fels AO | Mr John McGrath AM

# Submission
## Royal Commission into Aged Care Quality and Safety

Lived Experience Australia (LEA) is the representative organisation for Australian mental health consumers and carers and is the trading name of the Private Mental Health Consumer Carer Network (Australia) Ltd, formed in 2002. Our core business is to advocate for systemic change, empowerment of consumers and carers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

We thank the Royal Commission into Aged Care Quality and Safety for the opportunity to provide this Submission and welcome the focus on mental illness.

We also welcomed the telephone conversation with relevant staff of the Royal Commission and Janne McMahon OAM (Executive Director) previously who sought our knowledge and expertise in the mental health sector.

The areas Lived Experience Australia wishes to comment on are:

### 1 Suicide and age

What we do know is that the age-specific suicide rate in 2018 was highest in the 80+ age range for both men and women.[1]

*For Males*: The highest age-specific suicide rate in 2018 was observed in the 85+ age group (32.9 per 100,000). This rate was higher than the age-specific suicide rate observed in all other age groups.
*For Females*: The highest age-specific suicide rate in 2018 was observed in the 80-84 age group (9.0 per 100,000)

These statistics demonstrate that a strong focus is required on:

- Early identification of risk factors for older Australians living in their own accommodation or with family, such as an overwhelming sense of hopelessness, the death of a lifelong partner or friend, losing independence in transferring to an aged care facility or losing a home with fond memories. The potential for family conflict as the person ages and loses independence is also an important consideration. The older person may feel that they have become a burden, or they may experience elder abuse as a result of these changes in their circumstances.

- Early intervention is equally critical in residents in Residential Aged Care Facilities (RACFs) with depression and anxiety to ensure factors are treated by appropriately trained staff with mental health training, psychologists, or psychiatrists. Barriers of access to quality psychiatric care must be identified and removed.

- In addition to the above, for older people living independently or living in RACFs, better quality human and other resources for providing meaningful activities of daily living are also needed. This includes improved staffing ratios of staff to residents in RACFs so that residents are supported to engage in activities in their own self-care as much as they have capacity to do so.

[1] ABS (released 2019)

This gives opportunities for improved self-esteem, dignity in care, self-respect, purpose in life and meaning, which are all important for mental health and wellbeing. For both older people living at home or in RACFs, this need also includes more resources for older people to continue to participate in their community and maintain their familial and friendship ties.

## 2 Dementia

Dementia has profound consequences for the quality of life of the person with the illness and their families and carers. People with dementia become increasingly dependent on support for daily living. Dementia is often associated with ageing, but it can affect young people also.

Dementia is not a single specific disease rather a term used to describe a syndrome associated with many other different diseases that are characterised in the same manner in relation to impairment of brain functions, memory, perception, personality and cognitive skills. As it is a progressive disease, the impact increases as the severity of the condition progresses. It is usually gradual from onset, progressing in nature and severity and currently is irreversible.

Dementia and depression can occur separately or together. Sometimes it may be difficult to distinguish between them because the signs and symptoms are similar. However, dementia and depression are different conditions, requiring different responses and treatment.[2] Many families and carers report that there is often a misdiagnosis or misunderstanding of depression and dementia - and perhaps other mental illnesses - which would require different management.

Psychiatric Inpatient dementia units where the elderly are cared for are mostly in a secure setting. Aggression is evident in many, requiring acute care in mental health inpatient settings to meet their needs. Younger people, some in their early 40s, are also admitted to these units and cared for alongside the elderly. Area mental health services and some private psychiatric hospitals have aged care psychiatry services, and there are a limited number of psychiatrists who specialise in treating the elderly and providing treatment to those more seriously affected.

Our concerns are that:

- people with dementia retain the same rights as any other person with a mental illness. We know that the word dementia for many becomes a 'label' that tends to describe all behaviours, especially in the ageing. The risk to people with dementia is that treatment becomes directed to the diagnosis rather than to the person.

- Dementia is a very difficult area made more challenging in that if often occurs 'behind closed doors' for example where the person is a permanent resident of RACFs or aged care psychiatric units.

- Aged care psychiatry is an area requiring dedicated and caring staff. Their efforts and dedication often go unrecognised in the overall scheme of the mental health system.

- Given the predicted rise in dementia associated with the ageing population in Australia, the mental health workforce will be further compromised.

- People with dementia have many other health problems. This is often because of their age, although the health conditions of people with dementia are more prevalent and their overall physical wellbeing is much poorer than that of people of equivalent age without dementia within the general population.

- Clear understanding by RACF staff between depression and dementia or any other mental illness.

[2] beyondblue Fact Sheet 25 - Depression and Dementia

- People with dementia must retain the same rights as any other person with a mental illness.

- People with dementia and their families and carers must be as informed as any other person with mental illness and their families and/or carers.

## 3 Chemical restraint in aged care facilities

Lived Experience Australia fully supports the reduction and elimination in the use of chemical restraint in RACFs. We are concerned that chemical restraint is used as a mechanism to control, restrict or to address behavioural issues of aged persons.

Prescriptions for depression, anxiety or other psychotropic medications for existing mental illness should be administer in line with appropriate treatment. We know that 85% of residents in RACFs have a diagnosis of at least one mental health or behavioural condition. Depression is the most common mental illness in 47% of residents, while dementia has been diagnosed in just over half of the residents.[3][4][5]

- Any misuse of antipsychotic medications purely as a means to contain residents in RACFs, or as a convenience to workloads or as a consequences of staff shortages, must be abolished. Better resourcing of RACFs to provide least restrictive care is needed.

- Prescriptions for antipsychotic medications should be made by GPs to aged care residents with a formal mechanism for involvement of psychiatrists.

- The workforce must be expanded in the aged psychiatry area with positions made more readily available for trainee psychiatrists, psychologists, and mental health nurses etc.

## 4 Younger people with a disability and aged care residences

This is an area which needs to be addressed as a matter of urgency. Lived Experience Australia does not believe that an aged care facility is an appropriate setting for younger people with disability to reside.

Purposed build facilities must be built for people where their disabilities can be dealt with in a respectful and dignified setting and mental health issues are detected early, with treatment and support provided by mental health specific clinicians.

## 5 An Innovative approach

Lived Experience Australia wishes to raise an innovative approach in supporting people with mental health problems residing in aged care facilities. Employing peer workers in residential aged care facilities would be a new concept and new approach and we are not aware that this has been recommended previously but would ask the Royal Commission to investigate this with a view to a recommendation in this regard.

Not unexpectedly, as a relatively new occupational group, there is still a lack of shared understanding of the definitions, values, skills, practices, and challenges in peer work.

Lived Experience Australia actively supports the peer workforce in Australia. Peer work is a growing occupational group in the mental health workforce and has been reported to be growing at a faster rate than other disciplines in recent years.[6] Increasingly, peer workers are being employed within the

[3] Australian Institute of Health and Welfare. Depression in residential aged care 200802012. Canberra: AIHW: 2013
[4] Department of Health. People's care needs in aged care. Canberra: Commonwealth of Australia: 2018
[5] RANZCP Submission, Interim Report; April 2020
[6] *Peer Work in Mental Health*, IIMHL January 2013

public mental health system and community managed organisations (CMOs) and we see no reason why peer workers could not be employed in RACFs.

The increase in the employment of peer workers has been supported by the articulation of peer workers as a legitimate workforce firstly within the 4th National Mental Health Plan - *Increase consumer and carer employment in clinical and community support settings*[7] and the National Mental Health Commission's 2014 National Review of Mental Health Program and Services. These actions were further expanded within the 5th National Mental Health and Suicide Prevention Plan.

**What is a peer worker?**
Peer work, peer workers and peer workforce include all workers in mainstream or alternative services or initiatives who are employed to openly identify and use their lived experience of mental distress or as a carer supporting someone with mental ill-health as part of their work. As this workforce develops, there is a greater need to create new roles and define the boundaries between them.

Peer workers work in a paid role and provide support for personal and social recovery to people with mental health problems, including in acute mental health services, housing, supported employment, community support etc. and provide support to their families and carers.

A major initiative for a nationally recognised qualification has been the development of training and assessment resources for the **Certificate IV in Mental Health Peer Work CHC43515** (which includes and elective unit of either a consumer stream or a carer stream) designed specifically to support the emerging peer workforce. This qualification is designed for consumer peer workers and carer peer workers who are seeking employment within government, private, public or community managed services where mental ill-health or mental illness is a component.

As mentioned, we see no reason why peer workers could not be employed within residential aged care facilities. The relevance of age (peer to peer of a similar age group) may be raised as an issue, but the lived experience, knowledge, skills, values, and professionalism of peer workers would counteract any argument that may be raised as a deterrent.

Peer workers are highly skilled and can adapt to various settings. Workers within residential aged care facilities are also younger than the residents, and peer workers in these settings would bring a value not currently seen.

Lived Experience Australia thanks the Royal Commission and would welcome the opportunity of further expanding on any of the issues raised within this Submission or any other area pertaining to mental health within residential aged care facilities.

**Contact**
Janne McMahon OAM
Chair and Executive Director
Lived Experience Australia
PO Box 542, MARDEN SA 5070
Phone: 1300 620 042
Mobile: 0417 893 741
Email: jmcmahon@livedexperienceaustralia.com.au

[7], Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014, Priority area 4: Quality improvement and innovation