Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Depression is the leading cause of disability globally (World Health Organization, 2017a) and is the most prevalent mental illness in older adults (World Health Organization, 2017b). Between 10% and 40% of community-dwelling older adults experience depression (Blackburn, Wilkins-Ho, & Wiese, 2017; Pirkis et al., 2009). The rate of depression is significantly higher in residential aged care settings (Australian Institute of Health and Welfare, 2013). Anxiety is also common in older adults, and there are associations between anxiety and depression – alone or in combination –poor physical health and overall quality of life (DiNapoli, Pierpaoli, Shah, Yang, & Scogin, 2017; Subramanyam, Kedare, Singh, & Pinto, 2018).

Depression in older adults is associated with a decline in overall well-being, daily functioning, independence, increased disability, suicidal ideation and mortality (Almeida, Flicker, & Rees, 2014). Globally, older adults with depression report the highest mean number of health conditions, and those with depression visit a general practitioner (GP) and hospital emergency departments more frequently, use more medication, incur higher outpatient charges, and stay longer in hospital (Arias et al., 2017). Thus, the effect of a diagnosis of depression or anxiety extends beyond individuals, as they draw on formal and informal supports to manage their symptoms and improve their quality of life. In Australia, health care costs of older adults with depression are higher than those of their non-depressed peers, and they visit their GP more often than those who do not have depression (Searby, Maude, & McGrath, 2016). Suicide rates are highest in men and women aged 70 years and over in almost all regions of the world (World Health Organization, 2014). Further to this, men aged 80 years and above are most likely to die by suicide than other age groups in the Australian context (Australian Bureau of Statistics, 2015).

Although depression and anxiety in older adults are considered major public health challenges globally, older people are often overlooked in the mental health system (De Mendonça Lima & Ivbijaro, 2013).

To address this lacuna, there are three key interventions needed to reduce ageism and stigma, and improve outcomes for individuals, their families and the broader Victoria community.

First, at a fundamental level, the tendency to normalise poor mental health as a 'normal' part of ageing reflects a prevailing attitude of ageism towards older adults. From policy and service perspectives, ageism is evident in the way older adults are portrayed as a burden on society (Chrisler, Barney, & Palatino, 2016). In the healthcare setting, ageism has been shown to occur frequently in the interaction between health professionals and older patients where health professionals patronise older patients, listen less to their views, give less time to clinical interviews and attribute symptoms to age rather than to treatable conditions (Polacsek, Boardman, & McCann, 2019; São José, Amado, Ilinca, Buttigieg, & Taghizadeh Larsson, 2017). This problem is compounded by an overall lack of skills in health professionals to diagnose depression in older adults. Health professionals regularly misattribute common depressive symptoms such as a loss of interest in life, chronic unexplained pain, poor sleep or impaired memory to old age, dementia, or poor health (Von Faber et al., 2016; Webb, Cui, Titus, Fiske, & Nadorff, 2018). The natural experience of grief at a loss is also often poorly managed in older adults, increasing the risk of complicated grief and depression, and cognitive decline (Pérez, Ikram, Direk, & Tiemeier, 2018).

Second, it is important to reduce the stigma of mental illness in older adults by tackling the intersecting associations between ageism, racism, and sexism, as well as the determinants of poor mental health including social isolation and loneliness, and socio-economic disadvantage. Older adults who experience high levels of stigma are less likely to seek help and more likely to discontinue treatment early (Sirey, Greenfield, Weinberger, & Bruce, 2013).

Finally, the Commission is well placed to challenge the media's role in reinforcing the pervasive ageism and mental illness stigma that prevents timely and appropriate diagnosis and treatment. Negative perceptions of

ageing often result in decreased motivation to engage in healthy behaviour, imposing self-fulfilling limitations on the individual's expectations of well-being. The media also has direct effects on public attitudes towards mental illness. These attitudes can, in turn, influence health policies and practices in ways that affect resource allocation for preventing, treating and supporting mental illness in older people (Zhang, Jin, Stewart, & Porter, 2016). The potential for the media to play a role in debunking stereotypes of older age and mental illness is supported by a considerable amount of literature (Malta & Doyle, 2016; Zhang et al., 2016). A more positive portrayal of older adults and those with mental health issues aligns with policies that support the health and human rights of all people.

Operationalising these interventions is easier than we think and cost-effective. The National Ageing Research Institute (NARI), based in Melbourne, is recognised as a leader in clinical and psychosocial research that aims to guide policy to improve the quality of life and ageing experience of Australia's older people. Notable projects include IMPACCT: Improving Mood through Physical Activity for Carers and Care Recipients Trial, Pleasant Activities for Wellbeing (PAW): Using behavioural activation to reduce depression in residential aged care, and The BEFRIENDAS Study: The impact of befriending on depression, anxiety, social support and loneliness in older adults living in residential aged care facilities. NARI is well-positioned to expand on its current work towards reducing stigma and discrimination of mental illness among older adults (Brijnath & Antoniades, 2018a), including in vulnerable and/or diverse groups, such as older people from culturally and linguistically diverse (CALD) backgrounds (Brijnath & Antoniades, 2018b), and in older gay, lesbian, bisexual, transgender and intersex Australians (Tinney et al., 2015). NARI's approach draws extensively on the principles of co-design and engagement with individuals, carers, the broader community, policy makers and service providers, and national and international collaborators. Its explicit focus on improving the health and quality of life of older people underpins its translational research that aims to inform a better future for all.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Befriending, behaviour activation, and peer support initiatives are psychosocial interventions that have been proven to prevent mental illness in older people as well as promote personal recovery among those already unwell. Alongside, socio-structural influences such as socio-economic status, marital status, education, English language proficiency, and migration trajectories shape mental health (Mollah, Antoniades, Lafeer, & Brijnath, 2018). Approaches for prevention and support of people with mental illness are more effective when they are tailored to the needs of specific groups(e.g. older people in residential aged care, new migrants).Researchers at the National Ageing Research Institute (NARI) recently conducted a study using behavioural activation to reduce depression in residential aged care. In the Pleasant Activities for Wellbeing (PAW) project, residents were partnered with specially trained volunteers to increase participation in enjoyable and meaningful activities. Preliminary data analysis indicates the success of the program for residents and volunteers, and further research to strengthen the evidence base for this non-pharmacological approach is warranted. In another study at NARI, befriending is being used to reduce loneliness and symptoms of depression and anxiety in older adults in residential aged care. Through these two studies, NARI is focusing on the significant number of older adults living in residential aged care, who have depression. By addressing social isolation and loneliness, symptoms of depression and anxiety are reduced.

3. What is already working well and what can be done better to prevent suicide?

Suicide rates are highest in men and women aged 70 years and over in almost all regions of the world (WHO 2014). Australian men aged 80 years and above are most likely to die by suicide than other age groups (Australian Bureau of Statistics, 2015). Particularly vulnerable are those living in residential aged care (Murphy, Bugeja, Pilgrim, & Ibrahim, 2018). Depression is common in older people who died by suicide, while most also present with a major psychiatric disorder at the time of death. With an ageing population and increasing prevalence of depression, the numbers of suicides in older people is expected to increase.

Suicide in residential aged care is an increasing public concern. There is a particular need to facilitate the transition into residential aged care, with data showing that half the residents who died from suicide had entered the home within the past 12 months (Murphy et al., 2018). Recent consultations between the National Ageing Research Institute (NARI) and the aged care sector have identified the urgent need to reduce the risk of suicide among older men, in particular. Members of the research team recently completed a study into suicide

and older men, which involved 33 men aged 80 years or over, living in the community. Findings suggest that suicide risk among older men was associated with loss of meaningful activities and life transitions, such as loss of a spouse and/or job, as well as their perception of being a burden on others. The men identified the need to develop practical strategies to enable identification and prevention of suicide in older men. These include challenging the typical masculine norms of stoicism, independence, invulnerability and avoidance of negative emotions (Schlichthorst, King, Turnure, Phelps, & Pirkis, 2019).

Interventions to prevent suicide in older people should be targeted to specific groups and use active and empowering language (Schlichthorst et al., 2019). Prevention should focus on improving the overall conditions in residential aged care, to improve residents' quality of life. Following a recovery or chronic care model, suicide prevention programs should be developed with older adults and be adapted for those with long-term conditions (Conejero, Olié, Courtet, & Calati, 2018). Efforts should also be made to maximise older people's independence at home, reduce depression, social isolation, and enhance overall wellbeing. These efforts should be underpinned by current evidence and reflect best practice for supporting older people with mental illness.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Determinants of mental health include personal attributes, as well as social, cultural, economic, political and environmental factors. Hence, research strongly supports a life course approach to mental health, with many studies demonstrating the influence of individual circumstances throughout life on subsequent health and wellbeing (Pearce, Cherrie, Shortt, Deary, & Ward Thompson, 2018; Sutin et al., 2013). To reduce the risk of mental illness, policies are needed that aim to improve conditions of daily living from birth through to old age (cradle to grave), through childhood and adolescence, in working ages, and into older age.

In the absence of a life course approach, there are serious gaps in evidence-based services and support for older adults with mental illness. To illustrate, the National Mental Health Commission contains almost no information on older adults, despite the prevalence and impact of mental illness in this cohort. There is an urgent need to demonstrate through research, policy and practice that older people matter, and that their mental health is recognised as important.

It is clear that older people frequently encounter difficulties obtaining a diagnosis and appropriate treatment for depression (Polacsek, Boardman, & McCann, 2018). Our research shows that these difficulties are compounded in vulnerable or diverse populations, including those from culturally and linguistically diverse (CALD) backgrounds (Mollah et al., 2018), Aboriginal and Torres Strait Island people (Phillips et al., 2017), those living in rural and remote areas (Haralambous et al., 2009) and in older gay, lesbian, bisexual, transgender and intersex people (Tinney et al., 2015). Common help-seeking barriers include attitudes of older adults and health professionals towards depression in older age, poor motivation to seek help, stigma, inconsistent screening for depression and difficulty accessing formal support and previous negative experiences (Rhee et al., 2017; Xiang et al., 2018).

We have identified several opportunities to improve mental health in older adults, and facilitating access to services. The CHIME (connectedness, hope and optimism about the future, identity, meaning in life and empowerment) framework, for example, places the individual and their families at the centre of meeting personal recovery goals (Brijnath, 2015). However, more research is needed to inform wider structural influences on recovery, which have the potential to extend beyond individual recovery to broader policy and service provision initiatives that are more effective, efficient and sustainable. Culturally-specific frameworks and approaches are also recommended, including training mental health staff on how to deliver culturally competent care (Mollah et al., 2018).

Another project currently underway at the National Ageing Research Institute (NARI) is considering the use of existing translation technology for everyday communication between older people and their care workers who do not speak the same language. It is challenging to identify and discuss healthcare needs when all parties do not speak the same language. Interpreters can be costly and difficult to access for everyday communication in care settings. Consequently, the potential for miscommunication resulting in inappropriate or inadequate care

provision is high. By SCOping the Use of Translation Technology (SCOUTT), researchers at NARI are evaluating the accuracy, feasibility, and acceptability of using existing voice-based translation technology to assist everyday communication between older people and their care worker(s) who do not speak the same language. The findings will be assessed with older people from CALD backgrounds to evaluate their feasibility and acceptability for healthcare related conversations. However, it is crucial to extend this research to a broader range of cultures and languages, and facilitate appropriate advances in the technology to make real change.

Finally, our work also shows that help-seeking is strongly associated with the beliefs and attitudes that influence how mental illness is recognised and treated (Brijnath & Antoniades, 2018b). Significant variations in how mental illness is perceived among different groups of people influence when and how help is sought, and treatment concordance. Hence, improving mental health literacy in the community and among health professionals is urgently needed.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

It is critical to include older adults as a specific focus area. The number of older Australians will almost double by 2055. Population ageing will see an increase in depression, anxiety, elder abuse and other mental illnesses in older adults. High rates of depression and anxiety are associated with increased physical illness, disability and self-neglect, suicidal ideation and mortality. Older adults in residential aged care and from culturally, those from linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people are particularly vulnerable.

Up to half of people living in residential aged care facilities (RACFs) have significant depression symptoms. Many residents are socially isolated in RACFs even though they are in communal living, and social isolation is a contributor to depression. Depending on the severity of the condition and the individual's preferences, evidence based recommendations can include administration of a course of anti-depressants or other medical treatments, psycho-education, social support, and psychological interventions such as cognitive behaviour therapy or interpersonal therapy (NICE Guidelines, 2016). For residents in RACFs, access to these recommended steps in management can be problematic. Studies attempting to train staff in detection and management of depression have met with short term success but little sustainable change (Low et al, 2015). Use of psychotropic medication for nursing home residents is high (Mann, Kopke, Haastert et al, 2009; Roberts et al, 2012), but medical management is hampered by attitudes toward use of antidepressants among older adults who have expressed concerns about side-effects, stigma, fear of addiction and prevention of natural sadness (Fawzi, Mohsen, Hashem et al, 2012). Management of depression and anxiety through psychological interventions for RACF residents is hampered by lack of access to psychological services (Davison et al, 2016) through the Better Mental Health Plan as nursing home residents are ineligible for this subsidy. Previous work by researchers at the National Ageing Research Institute (NARI) has shown that psychological services are difficult to access in many RACFs (Davison et al, 2016), and that psychologists are not typically employed in such settings (Stargatt et al, 2017). Provision of social activities and effective interventions such as music through lifestyle programs is variable and not always relationship-centred to address individual needs (Edvardsson, Winblad and Sandman, 2008). Residents who are depressed or anxious are less likely to want to join in activities by the very nature of their condition (NICE Guidelines, 2016). Current research at NARI is investigating the impact of a course of befriending delivered by trained volunteers to alleviate primarily depression symptoms and second to alleviate anxiety, improve social support and relieve loneliness. However, more studies in this area are needed to inform policy and practice.

Consistent with other national and international data, research done at NARI shows that older migrants are at high risk of developing depression (Brijnath & Antoniades, 2018b; Straiton, Grant, Winefield, & Taylor, 2014). However, people from CALD backgrounds are less likely to access support for their mental health.

To our knowledge, there have been no studies exploring depression in older Aboriginal communities in Victoria. However, the Healing Foundation held a recent consultation in Victoria (June 2019) to explore the specific needs of members of the Stolen Generation as they age. Data from the Australian Institute of Health and Welfare reveals the survivors of the Stolen Generations have been significantly more impacted in terms of health and welfare outcomes even compared to their Aboriginal and Torres Strait Islanders contemporaries,

who are already facing greater challenges in Australia. They are calling for urgent action for survivors of the Stolen Generation who suffered profound childhood trauma when they were forcibly removed from their homes, isolated from family and culture and often institutionalised, abused and assaulted. The Chair of the Healing Foundation has identified that access to aged care services as a particularly vulnerable time and services should be consciously working to make this journey as smooth as possible for survivors in the face of this trauma.

6. What are the needs of family members and carers and what can be done better to support them?

Population ageing and the increasing shift towards remaining at home for as long as possible mean that an increasing number of older people are being cared for by partners or adult offspring. At the National Ageing Research Institute (NARI), researchers are working to improve the knowledge base regarding family support needs and preferences for older people (Temple & Dow, 2018). Addressing unmet support needs of carers is important, not only for the planning of services for carers in an aging population, but also because of the association between unmet support needs and carers' mental health. In general, carers are significantly more vulnerable to financial, physical and emotional stress than the general population.

The evidence shows that higher social support – that is, provided by family or friends – is associated with better help-seeking, improved recovery, higher treatment concordance and reduced duration of symptoms in older people with depression (Lyberg, Holm, Lassenius, Berggren, & Severinsson, 2013). Conversely, a lack of support, family dysfunction and criticism are associated with a longer course of depression (Lyberg et al., 2013). It is important for mental health policy to make provision for measures to strengthen carers' wellbeing and to provide them with satisfactory emotional, financial and instrumental support.

In addition to caring for a person with mental illness, many older Australians are also looking after a spouse or parent with dementia (Temple & Dow, 2018), as well as grandchildren. In Australia, 70% of people with dementia are cared for in the community by a family member or friend. Carers supporting a person with dementia have an almost twofold risk of distress compared to those caring for a person without dementia, and higher levels of social isolation and loneliness (Temple & Dow, 2018). Grief is also common in these groups (Wilson et al., 2017). In an NHMRC-funded project, researchers at NARI have used a co-design process to improve support for older people with dementia living at home. Extending this work to focus specifically on family carers has the potential to improve their resilience and coping strategies, and reduce their psychological distress.

Through consultation with individuals and their family carers, it is evident that health professionals should discuss family support with their patients, and work together to maximise the quality and availability of that support. However, further research is needed to understand the effect of how family networks are changing in response to ageing populations, increased urbanisation, migration, and a tendency towards smaller families. The meaning and value of different family relationships should also be better understood, as should the increasing reliance on older women to look after family members. As a minimum, health professionals should promote social support by facilitating open communication, shared decision-making and problem-solving.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

There is a clear need to invest in a workforce from the same communities as those who need support. This enables communication, trust etc. In addition, a shift in the way society currently views the mental health and aged care workforce is needed. These roles are typically under-valued, with the workforce highly casualised and poorly paid, with little continuity of care for those who need it most. The composition of the mental health and aged care workforce should also be reviewed, to ensure that appropriate support is available. For example, there is great potential for mental health nurses and social workers to provide timely support when other specialists are unavailable. There is also a clear need for GPs to receive specialist training in mental health in older age. All parts of the mental health workforce also need to be better supported to offer culturally competent care – researchers at the National Ageing Research Institute have shown that there are common understandings of cultural competence across the mental health workforce but its operationalisation differs by profession, health setting, locality, and years of experience (Mollah et al., 2018).

8. What are the opportunities in the Victorian community for people living with mental illness to improve

their social and economic participation, and what needs to be done to realise these opportunities?

NO RESPONSE TO THIS QUESTION

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Depression is the most common mental health problem in older people. The number of older people with depression is expected to increase significantly, commensurate with global population ageing (World Health Organization, 2017b). Yet depression in older people is frequently under-recognised and poorly treated (Arias et al., 2017).

Although it is a serious condition at any age, depression is particularly complex in older people. It is often associated with physical illness, a decline in functioning and loss of independence, and greater self-neglect (Blackburn et al., 2017). It follows a more chronic course, has higher relapse rates than depression earlier in life and is associated with greater risk of (Murphy et al., 2018). Help-seeking for an early diagnosis and treatment are critical. However, our work shows that older people frequently encounter difficulties obtaining a diagnosis and appropriate treatment for depression (Polacsek et al., 2018). Two of the major barriers to help-seeking are prevailing attitudes towards depression and ageing, and health professionals' knowledge and skills to diagnose and treat depression in older adults.

At a fundamental level, health professionals need to challenge prevailing misconceptions about age and mental illness. The common, but erroneous, view of depression as a normal part of ageing serves as an obstacle to effective diagnosis and treatment, and should be addressed through education and training. At all levels of health care, the ageist attitude that older adults are less functional or capable of actively participating in optimising their health and quality of life should be addressed. In addition, to improve depression screening for older adults, models of care that integrate mental health into medical care are urgently needed (Xiang, Danilovich, Tomasino, & Jordan, 2018). These models should also facilitate everyday cultural competency in healthcare (Mollah et al., 2018).

The use of psychotherapy, particularly cognitive behaviour therapy (CBT), to support older adults with depression should also be promoted. There is considerable evidence that older adults respond very positively to CBT. Its use may be particularly appropriate for those who are reluctant to take antidepressant medication. However, our work shows that GPs appear disinclined to refer older patients for psychotherapy (Polacsek et al., 2018). As a result, it often remains up to the individual or significant other to negotiate a service pathway to access this form of treatment.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

The evidence base for improving the mental health of older adults is relatively small, and there are few resources to inform or evaluate current interventions aimed at improving help-seeking, facilitating diagnosis and maximising treatment options. More research that acknowledges the lived experience of mental illness across diverse communities, and uses the principles of co-design are needed to develop interventions and resources that support older adults, their family carers, service providers, and the broader community. Through novel ways of engaging with all stakeholders, these improvements are more likely to be sustainable in genuinely responding to the needs of those who need them most.

11. Is there anything else you would like to share with the Royal Commission?

Several other factors might be considered by the Royal Commission, regarding the mental health of older adults. These include the benefits of intergenerational exchange, co-morbidity of depression or anxiety with dementia, pain, and other conditions that may be associated with ageing (such as reduced mobility or incontinence). The relationship between elder abuse and depression should also be explored. Finally, the introduction of voluntary assisted dying in Victoria requires clear, evidence-based approaches to end-of-life care of older adults.

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