Australian Government

Department of Health and Ageing

REPORT TO THE MINISTER FOR AGEING
ON
RESIDENTIAL CARE AND PEOPLE WITH PSYCHOGERIATRIC DISORDERS

2008

Summary of Recommendations

1. *Maintain appropriate support to people with psychogeriatric disorders as a high profile 'front of mind' issue, for senior level aged care administrators and planners by establishing an expert group comprising old age psychiatrists, service providers and expert nursing staff to report to the new Australian Ministerial Conference on Ageing at its regular meetings.*

2. *Develop principles of effective care and support including protocols for effective collaboration across the residential aged care and State mental health systems.*

3. *Establish evidence-based guidelines on effective care and behaviour management for residential aged care services which would include strategies for maintaining networks across the broader service system.*

4. *Nurture and establish collaborative networks across the primary, acute, mental health and aged care service sectors.*

5. *Promote leadership in the sector by encouraging leading residential aged care providers to take a proactive role.*

6. *Consider possibilities provided under the Aged Care Act 1997 to extend and strengthen care to this client group.*

7. *Expand current workforce training strategies which could include, as an early target, training in managing aggressive and sexually inappropriate behaviour.*

8. *Encourage GP training and access by engaging with the Australian General Practice Network, General Practice Education and Training, Royal Australian College of General Practitioners and Australian Medical Association to encourage more focus on the needs of people with behavioural problems and/or dementia both in terms of training for GPs and providing onsite support to clients within facilities.*

9. *Facilitate ‘ progression’ models of care through ongoing discussion with residents, relatives and staff to enable progression from and to specialist care in a high dependency unit as required.*

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1 Introduction

Successive Australian governments have made significant commitments to addressing the care needs of older people with dementia, and the majority of people with dementia and cognitive impairment can be, and are, successfully cared for both in the community and in aged care homes. Commonwealth, State and Territory governments have also responded to the growing body of evidence that a coordinated approach is needed to improve psychogeriatric care services by collaborating on the development and implementation of the National Mental Health Strategy and National Framework for Action on Dementia 2006-2010, and the National Action Plan for Improving the Care of Older People Across the Acute-Aged Care Continuum, 2004-2008.

Despite this activity, the appropriate care and services for people with more severe and complex psychogeriatric disorders resulting in behaviours that may place either themselves or others at risk still presents challenges. These challenges are for both the aged care and mental health sectors, as effective integration and collaboration across these sectors is necessary to ensure quality care[1].

1.1 Purpose of the Report

The purpose of this report is to advise the Minister for Ageing on:

- current issues on the management of older people with significant violent or aggressive behaviours in aged care homes;
- practices and service delivery models that appear to be effective in caring for this client group;
- the extent of collaboration needed across sectors to meet the care needs of this client group;
- immediate steps that could be undertaken to improve care delivery; and
- longer term options to promote, if desired, national consistency in care delivery.

[1] Royal Australian and New Zealand College of Psychiatrists (1998) Position Statement #22: Psychiatry services for the elderly. Renewed May 2008.

1.2 Scope of the Report

Disorders that are grouped under the umbrella of psychiatry of old age, known as psychogeriatric, include psychiatric conditions that predate the ageing process such as schizophrenia or depression, as well as the various forms of dementia that can result from the ageing process. In addition, co-morbid mental health problems are common in people with dementia, in particular depression and psychosis.

The appropriate care and service delivery models for people with more severe and complex psychogeriatric disorders varies depending on the risks and severity of behaviours that are demonstrated. Unrestrained behaviour resulting from a lessening or loss of inhibitions or a disregard of cultural constraints is a particular problem for care planning and delivery. The term 'behavioural and psychological symptoms of dementia (BPSD)' is used to describe behaviours of concern or challenging behaviours that result from dementia and that affect care planning and service delivery. Mental health disorders are generally described in terms of severity and diagnosis. Appropriate care and services can range from care and management in the community to management in intensive specialist care units and includes input from psychogeriatricians, geriatricians and other health professionals.

A useful representation of this spectrum of care needs and modalities is provided by the seven tiered Brodaty-Draper triangle of interventions and service delivery (Figure 1), which ranges from no dementia or mental disorder through tiers of increasingly severe behavioural and psychological symptoms associated with extreme mental disorders and/or dementia[2] [3] [4]. Diagnosis is important and includes identification of precipitating and exacerbating factors, including acute illnesses, which can result in a delirium.

People with either extreme mental disorders or behavioural and psychological symptoms of dementia, as represented by Tier 7 in the Brodaty-Draper triangle, require either acute or specialist mental health services. However, older people whose behaviours are in the moderate to severe range (Tiers 4-6) do not need services of this intensity, but may still

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[2] Brodaty et al (2003) proposed a seven tier model ranging from no dementia through tiers of increasingly severe behavioural and psychological symptoms of dementia. This model was further developed by Draper et al (2006) to include psychiatric disorders, ranging from no mental disorder to extreme mental disorders.

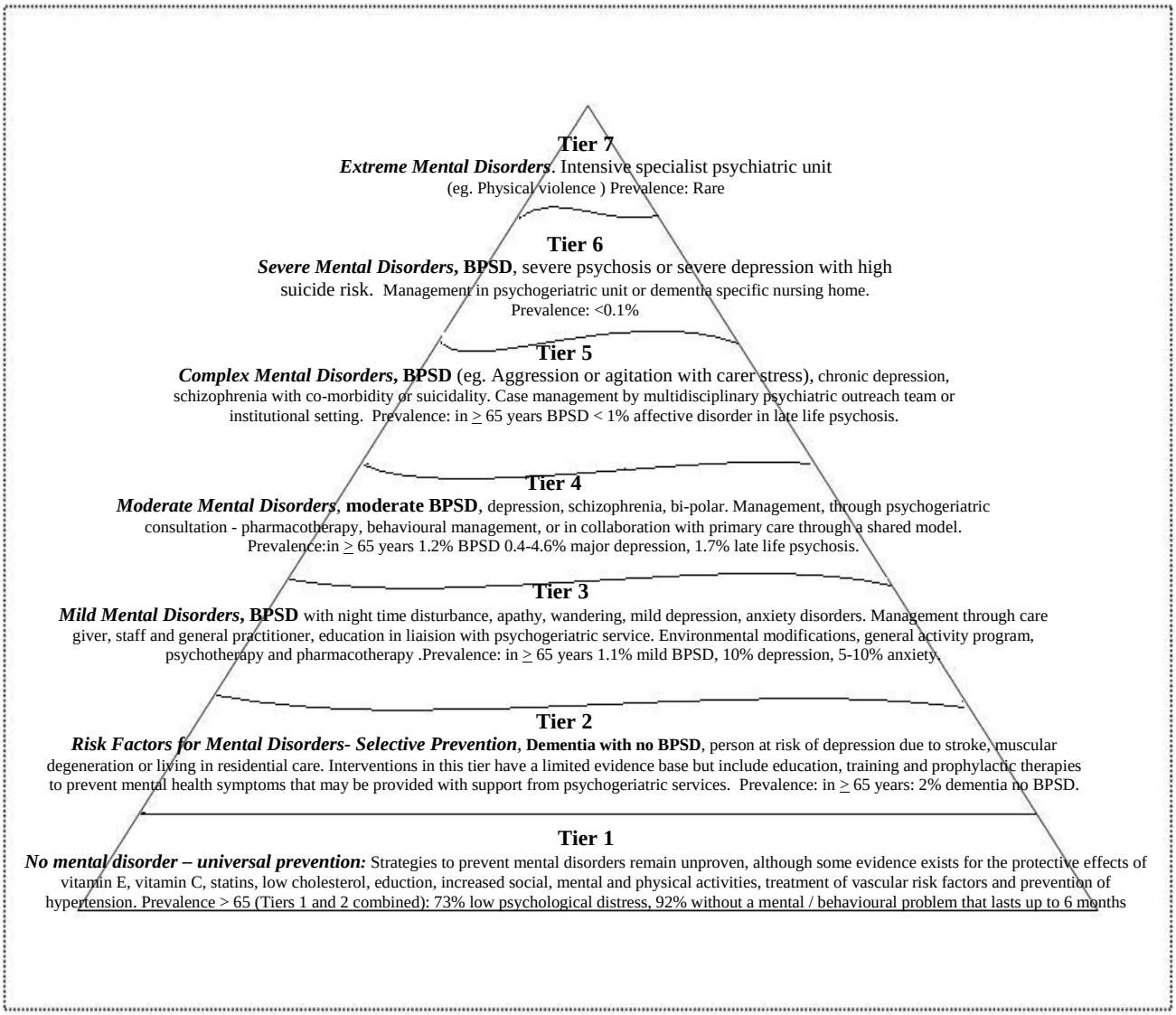
[3] Brodaty, H., Draper, B. M. and Low, L.- F. Behavioural and psychological symptoms of dementia: a seven- tiered model of service delivery. Medical Journal of Australia 2003; 178(5): 231-4.

[4] Draper, B., Brodaty, H. and Low, L.-F. A tiered model of psychogeriatric service delivery: an evidenced-based approach. International Journal of Geriatric Psychiatry 2006; 21: 645-53.

require access to specialist expertise, including tailored behavioural management strategies and higher levels of care. It is services for this client group that are specifically considered in this report.

It is important to note that care recipients may not, in general, remain in a single tier throughout an episode of care. In some people, the behavioural and psychological symptoms may become increasingly severe over time, with the care recipient moving to a higher tier in the Brodaty-Draper triangle. In other cases, a care recipient's behavioural and psychological symptoms may be stabilised, so that they move to a lower tier in the Brodaty-Draper triangle.

Figure 1: Seven-tiered model of service delivery for mental health disorders in old age.



1.3 Methodology

This report is the result of a purposeful consultation, using a set of open ended questions, with recognised experts in the disciplines of old age psychiatry, geriatrics, mental health and gerontological nursing, including the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists. Appendix A provides a list of those consulted.

As the inquiry progressed, the emergent issues were explored and the scope of the consultations widened to include visits to identified facilities considered to offer appropriate or innovative care delivery for people with extreme behaviours. These included:

- Hammond Care, New South Wales
- ADARDS, Tasmania
- Bundoora Extended Care Centre, Victoria
- Southern Cross, Western Australia
- Ian George Court, South Australia.

In addition, a targeted literature review was undertaken, including service plans or models for mental health service delivery for each state. Of particular relevance is "The management and accommodation of older people with severely and persistently challenging behaviours" (2004) prepared by the Faculty of Psychiatry of Old Age, NSW Branch of the Royal Australian and New Zealand College of Psychiatrists, for the NSW Centre for Mental Health. The 2005 report "Prevention and Service Provision: Mental Health Problems in Later Life" from the Institute of Health Sciences & Public Health Research, University of Leeds, and Division of Dementia Studies, University of Bradford in the UK was also referenced.

2 Background

The emergence of a small yet significant client group as a challenge for the aged and mental health service systems can be understood in the context of Australia's changing demographics and the care delivery reforms that have occurred over the past three decades in the health, mental health and disability sectors.

2.1 The implications of changing demographics

Age is regarded as a major risk factor for dementia with the prevalence of dementia rising from 1 in 15 people aged 65 years and over to 1 in 4 people aged 85 years and over. At the same time, the Australian population is ageing due to lower birth rates and increasing life expectancy. The age group with the greatest need in terms of aged care services, those 85 years and over or the 'older aged', is expected to increase more rapidly than other groups[5]. As a result of this ageing of the population, the number of people with dementia is projected to increase by 166 per cent between 2003 and 2031[6]. It is noted that prevalence rates may change as a result of medical discovery, changes in prevention, detection and management of the disease.

2.2 The legacies of past system reforms

The acute care, mental health and disability sectors have all engaged in system reforms which have impinged on aged care services. These reforms have resulted in a changed client group in residential aged care. A report prepared for NSW Health notes: 'the residents in aged care facilities are older, frailer, more dependent and more cognitively disabled than ever before. The traditional boundaries of 'health care' and 'residential care' are growing increasingly indistinct; particularly in the treatment and management of severely challenging behaviours where environmental, social, medical and psychiatric care, require coordinated intervention for the best outcomes'[7].

[5] Australian Institute of Health and Welfare (2007). Older Australians at a Glance - 4th Edition.
[6] Australian Institute of Health and Welfare (2007). Dementia in Australia: National data analysis and development. AIHW Cat. No. AGE53. Canberra: AIHW.
[7] Faculty of Psychiatry of Old Age, The Royal Australian and New Zealand College of Psychiatrists (2004). Unpublished.

In the last two decades the role of acute hospitals has changed in line with the developments in medical care and pharmacology. The introduction of casemix funding, and the increasing use of 'high-tech' treatment strategies has led to a high throughput service model but without commensurate planning for the downstream impact in terms of long term care provision. During this time deinstitutionalisation of mental health care with the resultant closure of many long stay psychiatric hospital beds and an increasing focus on short-term acute admissions and community based care delivery has also taken place.

The downstream impact on aged care of the developments in both the acute and mental health sectors has been very pronounced. Aged care homes have to a large extent taken on the burden of providing care to people with increasingly complex medical conditions and behavioural disorders who would have previously been cared for in the medical or psychiatric hospital environments.

Sector reforms such as early discharge strategies and deinstitutionalisation have to some extent been supported by a number of alternative care options, including community based older persons mental health services. The particular care delivery problems for people with psychogeriatric disorders resulting in extreme behaviours which place themselves or others at risk have been recognised by most State and Territory governments with some responding to the emergent needs of this group with the provision of specialised targeted services, usually short term.

New South Wales initially established a number of small, highly secure long term residential facilities - Confused and Disturbed Elderly (CADE) units. More recently these have been restructured into shorter term transitional facilities designed to stabilise conditions prior to placement in longer term care arrangements. Options to provide the longer term care arrangements are being piloted in collaboration with Commonwealth funded aged care facilities.

Western Australia has aimed to address care for people with more extreme behavioural disorders by supporting existing Commonwealth residential aged care funded services through the provision of top-up funding to support the higher care needs of this client group, and significant access and support from their older persons mental health services.

Victoria has moved to address the needs of these clients in a systemic way, through the establishment of its regional network of psychogeriatric homes.

In general, aged care services have successfully absorbed the changes imposed by other sectors. However, recent incidents in South Australia, where a resident with violent behaviours as a result of impaired cognition has been charged with the murder of another resident, and in Queensland, where allegations of sexual assault against a resident with dementia, have prompted consideration of the ability of aged care services to continue to absorb further pressures from other sectors without additional structured collaboration. This is especially the case with respect to the long term care arrangements for people whose extreme behaviour may not warrant ongoing acute mental health services but in the context of a mainstream aged care home may pose a threat to either themselves or to other people.

A characteristic of dementia and psychiatric illness can be the intermittent occurrence of severe aggression. If this occurs, it is very difficult to manage in mainstream aged care homes. Ongoing intersectorial collaboration that can respond to changes in treatment needs is essential for older people who have extreme behaviours.

2.3 Commonwealth Government Initiatives

Dementia emerged as a policy issue in the early 1980s and there has been a range of coordinated and individual responses by successive governments since that time.

Whilst early measures, such as funding dementia pilot programs in hostels in 1983-84, raised the profile of dementia, the major turning point occurred in 1985 with the introduction of the Commonwealth Aged Care Reform Strategy. The review of nursing homes and hostels undertaken in 1986 identified people with dementia as a special needs group for residential care. In addition, the Home and Community Care (HACC) program, which was established at this time, identified people with dementia as a special needs group and dementia specific programs were set up to provide appropriate care. By 1990, fifty dementia specific day care centres were established[8].

[8] Aged Care Reform Strategy Mid-Term Review 1990-91. Discussion Papers.

A five year National Action Plan for Dementia was implemented in 1992. This plan aimed to increase the extent to which the aged care sector could care for people with dementia. A national helpline, training materials for care workers, and a public awareness campaign were key elements developed under the plan.

In 1994, the Australian Government recognised the special care needs of people with dementia and challenging behaviours by funding the Psychogeriatric Care Units pilot program. The pilot was established to help meet the needs of older people in residential care who displayed complex and challenging behaviour. The primary role of the Psychogeriatric Care Units was to provide support and training for residential care staff through access to experts with psychiatric, psychological and geriatric experience who were able to offer diagnostic and treatment advice, assessment and care planning support. After an evaluation of the pilot in 2004, it has now been transformed into the Dementia Behaviour Management Advisory Service (DBMAS)[9]. DBMAS operates in both regional and metropolitan areas and has expanded support services to include residential care staff, community care staff and family carers. DBMAS plays an important role in capacity building for the residential aged care sector which can assist in the prevention of escalating behaviours. Services include clinical support, short term case management and care planning, mentoring, behaviour management advice and information and education workshops.

In 1997, a revised Resident Classification Scale provided better recognition of care needs and the associated costs of people with dementia. Funding for 26 new dementia respite centres was introduced the following year. A national forum on dementia was undertaken in 1999 to identify issues and themes for input into a National Strategy for an Ageing Australia.

In the 2004 Budget, the government recognised the importance of dementia by contributing $70.5 million to make it a National Health Priority. In line with this new status, $225.1 million was provided for specific Extended Aged Care at Home Dementia (EACHD) places to care for people with dementia in the community and $25 million for training of workers. Funding for a range of other dementia projects is described in Appendix B.

[9] Vivienne Tippett and Associates. Evaluation of psychogeriatric care units. May 2004.

The Aged Care Funding Instrument (ACFI), which commenced on 20 March 2008, provides better targeted funding for residents with behavioural and psychological symptoms of dementia. This is paid through the Behaviour Supplement which is in addition to the subsidy paid for a resident's personal care needs. The Behaviour Supplement within ACFI has three funded levels for residents with low, medium and high levels of assessed behavioural needs. The more frequently a resident's symptoms of dementia are expressed through wandering, verbal or physical behaviours, or the greater the impact of cognitive skill deficit or depression, the higher the level of the supplement.

The 2007 Budget provided ongoing additional funding of $20 million per year to top up the Behaviour Supplement. Under the former RCS, the maximum care funding payable for a resident with dementia and other complex health care needs was $125 per day. The maximum payable under ACFI for such residents will be more than $167 per day by 2011. However, the Behaviour Supplement was not developed in expectation that aged care homes would be providing care to people with extreme behavioural problems.

3 Review of Care Delivery for People with Difficult Behaviours

3.1 Complexity of Care Delivery

Consultations identified that the complex nature of the care needs for this client group have implications for both the pharmacological regimens and behaviour management strategies, as well as for appropriate service delivery models. There was general consensus that the care needs of this small group of older people could impact disproportionately on the entire health care system.

Consultations with clinicians in NSW revealed that formal assessment leading to an accurate diagnosis by both medical and old age psychiatry practitioners is fundamental for ensuring good care. This includes advice about appropriate pharmacological regimens as well as behavioural management strategies. The importance of such assessment and diagnosis was reinforced in subsequent consultations. The need for multidisciplinary care planning and interventions has also been highlighted[10]. While referrals from general practitioners (GPs) to old age psychiatrists and geriatricians allowed the system to work more efficiently, most states noted that access to GPs was problematic and there was potential to strengthen their skills in the diagnosis and management of psychiatric and behavioural disorders in older people. One of the major issues identified by clinicians was the lack of early referral of clients, often too late for effective preventative measures, such as medication therapy, to decrease the severity and progression of the cognitive failure.

The complex care needs of people with extreme behavioural disorders often means that their pathways through the health systems vary. Structural barriers between systems often results in people not experiencing continuity of care, but rather bouncing and slipping from one system to another[11]. The importance of co-location or functional integration between both old age psychiatry and geriatric medical services[12], the need for effective relationships between acute and sub-acute, residential and community services[13], and the need for GP engagement in the

[10] NSW Health. Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours. Page 17
[11] Dr John Cullen (9/4/2008). NSW meeting.
[12] The Royal Australian and New Zealand College of Psychiatrists. Position Statement #31. (Joint Statement of the Faculty of Psychiatry of Old Age of the Royal Australian and New Zealand College of Psychiatrists, the Australian Society of Geriatric Medicine and the New Zealand Geriatric Society).
[13] Dr John Cullen (9/4/2008). NSW meeting.

system were all highlighted during the consultations. In an effort to strengthen the role of GPs, some old age psychiatrists, for example in West Australia[14], are now providing education on topics such as psychopharmacology to enhance the effective management of these clients.

Aged care homes' responsibility to provide safe and appropriate care to all residents and the 'risks' that need to be managed in appropriate placement of people with significant behavioural disorders were recognised in consultations. These may present barriers to service access. In managing this, all clinicians and specialist service providers consulted emphasised the importance of appropriate placement of clients to ensure best 'client fit'. In making such decisions, it was necessary to know the capacity of a service to implement specialised management programs to meet the client's needs[15], which would include consideration of both the built environment and staffing levels and skills. It was also important to consider the potential impact of a new client on existing residents and the potential impact of existing residents on a prospective client. For example, it was noted that the care needs of ambulant, physically robust people with impaired cognition were different to those of frail older people with dementia who could often be targeted as victims.

Clinicians noted that in some facilities there has been a reduction in physical restraint of residents in favour of pharmacological restraint or transfer to an acute care setting. It was recommended that trials were needed to build better evidence base for pharmacological and behavioural management strategies[16].

3.2 System responses

Some states and territories have responded to the challenges in providing care to this client group with the provision of specialised, targeted services underpinned by support from the relevant older persons' mental health system. These services provide higher levels of support than mainstream, or even dementia specific residential aged care, and sit at the nexus of residential aged care and older persons mental health services. The focus of these services is on transition and throughput with short term transitional services provided in sympathetically

[14] Dr Mathew Samuel (18/4/2008). WA meeting.
[15] Dr Peter Gronski (9/4/2008). NSW meeting.
[16] Dr Wijeratne (9/4/2008). NSW meeting.

designed facilities and longer term services intended and designed to graduate clients to less intensive care options, eg mainstream residential care, as their care needs stabilise or their frailty increases.

While there was not an opportunity to visit services in every state and territory, visits to specialised services in New South Wales, Victoria, South Australia, Western Australia and Tasmania were undertaken. The following is an exploration of the service models visited during the consultations which provide a high level of care for older people with behavioural disorders and operate as transitional care models.

3.2.1 New South Wales

New South Wales' initial response to the emergence of this client group was, as mentioned earlier, the establishment of the CADE units. While state-funded, beds in CADE units were considered to be residential care beds and not for transitional care[17]. This did not provide the opportunity to relocate residents as care needs stabilised, or where increasing frailty meant that residents no longer needed the level of care provided in these secure units. In July 2007 these units were restructured as Transitional Behavioural Assessment and Intervention Service (T-BASIS) units and now operate as non-acute mental health inpatient units. Operated by the Older Persons Mental Health Services (OPMHS) in collaboration with aged care services, these units provide multidisciplinary clinical assessment, care planning and intensive treatment for older people with severe behavioural disturbances associated with dementia and/or mental illness. It is anticipated that length of stay will be 8-10 weeks, but there is allowance for longer stays, and discharge occurs when the care needs of the clients are no longer met in the T-BASIS units and more community-based care is appropriate and available.

OPMHS has supported this non-acute and transitional inpatient model of service delivery with the establishment of community-based Behavioural Assessment and Intervention Services (BASIS) in all areas. Working as an integral component of OPMHS community teams in collaboration with local community aged care teams, these specialist community clinical staff provide outreach education and training services to residential aged care facilities and

[17] NSW Health Policy Directive Transitional Behavioural Assessment and Intervention Service (T-BASIS) Units reporting rules – 1/7/07.

community care providers (particularly in rural areas) to enhance the capacity of these services to care for this group of older people, and to promote discharge from, and reduce unnecessary admissions to, the T-BASIS Units.

Coupled with the creation of the T-BASIS units, NSW Health has been exploring the development of high dependency services which, while providing longer term care than provided under the T-BASIS model, are nonetheless designed to graduate clients to less intensive care options such as mainstream aged care homes. A high dependency unit, Linden Cottage, has been established in collaboration with Hammond Care which is recognised for its work in dementia care. NSW Health is also collaborating with Catholic Health Care for the provision of similar services on their Croydon campus. An interim evaluation report is due shortly on both these services.

Linden Cottage operates as an eight bed Special Care Unit (SCU) located within Southwood, one of the aged care homes on Hammond Care's complex at Hammondville. Clients can be accommodated in Southwood, or one of the other homes on the complex, as their care needs stabilise. An additional bed is provided in the unit which allows for clients to return to Linden Cottage should the placement fail. Linden Cottage will accept people whose behaviours place them at the upper end of the Brodaty-Draper triangle, typically tiers 5 and 6. They do not accept people whose behaviours would be categorised as falling into Tier 7.

The SCU's apparent success is attributed to the combination of a number of factors: its location within a large complex which incorporates purpose built dementia specific facilities; its ability to assess the suitability of the client for the SCU based on the capacity of the unit, the client case history and the potential impact of the client on the resident group; the inclusion of a well resourced supported internal relocation program; the application of security of tenure across the organisation rather than restricted to the SCU; and the concentration of resources on site which allows for intensive support for the residents, their families and staff. Access to clinical expertise, particularly old age psychiatrists, is an essential component, and the SCU has a clinical advisory committee comprising a psychogeriatrician from the area health service, a senior clinical carer, a psychology intern and a GP, as well as the program manager. However, good GP access to ensure appropriate prescribing has presented a challenge to Hammond Care, and access to appropriate support from GPs was consistently raised in consultations. Note: a new Aged Care Access initiative

announced in the 2008 Budget will provide additional support for GP consultations and allied health services to residents of aged care facilities from July 2008.

The SCU has been established with beds funded under the *Aged Care Act 1997*, and with significant state government funding and support for the additional staff and expertise required to care for this client group. As well as the SCU, the trial includes eight places in a Supported Internal Relocation Program to facilitate discharge of SCU clients into other permanent aged care places in Hammond Care. One additional bed in the SCU is available to provide additional support for residents who face difficulties during the supported relocation phase of discharge.

Clients are generally those who could not be supported in mainstream or dementia specific facilities and would otherwise be referred to the state-run Aged Care Psychiatric Unit at Braeside Hospital. Hammond Care stressed the importance of having its own specific admission criteria and undertaking its own assessment before accepting a client.

Like the other dementia specific facilities in the complex, the SCU is purpose built, small in scale, providing both a secure and a domestic and familiar environment, and with a focus on reducing external stimuli. The importance of the environment in minimising behavioural disturbances was emphasised, as was the importance of staff selection, training and support. Hammond Care considered it vital that staff were selected for their attitudes to older people, were provided with ongoing training as well as additional support given the challenging environment they worked in. Hammond Care's psychologist holds weekly support meetings with groups of staff.

3.2.2 Victoria

Victoria responded in a comprehensive manner to deinstitutionalisation by establishing a regional network of 18 high dependency units or Psychogeriatric Nursing Homes (PGNHs) which provide care to this target group. These units have been established in each area health region and are designed to operate as longer term transitional care models, with clients being relocated to less intensive service options when appropriate. In metropolitan areas PGNHs are situated within larger service systems which provide both mainstream residential aged care and acute inpatient services. While PGNHs provide long term accommodation for

approximately 12-24 months, on-going assessment, treatment and rehabilitation is provided with the aim of enabling eventual discharge to dementia specific or mainstream aged care homes. Similar to the Linden Cottage Special Care Unit, PGNHs typically provide care to older people whose behaviours would place them in tiers 5 and 6 of the Brodaty-Draper triangle.

The inpatient facilities within each health region operate as short term transitional care (up to 6-8 weeks) and provide support to PGNHs by enabling step-up care for clients experiencing acute episodes to have their behaviours stabilised, medication calibrated and comprehensive behaviour management plans developed. The mainstream aged care homes facilitate step-down care for residents whose behaviours have either stabilised or whose increasing frailty means that they no longer represent a risk to either themselves or others. However, inpatient services identified that some mainstream residential facilities that specialise in the care of these residents do not always have the capacity to manage when a client's behaviour escalates. Frequently the response is to send these residents to emergency departments, thereby placing increased pressure on the acute care sector[18].

The network of PGNHs in Victoria utilises beds approved and funded under the *Aged Care Act 1997* with additional top-up funding provided from the state government to provide for high service levels. PGNHs have strict admission and discharge criteria and close relationships with acute and community-based service providers through the Aged Psychiatric Assessment and Treatment Teams (APATTs). The APATTs are part of the older persons mental health services and provide the PGNHs with access to old age psychiatrists and mental health expertise, which was seen as essential. In addition, these teams provide assessment, case management, referral and gate-keeping services across the entire mental health services from acute inpatient to residential and community care services, thereby providing essential resources for mainstream aged care homes.

As well as ensuring access to relevant expertise and step-up and step-down care, situating the PGNHs within a broader network of services was seen to facilitate a culture of cooperation and collaboration between the mental health and aged care systems. There is also more confidence that clients can receive appropriate support when needed and can be moved to

[18] Dr Benji Soosai (16/4/2008). Victoria meeting.

services that provide the required level of care. For instance, a client can be transferred to acute inpatient care if their behaviour escalates and they cannot be managed in the PGNH or they can be transferred to a mainstream residential facility when their condition stabilises. The location of the Victorian provider of DBMAS within the state older persons' mental health system facilitates continuity of care in residential care facilities to prevent the exacerbation of behaviours and re-admission to the PGNH or higher level of care.

Bundoora Extended Care Centre (BECC), which is part of the Northern Health Service, is a good example of a large campus providing a range of geriatric and psychogeriatric inpatient, residential and community health services. The North Western Aged Persons Mental Health Services, in partnership with the Northern Health Service, provides specialist mental health services and staff to the state-run and funded 15-bed acute mental health inpatient assessment unit, the Merv Irvine Psychogeriatric Nursing Home (a long term transition unit), the APATT and community mental health teams. Aged Persons Mental Health also offers a psychiatric liaison service to 3 sub-acute geriatric wards at the BECC site. With all these services located within one campus at BECC, there is an effective ladder of referral that ensures support for each level of care.

The design of the PGNH is considered to enhance the overall behavioural management of the residents. The facility consists of three 10-bed wings, residents having their own bedroom, most with an en-suite bathroom. Each wing has its own kitchen, dining and recreational areas, secure garden and walking paths for secure wandering. The units are generally carpeted and have a homely feel. The fourth wing of the building contains the nurses' station, meeting rooms and utilities areas. Thus, corridors are minimised and the smaller grouping of residents reduces the stimulus that would result from a large and noisy environment.

3.2.3 Tasmania

The ADARDS Nursing Home was established as a purpose built dementia specific facility in the context of deinstitutionalisation of mental health clients. Established with personal commitment and leadership from Dr John Tooth, along with local GPs, carers and families, it provides high level dementia care to clients with significant behavioural disorders, including aggression and sexually inappropriate behaviours. The 36 bed facility is funded under the

Aged Care Act 1997 and receives clinical support through its close association with the state-funded psychogeriatric service.

Like the Psychogeriatric Nursing Homes and Special Care Units, ADARDS has emphasised the importance of clear admission and discharge criteria, as well as access to clinical and psychiatric expertise which it receives through regular meetings with the psychogeriatrician in the older persons mental health services, the local geriatrician and a small number of GPs who support 80 per cent of the residents.

Other features critical to the care model at ADARDS are the design, with specific attention given to the progression of the disease, the staff profile and skills mix, and the provision of structured and meaningful activities to stabilise behaviours.

As a small stand-alone facility, ADARDS is limited in its capacity to operate as a throughput service model by the lack of either other residential places within the organisation or a strong network of cooperation with mainstream aged care homes. This is compounded by residents' families' reluctance to support the transfer of residents to other facilities.

In addition to providing clinical support to staff and residents at ADARDS, the Tasmanian older persons' mental health service operates the Roy Fagan Centre. The facility is comprised of a 20-bed, short term inpatient assessment and treatment facility for elderly people with difficult behaviours attributed to dementia and psychiatric illnesses, and 10 long term beds for people who have complex mental and physical health needs, some of whom have a dementia. Residents of aged care facilities or people living at home can be admitted for assessment and treatment when their behaviours become severe. However, as this is a short term inpatient transition model of care, there is pressure to move people through the centre as quickly as possible. As DBMAS is well integrated into Tasmania's older persons mental health service, it is able to provide some support to these people in residential aged care facilities or their own homes in conjunction with the community mental health teams.

3.2.4 Western Australia

Western Australia's seven state-funded acute psychogeriatric assessment centres act as a transition between acute inpatient wards and long term care models. Operated by the Area

Health Services, they are increasingly accommodating long stay clients. These clients exhibit severe challenging behaviours that are resistant to treatment and cannot be cared for in mainstream nursing home facilities. To address the consequent blocking of acute care beds by this client group, Western Australia embarked on a number of initiatives to move long stay clients from acute assessment facilities and to promote the transfer of these clients to mainstream residential aged care where possible. One such initiative is the provision of a 20-bed transition unit in conjunction with Aegis and operated by the area health service; another is located at Southern Cross Care.

Two eight-bed high dependency units for older people exhibiting extreme behaviours have been purpose-built within the Southern Cross Care residential aged care complexes at Success and Shelley in Western Australia. Clinical and behavioural care programs are developed and implemented by registered staff in the units and overseen by a consultant psychiatrist from the area health service. The area health service promotes effective GP involvement by providing regular education on topics such as psychopharmacology at their practice meetings and by liaising with the Divisions of GP. As a consequence, Southern Cross Care considered the medical care provided by the residents' GPs to be an effective component of care in the overall management of their residents.

Southern Cross also emphasised the importance of staff selection and valued characteristics such as resilience, acceptance and respectfulness. As a means of ensuring staff skills are continually developed and supported, Southern Cross, like Hammond Care, has a program of staff training, considering its in-service programs essential to the success of their service delivery model and an important factor in helping to minimise staff turnover. Southern Cross holds weekly staff meetings with an experienced mental health nurse.

Similar to the Victorian PGNHs, these services are designed to operate as throughput models and strict admission and discharge criteria are applied. Residents who are frail and non-ambulant are not admitted as their behaviour is generally no longer considered to present a risk to themselves or other residents and can be managed in a mainstream facility. While security of tenure was identified as an impediment to the transition model of care, in the five years the high dependency units have been operating, there have been a total of 35 discharges from both facilities due to stabilisation of behaviours or frailty. Most people have been transferred to other Southern Cross residential facilities, some have been placed in residential

aged care homes outside the organisation, and one resident has been discharged to their own home. Nevertheless, Southern Cross Care also identified that it is experiencing extended length of stays due to the difficulty of placement in residential aged care facilities[19].

There is also increasing evidence of effective collaboration across Western Australia's mental health and aged care systems in both the acute care and community care sectors. In addition to acute inpatient services, tertiary hospitals are introducing specialist delirium units to facilitate the diagnosis and treatment of behavioural disorders that may be caused by a treatable medical condition. Sir Charles Gairdner Hospital has introduced a specialist consultation and liaison psychiatry service for older adults that supports both the delerium unit and the rest of the hospital. This provides for early and accurate diagnosis, reduced length of stay and subsequent better outcomes for this group of clients. It also provides the opportunity for close collaboration between geriatricians and old age psychiatrists. Royal Perth Hospital is also developing a similar model[20].

The recent addition of DBMAS to the services provided by the community mental health sector is enhancing mainstream residential aged care facilities in their provision of therapy and behavioural management programs for this client group.

[19] Dr Helen McGowan (17/4/2008). WA meeting.
[20] Dr Helen McGowan (17/4/2008). WA meeting.

4 Findings

From these consultations, and from the findings of a report prepared for NSW Health[21] and a comprehensive research study in the UK[22], it is possible to identify:

- an optimal system of care for older people who are ambulant and who have moderate to severe behavioural disorders resulting from dementia or cognitive impairment;
- lessons for improving the current provision of care to these people; and
- options to strengthen the current system over the longer term.

4.1 The 'optimal' system

An optimal system of care for older people who are ambulant and who have moderate to severe behavioural disorders resulting from dementia or cognitive impairment would include the provision of high dependency units though in the main, for time limited rather than long-term care. Older people who are no longer ambulant can be accommodated in mainstream aged care homes.

The high dependency units would operate as longer term transition models designed to graduate clients to less intensive care options and be purposefully structured to meet both the aged care and mental health care needs of this client group. An optimal system of care would also include a case management approach to care delivery to ensure continuity of care when a person leaves the high dependency unit.

Ideally, high dependency units operating within a single 'campus', either physical or virtual, offer the most effective models of care observed providing for both step-up and step-down care as well as access to clinical and psychiatric support and expertise. A single / broader 'campus' providing effective and timely access to the full range of services and expertise required in either a residential aged care complex or as part of other hospital facilities provides a significant advantage in allowing for a ladder of referral and closer collaboration in case management to occur between services.

[21] Royal Australian and New Zealand College of Psychiatrists (2004).
[22] Institute of Health Sciences & Public Health Research, University of Leeds, & Div. of Dementia Studies, University of Bradford. Prevention and Service Provision: Mental Health Problems in Later Life. Final Report. October 2005.

However it is recognised that in some situations, it may not be feasible to replicate the campus model. In these cases, it may be possible to establish and operate high dependency units within a regional network. For an 'island' high dependency unit to operate effectively as a throughput model, a high level of collaboration and cooperation between other services across a region is necessary. In particular, close relationships with facilities are needed to ensure step-up care is available to stabilise client behaviours when required. The involvement of a case manager in the step-down transition to mainstream aged care homes willing to and with the capacity to accept clients whose condition has stabilised or frailty increased, is essential to ensure continuity of care and prevent the escalation of behaviours that can be triggered by a change in environment.

4.2 Improving the current arrangements

Although the optimal solution will not always be available, it is possible to draw several conclusions from the successful operation of such a system for the current arrangements.

- **Mainstream aged care homes**. Mainstream facilities' capacity to care for people with behavioural problems is important not only to facilitate step-down care but also, as was emphasised in the consultations, to contain growth in the number of clients requiring high dependency services by preventing escalation of behavioural problems[23]. For this to occur, mainstream aged care homes also need to incorporate dementia sympathetic design, with committed management and staff with the necessary skills.

- **Access to medical and psychiatric diagnosis and care**. GPs, often the first point of contact in the system, need to ensure that conditions are properly diagnosed, that early signs of behavioural problems or onset of dementia are identified, and that timely referrals to old age psychiatrists are made. Accurate and expert diagnosis is essential to distinguish those conditions which are treatable from those with symptoms which can only be managed[24] and to ensure appropriate pharmacological regimens as well as behavioural management strategies are in place.

[23] Dr McKay (9/4/2008). NSW meeting.
[24] Dr Jane Tolman (24/4/08). Tasmania teleconference.

It was noted that people 65 years and over have poor access to psychiatrists in Australia with per capita Medicare funding of persons aged 65+ being only 25 per cent of that for younger adults[25]. However all high dependency units emphasised that on-going support from psychiatrists and mental health teams is necessary for effectively managing clients' care needs. Access to expert assessment, diagnosis and treatment can prevent unnecessary admission to acute care, or, admission to acute care can be facilitated when escalating behaviours need more intensive specialist intervention than is provided in the high dependency units. This support is also important for mainstream aged care homes. Access to old age psychiatrists is primarily through older persons mental health services and through State funded community based assessment and support teams, operating within the older persons mental health services. The Dementia Behavioural Management Advisory Service can play an essential role in this area.

- **Admission criteria managed by the receiving facility.** The concept of appropriate 'client fit' presented during the consultations clearly indicated this as an important factor for good resident outcomes. Clear eligibility criteria for admission were based on factors such as the current client mix (the potential impact of the new client on the existing residents and the existing residents on the new client), and the ability of the facility to provide appropriate care. For instance, residential aged care facilities need to be able to ensure that frail non-ambulant residents can be protected from potential aggression of ambulant residents.

- **Staffing**. The higher levels and the specialist nature of care provided in high dependency units require different staff selection criteria, skills mix and support for staff than in mainstream residential aged care facilities. High dependency units have comparatively stable workforces and use few, if any, agency staff. Staff were generally selected for their personal qualities, such as resilience, acceptance and respectfulness, as well as for their professional qualifications. The capacity to deliver diversional activities was considered an essential element in the staff skills mix to facilitate decreased levels of anxiety and agitation in these clients[26].

[25] Draper, B. and Koschera, A. Do older people receive equitable private psychiatric service provision under Medicare? Australian and New Zealand Journal of Psychiatry 2001; 35: 626-630.
[26] Mr Peter McHale (18/4/2008). Southern Cross Care site visit.

- **Training**. Experienced and well trained staff have the capacity to recognise early signs of behavioural disturbances and prevent both their escalation and possible need for higher level services[27]. As staff are often the target of violence, the advice received was if staff received training in this area, violent behaviour could be better managed and escalation often avoided[28].

  Skills in managing clients with aggressive behaviours are important in all service areas. While it is essential that high dependency units have some staff with mental health nursing qualifications, it was also evident that on-going in-service training and support for staff are necessary to ensure the continuing development of staff skills and a stable workforce.

- **Design**. Design of the physical environment is an important tool to care for people with dementia and for assisting to minimise behaviours which result from a response to noise or other disturbances[29]. All high dependency units observed had incorporated specific design features such as single bedrooms, secure indoor and outdoor areas for wandering, smaller units with their own kitchen and living areas to promote a homelike atmosphere, and attention paid to reducing unwanted stimuli or highlighting helpful stimuli.

4.3 Strengthening the current system

The consultations undertaken have established that there is an enormous commitment to supporting this client group by individual psychiatrists, geriatricians, clinicians and specialists, as well as the Australian and New Zealand College of Psychiatrists, and the Australian and New Zealand Society for Geriatric Medicine. A number of providers have demonstrated significant enthusiasm and have embraced the need to provide good quality care in this area.

It is also clear however that this is not a high profile area, and comes into prominence when there is a catalyst of one or more sentinel events such as those which recently occurred in

[27] Prof. David Ames (16/4/2008). Victorian meeting.
[28] Assoc. Prof Draper (7/5/2008). Teleconference.
[29] Day, K., Carreon, D. and Stump, C. The therapeutic design of environments for people with dementia: A review of the empirical research. The Gerontologist 2000; 40(4): 397-416.

South Australia and Queensland. So while a number of initiatives have been undertaken by service providers and state governments, there has only been modest progress in terms of systematic planning across jurisdictions, and indications are that funding and service delivery across states and between regions within states has tended to be unevenly distributed. Data collection and reporting could facilitate more ready identification of pressure points in the existing system and also support appropriate intersectorial planning and collaboration to strengthen service provision in these areas.

National consistency across Australia would require consideration by the Council of Australian Governments (COAG). Short of this it is possible to strengthen and extend care provision by encouraging leadership and on-going innovation within the sector. The following strategies are recommended:

1. *Maintain support for people with psychogeriatric disorders as a high profile 'front of mind' issue,* for senior level aged care administrators and planners by establishing an expert group comprising old age psychiatrists, service providers and expert nursing staff to report to the new Australian Ministerial Conference on Ageing at its regular meetings. (It is noted that this has been agreed to by the Conference.) The Australian Ministerial Conference on Ageing may provide the appropriate forum for ensuring that this issue retains currency, and could allow for further activities that would facilitate integration and collaboration within the service systems particularly in relation to collaborative regional planning of specialist care services.

2. *Develop principles of effective care and support including protocols for effective collaboration across the residential aged care and State mental health systems.* Agreement by State and Territory and the Australian Government on such protocols would enhance client access to appropriate assessment, support and clinical expertise.

3. *Establish evidence-based practice guidelines.* Funds could be identified under the Encouraging Best Practice in Residential Aged Care program to support better practice in aged care homes. This program encourages a consortium approach which brings together research or educational institutions with residential aged care providers to implement existing clinical practice. This could include implementing practical guidelines for aged care homes on dementia and behaviour management. This could

build on work already undertaken by Alzheimer's Australia, and could include strategies to create and maintain effective networks with the broader service system, and facilitate developing and implementing resident centred individual care planning.

4. *Nurture and establish collaborative networks across sectors*. The importance of this cannot be overstated. Collaborative partnerships and effective interface between primary, acute, mental health and aged care service systems are essential to ensure access to relevant expertise and provision of appropriate care and services[30]. The availability of specialist mental health diagnosis and treatment assistance, either in situ or at a specialist unit, will build trust for mainstream aged care homes to admit people at risk of aggressive behaviour.

5. *Promote leadership in the sector* by encouraging leading residential aged care providers, including those who operate a group of homes, to take a proactive role by establishing referral mechanisms for this client group in the homes they run, and within the region more broadly. These organisations could also consider establishing a high dependency unit within one of their facilities, to care for clients within their organisation and also provide care to residents of other aged care providers in the region.

6. *Consider possibilities provided under the Aged Care Act 1997* to extend and strengthen care to this client group. The reviews in relation to the aged care planning ratios and the allocation of places under the Aged Care Approvals Round (ACAR) both provide opportunities to give the needs of this client group greater prominence and/or consideration. In particular, consideration could be given to incorporating planning provision for high dependency transitional services within the aged care planning ratios. Measures to encourage the establishment of more services targeting people with significant behavioural problems could be incorporated into the ACAR.

7. *Workforce training.* Initial funding has been provided through the Dementia Program to train community and residential aged care staff in providing care support focused on the specific nature of dementia and this is currently being delivered. However, ongoing

[30] Dr J Cullen (9/4/2008). NSW meeting.

funding for workforce training could be deployed specifically to train aged care nurses and personal care staff in managing more extreme behaviours. Training in managing aggressive and sexually inappropriate behaviours could be an early priority, as this has been identified as a significant challenge for staff, who are often the target of aggression. This is not a focus of current training initiatives. Ongoing training in relation to behaviour management, including managing difficult behaviours, is essential as high staff turnover in mainstream homes can mean that qualifications and skill mix amongst staff change quickly, negatively impacting on facilities' capacity to deliver quality services.

In addition to a skilled workforce, an organisation's capacity to deliver care in this area is frequently dependent on a strong commitment and relevant knowledge at the service manager level[31]. Training could be provided to senior staff and managers focussing on selection and training of staff, creating appropriate environments, and developing and implementing resident centred individual care planning.

8. *Encourage GP training and access*. The Department could engage with the Australian General Practice Network, General Practice Education and Training, Royal Australian College of General Practitioners and Australian Medical Association to encourage more focus on the needs of people with behavioural problems and/or dementia , both in terms of training for GPs and providing onsite support to clients within facilities.

9. *Facilitate progression models of care*. Ongoing discussion with residents, relatives and staff about the desirability of a progression model of care to enable progression from and to specialist care in high dependency units as necessary.

4.4 Conclusion

The importance of ensuring appropriate care services for this relatively small client group with complex care needs and behaviours that put individuals at risk of harm cannot be overstated. Effective care delivery operates at the interface between mental health and aged care, and cooperation and collaboration across the primary, acute, mental health and aged care

[31] Dr McKay (9/4/2008). NSW meeting.

systems is required. All areas of the health and aged care system need to share the responsibility for providing an appropriate continuum of care for this client group. This includes mainstream aged care homes, whose effective management of people with dementia and behavioural disorders can often prevent escalating behavioural problems and the subsequent need for higher level services. However, in considering their exposure to risk, residential aged care providers will be reluctant to accept people with psychogeriatric conditions if they cannot be confident of appropriate collaboration and access to expertise and support, particularly access to step-up care, as needed.

Consequently, it is important that the service provision for people with high levels of aggression and/or disinhibition remains a focus for both Commonwealth and State/Territory governments, and that there are strategies to:

- facilitate collaboration across service sectors;
- enhance the current provision of specialised services to clients and their carers; and
- strengthen the overall system to support residential service providers to more effectively manage residents with psychiatric conditions or behavioural and psychological symptoms of dementia.

Glossary

ACAT	Aged Care Assessment Teams
AD	Alzheimer's Disease
ADARDS	Alzheimer's Disease and Related Disorders Society
APAT	Aged Person's Assessment Team
APMHS	Aged Persons Mental Health Service
BASIS	Behavioural and Assessment Intervention Service
BPSD	Behavioural and Psychological Symptoms of Dementia
CACP	Community Aged Care Package
CADE	Confused and Disturbed Elderly
DBMAS	Dementia Behaviour Management Advisory Service
EACHD	Extended Aged Care at Home Dementia
HACC	Home and Community Care
HDU	High Dependency Unit
OAMH	Older Adult Mental Health
PECU	Psychiatric Extended Care Unit
PGNH	Psychogeriatric Nursing Home
PGU	Psychogeriatric Care Unit
SCU	Special Care Unit
T-BASIS	Transitional Behavioural Assessment and Intervention Service
the Act	Aged Care Act 1997
the Department	Department of Health and Ageing

Appendix A Stakeholders consulted for this report

New South Wales	
Dr Rod McKay	• Old Age Psychiatrist • Clinical Advisor, Older Persons Mental Health, Centre for Mental Health, NSW Health • Director Specialist MH Services for Older People, SSWAHS
Dr John Cullen	• Senior Staff Specialist, Geriatric Medicine, Concord Hospital • Acting Clinical Director, Aged Care and Rehabilitation Services, SSWAHS • Centre for Education and Research on Ageing
Dr Chanaka Wijeratne	• Old Age Psychiatrist • Senior Staff Specialist, Prince of Wales Hospital • Senior Lecturer in Psychiatry (conjoint), UNSW • Chair, NSW Faculty of Psychiatry of Old Age
Dr Peter Gonski	• Senior Staff Specialist Geriatrician and Director of Southcare, Division of Aged and Extended Care, Sutherland Hospital and Community • Associate Professor (conjoint), UNSW
Dr Brian Draper	• Chair, RANZCP Faculty of Old Age Psychiatry • Assistant Director, Academic Department for Old Age Psychiatry, Prince of Wales and Prince Henry Hospitals • Associate Professor (conjoint), UNSW
Dr Kate Jackson	• Manager, NSW Older People's Mental Health Policy Unit, NSW Department of Health
Dr Stephen Judd	• CEO, Hammond Care
Ms Sally Yule	• Deputy CEO, Hammond Care
Ms Angela Raguz	• General Manager Services Development, Hammond Care
Mr John Nadjarian	• Special Care Program Manager, Hammond Care
Ms Joy Robinson	• Southwood Manager, Hammond Care
Ms Catriona Lorang	• Intern Psychologist, Hammond Care
Victoria	
Professor Rhonda Nay	• Professor of Gerontic Nursing, Australian Centre for Evidence Based Aged Care, La Trobe University
Dr Susan Koch	• Assoc. Professor, Australian Centre for Evidence Based Aged Care, La Trobe University
Ms Margaret Winbolt	• Research Officer, Australian Centre for Evidence Based Aged Care, La Trobe University
Dr Michael Murray	• Director of Geriatric Medicine, St Vincent's • Adjunct Assoc. Professor, Australian Centre for Evidence Based Aged Care, La Trobe University
Dr Benji Soosai	• Group Manager for Aged Psychiatry, Residential Care and DBMAS, St Vincent's
Ms Margaret Morrissey	• Community Psychiatric Nurse, St Vincent's
Ms Rose McCrink	• Nurse Manager, Aged Psychiatric Unit, Bundoora Extended Care Centre
Ms Catherine Edgar	• Wound Consultant, Bundoora Extended Care Centre

Professor David Ames	• Professor of Ageing and Health, University of Melbourne • Director National Ageing Research Institute • Editor International Psychogeriatrics
Mr George Osman	• Program Manager, North Western Aged Persons Mental Health
Mr Bryan Lipmann	• CEO, Wintringham
West Australia	
Dr Helen McGowan	• Psychiatrist of Old Age • Clinical Director, North Metropolitan Older Adult Mental Health Service
Assoc. Professor Barbara Horner	• Director, Centre for Research on Ageing, Division of Health Sciences, Curtin University of Technology
Assoc. Professor Dianne Wynaden	• Director, Research and Development /Assoc. Prof. Mental Health, School of Nursing and Midwifery, Curtin University of Technology
Professor Leon Flicker	• Professor of Geriatric Medicine, University of WA • Head of Inner City Aged Care Services
Mr Peter McHale	• Clinical Nurse Manager, Southern Cross Care
Dr Mathew Samuel	• Consultant Psychiatrist of Old Age, Fremantle Hospital and Health Service • Adjunct Associate Professor, School of Exercise and Health Science, Edith Cowan University
South Australia	
Mr Derek Wright	• Executive Director Mental Health
Ms Learne Durrington	• Executive Director, Central Northern Adelaide Mental Health Service
Ms Elaine Nicholson	• Registered Mental Health Nurse • Aged Care Services Manager, Ian George Court
Mr Peter Wright	• CEO, Anglicare Aged Care Services
Tasmania	
Dr Jane Tolman	• Geriatrician • Director, Rehabilitation and Aged Care Services, Royal Hobart Hospital
Ms Liz Musgrove	• Director of Care, ADARDS Nursing Home
Ms Jackie Morling	• State wide Coordinator, Dementia Behaviour Management Advisory Services (DBMAS)
Professor Andrew Robertson	• Professor of Aged Care Nursing, Clinical School, Royal Hobart Hospital
Queensland	
Dr Gerard Byrne	• Head, Discipline of Psychiatry, Mental Health Centre, University of QLD
Dr David Lie	• Director, Aged Care Mental Health Service, Princess Alexandra Hospital
Ms Heidi Kitson	• Assistant Director, Disability Services Queensland
Ms Meralie Boaden	• Clinical Nurse Consultant, Royal Brisbane Hospital ACAT

Appendix B Commonwealth Dementia Program

Summary of the Commonwealth Dementia Initiative

Overview

- Helping Australians with dementia, and their carers- making dementia a National Health Priority (Program 4.6).
- $320.6 million over five years: Announced 2004-05 Budget.
- Funding beyond June 2009 has been provided through Forward Estimates to support programs under the Dementia Program, this was supported by the Government Election Commitment. Program monitoring and evaluation will inform the Dementia Program's future directions and activities beyond June 2009.

Focus

The focus of the Dementia Program is on:

- Research
- Prevention
- Early intervention programs
- Improved care initiatives, and
- Training for aged care workers, carers, police and ambulance officers.

Key elements of the Dementia Program:

- Extended Aged Care at Home Dementia Packages - $225.1 million for 2,000 new dementia specific Extended Aged Care at Home places.

- Dementia Behaviour Management Advisory Services (DBMAS) - $9 million committed to expand and refocus the existing Psychogeriatric Care Unit (PGU) Program. DBMAS services assist health and aged care staff in residential and community care services to provide improved dementia care through clinical supervision, diagnosis support, short term case management, improved clinical care support and education services.

- Dementia Research Grants - $17.4 million committed to fund multidisciplinary, multi-sectoral research that will inform and address factors that impact on the health and well-being of people with dementia. The grants program is managed, on behalf of the Department of Health and Ageing, by the National Health and Medical Research Council (NHMRC).

- Collaborative Research Centres - $7.2 million committed to fund three Dementia Collaborative Research Centres (on university campuses) that bring together key national and international ageing and dementia researchers to progress major dementia research areas.

- National Dementia Support Program (NDSP) - $14 million (from 31 March 2007 to 30 June 2009) committed to fund Alzheimer's Australia to deliver the NDSP which provides the following services and programs:
    - The National Dementia Helpline 1800 100 500 and referral services;
    - Dementia and Memory Community Centres;
    - Early intervention programs, such as the Living with Memory Loss Program;
    - Advice, counselling and support services;
    - Education and training;
    - Awareness raising services, including activities such as Dementia Awareness Month; and
    - Support for people with special needs including the Dementia Cross Cultural Network and new activities for Aboriginal and Torres Strait Islander people.

- Dementia Training Study Centres (DTSCs) - $8.6 million committed for four DTSCs that promote dementia studies in universities as well as providing tertiary dementia studies career pathways.

- Dementia Training - $25 million committed to fund seven organisations to provide dementia training for aged care workers. Training will also be provided to carers, and community workers such as police and ambulance officers. Training resources for special needs groups are also being developed.

- Minister’s Dementia Advisory Group - $9 million to provide sitting fees, travel and meeting expenses, and projects identified as priority areas by the Group and agreed by the Minister for Ageing. Funding under the program also provides for communication activities, product development and despatch.

- National Evaluation of the Dementia Initiative - $1.7 million committed to fund an independent evaluation of key dementia projects under the Dementia Program.

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