PSYCHOGERIATRIC CARE EXPERT REFERENCE GROUP REPORT TO THE MINISTERIAL CONFERENCE ON AGEING

DECEMBER 2010

INTRODUCTION

In its first report to the Ministerial Conference on Ageing (MCA) in September 2009, the Psychogeriatric Care Expert Reference Group (ERG) highlighted a number of key issues that contribute to challenges in psychogeriatric care across the spectrum of health care. At both an individual case level and a national policy level, the lack of coordination and collaboration, combined with gaps in services, can result in poor health outcomes for the individual.

The first ERG report to the MCA highlighted the requirement for a comprehensive national plan for the management of severely disturbed residents who are unable to be cared for in mainstream residential aged care homes. Since this report, the ERG has been working on the development of a broad framework outlining the principles and elements of care that are necessary to ensure appropriate provision of care and services for older people with behavioural disorders.

This second report presents further development of the framework, for endorsement by the MCA, with the recommendation that establishment of the framework be considered in the context of implementation of the Fourth National Mental Health Plan.

The framework is represented in the attached diagrams as being designed around the person, with access to the required elements of care and services within care locations across a continuum of care as their needs change. It is acknowledged that the types of services may vary across jurisdictions.

A summary of issues raised by the ERG in its submission to the review of the Aged Care Funding Instrument (ACFI) has also been included in this report to inform the MCA of concern around the funding for this client group.

In addition, the ERG verbal submission to the Subacute Benchmarking Study is summarised.

INFLUENCES IN THINKING

The *Report to the Minister on residential care and people with psychogeriatric disorders* (the Report to the Minister) highlights that the best care outcomes for older people with behavioural disorders are achieved when there is effective integration and cooperation across the primary, acute, mental health and aged care systems. The Report cites that, as all areas of the health and aged care system share a responsibility across the continuum of care for this client group, the collaboration of States, Territories and the Commonwealth at the service delivery level is essential, and where this occurs, residential aged care facilities are more able to admit and/or maintain people with severe and complex psychogeriatric disorders[1].

A number of documents at national and jurisdictional levels also highlight the need for an active interface between all health systems[2]. The National Health and Hospitals Reform

1 Report to the Minister on residential care and people with psychogeriatric disorders. June 2008.

Commission (NHHRC) final report released in June 2009 supports the connection and integration of health and aged care services to meet the needs of people with complex health problems and notes that "we need to redesign health services around people, making sure that people can access the right care in the right setting"[3]. The NHHRC report states that redesign of the health system "must include a 'full service menu' of health and aged care services necessary to meet the needs of an ageing population and the rise of chronic disease. Redesign also involves ensuring that this complex array of services is well coordinated and integrated through more effective use of tools including standard assessment tools (to augment good clinical method), agreed communication systems with some built in protocols, shared understanding of care pathways and engaging the whole health care team".

On April 19 and 20, 2010, COAG , with the exception of Western Australia, agreed to the establishment of the National Hospitals and Health Network and further reforms to promote the integration of health services. The reforms are in response to major challenges facing the health system including "overlapping responsibilities and lack of coordination and integration of service systems that lead to patients falling through the cracks". All States, except West Australia, agreed to work with the Commonwealth on system-wide primary health care policy, "including where coordination is required to improve system integration or service planning"4. COAG also "agreed, with the exception of Western Australian, to undertake further work on the scope for additional mental health service reform for report back in 2011, including the potential for further improvements to the allocation of roles and responsibilities in the mental health sector."[5]

Service access, coordination and continuity of care are also priority areas of the Fourth National Mental Health Plan (4th NMHP). The 4th NMHP notes that a collaborative whole of government approach will be required across State, Territory and Commonwealth Governments to provide capacity for clients to move between systems as their care needs change[6]. The removal of structural and attitudinal barriers, and a good governance system that allows for dispute resolution will be needed to achieve this goal.

FRAMEWORK FOR SERVICE PLANNING AND CARE DELIVERY – PEOPLE WITH PSYCHOGERIATRIC DISORDERS

The ageing population presents many challenges for those planning health care for older people, such as how to offer individualised residential care. The complex needs of people with dementia can be difficult to meet, leading to need-driven dementia-compromised behaviours – also called behavioural and psychological symptoms of dementia (BPSD). Similarly, physically frail older people with severe mental disorders such as schizophrenia, bipolar disorder and depression also have complex needs. The framework attempts to address the needs of both these groups.

2 These include:

- National Mental Health Plan 2003–2008;
- Fourth National Mental Health Plan, An agenda for collaborative government action in mental health 2009–2014;
- From hospital to home: Improving care outcomes for older people 2006–07; and
- A Healthier Future for all Australians, Final report June 2009. National Health and Hospitals Reform Commission.

3 Chapter 4, pg. 102: Connecting and integrating health and aged care services for people over their lives.

4 Communiqué, Council of Australian Governments Meeting, 19 and 20 April 2010

5 Communiqué, Council of Australian Governments Meeting, 19 and 20 April 2010

6 Fourth Mental Health Plan, Priority 3: Service access, coordination and continuity of care; and
Principles 1 and 2 from the report From hospital to home: Improving care outcomes for older people 2006–07, the third annual report on achievements under the Australian Health Ministers' Advisory Council's National action plan for improving the care of older people across the acute-aged care continuum, 2004–2008.

Traditional models of planning for health care service provision have focussed on the services provided to an individual, with health care professionals making decisions regarding the types of support given. These models can result in the provision of services directed towards particular deficits in the person rather than addressing all factors that impact the person's health and well-being.

A national service planning framework that incorporates overarching key principles to support and promote the connection and integration of health and aged care systems and services for older people with behavioural disorders is proposed in this report.

Key principles to support appropriate service delivery for people with severe and complex psychogeriatric disorders

The key principles provide the basis for person-centred, integrated and holistic models of service delivery that will support the coordinated and comprehensive care needs of this client group, as well as their carers, and assist in planning the services required.

The proposed framework also incorporates all the services and elements of care that underpin the key principles and that are necessary to support the care needs of these groups of people.

The principles of this framework are for appropriate service delivery for people with severe and complex psychogeriatric disorders, and include the following:

1. Integration at all levels within the broader health care system with appropriate facilities to assist older people with BPSD and/or mental health issues
2. On-going access to and utilisation of specialist clinical expertise and care
3. Appropriate assessment mechanisms and placement to ensure best 'client fit'
4. Appropriate staff levels and skills mix across the continuum of care

1. Integration at all levels within the broader health care system with appropriate facilities to assist older people with BPSD and/or mental health issues

The majority of people with dementia and cognitive impairment are successfully cared for both in the community and in aged care homes. Despite this, and because of the complexity of dementia, the appropriate care and services for people with severe and complex psychogeriatric disorders resulting in behaviours that may place either themselves or others at risk still present challenges. These challenges are for both the aged care and mental health sectors, as effective integration and collaboration across these sectors are necessary to ensure quality care[7].

Person-centred care is an alternative to conventional care practices. It considers a person's needs and preferences from a holistic perspective so that services and supports are organised in a personalised way rather than attempting to fit within pre-existing service systems. By treating the person as an individual, person-centred care encourages independence and autonomy rather than control by carers and/or staff. Use of person-centred care is becoming more common in residential care because it can reduce need-driven dementia-compromised behaviours, help maintain personhood and mitigate cognitive and functional deterioration[8].

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

8 Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial. Lynn Chenoweth, Madeleine T King, Yun-Hee Jeon, Henry Brodaty, Jane Stein-Parbury, Richard Norman, Marion Haas, Georgina Luscombe. ww.thelancet.com/neurology Published online March 12, 2009. DOI:10.1016/S1474-4422(09)70045-6.

To successfully implement a person-centred approach, it is necessary to understand both the nature and degree of variation in each person's needs and to have access to integrated services that are responsive to the needs of people rather than prescriptive in the types of services offered.

A characteristic of dementia and psychiatric illness can be the intermittent occurrence of acute episodes of challenging behaviours such as severe aggression. Despite best efforts to minimise these behaviours in situ with input from the GP, Dementia Behaviour Management Advisory Service (DBMAS), and liaison model specialist old age psychiatry and geriatric services, a person may need to move into a higher care environment for a limited time to stabilise symptoms to enable management in a lower care environment. In the majority of acute cases, medical factors trigger the problem, which if not successfully treated by the person's general practitioner, require treatment which can be provided within either a mental health or geriatric specialty depending on local availabilities. It is also acknowledged that delirium can contribute in the short term to acute episodes of challenging behaviour.

In addition to mental health problems, this group of people may have acute and chronic medical conditions which require multidisciplinary management, including medical, nursing and pharmacy involvement. The complex care needs of people with extreme behavioural disorders often means that their pathways through the health systems vary, and can be affected by the availability of appropriate care environments, especially for those that also have high physical dependency needs.

A person-centred model of care based on the complex needs of this group of people must therefore incorporate an integrated range of care and services, from care in the community to management in intensive specialist units. A model of care that allows for a fluid and flexible movement between the systems is needed. The model of care must also be able to accommodate changes in care needs as the symptoms stabilise and the individual care needs change. An overarching principle of this model is that access to each level of care requires that care cannot be managed at a lower level of care.

Mainstream residential aged care facilities
Mainstream facilities are equipped to provide care for people with no or mild BPSD, however they need to develop the capacity to prevent the escalation of behavioural and psychological problems. Apart from improving the quality of life for residents, this approach will reduce the number of clients requiring higher levels of expertise and care. The Report to the Minister notes that, to build this capacity, mainstream aged care homes need to incorporate dementia sympathetic design, have a committed management and staff with the necessary skills, provide on-going training for staff, have active involvement of GPs, and have access to specialist expertise and services[9].

To assist them in managing difficult behaviours, residential aged care facilities need to be able to access GP services in the first instance, and to draw on specialist services. These include psychogeriatric outreach teams, which provide a consultation liaison model to aged care facilities, and the DBMAS which has a number of core functions including clinical supervision and mentoring and modelling of behaviour management techniques. Currently, specialist outreach teams, where they exist, react to referrals precipitated by unmanageable behaviours or psychological symptoms. An alternative model is for outreach teams to provide a pro-active service by visiting residential aged care facilities on a regular basis to

9 pg. 21: Report to the Minister on residential care and people with psychogeriatric disorders. June 2008.

provide advice, supervision and training before behaviours escalate and thereby prevent severe problems occurring.

As well as providing early intervention to prevent behavioural crises, these services aim to build staff capacity in aged care services so that they gain increased knowledge and confidence in understanding the needs of people presenting with BPSD.

Dementia-specific residential aged care facilities
These facilities provide specialist dementia care for those residents with moderate to severe BPSD. In keeping with dementia specific design principles, dementia-specific residential aged care facilities provide both a secure and a domestic and familiar environment and with a focus on reducing excessive external stimuli. They need to access the same range of support services as mainstream facilities but may require more regular input. Other features of the care model which are critical in minimising behavioural disturbances at these facilities are the higher staff profile and skills mix, and the provision of structured and meaningful activities. These facilities generally offer long term care. However, short term respite is also possible within these environments.

High Dependency Units
An optimal system of care for older people who have severe behavioural disorders resulting from severe BPSD or mental illness would include the provision of high dependency units (HDUs)[10]. 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. With responsibilities for aged care and mental health governance divided between the Commonwealth and States and Territories respectively, HDUs would require the combined input of both jurisdictions.

HDUs would operate as longer term transition models designed to graduate residents to less intensive care options and be purposefully structured to meet both the aged care and mental health care needs of this group of people. As such, HDUs would provide for both step-up and step-down care as well as access to clinical and psychiatric support and expertise.

This system of care would also include a case management approach to care delivery to ensure continuity of care when a person leaves a HDU, thereby supporting appropriate care practices which prevent the escalation of behaviours that can be triggered by a change in environment.

There may be circumstances in some larger jurisdictions that have a network of HDUs for one of them to be designated as an Intensive Care Residential Behavioural Unit (ICRBU) for residents with extreme intractable behavioural issues. ICRBUs require on-going support from psychiatrists and mental health teams to effectively manage the person's care needs.

Access to emergency or acute mental health care may be required when a person's behaviour can no longer be managed in HDUs or ICRBUs, for instance when a person is persistently physically violent. Alternatively it may be possible for a person to transition back from these units to a residential aged care facility, particularly if they are no longer ambulant and do not pose a risk to themselves or fellow residents.

Acute care and Subacute care environments

[10] pg. 20.

A secure acute inpatient environment with adequate specialist staffing capable of managing acute care for people with behavioural disorders due to mental illness is required in acute care and subacute care settings. The design principles for dementia care settings are well-known in residential aged care settings; acute care and subacute care settings should apply similar design concepts for this group of people. Unfamiliar environments such as clinical acute care settings can be confusing, and increased confusion and agitation in these people may rapidly escalate to aggression and violence.

2. On-going access to and utilisation of specialist clinical expertise and care

The ability for this client group to access specialist clinical expertise and care according to their care needs is essential. This is recognised in the NHHRC report which notes that "the ongoing management and support of people with chronic and complex conditions in partnership with specialist medical consultants and teams who provide assessment, complex care planning and advice."[11] In addition, the Government has endorsed the NHHRC report recommendation that the volume and quality of sub-acute services be increased, including psychogeriatric care. As part of the Government's rollout of funding for this sector, States are required to commit to specific numbers of new sub-acute beds or bed equivalents.[12]

Access to acute primary care and mental health and geriatric specialist services with clear agreed protocols and referral pathways is necessary at all levels within the broader health care system. A collaborative person centred approach is necessary that utilises the different skills sets of the services involved. Accurate and expert diagnosis is essential to distinguish those conditions which are treatable from those with symptoms which can only be managed, and to ensure appropriate pharmacological regimens as well as behavioural management strategies are in place. Expert assessment, diagnosis and treatment can prevent unnecessary admission to acute care, or can stabilise a care recipient's behavioural and psychological symptoms so that they can be moved to a lower level of care.

Residential care facilities must be able to access expertise and support. On-going access on an 'as needs' basis is important to provide the appropriate continuum of care for the resident and to sustain the 'client fit' within the facility. In cases where behaviours escalate however, aged care services need to be able to access expert assessment to facilitate admission to acute care. This may occur through the relevant older persons mental health service or community based assessment and support teams.

Other mental health professionals who are able to support aged care services include the DBMAS. DBMAS services provide clinical interventions, advice and education to help aged care staff and carers improve their care of people with severe behavioural disturbances.

Models such as consultation-liaison psychiatry may be appropriate as well as other formal links between residential aged care and older persons mental health services. Case management of a resident by an older persons mental health team member in the transition period following the resident's transfer from one facility to another can ensure the continuation of appropriate care and management.

3. Appropriate assessment mechanisms and placement to ensure best 'client fit'

[11] Recommendation 20.
[12] Response to the National Health and Hospitals Reform Commission Final Report.

Reforms in the community, health, mental health and disability sectors have resulted in a changed client group in residential aged care. Residential aged care facilities 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. While the majority of older people with mental health problems are successfully cared for both in the community and aged care homes, appropriate care and services for older people with severe and complex psychogeriatric disorders resulting in behaviours that place themselves or others at risk continue to present significant challenges.

In assessing the care needs of older people with such complex disorders, Aged Care Assessment Team (ACAT) assessors require access to appropriate expertise and must have relevant information provided to ensure an informed assessment procedure is conducted. In the event of an ACAT assessment recommendation for admission of the person to an aged care facility, a facility needs to be able to make the final decision regarding suitability of the admission based on their capacity to provide the care and services required by the person. This includes consideration of the potential impact of existing residents on the person and the person on existing residents. Residential aged care facilities need to be able to ensure that frail non-ambulant residents can be protected from potential aggression of ambulant residents.

Factors such as the facility design, the skills mix of all staff, and access to clinical expertise also need to be considered when assessing the suitability of placement. With the increasing prevalence of behavioural problems associated with dementia and mental illness in older people, mainstream residential aged care facilities need to develop the capacity to prevent the escalation of behavioural and psychological problems. The Report to the Minister notes that, to build this capacity, mainstream aged care homes need to incorporate dementia sympathetic design, have a committed management and staff with the necessary skills, on-going training for staff, active involvement of GPs, and have access to specialist expertise and services[13]. Dementia specific design features reduce the impact of the environment on behaviours and can assist in minimising behaviours that are triggered by issues such as noise.
As well as improving the quality of life for residents, capacity building in residential aged care facilities will contain the growth in numbers of people requiring high dependency services by preventing the escalation of behaviours.

In addition, the placement of younger people with behavioural disorders in aged care homes is generally not appropriate as aged care facilities cannot provide the social support and services younger people need. In these situations, frailer older people can be victims of unmanaged aggression. Younger people who require residential care need age-appropriate residential care and services. There is, however, a dearth of these facilities in Australia and there is an urgent need to rectify this problem.

4. Appropriate staff levels and skills mix across the continuum of care
Skills in managing clients with aggressive and/or all types of disruptive behaviours are important in all service areas. Well trained and experienced staff have the capacity to recognise early signs of behavioural disturbances and prevent their escalation, while conversely, the actions of inexperienced staff can readily escalate behaviours.

HDUs require higher levels of staff than in mainstream residential aged care facilities. While it is essential that high dependency units have some staff with mental health nursing

[13] pg. 21.

qualifications, it is also essential that all staff receive on-going in-service training and support to ensure the continuing development of staff skills and a stable workforce.

DBMAS has a number of core functions including the provision of education and tailored information workshops, clinical supervision, and mentoring and modelling of behaviour management techniques. In New South Wales, these services are complemented by Behavioural Assessment and Intervention Services (BASIS). These services aim to build staff capacity in aged care facilities so that they gain increased knowledge and confidence in understanding the needs of people presenting with BPSD and alleviating them.

Summary of proposed National Framework for the provision of appropriate care and services for older people with behavioural disorders

The framework has been developed to incorporate all the services and elements of care within a range of care environments an older person with behavioural disorders will potentially utilise. Implicit in the effectiveness of such a framework is the ability of a person to move freely between care environments and to access appropriate specialist assessment and management according to their care needs.

The aim of this framework is to increase coordination and collaboration across all health care sectors, including those servicing rural and remote areas, thereby increasing the efficiency and effectiveness of service delivery, and to improve the health outcomes for older people with severe and challenging behaviours.

RECOMMENDATIONS

1. That the MCA endorse the national framework as proposed in this report including all of the elements of care required to be in place to develop a system in each jurisdiction that provides appropriate care and services for older people with behavioural disorders; and

2. That the national framework be considered in the context of the implementation of the Fourth National Mental Health Plan.

SUBMISSION TO THE REVIEW OF THE AGED CARE FUNDING INSTRUMENT

The focus of the ERG submission to the review of the Aged Care Funding Instrument (ACFI) was on issues related to funding of the care and management of people with psychogeriatric disorders including the small yet significant group of people with high level behavioural disorders.

The ERG highlighted two particular areas of concern in relation to this client group:

1. The deficiencies in funding under the behaviour domain within the current ACFI model for the general client group within residential aged care.

   Current funding of high in the ACFI domain of behaviour does not reflect the care needs of people who exhibit frequent and/or severe behavioural disorders, nor does it distinguish between the resources for the different manifestations of physical behaviour. For instance, the resources required for people who exhibit aggressive behaviour are quite different to those required for people who wander frequently or who shout persistently.

2. The lack of funding for people with severe behavioural disorders.

   The behaviour domain in the current ACFI model was not developed in the expectation that aged care homes would be providing care to people with extreme behavioural problems. Therefore funding does not capture people whose behaviour is considered too difficult for mainstream aged care homes. The result is that it is increasingly difficult to find accommodation for ambulant people with dementia and more severe behavioural problems. These people therefore often become homeless or are marginalised in mental health or acute services which may be unnecessary or inappropriate to their needs and can be costly.

Reforms in the acute care, mental health and disability sectors have resulted in a changed client group in residential aged care. 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.

A key recommendation of the submission was that a special funding supplement be developed specific to this group of people whose behaviour often excludes them from mainstream aged care. The ACFI Behaviour domain must place more emphasis on challenging behaviours to enable mainstream aged care facilities to meet the needs of the increasing number of people with dementia. In particular, issues such as the severity of behaviours, the ceiling on frequency of behaviours, and incorporation of non-behavioural issues in the behaviour domain should all be reviewed.

The special supplement should include an increase in subsidy levels, mechanisms in place to ensure the supplement is reserved for residents with more severe psychogeriatric behaviours, the use of sophisticated screening tools, and assessment by mental health and/or geriatric specialists. Mainstream aged care facilities are more likely to cope with residents with behaviours of concern if they have confidence in support from external specialists.

SUBMISSION TO THE SUBACUTE BENCHMARKING STUDY

The Commonwealth Department of Health and Ageing Subacute Benchmarking Study is being carried out under the National Partnership Agreement on Hospital and Health Workforce Reform (NPA) Schedule C: Subacute Care. The objectives of the study are to:

- conduct a population-based needs analysis of subacute care in Australia, taking into account best practice models of care and identify key demand drivers as part of this analysis; and
- recommend population-based service level benchmarks for subacute care services in Australia, in light of the population based needs analysis above.

As a part of this study, the ERG provided a verbal submission with regard to psychogeriatric care, one of the care types included under subacute care.

The ERG advised that there are currently no benchmarks on subacute psychogeriatric care in Australia. World-wide, there is no work that clearly **defines** when acute care becomes subacute care, and there are no specific characteristics that definitively delineate psychogeriatric subacute care from acute care. In addition, there is no empirical definition as to who comprises the psychogeriatric group, and the ERG noted that this is an area of work that needs to be undertaken.

Research in NSW has shown that patients with dementia are more likely to be **categorised** as receiving rehabilitation than psychogeriatric care. The ERG noted there is a lack of appropriate hospital-based subacute care settings in Australia for patients with psychogeriatric disorders which leads to them being treated in other settings such as aged care rehabilitation or residential aged care. This affects how they are viewed and how their care is classified.

Victoria was identified as the jurisdiction closest to having the preferred **model of psychogeriatric care** that has been operating effectively for a number of years. It was also noted that NSW had developed a model of psychogeriatric care that has been influenced by the Brodaty/Draper triangular model of service delivery, which considers the care setting based on patient needs.

The ERG is currently undertaking work on models of care in psychogeriatric care, which is expected to be completed and reported upon later in 2010.

The ERG identified a number of **drivers of demand** for subacute psychogeriatric care:

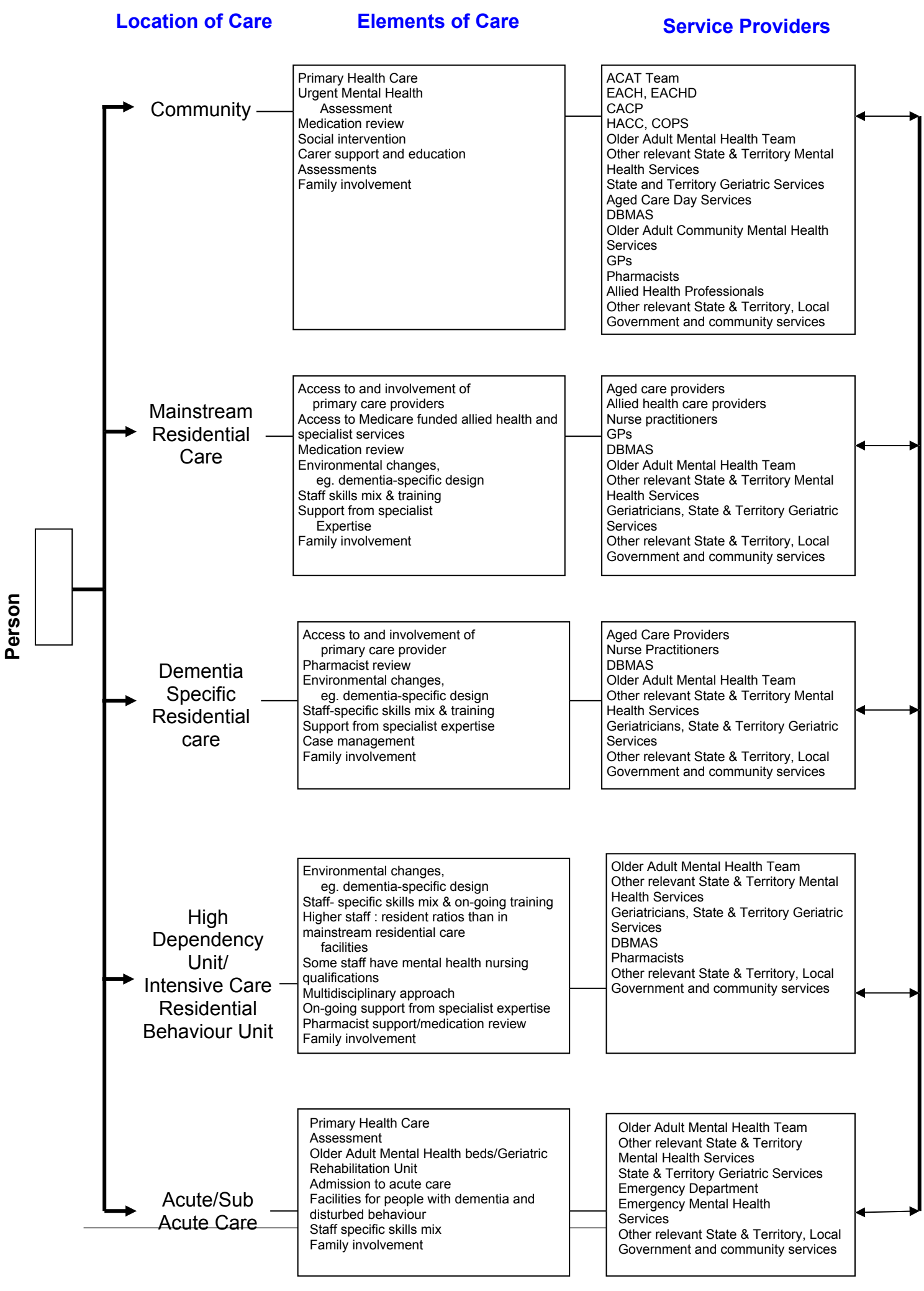
- the ageing of baby boomers, along with the likelihood that their expectations will differ from the previous generation;
- the concomitant increase in prevalence in younger persons with dementia; and
- a growing, world-wide recognition that people who have dementia and are in hospital are not well looked after in this regard. This is increasing the pressure to improve provision of psychogeriatric care in hospitals.

In **the future**, it is not known what impact possible disease modifying drugs might have on this care group over the next 20 years, as well as the impact of workforce shortages and inadequate skills. In addition, the limits of the provision of comprehensive community based care, for example beyond EACHD packages, have yet to be established.

FURTHER AREAS OF ERG ACTIVITY

The ERG has formed a sub-group to analyse mental health workforce priorities and the workforce implications of a national service planning and delivery framework, including:

- the training needs and skills required in behaviour management in the aged care sector across the entire mental health workforce;
- the workforce mix in terms of services that need to be provided; and
- leadership support and training for capacity building in residential aged care, for instance through links with external services.


Location of Care
Elements of Care
Service Providers
Person
Community
Primary Health Care
Urgent Mental Health Assessment
Medication review
Social intervention
Carer support and education
Assessments
Family involvement
ACAT Team
EACH, EACHD
CACP
HACC, COPS
Older Adult Mental Health Team
Other relevant State & Territory Mental Health Services
State and Territory Geriatric Services
Aged Care Day Services
DBMAS
Older Adult Community Mental Health Services
GPs
Pharmacists
Allied Health Professionals
Other relevant State & Territory, Local Government and community services
Mainstream Residential Care
Access to and involvement of primary care providers
Access to Medicare funded allied health and specialist services
Medication review
Environmental changes, eg. dementia-specific design
Staff skills mix & training
Support from specialist Expertise
Family involvement
Aged care providers
Allied health care providers
Nurse practitioners
GPs
DBMAS
Older Adult Mental Health Team
Other relevant State & Territory Mental Health Services
Geriatricians, State & Territory Geriatric Services
Other relevant State & Territory, Local Government and community services
Dementia Specific Residential care
Access to and involvement of primary care provider
Pharmacist review
Environmental changes, eg. dementia-specific design
Staff-specific skills mix & training
Support from specialist expertise
Case management
Family involvement
Aged Care Providers
Nurse Practitioners
DBMAS
Older Adult Mental Health Team
Other relevant State & Territory Mental Health Services
Geriatricians, State & Territory Geriatric Services
Other relevant State & Territory, Local Government and community services
High Dependency Unit/ Intensive Care Residential Behaviour Unit
Environmental changes, eg. dementia-specific design
Staff- specific skills mix & on-going training
Higher staff : resident ratios than in mainstream residential care facilities
Some staff have mental health nursing qualifications
Multidisciplinary approach
On-going support from specialist expertise
Pharmacist support/medication review
Family involvement
Older Adult Mental Health Team
Other relevant State & Territory Mental Health Services
Geriatricians, State & Territory Geriatric Services
DBMAS
Pharmacists
Other relevant State & Territory, Local Government and community services
Acute/Sub Acute Care
Primary Health Care Assessment
Older Adult Mental Health beds/Geriatric Rehabilitation Unit
Admission to acute care
Facilities for people with dementia and disturbed behaviour
Staff specific skills mix
Family involvement
Older Adult Mental Health Team
Other relevant State & Territory Mental Health Services
State & Territory Geriatric Services
Emergency Department
Emergency Mental Health Services
Other relevant State & Territory, Local Government and community services

Assessment & Diagnosis

Services/Specialists

Person can be managed in the community.

Yes

- ACAT Team
- EACH, EACHD
- CACP
- HACC, COPS
- Older Adult Mental Health Team
- Other relevant State & Territory Mental Health Services
- State and Territory Geriatric Services
- Aged Care Day Services
- DBMAS
- Older Adult Community Mental Health Services
- GPs
- Pharmacists
- Allied Health Professionals
- Other relevant State & Territory, and local Government and community services

No

Person can be managed in residential aged care.

Yes

- Aged care providers
- Allied health care providers
- Nurse practitioners
- GPs
- DBMAS
- Older Adult Mental Health Team
- Other relevant State & Territory Mental Health Services
- Geriatricians, State & Territory Geriatric Services
- Other relevant State & Territory, and local Government and community services

No

Person can be managed in dementia-specific residential aged care or with a special residential care package.

Yes

- Aged Care Providers
- Nurse Practitioners
- DBMAS
- Older Adult Mental Health Team
- Other relevant State & Territory Mental Health Services
- Geriatricians, State & Territory Geriatric Services
- Other relevant State & Territory, and local Government and community services

No

Person can be managed in a high dependency unit or intensive care residential behaviour unit.

Yes

- Older Adult Mental Health Team
- Other relevant State & Territory Mental Health Services
- Geriatricians, State & Territory Geriatric Services
- DBMAS
- Pharmacists
- Other relevant State & Territory, and local Government and community services

No

Person can be managed in an acute care or sub-acute care unit.

Yes

- Older Adult Mental Health Team
- Other relevant State & Territory Mental Health Services
- State & Territory Geriatric Services
- Emergency Department
- Emergency Mental Health
- Service
- Other relevant State & Territory, and local Government and community services