Psychogeriatric Care Expert Reference Group (PERG) – Second submission to the Productivity Commission inquiry, *Caring for Older Australians*

Overview

The Psychogeriatric Care Expert Reference Group (PERG) welcomes the opportunity to comment on the Productivity Commission's draft report *Caring for Older Australians.* The PERG believes that the draft report fails to adequately address the needs of older Australians with dementia and other mental disorders that require care; yet the majority of residents in aged care facilities require care due to dementia. None of the recommendations in the draft report focus on this special needs group.

This submission seeks to reiterate the main points of the PERG's initial submission, including:

- the increasing need for psychogeriatric care;
- challenges in funding for the provision of psychogeriatric care;
- an optimal system of care delivery for people with psychogeriatric disorders;
- special needs groups;
- younger people in residential aged care; and
- information for consumers and carers.

The PERG's first submission to *Caring for Older Australians* inquiry (Submission 299) forms part of this second submission and is Attachment A.

In addition, the PERG wishes to further comment on aspects of funding and person centred care and the service system that were raised in the draft report *Caring for Older Australians.*

Funding of the provision of psychogeriatric care in residential aged care

The PERG, in its initial submission to the inquiry highlighted the need for consideration of people with psychogeriatric disorders as a special needs group under the *Aged Care Act 1997*. The PERG submission also highlighted the need for an increase in the level of psychogeriatric care and funding models that support the provision of appropriate care to this client group.

The PERG notes that the Productivity Commission's draft report, *Caring for Older Australians*, acknowledges the challenges residential aged care facilities face in meeting the needs of people with extreme challenging behaviours. The draft report also acknowledges that for providers, the pricing of services provided to people with complex behavioural disorders may not reflect the cost of services (p111).

A broad based funding model in general fails to fully recognise the costs associated with providing care to special needs groups such as the psychogeriatric client group. The Behavioural Supplement of the Aged Care Funding Instrument (ACFI) in particular was not designed with the expectation that residential aged care facilities would be providing care to people with extreme behavioural disorders. In addition, funding under the ACFI does not reflect the costs involved in engaging, training and developing a workforce that has the special skills set to provide care to this client group nor does it reflect the higher staff ratios required to provide care. A model that includes tiered, supplementary funding based on actual care needs and workforce needs would be more appropriate to meet the needs of this client group.

Person-centred care and service system

The PERG fully supports the recommendation that care provision should "*be consumer-directed, allowing older Australians to have choice and control over their lives"*, however

notes that this recommendation is based on the premise that all older people have the ability to exercise autonomy in making choices. The ability to exercise autonomy varies significantly within the psychogeriatric client group with substitute decision makers being the rule rather than the exception. Many in this group require proxy consent to obtain an Aged Care Assessment program assessment and a legal guardian appointed to enter contractual arrangements with service providers. The draft report fails to adequately address this issue.

The PERG also supports the recommendation that the aged care system should "*ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change"*. The PERG has developed a *Framework for Service Planning and Care Delivery for People with Severe Behavioural Disorders,* which identifies principles and elements of care that underpin the provision of person centred care and services to people with complex behavioural disorders in a range of care settings.

The framework addresses the complex needs of people with behavioural and psychological symptoms of dementia (BPSD) and older people with severe mental disorders such as schizophrenia, bipolar disorder and depression. The framework recognises that integration across aged and health care sectors, in particular, access to primary and specialist care is critical in ensuring health and aged care outcomes for people with psychogeriatric disorders.

Key principles of the framework include:
- integration at all levels within the broader healthcare system with appropriate facilities to assist older people with BPSD and/or mental illness;
- ongoing access to and utilisation of specialist clinical expertise and care;
- appropriate assessment mechanisms and placement to ensure best client fit; and
- appropriate staff levels and skill mix across the continuum of care.

This framework is being considered in the context of mental health planning and service reform. A copy of the framework is provided in confidence at Attachment B.

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Psychogeriatric Care Expert Reference Group

21 March 2011

Attachment A

Psychogeriatric Care Expert Reference Group (ERG)
First Submission to the Productivity Commission Inquiry
Caring for Older Australians

The Psychogeriatric Care Expert Reference Group (ERG) was established in December 2008 to provide advice to the Ministerial Conference on Ageing about the care of older people in residential care who have psychogeriatric disorders and associated behavioural disturbances. A particular area of expert advice to the MCA is in models of care and service delivery challenges for joint mental health/aged care planning, service delivery and performance.

The ERG is comprised of identified experts and clinicians in the fields of old age psychiatry, geriatrics, mental health and gerontological nursing, aged care provision and aged care policy.

The purpose of this submission is to highlight the need for:

- an increase in the level of psychogeriatric care;
- funding models that support the provision of appropriate care for this group of people;
- the inclusion of high dependency units within the broader aged care and health systems;
- the consideration of people with psychogeriatric disorders as a special needs group under the *Aged Care Act 1997*;
- appropriate care for younger people with behavioural disorders; and
- information for consumers and carers in terms of which facilities are best equipped to accommodate people with severe behavioural disorders.

BACKGROUND

In April 2008, the Minister for Ageing, the Hon Justine Elliot MP requested a report be prepared on residential care and people with psychogeriatric disorders. The *Report to the Minister for Ageing on Residential Care and People with Psychogeriatric Disorders* (the Report) was written following targeted consultations with identified experts and services across Australia.

The Report highlights that the best care outcomes for people with psychogeriatric disorders are achieved where there is effective integration and cooperation across sectors and cites as critical that collaborative networks across the primary health, mental health and aged care service sectors are established.

The Psychogeriatric Care Expert Reference Group (ERG) was established in response to the first recommendation of the Report: “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.”

The Report was provided to all State and Territory Ministers responsible for health and ageing in September 2008 and was subsequently considered at the inaugural meeting of the Ministerial Conference on Ageing (MCA) on 7 November 2008. MCA members endorsed the establishment and membership of the ERG, and noted the importance of monitoring the

development of appropriate care and services for people with psychogeriatric disorders whose behaviours may place themselves and others at risk.

INCREASING NEED FOR PSYCHOGERIATRIC CARE

The 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. Despite not being funded or equipped to provide care for people with mental disorders, 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.

There is evidence to suggest that the numbers of older people with extreme behavioural problems due to mental illness, such as Huntington's disease, dementia, schizophrenia, bipolar disorder and other diagnosable mental health conditions, are increasingly residing in aged care facilities. 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'[1].

With predictions of an increase in the number of people with dementia in Australia, from 245,000 people in 2009 to around 1.13 million people by 2050,[2] and the acknowledged Australia-wide shortage of specialist psychogeriatric aged care homes and high dependency units, the expectation is that there will be much higher numbers of older people with mental illnesses in years to come that will require management in generic settings.

CHALLENGES IN FUNDING FOR THE PROVISION OF PSYCHOGERIATRIC CARE

Jurisdictional constraints

As recognised in the Productivity Commission Issues Paper, responsibility for the funding and delivery of aged care services is spread across all three levels of government. The division of aged care and mental health governance responsibilities between the States and the Commonwealth can result in poor coordination, lack of collaboration, and gaps in services. As all areas of the health and aged care system share a responsibility for providing an appropriate continuum of care, the collaboration of the Commonwealth, States and Territories is essential.

Some individuals with severe challenging behaviour related to dementia or mental illness require aged care and mental health care in either residential care or a community setting. In recognition that people with more extreme behavioural disorders require higher care needs than can be provided in mainstream aged care facilities, some jurisdictions have aimed to address this requirement by supporting existing Commonwealth residential aged care funded services through the provision of top-up funding. However this funding is only applied to a small number of specialist services.

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[1] Faculty of Psychiatry of Old Age, The Royal Australian and New Zealand College of Psychiatrists (2004). Unpublished.

[2] *Keeping dementia front of mind: incidence and prevalence 2009-2050,* Access Economics (August 2009), a report commissioned by Alzheimers Australia

Victoria, New South Wales and Western Australia have all invested, to different degrees, in assisting Australian Government funded aged care to respond to the care needs of this group and have thus created the possibility of ongoing collaboration between mental health and aged care. Where this does not occur there is noticeably more reluctance on the part of mainstream aged care providers to admit and/or maintain people with severe and complex psychogeriatric disorders.

Nevertheless, overall there are very limited residential care beds that receive funding from jurisdictions to manage people with behavioural and psychological symptoms of dementia (BPSD) or mental health issues. This is reflected in lengthy delays in finding residential aged care for elderly people with BPSD or mental health issues, with the associated pressure on acute aged care, psychogeriatric and tertiary health beds.

Such top-up funding arrangements need to be considered and optimally configured in all States in both residential care and Commonwealth funded community programs for persons with dementia or mental illness.

The provision of appropriate models of care and adequate access to expert support for residential aged care services will enable the most effective utilisation of health resources, and avoid escalation to higher cost care models. It will also enable more effective family and carer support.

The exclusion from funding of people with severe behavioural disorders

Current funding does not capture people whose behaviour is considered too difficult for mainstream aged care homes. The Behavioural Supplement under the Aged Care Funding Instrument (ACFI) was not developed with the expectation that aged care homes would be providing care to people with extreme behavioural disorders. The result is that it is increasingly difficult to find accommodation for ambulant people with dementia and 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.

It is widely recognised that the higher levels and the specialist nature of care provided in dementia-specific residential care facilities and high dependency units require different staff selection criteria, skills mix and support for staff than in mainstream residential aged care facilities.

In our recent submission to the Review of the ACFI, the ERG recommended the addition of a special needs supplement to the ACFI for this client group who are difficult to manage. The supplement would provide an increase in subsidy levels to fund the higher levels and the specialist nature of care required for this group. It is recognised that access to the special supplement would need to be restricted, assessment would include more sophisticated tools than are used in the behaviour domain, and assessments by mental health and geriatric specialists would be required.

In addition, funding under the ACFI does not reflect the need to engage, train and develop staff with special skills sets, including the need to employ Mental Health Nurses, nor does it reflect the higher staff ratios required to care for those with behavioural/mental health needs.

AN OPTIMAL SYSTEM OF CARE DELIVERY FOR PEOPLE WITH PSYCHOGERIATRIC DISORDERS

The appropriate care and service delivery models for people with severe and complex psychogeriatric disorders vary depending on the risks and severity of behaviours that are demonstrated. 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.

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, however usually short term.

Victoria is the jurisdiction closest to having the preferred model of psychogeriatric care that has been operating effectively for a number of years. In NSW, a model of psychogeriatric care has been developed that has been influenced by the Brodaty/Draper triangular model of service delivery, which considers the care setting based on patient needs[3].

The Report identified 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. Such a system of care would include the provision of high dependency units (HDUs) for time-limited rather than long-term care. Older people who are no longer ambulant can be accommodated in mainstream aged care or dementia specific homes.

The HDUs 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 HDU.

The Report proposed the establishment and operation of HDUs within regional networks of aged care and health care services. For a HDU to operate effectively as a throughput model, a high level of collaboration and cooperation between all services across a region is necessary.

Currently there are only a few HDUs in total across all jurisdictions. Some of these HDUs are located within a much larger campus of residential aged care, which provides the necessary economy of scale to train and support staff and also provides security and support in the event of serious behavioural disturbance. This arrangement increases the family's willingness to move the client from the HDU when the level of care is no longer required as the client is frequently accommodated in a mainstream bed on the same campus, and has the additional advantage of increasing the throughput of the unit.

The higher levels and the specialist nature of care provided in HDUs require different staff selection criteria, skills mix and support for staff than in mainstream residential aged care facilities. Staff are generally selected for their personal qualities, such as resilience, acceptance and respectfulness, as well as for their professional qualifications. While it is essential that HDUs have some staff with mental health nursing qualifications, it is vital that

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[3] *A tiered model of psychogeriatric service delivery: an evidence-based approach.* Brian Draper, Henry Brodaty and Lee-Fay Low. Int. J Geriatric Psychiatry 2006; 21: 645-653.

all staff receive on-going in-service training and support to ensure the continuing development of staff skills and a stable workforce.

Mainstream facilities' capacity to care for people with behavioural problems is important not only to facilitate step-down care from HDUs but also to contain growth in the number of clients requiring HDUs by preventing escalation of behavioural problems. For this to occur, mainstream aged care homes also need to incorporate dementia sympathetic design, with committed management and staff with the necessary skills.

The ERG is currently developing a national service planning and care delivery framework for this client group which incorporates community care, mainstream residential aged care, dementia specific residential care, HDUs and acute or sub-acute care.

The implementation of such a coordinated system of care for older people with behavioural disorders will positively impact on productivity by providing better and more integrated care for this client group.

SPECIAL NEEDS GROUPS

Under section 12-5 of the *Aged Care Act 1997* (the Act), the Secretary may decide that a number of aged care places will be made available to focus on the care of particular groups of people. The special needs provisions in the Act are consistent with the aims of the Australian Government's Social Inclusion Agenda which, in part, aims to ensure strategies which provide a pathway to inclusion and a continuum of care.

People with special needs currently identified under the Act and Principles include people from Aboriginal and Torres Strait Islander communities, people from non-English speaking (culturally and linguistically diverse) backgrounds, people who live in rural or remote areas, people who are financially or socially disadvantaged, veterans (including spouses, widows and widowers of veterans), and care givers.

The ERG position is that people with psychogeriatric disorders also require careful consideration. To ensure continuity of care, this group of people require flexible models of care which are responsive to their changing care needs as their behaviours vary.

YOUNGER PEOPLE IN RESIDENTIAL AGED CARE

Within mental health there is usually a division, often occurring at age 65, about care responsibility and this can result in problems regarding the treatment of younger persons in mainstream aged care facilities which is often problematic as they can pose the greatest challenges to the system.

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. In addition, old age psychiatry services cannot safely manage strong aggressive elderly patients unless they are appropriately resourced and managed separately from the frail aged.

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.

INFORMATION FOR CONSUMERS AND CARERS

There is an absence of information for families and carers in terms of which facilities are best equipped to accommodate people with severe behavioural disorders. This can result in families accepting less than ideal placements in facilities keen to fill vacancies, but which may not have the necessary design features or staffing skills to provide appropriate care.

We feel there is a need for additional information for consumers and their carers to assist them in locating the most suitable service. This is supported by recommendation 44 of the National Health and Hospitals Reform Commission Final Report, "*A Healthier Future for all Australians*".

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5 August 2010