

Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours



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Contents

Foreword.....	ii	6.3 Joint state and national responses.....	12
Acknowledgements.....	iii	6.4 Responses through specialist residential aged care models – the interim specialist behavioural facility	13
1 Executive summary.....	1	6.5 Responses through specialist outreach care	14
1.1 Background.....	1	6.6 Critical factors for better management.....	14
1.2 The issue of severely challenging behaviours in residential aged care	1	7 A proposed model of care for older people with severely and persistently challenging behaviours.....	15
1.3 Methodology	2	7.1 The conceptual basis	15
1.4 Key findings.....	2	7.2 Scope.....	16
1.5 Proposed model of care	2	7.3 Objectives.....	17
1.6 Recommendations.....	3	7.4 Guiding principles	17
2 Summary report.....	4	7.5 Assumptions.....	17
2.1 Background.....	4	7.6 Model of care.....	18
2.2 What is severely challenging behaviour?	4	7.7 Service model elements.....	18
2.3 Project aim, objective and outcome.....	4	7.7.1 Behavioural Assessment and Intervention Services (BASIS).....	18
3 Methodology.....	5	7.7.2 Specialist Residential Aged Care Behavioural Packages	18
4 The issue of severely and persistently challenging behaviours in residential aged care.....	6	7.7.3 Specialist Interim Behavioural Facilities	19
5 Results	7	7.7.4 Intensive Care Behavioural Unit.....	19
5.1 Overview of the international literature.....	7	8 Discussion	20
5.1.1 Definitions.....	7	9 Conclusions.....	21
5.1.2 Key findings from the literature.....	7	10 Recommendations	22
5.2 Overview of consultations and focus groups	9	Appendix	
5.2.1 Key findings from the consultations and focus groups	9	Project advisory committee.....	23
6 What has been the response to severely and persistently challenging behaviours?	11	Glossary.....	24
6.1 Responses at a national level	11	References	25
6.2 Responses at a state level	11		

Foreword

Severe behavioural and psychological symptoms associated with dementia and/or mental illness are a considerable source of distress to those who manifest them and those who experience them. They are a common precipitant for nursing home admission, but can also be a barrier to accessing residential aged care services and can delay discharge from acute medical and psychiatric facilities. Such symptoms present real challenges for families and carers, primary health and community care services, residential aged care services and hospital services in providing care.

There is a pressing need for appropriate models of care and support for older people with severely and persistently challenging behaviours, particularly as the population ages and the pressure on services and communities increases. This is recognised in the *National Framework for Action on Dementia* released by the Australian Health Ministers in 2006.

To address this issue, the Centre for Mental Health, NSW Health commissioned this report to investigate accommodation and management options for older people with severely challenging behaviours, with a particular focus on developing long-term care models with the residential aged care sector. The Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists has produced the report, with advice from an expert advisory committee chaired by Professor John Snowdon. The chair and members of the advisory committee are thanked for their expert advice and commitment to this important project.

The report highlights the point that severely and persistently challenging behaviours have multiple causes that may be prolonged or ameliorated by a diverse and highly individual range of biological, psychological, social and environmental factors. It summarises the key features of successful models and interventions, based on best practice in the international literature and successful Australian service models. It proposes an integrated model of care for assessment, management and accommodation for these older people with complex needs, building on existing service infrastructures.

The model comprises integrated specialist Behavioural Assessment and Intervention Services (BASIS) and a number of other key service model elements. It is consistent with NSW Health and Australian Government policy and is endorsed in-principle, by NSW Health.

In response to this report, the NSW Government has committed funding to Specialist Mental Health Services for Older People (SMHSOP) to establish the BASIS model in Area Health Services, in partnership with specialist aged care services (Aged Care Assessment Teams and geriatric medical services). These services will provide specialist, multidisciplinary assessment for older people with severe and complex behavioural and psychological symptoms, and specialist consultation/liaison and case management services to identified clients in community settings, particularly residential aged care facilities. Funding has also been committed to a number of specialist transitional care facilities, as recommended in the report.

NSW Health is addressing other service model elements in this report in planning and service development under the *Service Plan for SMHSOP* and the *Framework for integrated support and management of older people in the NSW health care system* (NSW Health, 2004). Further service model development relating to specialist residential care service packages and specialist interim behavioural assessment and intervention facilities, in particular, will be pursued in consultation with the Australian Government Department of Health and Ageing.

The report is intended to inform mental health and aged care planning, service development and practice at the service level, as well as state and national policy and planning. Given that a range of agencies and service providers have a role in the care and support for older people with severely and persistently challenging behaviours, the successful implementation of the model will rely on strong collaboration and partnerships between all of these stakeholders.



Robyn Kruk
Director-General, NSW Health

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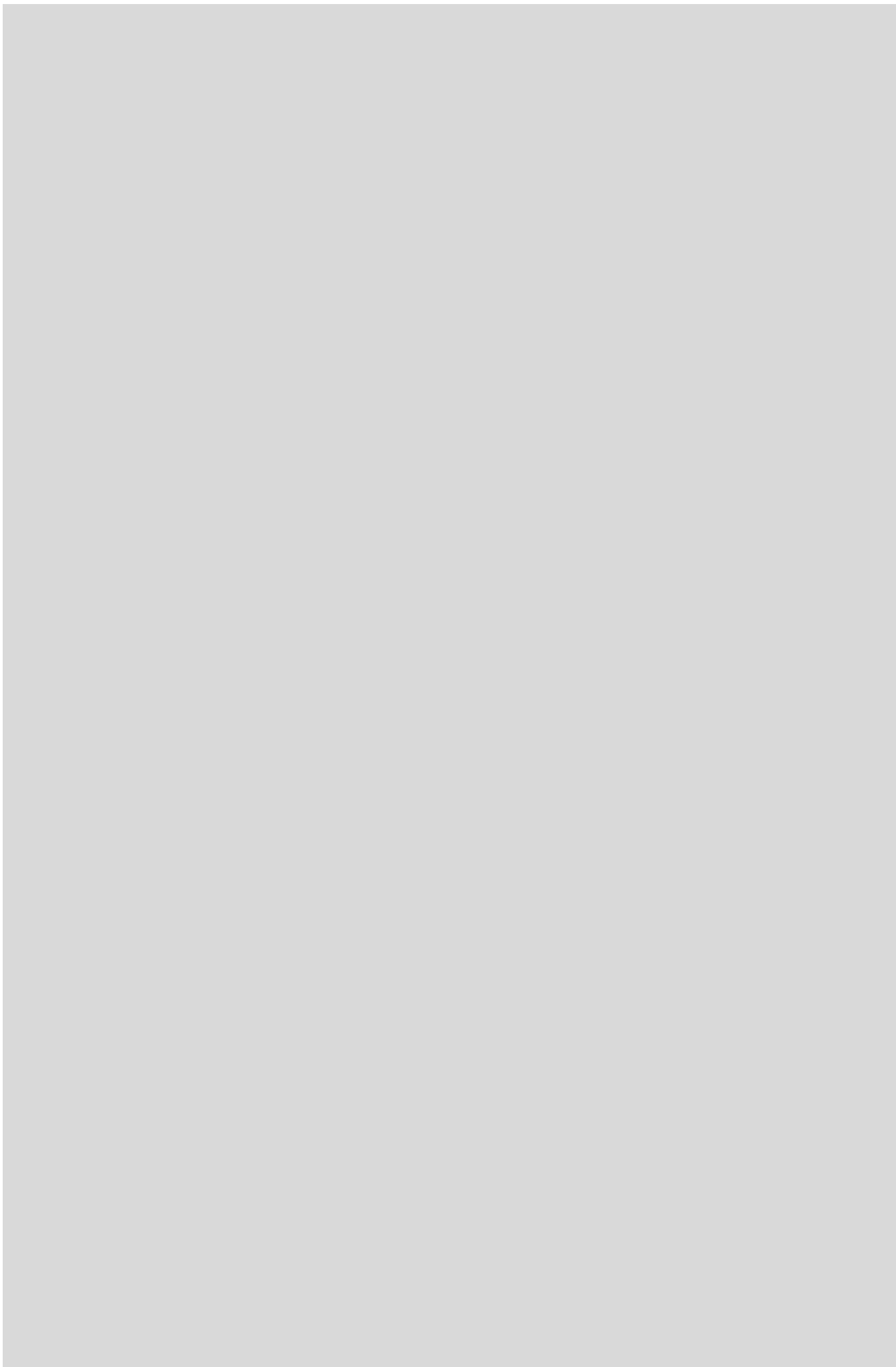
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Executive summary

1.1 Background

In 2002, the Centre for Mental Health, NSW Health, engaged the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists to investigate accommodation and management options for older people who manifest severely challenging or disturbed behaviours within residential aged care facilities in NSW.

The initial project brief involved trialling special care areas in nursing homes for older people with these types of behaviours. However, under the guidance of the Project Advisory Committee, the project expanded its focus to consider the broader implications of severely challenging behaviours in older people and responses in a range of community settings, particularly residential aged care facilities. The findings and recommendations of this project therefore provide a framework for policy, program and service responses across multiple agencies.

1.2 The issue of severely and persistently challenging behaviours in residential aged care

Severely and persistently challenging behaviours of older people in residential aged care and at the residential/acute care interface are of significant and increasing concern in NSW. Challenging behaviours are a significant source of distress to those who manifest the behaviours and those who experience them. They are a common precipitant for nursing home admission. Paradoxically, they have also been demonstrated to be a barrier to accessing residential aged care services and to delay discharge from acute medical and psychiatric facilities.

Severely and persistently challenging behaviours are often associated with dementia. People with dementia are affected by the disease in different ways, but frequently manifest non-cognitive symptoms and behaviours, or 'Behavioural and Psychological Symptoms of Dementia' (BPSD). The epidemiology of BPSD is complicated. However, Brodaty et al have estimated

that one third of people with dementia will experience moderate to severe behavioural and psychiatric symptoms. This group, which is estimated at 23,800 people in NSW based on current dementia prevalence rates, constitutes the broad target group for the model outlined in this report (Brodaty et al, 2003; Access Economics, 2005). However, the target group for the more intensive service model elements, such as specialist interim behavioural assessment and intervention facilities, is a smaller group of approximately 7,850 who experience severe behavioural and psychiatric symptoms.

Older people with long-standing mental health problems such as chronic schizophrenia can also present with severe behavioural or psychiatric symptoms associated with their existing mental illness and/or cognitive impairment, and they are part of the target group for the model described in this report.

Although the proportion of older people in NSW who manifest severely and persistently challenging behaviour is small, the impact they have on society is immense. There are repercussions in systems of care, workforce issues, and in legal, insurance and financial realms. There is a significant human toll for older people who manifest the behaviours, and for those who care for them.

The challenges of providing effective, coordinated assessment, intervention and accommodation for this group are increasing as the Australian population ages and the number of older people with dementia and/or mental illness grows. The number of older people (65 years and over) in NSW is projected to increase from 889,514 people in 2003 to 1,489,735 million by 2022, with dementia prevalence projected to increase from an estimated 71,400 in 2005 to 110,300 by 2020 (NSW Health, *Report of the Chief Health Officer, 2004*; NSW Health, *Framework for integrated support and management of older people in the NSW health care system 2004–2006*, 2004; NSW Health, unpublished DIPNR Projections, 2004; Access Economics, 2005).

1.3 Methodology

This project was overseen by an advisory committee comprising a range of key stakeholders and experts in the field (see Appendix). The basis of the project methodology was comprehensive and iterative consultations with recognised experts in the field of care, accommodation and management of older people with severely challenging behaviours. Other components of the methodology included a comprehensive review of international literature, site visits to relevant Australian services and focus group discussions in a variety of metropolitan and regional NSW Area Health Services.

1.4 Key findings

Key findings from the project were that challenging behaviours are very common in residential aged care in NSW and reported to be one of the most difficult issues facing residential aged care providers.

Severely and persistently challenging behaviours have multiple causes that may be prolonged or ameliorated by a diverse and highly individual range of biological, psychological, social and environmental factors.

Factors raised in the consultations that were seen as impacting on the ability of the aged care sector to provide high quality care include the following:

- Current resourcing of aged care is considered insufficient for the time and labour intensive nature of the management of severely challenging behaviour.
- There is regional variation in access to specialist geriatric, psychogeriatric and allied health support, as well as variation in the ability of primary health care services to effectively support older people with severely challenging behaviours.
- Older people with severely challenging behaviour present occupational health and safety issues for the residential aged care sector.
- Other industry-wide issues such as mixed cohorts of residents (including younger people with profound disabilities) and the use of agency staff are considered as contributing to poor care outcomes.

A number of Australian and international studies report successful outcomes of hospital, community and residential aged care based interventions with older people who are described as manifesting severely challenging behaviours. The common features of these successful interventions are that:

- Investigations and assessment are comprehensive, and include medical, psychiatric, social and environmental approaches.
- A highly integrated multidisciplinary approach is used.
- The intervention process is time and staff intensive.
- Management strategies are highly individualized for each client.
- The client's family and/or residential aged care staff are integral to the intervention process.
- Design of the physical environment has a major role in the care outcomes.

1.5 Proposed model of care

The outcome of the project was the development of an integrated model of care for older people with severely and persistently challenging behaviours in community settings to inform further policy, program and service development. An integrated specialist assessment model and a number of particular service model elements are proposed for development. These are as follows:

- 1 **Behavioural Assessment and Intervention Services (BASIS)** (building on the ACAT model). These services would provide joint assessment by specialists in mental health and aged care for older people with severe, persistent and complex behavioural symptoms, and consultation/liaison and case management services to identified clients, where appropriate.
- 2 **Special residential aged care service packages** (as per the Illawarra Dementia Support Team 'top-up' packages currently funded by the Australian Government under the Psychogeriatric Care Unit Program). These packages would provide intensive behavioural assessment and intervention 'in situ' (including 'specialling') for defined periods in community settings, particularly residential aged care facilities.
- 3 **Interim residential assessment and treatment facilities** (as per the Long Jetty Confused and Disturbed Elderly Unit currently operated and funded by NSW Health. Western Australia's High Dependency Unit (Southern Cross Care), Victoria's Psychogeriatric Nursing Homes and similar models in other states.) These facilities should have appropriate architectural and interior designs, and provide additional staffing and expertise to assess and manage severe behavioural challenges

and support the eventual transfer of the resident to mainstream care.

- 4 **Intensive care behavioural unit/s** (for an estimated 25–50 people with very severely challenging behaviour in NSW). The unit/s would provide intensive care for a very small number of extremely disturbed, aggressive and violent older people who cannot be safely managed in other inpatient or residential settings.

Further development of the consultation/liaison capacity of Specialist Mental Health Services for Older People (SMHSOP) will be fundamental to the effective implementation of the model.

The model seeks to increase the capacity of mental health and aged care services, including the residential aged care sector, to provide appropriate assessment and care for older people with challenging behaviours. It embraces the *Framework for integrated support and management of older people in the NSW Health system* (NSW Health, 2004) and has informed NSW Health's *Service Plan for Specialist Mental Health Services for Older People* (2006).

1.6 Recommendations

It should be noted that multiple agencies have a role in the management and accommodation of people with severely and persistently challenging behaviours and in the successful implementation of the model of care recommended in this report.

The report recommendations are as follows:

- 1 That NSW Health endorses, in-principle, the model of care described in this report and its service elements as part of a coordinated, integrated response to the care and support needs of older people with severely and persistently challenging behaviours across NSW.
- 2 That NSW Health seeks endorsement of the report by the Australian Government Department of Health and Ageing, and consequently convenes a broad reference group of key stakeholders to oversee the implementation of the model across NSW.
- 3 That NSW Health and the Australian Government Department of Health and Ageing work with key stakeholders to develop supporting strategies and address issues that are fundamental to successful implementation of the proposed model of care.

Summary report

2.1 Background

In 2002, The Centre for Mental Health, NSW Health, engaged the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists to investigate accommodation and management options for older people who manifest severely and persistently challenging or disturbed behaviours within residential aged care services in NSW.

The initial project brief involved trialling special care areas in nursing homes for older people with these types of behaviours. However, under the guidance of the Project Advisory Committee, the project expanded its focus to consider the broader implications of severely and persistently challenging behaviours in older people and responses in a range of non-acute care settings. The findings and recommendations of this project therefore provide a framework for policy, program and service responses across multiple agencies.

2.2 What is severely challenging behaviour?

'Challenging behaviour' refers to behaviour manifested by an older person that is considered dangerous, harmful, distressing or disturbing to self or others.

The origins of these behaviours are complex. They are frequently manifested in dementia, but also are related to a variety of other medical and psychiatric conditions.

The term 'challenging behaviour' is used interchangeably in the literature with a variety of descriptors such as behavioural disturbance, behaviours of concern and problem behaviours. Recently, the term 'Behavioural and Psychological Symptoms of Dementia' (BPSD) has been used to describe many non-cognitive symptoms of dementia. Behavioural symptoms include physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding, cursing and shadowing. Psychological symptoms occurring in dementia include anxiety, depression, delusions and hallucinations.

There are no objective criteria to determine when challenging behaviours become 'severely challenging', but it is suggested that, other than behaviours involving

physical violence or abuse, it is the impact on those who experience the behaviours (and on the environment in which the behaviour occurs) that creates the perception of behaviours being severe. For example, a resident who screeches loudly for several hours each night may be considered to have a severely and persistently challenging behaviour when accommodated in a multi-bed ward. The perception of severity may decrease if the same resident is located in a single, relatively sound proof room.

Impact of behaviour on others appears to be a common precipitant for intervention, although focussing on impact alone may result in certain symptoms being overlooked. Conditions such as depression and suicidality are frequently characterised by withdrawal and subsequent lack of impact on others, yet cause severe distress, sometimes over prolonged periods of time, for the individual older person.

2.3 Project aim, objective and outcome

The project aim was to seek opinions, investigate and form views on the appropriate accommodation and management of older people in NSW who manifest severely and persistently challenging behaviours.

The key objective was to develop recommendations to inform NSW Health's strategic directions and lead to improved management and care of older people who manifest severely and persistently challenging behaviours.

The outcome was the development of an integrated model of care for older people with severely and persistently challenging behaviours in non-acute settings. A number of particular service model elements are proposed for service development at the aged/acute care interface and in residential aged care. This model seeks to increase the capacity of mental health and aged care services, including the residential aged care sector, to provide appropriate assessment and care for older people with challenging behaviours. The proposed model embraces the *Framework for integrated support and management of older people in the NSW Health system* (NSW Health, 2004), and will inform the implementation of NSW Health's *Service Plan for Specialist Mental Health Services for Older People*.

SECTION 3

Methodology

The project was overseen by an advisory committee comprising a range of key stakeholders and experts, including clinicians, consumers, researchers, Area Health Services (AHSs), residential aged care providers, peak organisations and Australian and NSW government agencies with a key role in mental health and aged care (see Appendix).

The basis of the project methodology was comprehensive and iterative consultations with recognised experts in the field of care, accommodation and management of older people with severely challenging behaviours. Other components of the methodology included a comprehensive review of international literature, site visits to relevant Australian services and focus group discussions in a variety of metropolitan and regional NSW Area Health Services.

SECTION 4

The issue of severely and persistently challenging behaviours in residential aged care

Severely and persistently challenging behaviours of older people in residential aged care and at the residential/acute care interface are of significant and increasing concern in NSW.

Challenging behaviours are a significant source of distress to those who manifest the behaviours and those who experience them. In the community setting, challenging behaviours are a principal cause of carer stress, and present major challenges to primary health and community care services. They are a common precipitant for nursing home admission. Paradoxically, they have also been demonstrated to be a barrier to accessing residential aged care services and will delay discharge from acute medical and psychiatric facilities.

Challenging behaviours, in particular severely challenging behaviours, frequently have complex aetiology. The factors that ameliorate or prolong them are sometimes similarly complex. Despite greater understanding of the interactions of biological, psychological, social and environmental factors that influence behaviour, it remains very difficult for staff in residential aged and acute care to effectively address severely challenging behaviour. Frequently there are not the resources available to comprehensively address the issues.

Although the proportion of older people in NSW who manifest severely challenging behaviour is limited, the impact they have on society is immense. There are repercussions in systems of care, workforce issues, and in legal, insurance and financial realms. There is a significant human toll for older people who manifest the behaviours, and for those who care for them.

Results

5.1 Overview of the international literature

5.1.1 Definitions

Challenging behaviour has no generally agreed definition. Numerous terms are used in the medical literature to describe behaviour that is considered dangerous, distressing or disturbing to the person who manifests the behaviour, or to others.

Severity is a subjective construct that is mediated by numerous factors associated with the actual behaviour, the context in which the behaviour occurs and the perceptions of the behaviour by others in the environment.

For the purposes of this project, 'severely and persistently challenging behaviours' are conceptualized utilizing tiers four to seven of the hierarchical framework developed by Brodaty, Draper and Low (see p. 20). It should be noted that the model of care detailed in this report does not address the care of older people with acute mental and/or physical illness. This is the province of acute health services and is being addressed within other NSW Health policy, planning and service development initiatives.

5.1.2 Key findings from the literature

A comprehensive search from 1984–2003 revealed wide-ranging literature concerning behaviours of older people in residential aged care that are considered problematic. Despite the diversity, there is little that targets older people with very severely and persistently challenging behaviour. There was, however, considerable consistency in the findings of the literature concerning the ubiquity of challenging behaviours in older people in, or awaiting, residential aged care, and the conclusion that successful intervention requires integrated, comprehensive, individualized and intensive services. The comprehensive literature survey is available in the full project report.

Key findings from the literature can be summarised as follows:

- Challenging behaviours are very common in residential aged care facilities. One recent Australian report indicated that over 90 per cent of residents of a sample of eleven Sydney nursing homes manifested one or more challenging behaviour (Brodaty et al., 2001).
- Challenging behaviours may be manifested by any older person, but are most commonly associated with dementia.
- Challenging behaviours have multiple causes, and may be prolonged or ameliorated by a range of biological, psychological, social and environmental factors.

A study of 25 vocally disruptive Australian nursing home residents found for each resident an average of 5.7 possible causal factors for this challenging behaviour (Draper et al. 2000).

- Challenging behaviours can have negative consequences for the person who manifests the behaviours, those who experience them and for the health care system. They are reported to be:
 - A major precipitant for admission to residential aged care.

An American longitudinal study of 210 people with Alzheimer's Disease demonstrated that psychiatric symptoms were a greater risk factor for nursing home admission than cognitive or physical problems (Steele et al., 1990).

- A factor delaying discharge from acute facilities.

One UK prevalence survey demonstrated that almost a quarter of 1510 older people in London acute mental health assessment beds no longer required acute care and were awaiting discharge to residential aged care. These patients experienced difficulty in obtaining places due to complex needs and requirements for high levels of supervision (Koffman, et al., 1996).

- Associated with increased use of psychotropic medication and restraint.
- Associated with increased cost of care.

A US study of the population of Massachusetts Medicaid nursing home residents (n= 49,724) isolated behavioural problems as a 'distinct and measurable factor' that contributes to increased cost of care (O'Brien et al., 2000 p.56).

- Reducing quality of life for the person who manifests behaviours and others in their environment.
- A source of psychological distress and physical injury, and sometimes a factor contributing to a person's death.

A number of studies report successful outcomes of hospital and community based intervention with older people who are described as manifesting severely challenging behaviours. The common features of these successful interventions are that:

- Investigations and assessment are comprehensive, and include medical, psychiatric, social and environmental approaches.
- A highly integrated multidisciplinary approach is used.
- The intervention process is time and staff intensive.
- Management strategies are highly individualized for each client.

One US study described a Behavioural Intensive Care Unit that combines psychiatric, medical, and psychosocial interventions. This program is inclusive of family and professional caregivers in order to create highly individualized management strategies tailored to the patient's usual living environment. Of the initial cohort of 55 patients, who without treatment would have been admitted to residential aged care, over 80 per cent were discharged home and remained there at 6 month follow up (Mintzer et al., 1993, 1994).

Several studies highlight shortcomings in program and service models that do not use these features.

One Dutch study examined the effects of intensive activity therapy on three older people whose severely challenging behaviours were non-responsive to psychotropic medication. The authors concluded that an intensive, 'generalist' programme was insufficient to improve behaviour; and suggested that programmes need to be individualized to produce an effect (Sival et al., 1997).

A recent review of the literature of models of mental health services in nursing homes indicated that a traditional consultation – liaison service was the least effective of three identified models, and that routine presence of multidisciplinary, professional mental health staff in nursing homes was the favoured model (Bartels et al., 2002).

Most successful studies report that close liaison with family or nursing home staff is crucial for successful outcomes. These family or professional carers are involved in:

- The assessment process for background information.
- The design of interventions, to produce strategies that are realistic and able to be implemented.
- Accessing education and information to ensure continuation and compliance with the interventions.

Two Australian studies (Bird et al., 2002, Opie et al., 2002) demonstrated successful outcomes for nursing home residents with severe behavioural challenges through primarily psychosocial interventions, developed in conjunction with staff to produce strategies that were workable in the nursing home environment.

Specific therapeutic activity programming has demonstrated reductions in challenging behaviours and improvements in residents' quality of life.

Lantz and colleagues (1997) demonstrated that a weekly activity session utilising sensory stimulation and relaxation techniques produced significantly reduced agitation in residents with dementia. Sessions were also attended by general nursing home staff who were encouraged to incorporate these techniques into daily care routines.

'Dementia friendly' physical and social environments of aged care facilities have been demonstrated to positively impact on residents' behaviour, function and quality of life.

Education and training of care providers, both through didactic teaching and clinical supervision, have been reported to reduce both challenging behaviours and the impact of those behaviours on others.

The need for intervention with older people with very severe behavioural challenges to be comprehensive, multidisciplinary and intensive has been underscored in the literature by:

- The large number of clinical, social and environmental variables that have been investigated for association with behavioural challenges.
- The difficulties associated with the use of psychotropic medication for behavioural challenges.

One 12 month longitudinal UK study found that residents with BPSD were no more likely to have improved with neuroleptics than without (Ballard et al., 2001).

- The lack of evidence that single strategy approaches appear to be effective.

Lawlor (1996) described behavioural disturbance as "multi-dimensional and interactive" and said that "too much emphasis on the singular and the categorical will delay the development of comprehensive and effective treatments for behavioural disturbances" (p.261).

5.2 Overview of consultations and focus groups

Over 200 interested individuals representing the community, psychogeriatric and geriatric medical services, the residential aged care sector and government agencies were consulted for their views on the accommodation and management of older people with severely and persistently challenging behaviours during this project. Seven locations throughout NSW were selected based on different demographic and service characteristics for focus group discussions.

The thrust of the investigations was to examine the issues from the perspective of the residential aged care sector, as this formed the initial brief of the project. However, the multi-factorial nature of very severely challenging behaviour, and its consequences for wider systems of health and aged care extended the scope of the issues across multiple agencies and State and Australian Government sectors. Details are available in the full project report.

5.2.1 Key findings from the consultations and focus groups

Severely challenging behaviour was consistently reported as one of the most difficult issues facing residential aged care providers in NSW.

- Absolute numbers of older people with severely and persistently challenging behaviour are reported to be small, but the impact they can create is substantial.

- The use of sedation was suggested as a factor that may mask the actual incidence.

Major identified issues concerning the management of older people with severely and persistently challenging behaviours in residential aged care included the following:

- Managing severely challenging behaviour of older people is recognised by residential aged care providers as time and labour intensive. This type of care was consistently reported to be beyond the capacity of current funding, staffing and skill levels of residential aged care.
- The use of agency staff is perceived as poor clinical practice for the management of older people in residential aged care in general, but particularly for people with dementia and challenging behaviours. The use of agency staff is widespread and considered a product of industry wide workforce trends.
- Residential aged care providers perceived occupational health and safety risk issues associated with providing accommodation to potentially physically aggressive older people.
- Mixed cohorts of residents with widely varying needs were frequently perceived as a factor that compromised ability to deliver consistent high quality care to all residents. Residential aged care providers indicated that many of the most behaviourally disturbed residents in NSW aged care facilities are younger, very disabled adults. Some of the disturbed behaviour is considered to stem from, or be prolonged by, the inadequacies of the social environment in which they live.
- Isolated, culturally diverse or indigenous residents in residential aged care facilities are reported to be disadvantaged due to lack of staff knowledge or understanding of language and culturally appropriate behaviour. Culturally-based behavioural patterns are frequently interpreted as challenging by residential aged care staff.

Identified issues in the delivery of clinical services to patients in residential aged care facilities included:

- Current NSW medical and psychiatric services that provide assessment and intervention to residents were often considered under-staffed or unable to render timely assistance.
- In some regions of NSW, residents with severely challenging behaviours of complex aetiology were reported to be passed from service to service, with no agency willing or able to take a case management role.

- There were regional differences in availability of acute psychogeriatric (and psychiatric) inpatient facilities.
- The majority of General Practitioners were perceived not to have the specialized skills to manage older people with severely challenging behaviours.
- There were difficulties for residential aged care providers in accessing multidisciplinary staff for psychosocial intervention or advice.

Identified issues relating to the wider health, aged care and mental health systems included:

- Under Australian Government legislation, residents of aged care facilities may choose their own General Practitioner, whether accredited to the facility or not. While this supports resident preference, this practice was questioned in terms of organizational practicality, consistency of care, and promotion of a team approach. A variation in GP expertise in behavioural or psychiatric management and inadequate remuneration for the intensive work required in the investigation, treatment and case management of older people with severely challenging behaviours were also seen to be issues by residential aged care providers. It is acknowledged that some of these issues are currently being considered and addressed through the Australian Government's aged care initiatives under MedicarePlus.
- Strong relationships and arrangements between aged care providers and Area Health Services, particularly specialist geriatric and psychogeriatric services, were found to be a key factor in the willingness and capacity of residential aged care providers to accept potentially challenging residents.

Acute medical hospitals were perceived, in general, as unsuitable for older people with challenging behaviours, despite the recognition that medical illness underpins much behavioural disturbance. Inadequate acute facilities and staff experience for older people with behavioural challenges was recognised to be associated with poor outcomes.

- Acute adult psychiatric units were also reported to be unsuitable for older people with behavioural challenges, especially if the older person requires security. Acute psychiatric care staff expressed concerns regarding staff and patient safety in mixing older, sometimes frail people with younger, psychotic patients.

- Despite recognition of the shortcomings of the acute hospital environment, Emergency Departments were reported to be the 'intervention of desperation' by residential aged care service providers who did not have the capacity to cope with severe behavioural challenges, especially when staff felt threatened or when staff refused to work with aggressive residents.
- Similarly, Emergency Departments and the acute hospital system were considered to be 'sorting houses' for community clients with severely or persistently challenging behaviours who experienced difficulty securing access to appropriate long-term care arrangements including residential aged care services.

Current financing arrangements for residential aged care were not considered to be adequate to support care of older people with severely challenging behaviours.

Nursing shortages, particularly shortages of mental health nurses were reported to limit the capacity to care effectively for older people with severe behaviours.

Many of these issues are common across Australia and a number of these issues are addressed and confirmed in the report on the *Review of Pricing Arrangements in Residential Aged Care* commissioned by the Australian Government.

The full report on this project contains more detail concerning the findings from the focus group discussions.

What has been the response to severely and persistently challenging behaviours?

In NSW, intervention for people with dementia and mild-moderate behavioural disturbance is core business for a range of services including residential aged care providers, specialist geriatric and older people's mental health services, Aged Care Assessment Teams, primary health care services and community care services. A number of NSW Health and Australian Government programs and initiatives provide funding and support for dementia care, accommodation and support. However, the complex issues around assessment, management, support, accommodation and continuity of care for older people with severely and persistently challenging behaviours have promoted some targeted policy and program responses.

6.1 Responses at a national level

At a national level, the Australian Government has sought to address the care of older people with dementia, including people with more severe challenging behaviours through programs including:

- Commitment of \$52.2 million to dementia as a National Health Priority. This will strengthen the capacity of the health and aged care sectors in dealing with people with dementia.
- The announcement of 2,000 dementia specific EACH places to be allocated nationally through the aged care approvals round.
- The commitment to introduce new supplements to aged care subsidies to better target assistance to residents with higher care needs by supporting the provision of care to residents with dementia exhibiting challenging behaviours.
- Dementia training initiatives for residential aged care providers including the National Dementia Behaviour Advisory Service.
- An allocation of over \$6.4 million in 2004 for dementia research.
- NHMRC funding for projects commencing in 2005, includes over \$4.6 million over five years for dementia research.

- The Psycho-Geriatric Unit (PGU) Program, which has recently been reviewed with a view to informing an expansion of the program to provide national coverage.
- Ten dementia-specific pilots under the Aged Care Innovative Pool Program of the residential aged care program. The three pilots in NSW are:
 - Central Coast Short Term Intensive Community Care and Support (STICCS)
 - Greater Murray Dementia Behavioural Assessment Management Service (DBAMS) Pilot
 - Northern Rivers Mobile Dementia Rehabilitation at Home (DRAH) Pilot.
- Collaborative work with States and Territories, led by NSW Health, has led to the development of the *National Framework for Action on Dementia*. The Framework identifies the following five priority areas include:
 - Research
 - Information and Education
 - Access and Equity
 - Integration and Continuum of Care
 - Workforce Development and Training.

These programs and initiatives, along with other broader Australian Government initiatives, such as programs for carers, assessment, hospitals, workforce, palliative care and GP initiatives that directly benefit people with dementia and their families, offer some potential for policy and program responses to the recommendations of this report.

6.2 Responses at a state level

At the state level, a number of recent NSW Health policies and initiatives have begun to address the care of older people (with attention to the complex needs of older people with challenging behaviours) in different care settings. These include:

- The establishment of multidisciplinary Aged care Services Emergency Teams (ASETs) and Emergency Mental Health Nurses in Emergency Departments across NSW.

- The establishment of Dementia Care Clinical Nurse Consultants in a number of acute hospitals across NSW.
- The piloting of a NSW Ambulance Service telephone triage service for residential aged care providers, to prevent unnecessary admissions to Emergency Departments.
- The establishment of Clinical Coordinators for Specialist Mental Health Services for Older People (SMHSOP) at the Area Health Service (AHS) level.
- The development of a statewide *Service Plan for Specialist Mental Health Services for Older People* to guide service development in SMHSOP over the next five to ten years. Under this Plan, the NSW Government has provided \$63.8 million over five years from 2006/07 for SMHSOP community teams, BASIS staff and new community-based programs. This funding builds on \$3.95 million new funding provided for older people's mental health services in the community mental health funding package announced in the 2005 NSW Budget. Funding enhancements for older people's mental health under this package will total \$25.5 million over the next five years.

All AHSs provide multidisciplinary assessment through Aged Care Assessment Teams across NSW. Specialist aged care and mental health consultation/liaison services are provided in community and residential aged care settings in many areas, with some limitations due to workforce supply and other issues.

Confused and Disturbed Elderly (CADE) units for people with challenging behaviours are available in some AHSs. A number of innovative service models have recently been developed within CADE units, including the interim assessment and treatment facility model.

6.3 Joint state and national responses

A partnership between NSW Health and the Department of Health and Ageing has resulted in three Innovative Dementia Care Services (IDCS) pilots targeting people with dementia-related challenging behaviours; they are jointly funded under the Aged Care Innovative Pool Program.

- **Northern Rivers Mobile Dementia Rehabilitation Service** – a model providing short-term access to in-home, multidisciplinary, community-based, therapeutic interventions post-hospitalisation to improve the long-term functional capacity of people with dementia-related challenging behaviours through a mobile response team, working in partnership with GPs.
- **Greater Murray Dementia Care Pilot** – an intermediate care model involving a comprehensive assessment and management program for people with dementia or dementia-related challenging behaviours and a regional outreach education and support program to enhance the management skills of residential care facilities in dealing with challenging behaviours.

Terilbah Long Jetty CADE: Northern Sydney and Central Coast Area Health Service

Confused And Disturbed Elderly (CADE) units were developed in NSW in the 1980's to accommodate older people manifesting severely challenging behaviours in dementia, previously accommodated in state psychiatric facilities. Consisting of two, eight bed wings in a single storey facility, CADE Units were designed, staffed and operated on a strong philosophy of care (Fleming and Bowles, 1987) that espoused reducing excess disability imposed on the dementing person by the physical and social environments.

Operated by Area Health Services, all of the eight CADE units in NSW have developed regional differences in service provision. Terilbah, on the NSW Central Coast is seen as an integral part of aged care and aged care psychiatry services. Terilbah caters for ambulant older people living with dementia and severely challenging

behaviours, which cannot be managed in any other care environment. Terilbah is evolving into a medium-stay assessment and intervention unit.

Terilbah emphasises a low stimulus environment, increased staffing levels and aged care expertise. The focus of admission is the development of detailed care plans that identify triggers of behavioural problems, and provide effective pharmacological and behavioural strategies, suitable for use in mainstream facilities. Terilbah staff have additional roles in providing education and advice to support discharge of residents to ongoing care, primarily residential aged care facilities.

Day-to-day clinical management of residents is coordinated by a team consisting of Area geriatricians, psychogeriatrician and a nurse unit manager.

- **Central Coast Short Term Intensive Community Care (STICCS) model** – a model providing short-term access to in-home, multi-disciplinary, community-based, therapeutic intervention post-hospitalisation to enable people with dementia to return home.

The pilots have been evaluated by the Australian Institute of Health and Welfare and the final report is now available through the Institute’s website.

Some NSW residential aged care providers have developed innovative service models and particular strengths in the accommodation and management of people with challenging behaviours, often in partnership with health services.

6.4 Responses through specialist residential aged care models – the interim specialist behavioural facility

Both public and private facilities have been developed under a variety of funding models in a number of states and territories to cater for older people who manifest severely challenging behaviour and who are considered unsuitable for management in mainstream residential aged care or in the community, but who do not require acute medical or psychiatric care. These facilities provide interim care. Admission is based on comprehensive, multidisciplinary assessment, with the expectation that the psychiatric, behavioural and medical management offered will eventually enable the resident to be cared for by mainstream services.

Facilities in five states were reviewed using a semi-structured interview process. Details are provided in the full report. The sample of facilities included:

- Victorian Psychogeriatric Nursing Homes (Riverside House, Auburn House, Southstone Lodge, Mooraleigh Hostel, Yarraman and Allambie Residential Services).
- Queensland’s Extended Inpatient Psychogeriatric Services (Daintree Unit).
- Tasmania’s ADARDS Nursing Home.
- Western Australia’s High Dependency Unit (Southern Cross Care).
- New South Wales Confused and Disturbed Elderly (CADE) unit “Terilbah”.

Characteristics were identified that supported the management of older people with severely challenging behaviour. These included:

- **Specific design criteria** – apart from one retro-fitted unit (Queensland), all facilities utilized specific architectural design features to support resident function and care. Design features included buildings on a domestic scale, good visual access, provision for wandering and the reduction of unnecessary environmental stimulation.
- **A higher staff-to-resident ratio than mainstream facilities** – for example, in Tasmania and Western Australia staff configurations in special care units give an effective daytime ratio of one staff member per four residents, while Victoria’s Psychogeriatric nursing homes (PGNH) provide one staff member for approximately five residents.
- **Small numbers of residents in cluster developments** – the smallest clusters of eight residents were in NSW CADE units and WA’s High Dependency Unit, the largest cluster of ten residents were in Victoria’s PGNH.
- Staff with psychiatric expertise.
- Established links with specialist psychogeriatric services.
- Staff training targeted at needs arising from specific resident’s conditions.
- Highly individualized care strategies.
- Intensive, iterative assessment.

Capital funding for these facilities came from a variety of sources, including public subscription, cross-funding from commercial activities of not-for-profit residential aged care providers, and state and Australian government grants. Recurrent funding for facilities in three of the five states (Victoria, Queensland and Western Australia) is a combination of Australian Government residential aged care funding and varying amounts of state government mental health ‘top-up’ funding. Tasmania currently provides a specialist service with Australian Government residential aged care funding only; and the NSW CADE units are entirely state funded. Details are provided in the full project report.

These facilities provide the basis for the ‘specialist interim behavioural facility’ service model element of the proposed model of care for older people with severely and persistently challenging behaviours.

6.5 Responses through specialist outreach care

Two models of outreach services for older people with severely and persistently challenging behaviour in residential aged care were reviewed. Developed under the Australian Government's Psychogeriatric Unit Program, these services employ different service delivery methodologies.

South Australia's Behavioural Advisory Service (BAS) is primarily a telephone-based service that provides information, advice and structured assessments. The Illawarra Dementia Support Team (IDST) (NSW) provides a range of individualized and innovative interventions, including nurse 'specialling' in community, residential and acute care settings through access to a flexible care funding stream, in addition to training and behavioural management services. Both services report better management of older people with significant behavioural challenges by using intensive and comprehensive behavioural assessment and intervention.

Independent evaluations (commissioned by BAS), and external review of the IDST (commissioned by the Australian Government) as well as ongoing consumer advocate or client evaluative mechanisms report the following outcomes:

- Streamlined use of medical and psychiatric services.
- The provision of more comprehensive care plans to enable residents to remain 'in situ'.
- Enhanced safety of the resident and others during behavioural crises.
- Reduced referral rates to tertiary services.
- Flow-on effects which include improved assessment and intervention skills of staff in residential aged care facilities.

These models both confirm the need for targeted multidisciplinary assessment and strong specialist consultation/liaison services and demonstrate the value of intensive behavioural intervention programs or packages that can be deployed for defined periods in the mainstream residential aged care setting.

The Illawarra Dementia Support Team service model provides the basis for the 'specialist residential aged care package' service model element in the proposed model of care for older people with severely and persistently challenging behaviours.

6.6 Critical factors for better management

Some mainstream residential aged care services have reputations for coping with more severely challenging residents. Review of a selection of these facilities (eg Hammond Care; Marian Nursing Home, Parramatta; Brightwater Care, Perth) revealed a number of factors that appear to support this ability. These factors are congruent with findings in the literature and anecdotal evidence. They include:

- Commitment to exemplary dementia care at a philosophical and management level.
- Employment of staff with mental health experience.
- Consistency and ease of access to specialist psychogeriatric and geriatric expertise.
- Individualized client-centred care planning.
- Proactive use of activity therapy.
- 'Dementia friendly' environmental design.
- Understanding of good 'person-environment fit' for acceptance and placement of residents in the facility.

Factors identified that limit the capabilities of facilities to provide for residents with dementia included:

- Lack of consistency of staff, for example the extensive use of agency staff, or high staff turnover.
- Mixing frail or depressed elderly with ambulant dementing residents.
- Inability of psychogeriatric or other mental health services to offer more than a crisis service.
- Difficulty in obtaining appropriate levels of funding under the RCS for ambulant residents with challenging behaviours.

A proposed model of care for older people with severely and persistently challenging behaviour

This report offers an integrated approach to the assessment and management of people with severely and persistently challenging behaviours to inform further policy, program and service development. It outlines an integrated model of care for this target group in non-acute settings, with an integrated specialist assessment model and a number of particular service model elements proposed for service development at the aged/acute care interface and in residential aged care.

The integrated specialist assessment model builds on the existing ACAT model and infrastructure. The service model elements draw on successful initiatives in a number of states and territories across Australia, including a number of initiatives already in place in NSW. The model assumes that specialist aged care and mental health consultation/liaison services are available to the community and residential aged care sectors in all areas or will be further developed under other service development initiatives.

7.1 The conceptual basis

In 2003, Brodaty, Draper and Low presented a conceptual model of a seven-tiered hierarchy of behavioural and psychological symptoms of dementia (BPSD). This model categorises BPSD into seven 'tiers' according to symptom severity. As indicated below, as symptoms increase in severity, prevalence decreases. While this model does not specifically encompass older people with behavioural challenges relating to mental illness or other conditions, the general principles are applicable.

Each tier is associated with differing management modalities. Interventions are cumulative and increasingly intensive as symptom severity increases. Movement through the triangle is not necessarily stepwise.

- **Tier 1** comprises the general population without dementia. Intervention is aimed at prevention.
- **Tier 2** comprises the population of people with dementia with no BPSD. Intervention is aimed at the prevention of BPSD.
- **Tier 3** comprises dementia with mild BPSD. Examples include apathy, mild depression, or repetitive questioning. Management comprises psychosocial approaches: family carer training and behavioural management techniques. Intervention is provided by primary health care workers.
- **Tier 4** comprises moderate BPSD. Examples include verbal aggression, psychosis, or sexual disinhibition. The authors describe specially targeted intervention including specialist consultation, staff/carers education, individual behaviour programmes and referral to geriatric expertise, when indicated, for medical evaluation.
- **Tier 5** is described as dementia with severe BPSD. Examples include depression or aggression. The authors recommend a specialist case management model of intervention which includes specialist medical and psychiatric review, and tailored psychosocial intervention developed by a multidisciplinary team, including education of carers in the use of interventions.
- **Tier 6** the authors suggest that this tier comprises three distinct sub-groups:
 - People with delirium superimposed on dementia. These people require management in an acute medical ward by geriatrics and psychogeriatrics conjointly.
 - People with acute psychiatric conditions complicating their dementia, an example being suicidality. The authors suggest management in an acute psychogeriatric unit.
 - The third group comprises people with severe behavioural disturbance with dementia, for example dangerous physical aggression. It is suggested that this group is best managed in a specialist psychogeriatric residential facility, for the duration of their behaviours. This interim facility would have more intensive staffing in comparison to usual aged care residential arrangements. Staff would receive specific training.

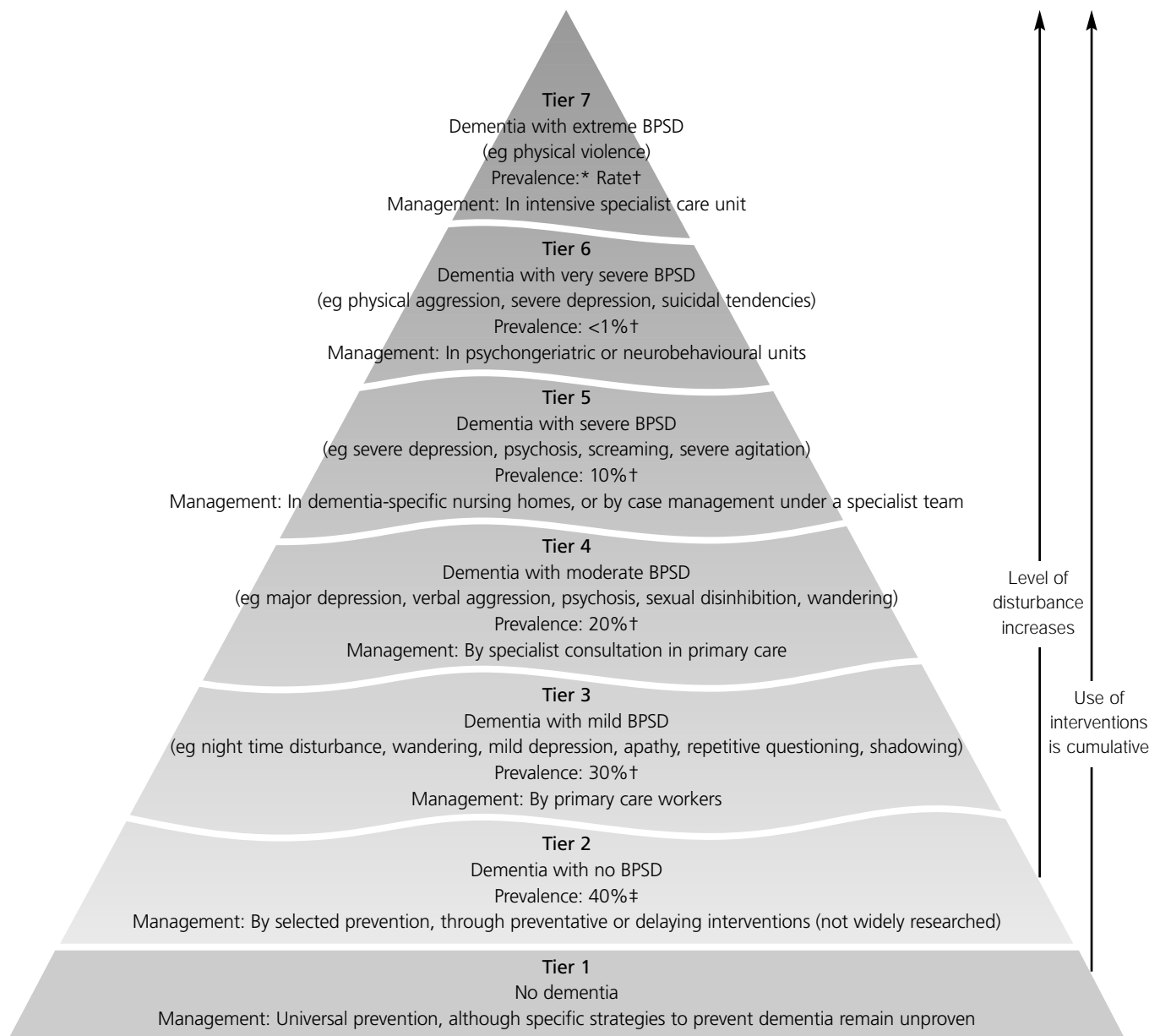
- **Tier 7** comprises a very small number of people with dementia who manifest violent behaviour. The authors suggest this would usually comprise younger, ambulant male clients with alcohol related brain damage or frontal type dementias. It is suggested that management would comprise a high security residential unit, with a high ratio of male staff to clients.

7.2 Scope

The proposed service model focuses on people who comprise levels four to seven of the Brodaty, Draper and Low seven-tier model. As previously noted it does not address, in detail, the care of older people with behaviours related to acute medical and/or psychiatric conditions.

As this model focuses on the top tiers of the seven-tier model, its effectiveness would be enhanced by complementary strategies targeting the lower tiers. Such strategies could reduce the demand for higher tier services.

Behavioural and psychological symptoms of dementia – a seven tiered model



* Prevalence is expressed as estimated percentage of people with dementia who currently fall into this category.

† Estimate based on clinical observations.

‡ Estimate based on Lyketsos et al²

Brodaty H et al. 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', MJA 2003; 178: 231-234. Copyright 2003. The Medical Journal of Australia – reproduced with permission.

7.3 Objectives

The principal objective is to achieve better clinical outcomes for older people in residential aged care who manifest severely and persistently challenging behaviours.

Further and associated objectives are to:

- Reduce distress for residents of NSW aged care facilities who share accommodation with older people who manifest severely and persistently challenging behaviours.
- Improve the working environment for those who provide care for older people who manifest severely and persistently challenging behaviours.
- Complement and enhance aged care and psychogeriatric teams in terms of integration of assessment and intervention.

From a broad service system perspective, the aim of the proposed model is to develop a comprehensive, integrated and coordinated tertiary system of specialist behavioural aged care for older people in NSW who manifest severely challenging behaviours.

7.4 Guiding principles

The following guiding principles of service development have been based on identified critical success factors from national and international literature, site visits and focus groups:

- Assessment and intervention needs to be highly individualized for each client.
- Assessment and intervention needs to be comprehensive (multidisciplinary).
- Assessment and intervention requires an integrated, bio-psycho-social-environmental approach.
- Carers (family and professional) and the social environment play a crucial role in determining outcomes.
- Care should be delivered in the least restrictive environment.
- Design of the physical environment has a major role in determining care outcomes.
- Care should be delivered in accordance with relevant legislative frameworks, including the *Aged Care Act (1997)* and *Mental Health Act (1990)*.
- The principle of 'mainstreaming' should be used.
- Service needs to promote effective and responsible use of public money.

7.5 Assumptions

Service development is based on the assumptions that:

- Severely challenging behaviour is frequently most effectively assessed in the environment in which it occurs (in the absence of a clear medical or psychiatric condition).
- Much severely challenging behaviour can be effectively treated in situ, with appropriate and timely expertise.
- Assessment and intervention in situ has potential flow-on effects of upskilling staff, (mainstreaming).
- Early assessment and intervention will prevent escalation of behaviours and reduce the need for more intensive (higher tier) intervention.
- A small percentage of older people will manifest severely challenging behaviour that fails to respond to enhanced mainstream treatment and intervention methodologies. A variety of specialist accommodation facilities is needed for this population.
- Older people with severely challenging behaviour will frequently have medical or psychiatric conditions that require specialist geriatric medical or psychogeriatric intervention.

7.6 Model of care

The service model elements (detailed below) provide the basis for the proposed model of care and for the future development of an integrated care pathway for the older person with severely challenging behaviour in NSW. The model is consistent with NSW Health's *Framework for integrated support and management of older people in the NSW health care system (2004–2006)*. It seeks to support targeted use of intensive, multidisciplinary assessment, and to offer appropriate levels of intervention and care by identifying the best care environment in which to deliver services.

The guiding principle of integrated assessment and intervention in the model underpins the necessity to identify the skills required to address behavioural challenges and the best environment in which to provide intervention. Following the principle of mainstreaming, consideration is given to whether the older person can be managed by primary health care services after each intervention, with service model elements providing a graded, supported transition between service elements, and mainstream care, thus targeting those most in need of intensive behavioural services.

7.7 Service model elements

The service model comprises four principle elements:

- 1 Behavioural Assessment and Intervention Services (BASIS).
- 2 Special residential aged care service packages.
- 3 Interim assessment and treatment facilities.
- 4 Intensive care behavioural unit.

These elements will build upon existing community supports, consultation and liaison services, case management and educational services.

7.7.1 Behavioural Assessment and Intervention Services (BASIS)

The development of Behavioural Assessment and Intervention Services (BASIS) is a key platform for the model of care. In their fully developed form, BASIS would offer integrated, comprehensive, multidisciplinary (psychogeriatric, medical, psychological, social and environmental) assessment, intervention and referral for complex cases with unclear aetiology, as per the guiding principles outlined on Page 16. The development of specialist mental health consultation and liaison supports for residential aged care, will be a function of Specialist Mental Health Services for Older People (SMHSOP) under governance of Mental Health, and will be addressed in the *NSW Service Plan for SMHSOP (2006)*.

It is proposed that BASIS functions of consultation and liaison, referral and case management should be provided by SMHSOP where available.

While the model develops, it may simply comprise enhanced psychogeriatric/SMHSOP and other input to ACAT assessment processes. BASIS would be developed in each area of NSW with reference to the existing structure and continuum of services, and existing service gaps.

The formal collaboration between SMHSOP and Aged Care Services in the development of consultation/ liaison and case management services to residential aged care services (as per the BASIS model) will require further policy and planning work by NSW Health.

Principal functions of BASIS

- To further the development of formal links between SMHSOP and aged care services (particularly ACATs).

- To provide integrated assessment and (where appropriate) intervention services for older people with severely and persistently challenging behaviours.
- To provide consultation, liaison and (where appropriate) case management services to identified clients in community and residential aged care settings.
- To provide timely intervention for older people with severely and persistently challenging behaviours.
- To perform gatekeeping functions (with ACAT) to specialist service model elements outlined below.

7.7.2 Specialist Residential Aged Care Behavioural Packages

Specialist residential aged care packages are proposed to provide time limited, top-up funding for specific assessed residents of aged care facilities. These residents will manifest behaviours that jeopardize their accommodation arrangements or threaten others in their environment. Packages will provide flexible, innovative care in situ, which is not currently available through tertiary consultative or other community services.

Examples of services would include:

- Specific additional assessments.
- Development of specific behavioural management protocols, and associated staff training, trialling and evaluation.
- Monitoring of specific medication trials (that otherwise would need to be done in an acute setting).
- Short-term nurse 'specialling'.
- Small environmental modifications.

Evidence based examples of this type of intervention include a controlled study of 33 older people with challenging behaviours in Northern Sydney. Bird et al. (2002) demonstrated a successful, intensive psychosocial outreach program that treated residents with very difficult behaviours in their usual accommodation. Comparison with controls receiving primarily pharmacologic treatment showed the psychosocial intervention group had fewer GP visits, medication changes and hospitalizations. Psychosocial intervention was intensive over the short term, but less time consuming than 'traditional' intervention over the long term.

A regular, 6-weekly visiting psychiatric clinic to nursing homes in Scotland demonstrated a drop in crisis requests and hospital admissions, improved understanding of challenging behaviours by nursing home staff and better communication with residents' GPs (Jackson and Lyons, 1996).

Both The Illawarra Dementia Support Team (NSW) and Southern Health Region Services (Victoria) provide examples of successful projects that use brokerage money to develop creative strategies to manage challenging behaviours and prevent the breakdown of accommodation arrangements.

7.7.3 Specialist Interim Behavioural Facilities

These facilities will provide interim residential accommodation for older people who are considered unsuitable for care in mainstream facilities, and who do not require acute medical or psychiatric care. These facilities will provide additional resources and expertise to assess and manage severe behavioural challenges, and to support the eventual transfer of the resident to mainstream care.

Key elements of this service include:

- Increased level of staffing consistent with current Australian benchmarks.
- A multidisciplinary approach.
- Enhanced staff psychiatric knowledge and skills in behavioural management.
- Access to specialist psychogeriatric and geriatric medical support and advice and clear clinical governance arrangements regarding personal, medical and specialist care needs of clients.
- Prosthetic architectural and interior design.

A study of one of Victoria's psychogeriatric nursing homes determined that the home was fulfilling its role of caring for the most behaviourally disturbed older people living with dementia. This study compared three groups of matched subjects from a psychogeriatric nursing home, people with dementia discharged from an acute psychogeriatric ward to mainstream nursing homes, and ambulant people with dementia living in nursing home wards of a geriatric centre (Martin et al., 1994).

Length of stay in interim facilities is a contentious issue and is influenced by factors relating to the resident's presenting problems, their responses to intervention and external variables such as availability of suitable

mainstream residential aged care places and the availability and quality of services to support the older person and the 'receiving' mainstream residential facility. None of the specialist facilities reviewed specify a length of stay. However, the Central Coast, NSW CADE unit 'Terilbah' is moving toward a 60–90 day assessment and intervention period before supported discharge, while other facilities, such as the Southern Cross Care High Dependency Unit predicts length of stay may be 9–12 months due to accepting frailer residents with more pervasive psychiatric symptoms.

Concern about the ability to re-integrate residents to mainstream care from interim behavioural specialist nursing homes has been raised. Issues included the ability to find mainstream accommodation able to provide the required levels of care for these residents and stereotyping of residents from interim facilities.

Factors identified crucial to effective re-integration were:

- Clear understanding by all stakeholders of the aims of the specialist unit and the interim conditions under which admission is made.
- Effective leadership and support to assist residents, their family and staff through transition.
- The ability to offer effective and timely outreach services to support the discharge and settling in of the resident in 'receiving facilities'.
- The ability to re-admit residents to specialist residential aged care, if the placement 'fails'.

7.7.4 Intensive Care Behavioural Unit

This model proposes the establishment of an intensive care behavioural residential unit. This unit would cater for the most disturbed and aggressive older people in NSW.

Brodsky et al. (2003) suggest that this unit would primarily cater for men under 70 who "are very strong and have been so violent they have harmed other residents or staff" (p.233–234). Current clinician estimates are that 25–50 people at any one time in NSW require such care. No such facility exists in NSW and this type of care has been identified as a service gap in other states.

Most of these people will have frontal lobe pathology, some due to head injury, some related to alcohol abuse and some to other causes.

It is proposed that this level of care would provide specialist accommodation for the length of time it is required.

SECTION 8

Discussion

This model has been developed on the basis of information gained from consultations, focus groups and site visits around Australia as well as findings from international and Australian literature. It follows the principles of the World Health Organization's Technical Consensus Statement of 'Organization of Care in Psychiatry of the Elderly' (WHO 1997), by providing opportunity for care in the least restrictive environment; and contributing to a comprehensive spectrum of community care and supported accommodation services.

The model builds from current processes of tertiary consultation within residential aged care. The model assumes that primary clinical services have investigated potential causes of disturbed behaviour and trialled strategies before referral is made.

The nature of intervention within the model is envisaged to be an active, on-going therapeutic model that stresses a balance between medical, psychiatric and social intervention.

There are limitations in the model. The model has sought to address severely and persistently challenging behaviours of the older person in residential aged care. The model does not address the need for crisis respite care. However, there may be opportunities to expand the model to provide such service. The model also does not address the issues residential aged care providers face in providing care for groups in society whose chronic conditions or lifestyle choices are considered unacceptable in many mainstream residential aged care facilities, such as older homeless people. The model also does not address the considerable issues concerning younger people with disability and behavioural disturbance accommodated in residential aged care.

Conclusions

The care of older people with severely and persistently challenging behaviours in NSW residential aged care facilities is currently inadequately addressed. Limitations in psychogeriatric services and appropriate facilities for this target group underpin this situation.

Providers of residential and community care have identified people with severely and persistently challenging behaviours as one of the most difficult groups to care for. Not only has the behaviour per se been difficult to manage, the impact of the behaviour on other residents and staff is significant.

Studies of the prevalence and incidence of severely challenging behaviour are limited and based in part on clinical observation. The tendency of behaviour to fluctuate and be responsive to environmental conditions creates difficulty in estimating the extent of the problem. Similarly, the use of sedation may mask actual need across the state.

Clinical responsibility for older people with severely disturbed behaviour has been identified as usually beyond the remit of the General Practitioner alone. Staffing levels, expertise and facilities within residential aged care were not designed to assess and manage the complex and multi-factorial nature of very challenging behaviours of older people. Additional expenses incurred in caring for this group and lack of recognition of their needs under the current funding arrangements make this population a financial liability for residential aged care organizations, and an unattractive proposition to admit to residential aged care.

Lack of residential or long term care arrangements and services for other groups of people who manifest severely challenging behaviours (eg developmentally disabled or brain injured people) have placed residential aged care into a position of 'service provider of default' to a proportion of the very disabled, dependent and behaviourally disturbed adult population.

Controlled studies in inpatient, community and residential settings have demonstrated effective reduction in severely and persistently challenging behaviours of older people and their associate sequelae. These successful studies are characterised by comprehensive, intensive and highly individualized assessment and treatment. They have demonstrated the ability to maintain older people with severely and persistently challenging behaviours in their existing accommodation and in some cases relocate older people to less intensive (and less expensive) forms of residential aged care.

A number of models of care for this population have been identified. Each model emphasises a balance of psychiatric, medical and social care that is intensive, comprehensive and multi-disciplinary.

A comprehensive model of care for older people with severely and persistently challenging behaviours is proposed for NSW. This model is designed to enhance the current capacity of residential aged care providers to manage challenging behaviours, and to bridge the gap between acute care and residential or community care for this vulnerable and needy group of people.

Recommendations

It should be noted that multiple agencies have a role in the management and accommodation of people with severely and persistently challenging behaviours and the successful implementation of the model of care recommended in this report.

Principal recommendations:

- 1 That NSW Health endorses, in-principle, the model of care described in this report and its service elements as part of a co-ordinated, integrated response to the care and support needs of older people with severely and persistently challenging behaviours across NSW.
- 2 That NSW Health seeks endorsement of the report by the Australian Government Department of Health and Ageing and consequently convenes a broad reference group of key stakeholders to oversee the implementation of the model across NSW.
- 3 That NSW Health and the Australian Government Department of Health and Ageing work with key stakeholders to develop supporting strategies and address issues that are fundamental to successful implementation of the proposed model of care.

Supporting strategies that are fundamental to enacting the model of care are:

- That clear criteria are developed for entry to and discharge from each stage of the model.
- That NSW Health continues to develop the capacity of old age psychiatry (psychogeriatric) services across NSW.
- That NSW Health and the Australian Government Department of Health and Ageing continue to develop strategies to enhance the capacity of primary care services, particularly GPs, to support and engage in the model.
- That the Australian Government supports the residential aged care sector to engage in this model by continuing to actively support psycho-social and environmental approaches to the management of older people with challenging behaviours.

APPENDIX

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Glossary

ACAT	Aged Care Assessment Teams
AHS	Area Health Services
ASETS	Aged care Services Emergency Teams
BAS	Behavioural Assessment Service
BASIS	Behavioural Assessment and Intervention Services
BPSD	Behavioural and Psychological Symptoms of Dementia
CADE	Confused and Disturbed Elderly
DBAMS	Dementia Behavioural Assessment Management Service
EACH	Extended aged care at home
FPOA	Faculty of Psychiatry of Old Age
IDCS	Innovative Dementia Care Services
IDST	Illawarra Dementia Support Team
NHMRC	National Health and Medical Research Council
PGNH	Psychogeriatric Nursing Home
PGU	Psychogeriatric Care Unit
SMHSOP	Specialist Mental Health Services for Older People
STICCS	Short Term Intensive Community Care and Support

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