
Victoria's Mental Health Service

The Framework for Service Delivery

Aged Persons Services

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Foreword

I am pleased to provide you with *Victoria's Mental Health Services: The Framework for Service Delivery—Aged Persons Services*. This publication is a companion document to *Victoria's Mental Health Service: The Framework for Service Delivery—Better Outcomes Through Area Mental Health Services*, which provides the overall frame of reference guiding reform of mental health services in this state.

The framework for Aged Persons Mental Health Services (APMHS) is the product of close collaboration between the Psychiatric Services and Aged Care Divisions of H&CS and extensive consultation with a range of service providers.

The aim of the aged persons mental health strategy is to strengthen services for aged persons with a mental illness and to make the service system more responsive to their complex needs.

This document outlines a 'seamless' model of service delivery based on a well-developed relationship with the general aged care system and the successful development of community-based services. Traditional approaches to the treatment and care of this vulnerable client group will be replaced by community-based care and case plans based upon individual client need.

H&CS will continue to foster Aged Persons Mental Health Services as an area of clinical expertise and practice excellence. This framework will provide planners and practitioners with a solid foundation for the further development of a high-quality, customer-focused service system and provide the basis for H&CS purchasing decisions.



Jennifer Williams
Director, Psychiatric Services

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Introduction

This document, *Victoria's Mental Health Service: The Framework for Service Delivery—Aged Persons Services* is a companion document to *Victoria's Mental Health Service: The Framework for Service Delivery*, which was published in April 1994 and which remains the frame of reference informing mental health reform in this State.

The Framework for Aged Persons Mental Health Services builds on the April 1994 Framework's overall directions for redevelopment and relies upon the earlier document for its description of key parameters such as resourcing arrangements and the nature of statewide services.

The April 1994 Framework outlined the organisation of mental health services into three client groups within each region: children and adolescents, adults and aged persons (see figure 1). This aged persons policy document complements the April 1994 Framework by describing in more detail the nature of aged persons mental health services (APMHS).

Key principles underlying the redevelopment are:

- Mental health services will be responsive to the needs of the clients.
- Choices for treatment and care are available.
- Services are delivered in a timely manner and in the least restrictive environment.
- The rights of the clients of mental health services are respected, protected and promoted.
- The providers of services are accountable.
- Services do not stigmatise patients.
- The best possible standards of care are used.
- Value for money is achieved.

These principles are in accordance with the National Mental Health Policy and Plan, which has established broad nationwide directions for service reform in mental health services.

The strategy will also reflect the significant changes in Commonwealth and State policies for mainstream aged care services which have occurred since 1985. Some initiatives/policy statements which either target specifically the needs of aged people with a mental illness or which are likely to affect significantly the policy development for this client group include¹:

- *Putting the Pieces Together: A National Action Plan for Dementia Care* (NAPDC).
- A national study aimed at identifying residential care needs for people with dementia and challenging behaviours has been commissioned as part of the NAPDC.
- *Everyone's Future. Directions for Aged Care Services in the 1990s*.
- Nationwide reviews of aged care assessment.
- *Living in a Nursing Home. Outcome Standards for Australian Nursing Homes*.
- *1991 Commonwealth/State Disability Agreement* and standards.
- Australian Health Ministers' Statement on Rights and Responsibilities.

The contention that APMHS is a specialist service within the broader network of aged care services raises issues in relation to both expertise and program integration. The central issue throughout this document is therefore the nature and extent of APMHS linkages with service providers. Addressing these issues involves identifying the range of client needs, clarifying the respective target populations of each service component or provider and describing the parameters underlying collaborative practice and operational integration.

The more sophisticated development of outcome measures, performance indicators and service standards will enable a reducing focus on inputs in regard to requirements for Victoria's mental health service. Until

¹ Details of these publications can be found in the bibliography.

such developments have occurred, however, the premature move to unsophisticated outcome measures would and has resulted in the erosion of specialist expertise and commitment of effort. It should be noted that this issue is not unique to mental health services in Victoria, but is reflected in both national and international practices.

The Framework for Aged Persons Mental Health Services presents a detailed and coherent picture of the APMHS service system and provides, through the objectives and strategies identified, a sound basis for strategic planning, regional service development and the creation of an integrated network of aged mental health and general aged care services.

The development of the draft document has occurred in close liaison with service providers (both general aged care and psychiatric services), H&CS regional staff and the Aged Care Division. Membership of the Reference Group is shown in attachment 1.

The Basis for Aged Persons Mental Health Service Provision

APMHS primarily assist persons over 65 years of age who suffer from a severe mental illness.

The emphasis of the *Mental Health Act 1986* and of the policy framework developed to inform subsequent reforms is upon providing the best possible care in the least restrictive environment and accordingly determines how people with a severe mental illness, who are among the most vulnerable in our society, should be assisted.

Major reform initiatives have included the mainstreaming policy and the development of community-based services.

The primary aim of the mainstreaming process is to reduce the relative isolation of mental health services

and thereby lessen the stigma which applies to those services and the people using them. With regard to APMHS services this will result in the management and collocation with aged care services.

Aged persons often present with a range of complex needs. APMHS will therefore develop and sustain a collaborative working relationship with aged care, adult psychiatric services and other service providers in order to build a comprehensive and responsive service system where continuity of care is achieved through a consistent case management approach.

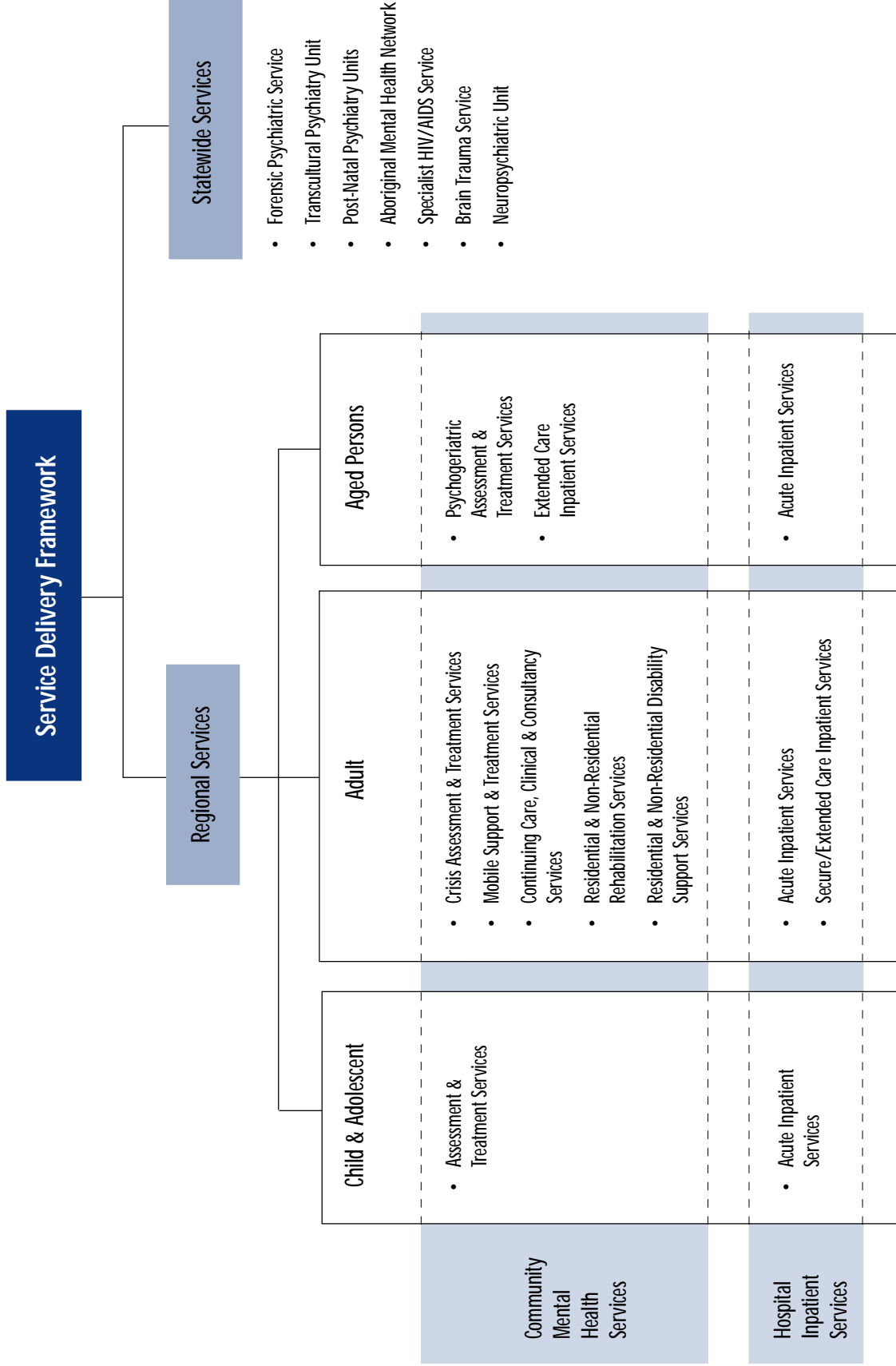
The aim of mainstreamed APMHS is the support and treatment of clients with a mental illness by trained expert staff in a community-based system. Services for aged persons with a mental illness include prevention and community support, consultation and community education, assessment, treatment, rehabilitation, inpatient and residential services. Clinical expertise in the delivery of mental health services is of vital importance at the individual level and, more broadly, as a quality assurance tool informing the various components of APMHS.

Two Imperatives: Expertise and Integration

Geriatric psychiatry is a sub-specialty of psychiatry which focuses on the needs of older persons with a mental illness. Its core knowledge, skills and practices are based upon general psychiatry, with psychiatrists and clinicians whose specialist clinical expertise involves assessment, treatment, rehabilitation and support for elderly people with a mental illness.

The management of disorders such as depression, manic-depressive illness, paranoid disorders, schizophrenia and personality disorders is closely related to the treatments provided for younger clients. However, treatment may also vary due to a range of factors,

Mental Health Service Framework



(Source: Victoria's Mental Health Services—
The Framework for Service Delivery, 1994, p. 13)

including elderly clients' different response to medication, their physical disabilities and the social aspects of aging. The elderly person's health and welfare needs are often complex and expertise in assessment is crucial for early diagnosis and treatment, with minimal intervention. Some clients have chronic or recurring episodes of mental illness and require lifelong care and case management. Other clients have developed a mental illness in later life. Functional and organic mental disorders may coexist, which requires a thorough evaluation of onset, sequencing of symptoms, course of illness and treatment response. Many elderly clients make an excellent recovery from functional mental disorders.

Mental disorders are identified initially in behavioural and/or clinical terms. For this reason mental health practitioners are expert in the recognition and management of problem behaviours. Psychiatric expertise provides appropriate therapies for the reduction of secondary behavioral disabilities for clients with dementia. This assists the sufferer and relieves carer stress. APMHS provides an expert system of follow-up, with a commitment to the provision of continuing help, optimal use of community resources and education of general practitioners (GPs) and other service providers.

Mental health practice has moved away from the notion of treatment and care being provided in segregated institutions to an emphasis on community-based service delivery. Institutionalised care encouraged patients to learn and behave in a context divorced from the community environment. The shift to a service model focused on community-based service provision with inpatient care as a last resort is beneficial for elderly people. However, the clinical aspects of care still require expert intervention and treatment. The positive concepts of community care and least intrusive intervention need to be differentiated from erosion of expertise and neglect of elderly persons who are mentally ill.

The importance of competent, expert case managers, who operate within a mental health framework and collaborate with other service providers to provide holistic care cannot be overstated. This is the fundamental platform upon which both National and State mental health policy are based.

Although it is a complex, demanding and specialist field, geriatric psychiatry has long occupied a peripheral position within the broader field of psychiatric services as resources, staffing and research have been directed overwhelmingly at services for adult clients.

Given the client population, there is also a strong requirement to establish linkages with aged care services. Unfortunately, as psychiatric clients have been managed for decades in an institutional setting, many service providers, including those in aged care, have not developed the expertise to assess and treat the mental health needs of clients.

Given the expected population growth and the attendant expected increase in the numbers of clients likely to present with a severe mental illness, it is apparent that a planned comprehensive health care system is required. The older person may have a range of problems and accordingly the service system must be able to accept a model of care which enables maximum flexibility for the clients and their families and provide a seamless model for elderly client care. That is, the service delivery system will be seamless to the individual client.

APMHS will therefore operate within the context of the general aged care system. In the long term full integration of services may become a possibility. To date, attempts at service amalgamation have been problematic—generally because of program drift away from the most vulnerable client group, namely elderly persons with a severe mental disorder and concomitant behavioural difficulties. An interim goal therefore will be to

establish operational integration. This will improve client outcomes through better coordination and maintain at the same time the integrity of the mental health service. Collaborative working relationships will be developed to complement the elements in each service system in assessing and/or treating the client. Clear identification of the two service systems is required but in practice will be flexible in order to facilitate service delivery and meet the needs of clients.

Thus, while this document attempts to define the respective client populations of aged care and APMHS, it does so within a frame of reference informed by cooperation and with a firm intent to avoid the individualistic, territorial stance which in the past has led to instances of dysfunctional service provision. It is noted, however, that the erosion of the program's foundation in clinical psychiatric expertise would affect adversely the service available to an extremely vulnerable group of people. This is not an area in which H&CS is prepared to compromise.

A comprehensive and integrated health care system will be characterised by the presence of a range of services which can be called upon flexibly to meet the needs of the various subgroups of the client population at the various stages of intervention. The interface between the service components—across the aged care and psychiatric services program boundaries—will be characterised by operational integration. Operational integration means that service components work in unison at service delivery level and retain sufficient integrity at management level to maintain and foster their clinical expertise and to avoid program drift. The expertise of APMHS will be maintained through recognisable management structures, data collection, outcome measures and budgetary integrity and control.

These conditions are clearly set out in key policy documents issued by H&CS, including the *Guidelines for Submitting Expressions of Interest To Manage a*

Component of Victoria's Mental Health Service and are restated in health service agreements which providers are required to sign. The expressions of interest (EOI) process requires that prospective providers signal compliance with these conditions in order to qualify for being contracted to provide a component of Victoria's mental health service.

The integrated aged care/aged mental health service system will be strengthened by collaborative practice including clear role statements, standards of care and adequate and equitable resource allocation supporting an integrated network of services. APMHS will facilitate referrals from GPs or other service providers so as to ensure early diagnosis and treatment, followed by effective follow-up, support and treatment. APMHS will work closely with health service providers, local government programs and residential care service providers to ensure that clients and their carers receive appropriate services within the context of a strong case management framework as articulated in the policy statement *Victoria's Mental Health Services: Improved Access through Coordinated Client Care*.

The Policy Context

Expert Community-Based Treatment

Psychiatric Services has commenced a five-year period of reform to strengthen services for persons with a severe mental illness. The underlying thrust is to make services optimally responsive to client needs in accordance with the Mental Health Act and within the principles contained in the April 1994 Framework for Service Delivery.

This reform will ensure that APMHS clients are supported and treated by expert staff in a community-based and community-orientated system, reflecting the legislative agenda to provide the best possible care within the least restrictive environment.

Working Together for Our Clients

A major focus of this document is the interface between aged care and APMHS. The Framework for Service Delivery: Aged Persons Services clarifies target populations of APMHSs and establishes criteria for determining whether the primary responsibility for the care and treatment of a client—in particular elderly people with dementia—rests with specialist psychiatric services or generic aged care services.

Many aged persons with mental disorders can be assisted adequately through generic health, aged residential and community care services. The thrust of the strategic plan will therefore be to develop or strengthen a range of services for aged people with severe and/or complex mental disorders whose needs exceed the clinical or practical capacities of other practitioners and agencies.

At the same time, APMHS will strengthen or develop collaborative working relationships with general adult mental health services and other service providers and examine options for preventive and support services.

Making It Work

Standards and protocols will be developed to harness learning, to describe best practice and to make explicit H&CS expectations of service providers. These standards will be monitored and enforced through health service agreements within the overall context of the expressions of interest (EOI) process conducted by Psychiatric Services in 1994. Furthermore, the APMHS strategic plan will include a comprehensive quality assurance program comprising training, data collection, monitoring and review, research and evaluation.

Regional staff will play a key role in implementing the vision underlying this The Framework for Service Delivery: Aged Persons Services document. They will analyse and continue to monitor the existing mix of

services in their region to ensure that APMHS clients have access to a broad range of appropriate services, ranging from expert assessment, in-home treatment and appropriate rehabilitation and support programs to access, where required, to acute inpatient and community-based extended care services.

The Clients and Their Needs

Demographic Trends

Australian people are living longer. Life expectancy for both men and women continues to rise. At the same time the birth rate is almost static. This means that the proportion of people over 60 years of age will increase steadily during this decade and will accelerate noticeably in the next decade.

The number of people over 70 years of age in Australia will increase by 55 per cent between 1991 and 2011. The growth in the number of people over 80 years of age will be even greater—it is the fastest growing population group in the community. The significant effects of the postwar ‘baby boom’ cohort attaining old age will not be felt until around the year 2020.

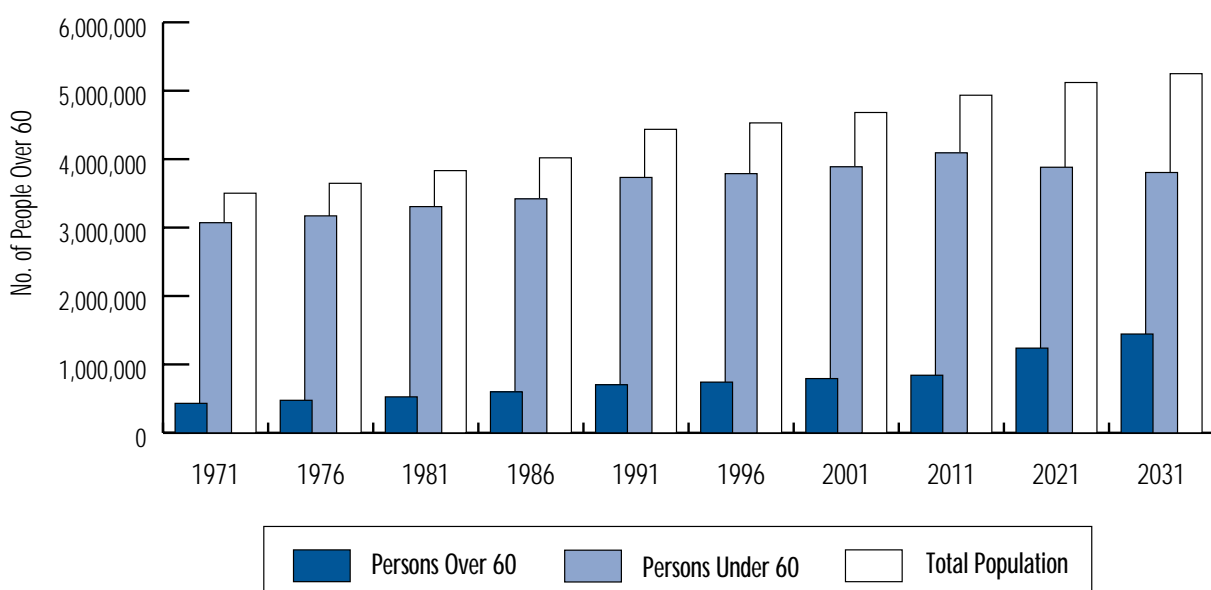
In Victoria, older people represent a growing proportion of the population as a result of the combined impact of increased longevity and the higher proportion of the population over 60 years of age (figures 2 and 3).

The combined effects of these key demographic changes can be observed at all levels of the aged care services system.

Most older people are in good health and are self-sufficient. Nevertheless, as a group, they are also the largest consumers of health services. The overall effect of a longer living population will be to increase demand for both health and community services.

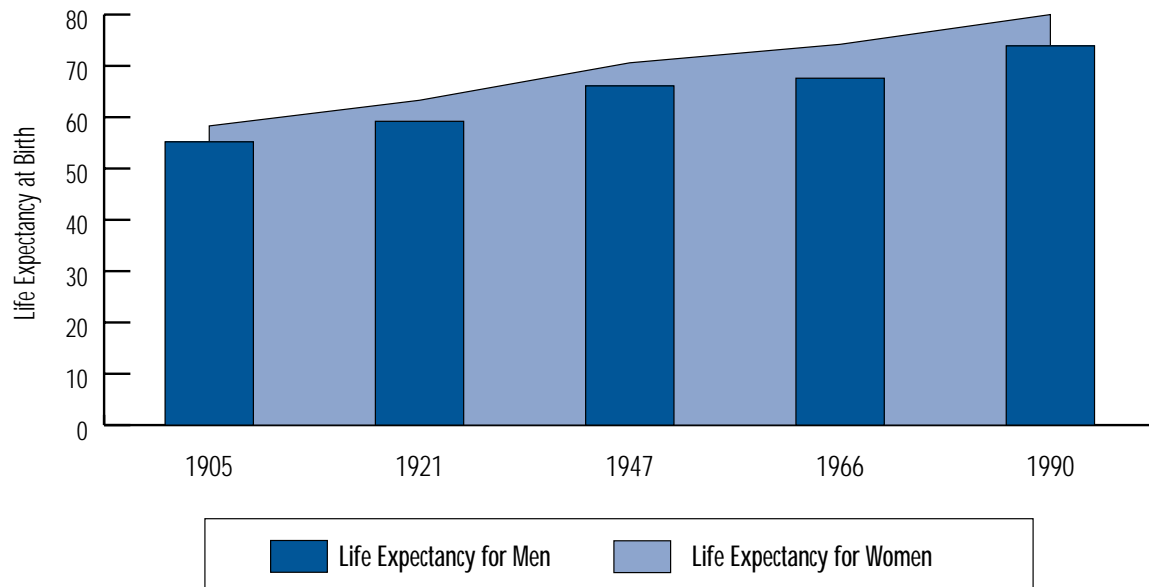
Increased longevity is also changing the nature of service needs. Longevity brings both increasing levels of late life disability and chronic illness (including functional and organic mental disorders) and greater likelihood of isolated living situations, less access to family and primary carers and the probability of multiple disabilities. The number of older people living alone, particularly older women, has increased rapidly in the last two decades of the century.

Figure 2: Victoria's Population 1971 to 2031



Source: ABS Census 1981, 1986—Projection for Populations

Figure 3: Rising Life Expectancy Since 1905



Source: ABS—Report 3302.0

It is expected that over the next 20 years there will be:

- An increase in the number of people with dementia, including Alzheimer's Disease.
- An increase in the number of people with pre-existing psychiatric disorders who survive into old age.
- An increase in the number of people who develop a functional mental disorder, especially depression, later in life.
- An increased prevalence of physical disorders and disabilities which give rise to social and psychological problems.

Defining 'Aged'

APMHS are available to persons aged 65 years and over. This is not a homogeneous group. The Aged Care Division within H&CS provides broad distinction between the following sub-groups, each with their own specific service provision needs.

The 'Young Old'

People over 65 years of age and usually under 75 years. This group largely contains active, healthy people who are mentally alert and function independently. Where illness occurs, it is often in the form of an acute condition and the person is generally able to return home following treatment.

The 'Older Old'

Usually persons over 75 years who have more acute illnesses. People in this group are likely to develop functional, social and economic dependencies resulting from chronic illness and disability.

The 'Very Old'

Usually people over 85 years. This group is more likely to suffer chronic illness, progressive disability, poorer recovery rates and physical frailty.

Service provision to people who are mentally ill becomes more complex as the effects of the ageing process become more prominent and clinical approaches differ according to the cause of the condition (see 'Functional and Organic Mental Disorders' section). The use of age as a guideline acknowledges that people over the age of 65 years with a mental illness often have coexisting physical problems which need attention from aged care services. This is particularly pertinent to the very old.

Functional and Organic Mental Disorders

APMHS provide services primarily to people aged 65 years and over. The client group includes:

- People who have had a mental illness for many years and who may now also experience complicating issues relating to growing older. These may be in the form of physical frailty, psychological stress and/or significant changes in their social circumstances.
- People who develop what is called a functional mental illness in later life and who may require treatment and care for the first time. The most prevalent disorders that develop in this group are depression, paranoid psychosis and heightened anxiety states. It is estimated that 20 per cent of people over 65 years report significant numbers of depressive symptoms; between 3 and 4 per cent have a major depressive disorder, and less than 1 per cent have a paranoid psychotic illness.
- People with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia. Organic disorders are characterised by physiological changes in the brain with the person experiencing a deterioration in their intellect, judgement and memory, and significant personality changes.

The most prevalent organic disorder in the elderly is dementia, with Alzheimer's disease and vascular (formerly multi-infarct) dementia being the most common types. Dementia can also be triggered by a

range of other causes, including strokes, brain tumours, alcohol abuse, vitamin B-12 deficiency and some infections (including AIDS). Severe dementia affects 4 to 5 per cent of the population over 65 years. A relatively small number of people develop dementia before the age of 65. Between 65 and 75 years the proportion increases up to 6 per cent and over 75 years there is a very marked increase in the incidence of a person developing dementia.

Dementia is characterised by global deterioration of intellectual functions in clear consciousness. This deterioration in intellectual functioning will affect skills and processes for dealing with the environment, including perception, memory and reasoning, and will result in a reduced capacity to cope with activities of daily living as well as in a range of new behaviours.

These different groups have different needs and require different approaches and treatments.

Functional and organic mental disorders in elderly patients often entail significant behavioural change. These behaviours require accurate assessment and diagnosis in order for treatment regimes to be effective.

Whatever the underlying diagnosis, admission of an elderly client to a residential aged persons mental health service is likely to be decided on the basis of a full diagnostic profile, in which treatment needs and behavioural problems are likely to be the determining factor. Behavioural problems are more clearly articulated and detailed in the section entitled 'The APMHS Client Population'.

Multiple, Complex Needs

Clients who come to the attention of APMHS generally present with a range of complex needs. They may need attention because of their mental illness and at the same time be frail and suffering from physical ailments. They may also have urgent problems in quite

disparate areas such as income, meals, transport or home maintenance.

A systematic and comprehensive assessment will be undertaken which addresses the presenting problems of the client, both medical and psychological; the cultural and social issues for the client such as family supports, social networks, community supports and financial and environmental circumstances; life history including preferred coping mechanisms, work history and personal hobbies and interests.

The Context for Aged Persons Mental Health Services

Metropolitan Hospitals Planning Board

The provision of health care in Victoria is currently undergoing major change. *Developing Melbourne's Hospital Network*, the report of the Metropolitan Hospitals Planning Board, proposed a new model of delivery of health care services, including mental health, acute health and aged care services. The vision for redevelopment is based on the creation of provider networks which incorporate aged, psychiatric, palliative, rehabilitation and home-based services. Seven networks have since been developed, of which five are based on geography, and two on specialist expertise.

The Board's vision of networks of care links a range of health services through common governance structures. These networks provide the means to establish a seamless system where patients can be treated locally with the benefits of home-based care, ambulatory care and increasing levels of intervention should that be required, often within the one network. The networks will also enable the more equitable distribution of health services, provide the basis for the rational development of services, reduce duplication and assist in the longer term capital planning of health services.

The report acknowledges that services for the elderly, including mental health services and general aged care services, have special characteristics which warrant particular consideration. These include the ongoing nature of many conditions, the longer length of hospital stay compared to acute patients and a greater requirement for post-discharge and ongoing care in the community.

Generic Aged Care Services

The aged care service system comprises a wide range of activities undertaken by government, the voluntary or charitable sector and commercial organisations. Core activities in this system include:

- Health.
- Residential care.

- Home and community care.
- Housing.

Other service activities include concessions, transport, education, recreation and public safety.

The service components described below are an important component of services provided to elderly clients with a severe mental illness. A more comprehensive listing of these services can be found in attachment 6.

Aged Care Inpatient Services

Extended care services are an extensive regional resource in aged care and have a key role in the development of an effective network of extended health care services. In many areas they provide the operational base for the local aged care assessment team (ACAT).

As from July 1994, aged care inpatient services in extended care centres were funded on a per day basis according to the service type (streams of care). The streams of care (see attachment 5) are categories which define levels of care for the purposes of the Department's purchasing framework and require extended care centres to define their activities in relation to it.

Aged Care Assessment Teams (ACATs)

The Aged Care Assessment Program is a joint Commonwealth/State venture introduced in 1984 as part of a broader strategy to address the perceived imbalance between the provision of residential and community services.

Currently there are 18 ACATs in Victoria. These ACATs provide assessment, linkage and brokerage services to people over 70 years of age. They provide a gatekeeping role for Commonwealth-funded nursing homes and hostels and ensure smooth transfer for the client between different types of care and service as

well as effective links between services. The role of ACATs is described in detail in the draft *Commonwealth Guidelines for Assessment Services* (1994). The draft guidelines are expected to be finalised in the wake of the 1995 review of the Victorian program.

ACATs typically include a geriatrician, a community nurse, a social worker and other health care professionals. The teams conduct approximately 40,000 assessments each year.

The average age of ACAT clients is 80 years, thus directing services to the most frail and vulnerable group in the older population.

Nursing Homes

General aged care nursing homes provide accommodation to people who require nursing supervision and care. They receive a nursing home benefit under an Act of the Commonwealth which is determined by the nursing dependency level of the resident according to the resident classification index (RCI). The Commonwealth funding formula for nursing homes is commonly referred to as 'CAM/SAM'². The rating is tied to funding levels and comprises a variable CAM funding as well as fixed amounts under the SAM and OCRE categories.

Hostels

General aged care hostels provide help with daily tasks for clients who cannot live at home but who do not require full-time nursing care. Accommodation is usually a single room, which residents can furnish with

their own belongings. Staff help with personal care, such as bathing, dressing and eating. Hostels are required to have staff on call 24 hours a day to help when needed. General hostels are funded and regulated by the Commonwealth Government.

Supported Residential Services

Supported residential services (SRSs) provide accommodation and personal care for profit. They are not required to have specially trained staff but may arrange for additional specialist services such as nursing care to be provided to residents. This may be financed by the SRS or the resident. SRSs are regulated by H&CS, which has the responsibility for registering SRSs and monitoring standards.

Home and Community Care (HACC)

Home and Community Care (HACC) is a joint Commonwealth/State funded program also involving local government funding. HACC services include home care, meals, nursing, personal care, home maintenance, transport, friendly visiting and day programs.

HACC services are an essential component in the overall strategy for reform of Victoria's aged care system. HACC services are being expanded and diversified, including:

- The development of more innovative services which address the loneliness and isolation of older people living at home alone.
- Additional home care, home nursing and allied health services in areas which are currently underresourced.
- Additional services to support carers, including a broader range of day activity services, particularly for people from non-English speaking backgrounds.
- Expansion of the Linkages Programs (see below).

Linkages Programs

Linkages programs are funded by the HACC Program and allow case managers to purchase flexible packages

² CAM is short for 'care aggregated module', which provides an allowance for the personal care requirements of residents including the cost of salaries and therapy. SAM stands for 'standard aggregated module' and provides a standard grant for non-nursing and non-personal care costs. SAM items include food, heating, landscaping, capital works as well as salaries of non personal care staff such as cooks and cleaners. The formula also has a third component, which relates to 'other cost reimbursements' (OCRE).

of services for people with complex care needs. Linkages services are provided across all H&CS regions.

Community Aged Care Packages

A community aged care package (CACP) is a planned and coordinated package of community care services aimed at assisting people with complex care needs. They are targeted specifically at frail elderly people living in their own homes (including rented accommodation) who are eligible for hostel care but who have a preference and capacity to remain at home.

The packages enable the ACATs to offer clients a further care option as an alternative to residential care.

CACP providers receive an undifferentiated daily subsidy (around \$23) per recipient which is equivalent to the 'personal care (low)' hostel subsidy.

The CACPs are Commonwealth-funded and were initially targeted at areas without HACC-funded Linkages places. They are also targeted at areas where residential facilities are difficult to establish or sustain, such as rural and remote localities.

Health Services

The graded definition in the previous chapter of what constitutes 'ageing' makes clear that levels of dependence cannot be predicted at the individual level. However, as a group, people over 65 are the largest users of health services. They account, for example, for approximately 45 per cent of hospital spending. Many APMHS clients will have general health needs in addition to their need for mental health services. Some of the major service providers catering for APMHS clients are described below.

General Practitioners

GPs, by the nature of their role in the community, are of great significance to APMHS. GPs are usually the

first point of contact for people with psychiatric illness or other mental health problems. They will often go on to provide the mental health care for such people and may strongly influence other services that an individual may go on to use. They are an important source of support and information for families and other carers of persons who experience mental illness.

The various components of this role are described in detail in *Sharing the Care: General Practitioners and Public Mental Health Services*. GPs offer many advantages as service providers, including:

- Accessibility.
- Continuity of care.
- Comprehensive health care.
- Mainstream service.

In addition, they may provide culturally sensitive practice, particularly when they have bilingual skills or close links with ethnic communities.

Sharing the Care promotes an interactive approach to service delivery. This has implications for the overall relationship between GPs and mental health services. Effective communication strategies along with joint service provision, consultation and transfer of care can all be important components of this relationship.

With the shift to mainstreaming, GPs are also increasingly involved in the care and treatment of APMHS residents in psychogeriatric nursing homes (PGNHs) and hostels.

With the increase in the aged population and frequency of organic mental disorders, GPs are treating more clients in the community with varying degrees of fragility and behavioural disturbance.

Community Health Centres

Community health centres are multidisciplinary, community-based primary care agencies. They aim to

improve the health of individuals and communities through the development and provision of locally accountable, high quality human services that are readily accessible. They provide comprehensive primary health care and illness prevention, health promotion and community development programs. The overall direction of each community health centre is determined by a committee of management comprising people living in the community. H&CS regional offices are responsible for service planning and development.

Attendance at community health centres by older people varies significantly, depending on the mix of services offered and the location of the centre. Like other primary care services, community health centres can be of benefit to APMHS clients by providing appropriate support to maximise clients' capacity for self-management and thereby their chances for continued residence in the community. This may be, for example, as part of their early intervention work or following episodes of acute care.

Public and Private Hospitals

The work of the Metropolitan Hospitals Planning Board has been described earlier. The key to realising the board's vision is the creation of networks. The Board defines a network as 'a collection of health care providers under common governance, possessing a wide range of health care facilities and attuned to meeting an individual patient's needs with the appropriate medical response'. Private hospitals will be a component of the provider system underpinning these networks.

Palliative Care Services

Palliative care assists clients with an incurable illness and limited life expectancy. It is a style or philosophy of care which aims to enhance the quality of life and meet the multi-faceted needs of the patient and family wherever the care is being provided. It embraces the notion of continuity of care by ensuring that the

delivery of services is underpinned by effective communication and that collaboration occurs between the different professional groups involved. This client-focused approach is compatible with the ethos of APMHS. Patients are admitted to a mental health service on the basis of their primary need. If the primary need of a terminally ill patient is for psychiatric service, this patient will be admitted. In other instances, the psychiatric service may be able to support the palliative care service.

Interface with Adult Mental Health Services

APMH services need to develop cooperative arrangements with adult mental health services to assist with the client's transition through the mental health services network where this is necessary. Effective inter-program linkages will assist in the development of appropriate and more effective treatment options for service users. Both service systems will at times need to complement each other in assessing and/or treating the client.

The need to foster and maintain psychiatric expertise has been discussed earlier in this document and the sections on 'Key Service Links' for each service component describe in detail the nature and extent of the interface.

This section therefore focuses on planning a client's transition from Adult Mental Health Services to APMHS.

Transition to APMHS

People who have had a mental illness for many years are likely to have been assisted by general AMHS. For these clients, the transition to APMHS will need to be managed sensibly. APMHS will become involved in an appropriate and timely manner around the time that the person turns 65. It is not expected that the person will move to a different service on their birthday, but equally plans must be made for the transition around

that time. This important transition should not be left to the last minute or until the person deteriorates or when they next need hospitalisation as these are the times that the person least needs a change in their environment. Professional clinical assessment and case planning will recognise that the client and their case manager may have had a long relationship but that it is in the client's best interest to make the change when they are best able to be an active participant in planning for and managing that change.

Interface of Aged Care and APMHS

The H&CS Aged Care Program policy was formalised in *Everyone's Future* and released in July 1993. The Psychiatric Services Program is described in Victoria's Mental Health Service: The Framework for Service Delivery. Both policy statements represent significant advances in the coherence and specification of State Government commitment to the aged and mentally ill.

The interface of the two programs is complex because of the potential for rapid change in the mental status of older people, and because of the historical structure of the service systems.

The Commonwealth Government's aged care programs, the Commonwealth-State Disability Agreement and H&CS Disability Services add a further layer of complexity. Psychogeriatric services involve two levels of government, and multiple program interfaces at both levels of government.

Interface and collaboration between the two service systems will be informed at all levels by the mainstreaming of mental health services and the development of metropolitan hospital networks.

The presence of mental illness of itself does not necessitate a referral to mental health services. The principle of mainstreaming implies that general aged care services will continue to assist elderly clients with a

mental illness until such time when the client's behaviour or illness will be more effectively managed by a specialist mental health service.

For example, the treatment of hip fractures in elderly people must take into account that a significant number of patients will be suffering from mental illness, and this may complicate the prognosis for resuming an independent lifestyle. Indeed, admission to acute hospital care for any reason may cause more disruption to the lifestyle of elderly persons with a mental illness than for other people of the same age, and may be the trigger for a move into residential care. Therefore mental illness as a complicating co-morbidity has important implications for the operation of all aged persons health services. These implications must not be sidestepped by assuming—incorrectly—that the management of mental illness is a specialised function within the aged care system and that sufferers are an easily identifiable group.

The implication for APMHS is that entry into the service system must not be exclusively on the basis of age, nor exclusively on the basis of a diagnosis, but on the basis of a full diagnostic profile. Many clients who enter APMHS do so, not because of a diagnosis of dementia or mental illness, but because their level of behavioural disturbance cannot be managed effectively by general aged care service providers consistent with the principle of least intrusive treatment.

The issue of the respective target populations of aged care and APMHS is discussed further in the next section.

Developing a Collaborative Practice

Collaborative practice between the general aged care system and APMHS is essential given the shared client population and the rapid move towards a mainstreamed geriatric system. The expected population growth with the attendant increase in the numbers

of people likely to develop mental disorders which require behavioural management skills, appropriate programs, psychotropic medications and mental health support for caregivers provide further incentive.

Collaborative practice will include the development of protocols and standards of care and a mechanism to ensure appropriate levels of resource allocation.

Regional psychiatric service managers will develop clearly articulated plans for APMHS which include a detailed description of links with generic aged care or acute health service providers, with community organisations and other stakeholders.

The Aged Persons Mental Health Service System

An Historical Perspective

APMHS were predominantly inpatient services for people with long-standing mental illness and associated disabilities. Of the 910 aged mental health beds available in 1991, two-fifths were concentrated at Beechworth, Bundoora Repatriation and Lakeside Hospitals. Many patients had been resident at these hospitals for a number of years, in some cases, decades.

The redevelopment of Victoria's mental health services has altered the mix of services. Resources are being distributed more equitably across regions and services have become more community-focused, with residential services being developed in the community and Psychogeriatric Assessment and Treatment Services (PGATS) being established as points of initial contact.

Of the 719 beds available for aged persons with a mental illness in 1993–94, 47 per cent were located in a community setting. Under the Commonwealth-funded Building Better Cities Program, a further 207 beds have been identified for collocation with an aged care service by 1996. This will increase the percentage of collocated services to 76 per cent.

Major Reforms

Mental health services are entering the third year of a five-year period of reform with significant improvements being made in the area of APMHS. These include:

- The majority of specialist residential services for aged persons with a mental illness has been mainstreamed.
- Establishment of new PGNHs and hostels. As at October 1995, there were nine PGNHs and three psychogeriatric hostels, with a combined capacity of 335 beds. Extended care services will continue to be strengthened and expanded through the ongoing redevelopment of institution-based inpatient services.

- Generic briefs for the design and construction of PGNHs and acute psychogeriatric units have been developed. These briefs provide an innovative blueprint for the care of seriously mentally ill elderly people and will continue to be used in development work across Victoria to ensure the quality of the environment meets the necessary design standards.
- Capital redevelopment will continue to replace existing inappropriate wards in large institutions such as North East Metropolitan Psychiatric Services (NEMPS) as well as provide a further increase in bed numbers. More specifically, the NEMPS redevelopment will allow the establishment of four PGNHs and four acute psychogeriatric admission and assessment units. Under the Building Better Cities program, PGNHs with a total capacity of 120 beds will become operational within three years. A 32 bed psychogeriatric hostel in Jacana was opened in March 1995. Fifty-five admission and assessment beds are being developed in 1995–96.
- There are 17 PGATS in Victoria, covering all regions. These PGATS, with their focus on prevention and early intervention, play a key role in the assessment of clients and in supporting them in the community as long as possible, as well as in educating consumers and carers.

The Legal Mandate

The Mental Health Act requires that persons who are mentally ill need to receive the best possible care and treatment in the least restrictive environment with hospitalisation or placement in a residential service as a last resort.

PGNHs are regulated by Commonwealth guidelines set out in *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes* which were developed for generic nursing homes.

Mix of Services

APMHS support and treat clients in the community for as long as possible. Many elderly clients can be assisted at home if adequate support can be arranged. Many clients have become frail and may have an acute medical problem, an ongoing physical disability and/or a need for social or practical support to cope with isolation or with home maintenance problems.

Effective case management ensures that clients receive appropriate services in a coordinated way. For example, in addition to the treatment for a client's depression, the case manager may arrange visits from the Royal District Nursing Service to monitor the client's medical condition as well as visits of HACC workers to provide personal care and meals.

PGATS act as an intake service to the aged psychiatry service system. PGATS are community-focused and provide assessment, treatment, rehabilitation and case management for older people with a mental illness, thereby preventing unnecessary treatment in a residential mental health service or minimising unnecessary stays in such services. A key role for PGATS is the primary and secondary interventions provided to older persons in order to minimise the need for a change in residential setting. This is discussed later.

Respite care can be arranged on a planned or emergency basis to give carers a break from the demanding and frequently exhausting task of looking after an elderly person (often a spouse or parent) with a mental illness. Respite care, day programs for elderly persons with a mental illness and support groups for carers can play a key role in supporting carers.

Sometimes elderly clients can no longer live at home, even with the best support. Their mental illness may lead to disturbed and pathological thoughts and behaviours (ranging from wandering to aggression or suicidal intent) which create an unacceptable risk to

their own safety or to that of their carers. If they are in a general nursing home, their behaviour may intrude upon other residents to an unreasonable extent or jeopardise the safety of residents and staff.

In these cases, specialised residential services are available. These include acute inpatient services, which provide assessment and treatment for older people with acute psychiatric symptoms who cannot safely or most effectively be cared for or supported within the community by the PGATS or generic aged care services. The assessment function enables the accurate diagnosis of the older person when their presentation is more complex or when their symptoms are creating acute distress or jeopardising their safety. In addition, acute inpatient services may provide respite care. The typical length of stay in an acute facility is around four weeks, after which clients may return to their home, hostel or nursing home—depending on their treatment and support needs.

Some people may need further specialist supervision and treatment in extended care services. Psychiatric extended care for the elderly used to be provided in large wards with minimal privacy. Despite the best efforts and the dedication and professionalism of staff, these old facilities could not provide a good environment for care. They are being phased out and replaced by new extended care facilities in the form of PGNHs or hostels.

PGNHs are nursing homes which are placed in the community and which specialise in caring for elderly persons with a mental illness. They provide medium to long-term residential care for those clients whose behaviour cannot be effectively managed in a less intrusive/restrictive manner in the general aged care system due to their level of persistent cognitive, emotional or behavioural disturbance. Their aim includes to stabilise the person's behaviour and to provide rehabilitation so that the person can return to generic residential care services or to provide the necessary

treatment until the person would be more appropriately cared for in a less restrictive setting.

Psychogeriatric hostels provide accommodation and help with daily tasks for elderly persons with a mental illness who can no longer live at home but who do not require full nursing care. They provide support and help clients to live comfortably and securely in a community which respects their independence, dignity and individuality.

Some older people with a mental illness, particularly dementia, may not need a specialised facility like those described above. They may be able to be cared for in a generic hostel or nursing home with specialist support from mental health services.

The components of the service system mentioned above are described in more detail in the following sections.

The APMHS Client Population

APMHS provide service to:

- people who are 65 years or older; and
- who have or appear to have a severe mental illness; and/or
- whose behaviour cannot be managed in the community or by other aged care service providers in a less intrusive manner.

These criteria are aimed at ensuring that the least intrusive form of intervention is always considered first. This means that general aged care services will be considered before a specialist mental health service and that, once mental health services are involved, community-based services are considered before a referral to more restrictive residential services.

Challenging and difficult behaviours cannot be defined in absolute terms. In general, such behaviours would be characterised by persistent cognitive, emotional or behavioural disturbance. Behaviours become

unmanageable when the safety or well-being of the client or other residents or staff can no longer be assured within the environment. The 'well-being' of the client and other residents includes the pursuit of objectives identified in their individual case plans.

Examples of such behaviours include:

- Strong suicidal ideas or actual suicide attempts.
- Violent or aggressive behaviour which is dangerous to the client or to other people.
- Extensive and persistent rummaging or wandering which cause considerable distress to other people or danger to the client.
- Other behaviours which make the person difficult to be cared for in his/her current environment or which cause an otherwise appropriate residential facility to deny admittance.

Persons under 65 years of age who exhibit symptoms of degenerative diseases associated with aging such as pre-senile dementia or Alzheimer's Disease will be admitted—to APMHS where indicated by clinical assessment.

The absence of categorical guidelines highlights the need for a comprehensive and professional assessment for each (prospective) client of APMHS. Specialist assessment services—the PGATS—are provided to meet this need. Once intervention has commenced, the case manager will review on a regular basis the full range of a client's needs. This review will examine whether the client can be treated and managed effectively within a generic facility.

Clients with Special Needs

The need to identify and address individual needs on a case by case basis is an intrinsic part of the case management approach. Workers in APMHS will take into account factors including culture, gender, language, religion and disabilities when making assessments and when examining or reviewing suitable treatment options for people with special needs.

Some client groups who are likely to present to APMHS with special needs are described below. They require different types and intensity of case management.

Gender-Specific Needs

The average life expectancy is 80 years for women and 73 years for men. This difference has an increasing impact upon the gender mix of the target population as people grow older. Whereas there are 1.1 females to every male aged between 65 and 69 years, there are 2.5 females to every male over 85 years. Therefore, as people grow older, there is an increasing likelihood that women will be living alone. Widowhood rises from 25 per cent of women in their sixties to 75 per cent of women over 80. In addition, most carers of aged persons with a mental illness are women—often a partner, who may herself be frail, or an adult child.

The support and education needs of all elderly persons with a mental illness need to be addressed. Given the divergence in life expectancy, this may require gender-specific analysis of ageing in order to ensure that the particular needs of elderly women are understood and recognised. This means addressing the impact of long-term caregiving and/or widowhood, as well as broader socio-economic issues and specific health needs. For example, special initiatives may be required to encourage health screening for women inpatients in psychogeriatric wards. In 1992 a women's advisory group was established by NEMPS to improve service responsiveness to the needs of women clients.

While suicide rates for women peak in midlife, older men have the highest mortality rate from suicide of any age/sex group. This means that threats of suicide or any form of suicidal behaviour must be taken very seriously. Attachment 7 lists some suicide prevention guidelines for service providers.

Clients from a Non-English Speaking Background

Language and cultural barriers can present significant obstacles to people from a non-English speaking background (NESB) in gaining access to mental health services and receiving optimum treatment.

The following strategies may be used to improve service access and effectiveness:

- The use of a professional interpreter will be an expectation when clinicians provide services (ranging from information to treatment) to NESB clients who lack proficiency in English.
- The case manager and other APMHS workers taking into account the language and cultural needs of NESB clients at all stages of intervention. This may range from considering the appropriateness of accommodation options to the validity of dementia screening instruments.
- Training for staff in mental health services will incorporate strategies to enhance cultural sensitivity and responsiveness in service provision.

Effective provision of community treatment and care often requires liaison and consultation with relevant ethnic agencies and bilingual health service practitioners as well as the provision of information and support for family members and other carers. Psychiatric Services is currently finalising a policy statement entitled *Victoria's Mental Health Service: Strategy Statement—Improving Services for People from a Non-English Speaking Background*. This document cites examples of good practice and suggests a number of strategies for making practice more responsive to clients from a NESB.

The Victorian Transcultural Psychiatry Unit provides understanding of cultural aspects affecting psychiatric disorders and their treatment. Action on Disability within Ethnic Communities provides advice for people

from non-English speaking backgrounds who have a disability. Its Psychiatric Ethnic Access Program aims to improve service provision and to increase NESB access in the mental health area.

Koori Clients

Koori clients will be given the opportunity to access specialised services for Aboriginal people where these exist, as well as being given the option of accessing generalist services.

The following strategies may be used to improve service access and effectiveness:

- When considering accommodation options, the case manager should pay particular attention to the client's family, community and cultural context.
- Training for staff in mental health services will incorporate strategies to enhance cultural sensitivity and responsiveness in service provision.

Clients from Rural and Remote Areas

The mix of APMHS in rural areas is typically configured differently in order to meet client needs. Services are delivered by smaller units which are often collocated with other service providers.

The development of area mental health services means that every area in the State will have access to the full range of mental health services for every age group. In some instances this may need to be achieved through formal agreements with other areas or regions. The mandatory condition of there being a single point of management for each mental health program means that service usage can be monitored and service gaps prevented or identified. This is of particular relevance for rural, remote and isolated areas where, in the past, mental health services may have been limited or lacking.

Homeless and/or Transient People

Homeless and transient persons referred to APMHS receive mental health assessment and treatment where they are currently located. The outreach role of PGATS is crucial in this regard. The PGATS support and treat the person and minimise the need for admission. Shelters, refuges, boarding houses and special residential services play an important part in the provision of a range of accommodation options. Every effort should be made to ensure that homeless clients are aware of PGATS and accommodation options.

People with Acquired Brain Injury

The Aged Care Division of H&CS has accepted responsibility for the development and management of a new service program providing long-term rehabilitation, medical and nursing support for highly dependent persons with acquired brain injury (ABI).

People with a serious mental illness and coexisting organic brain disorder or ABI may not be eligible for general nursing home services due to behavioural problems that cannot be easily managed. These persons may require access to the range of APMHS. Long-term care may need to be considered and staff need to pay particular attention to the client's behavioural difficulties as well as the needs of the family and/or caregivers.

A program statement on *Mental Health Services for People with Brain Disorders* is being developed by Psychiatric Services.

People with an Intellectual Disability

The *Protocol between Intellectual Disability Services and Psychiatric Services* outlines the interface between the two service systems and contains guidelines for determining primary case responsibility. It is the responsibility of the client's case manager to determine which service system can best assist the client and to

engage additional supports from the other system as required.

Consultation between the two services will occur at each stage of service delivery. This will ensure that the directions of the client's individual service plan (ISP) for mental health and intellectual disability are consistent and that clients and significant others are involved in decision-making about service provision. This process will determine what the supports are which each system can provide.

Clients with Drug and Alcohol Abuse

Drug and alcohol abuse by APMHS clients may seriously affect client treatment and care. Psychiatric services case managers will establish appropriate links with detoxification centres and other service providers in accordance with protocols.

Old People Who Have Been Abused

At some stage, most health and community service workers involved with older people will find themselves confronted with situations which can be described as 'elder abuse'. Many service response problems stem from the lack of agreement among agencies on how situations of abuse should be defined and on how responsibility for intervention should be allocated.

In order to address these issues, the Aged Care Division of H&CS has produced *With Respect to Age: A Guide for Health Services and Community Agencies Dealing with Elder Abuse*. The guide describes the context of elder abuse and outlines key policies and procedures which can assist agencies to develop or review their own response.

Coordinated Client Care

A client-focused service system for elderly persons needs to have the flexibility to identify, obtain and package resources for its clients in a way which meets

their needs as fully as possible, and without the client being unduly aware of program boundaries. An efficient and effective service will provide a range of appropriate and timely interventions.

For most elderly people, continuity of care is achieved through their GP. GPs play a pivotal role in educating clients and their carers, in providing treatment and in referring clients to appropriate services, including ACATs and PGATS.

Once a client is referred to APMHS, continuity of care is primarily achieved through the case management process.

Psychiatric Services case management policy is set out in the document *Victoria's Mental Health Services. Improved Access Through Coordinated Client Care*. It is centred around a service delivery model consisting of four stages: reception, duty, intake and service delivery. Important features of the crucial service delivery phase are:

- The appointment of a clinical staff member, generally from the area community mental health service as the client's case manager.
- The requirement that each client has a comprehensive needs assessment undertaken.
- The development of an ISP which is reviewed on a regular basis.

For APMHS, this means that a client's first case manager will normally be a member of local PGATS. A case manager is allocated as soon as possible following the client's initial assessment. In allocating a case manager every attempt will be made to match client needs and worker skills. The case manager will then negotiate the ISP with all relevant people.

Case managers identify, provide/obtain/purchase and coordinate services for their clients in ways which meet the clients' needs as fully as possible, and without the

client being unduly aware of program boundaries. Client need remains the prime focus throughout the various stages of intervention and treatment.

For example, the PGATS case manager whose client has been admitted to an acute inpatient unit will maintain contact with the client and monitor his/her treatment throughout their stay in the acute unit. The case manager will be involved in preparing the client discharge plan from the acute unit.

Case management responsibility ends only through case closure or through the formal transfer of case management responsibility to another service provider.

Successful case management depends on a number of factors including:

- Professional training, practice skills development and expertise.
- The ability to identify specific, attainable objectives for treatment and intervention.
- The case manager's willingness to involve the client and his or her carer or family or significant others in the decision making process.
- Good links with other service providers. These will normally be achieved through educating stakeholders about each other's service provision (including objectives, frequency and intensity of client contact and anticipated outcomes), combined with the existence of written protocols which are reviewed and updated on a regular basis.
- The existence of case management support systems—including supervision, teamwork, peer review and further education programs.
- The availability of appropriate services.

The Basis for Service Planning

Victoria's Mental Health Service: The Framework for Service Delivery provided a detailed framework upon which a comprehensive network of mental health services is established. Implementation of the April

1994 Framework is supported by the introduction of a purchaser/provider approach to funding.

Selection of auspice agencies for mental health service providers, including APMHS, has occurred through the June 1994 expressions of interest (EOI) process. The EOI process has resulted in a number of health service agreements being signed with service providers. These agreements specify the key parameters of service provision such as client population, service objectives and capacity and funding arrangements and are reviewed every year. Health service agreements are administered, monitored and reviewed by H&CS regional staff. This ensures that negotiations about service provision can take into account the local context as well as statewide guidelines.

For the purposes of organising and delivering mental health services, regions are typically divided into a number of local areas, each area comprising a mental health service system based on the needs of its community. These local areas are known as area mental health services.

Area mental health services are organised around defined catchment areas in order to ensure that services are available within the local community, that responsibility for service provision to an individual client is clearly identified and that strong linkages with other stakeholders are developed. Inter- and intra-regional agreements may be necessary in some instances to ensure clients have access to the full range of services.

Guides for service development for APMHS include four acute beds and 11 PGNH beds per 10,000 persons over 65 years of age. It must be noted, however, that these are guides only and must be placed firmly in the local area context and adjusted for local needs.



Psychogeriatric Assessment and Treatment Services (PGATS)

PGATS Roles

The initial specialist assessment and treatment of aged persons with a mental illness is undertaken by PGATS. The PGATS play a pivotal role, providing the first point of contact with the aged persons mental health service for clients and their families. PGATS can be contacted directly by the client or their carer as well as by professionals.

PGATS are community-focused and provide assessment, treatment, rehabilitation and case management for older people, thereby preventing unnecessary treatment in residential mental health services and minimising length of stay in such services. As a preventive service, PGATS provide education for consumers and carers, as well as consultation to other service providers.

The service is delivered through multidisciplinary teams. They provide clinical expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. A draft staffing profile for PGATS is shown in attachment 4. In practice, size and composition of the teams will vary as resources are matched to local needs.

PGATS are provided on a five day a week basis, typically during regular business hours. The level of after-hours demand for crisis support does not justify provision of PGATS on a 24-hour basis. Crisis assessment and treatment services (CAT services), which are part of the general adult mental health service system, provide a time-limited backup service for clients of PGATS who require an out-of-hours psychiatric crisis response. The CAT services are contacted through the senior clinician on duty at the appropriate psychogeriatric inpatient service.

All admissions to psychogeriatric beds funded by psychiatric services will occur with involvement of the

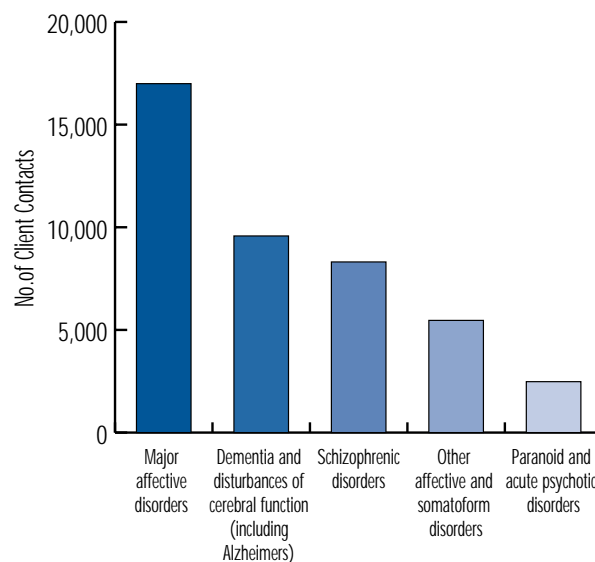
PGATS in order to ensure that clients are managed in the least restrictive setting.

PGATS at a Glance

- Assessment.
- Treatment.
- Rehabilitation.
- Case management.
- Education of clients and their carers.
- Consultation.

Figure 4 shows the five leading diagnostic groups of clients referred to PGATS³:

Figure 4: PGATS Contacts by Leading Diagnostic Groups



³ Source: PRISM data re PGATS activity 1994–95. Under-reporting by PGATS to PRISM means that the data understate the number of actual contacts for each of the above diagnostic groups.

Assessment

PGATS are required to conduct a comprehensive assessment of elderly people who have or are thought to have a mental illness in order to determine:

- Their mental state and requirements for psychiatric treatment.
- The level of support available.
- Additional supports required to maintain the client in the community.
- The level of risk of harm to self/others and management strategies.

The PGATS assessment is frequently undertaken at the client's home and the carer or other key informants may be invited to be present. Joint assessments with geriatric services may be conducted where appropriate.

The level of dependency and dysfunctional behaviour of APMHS clients is assessed in a number of ways. Team members undertaking the assessment will endeavour to look at the person's situation holistically. They will examine the presenting problems, the person's social and cultural profile, as well as their functional, medical and psychiatric profile. The initial assessment often includes well-known tools such as the mini mental state examination (MMSE) and the Barthel self care index as well as a tool to gauge the client's mobility and capacity to manage 'activities of daily living' (ADL).

Some other resources are:

- The psychogeriatric assessment scales (PAS). These are designed to gather information on the major psychogeriatric disorders, that is, dementia and depression. The scales rate depression, cognitive performance, cognitive change, behaviour change and history of stroke. The interview is fully scripted and can be administered after only brief training.
- Italian and Greek language versions of the PAS are being developed for use by interpreters.

- The geriatric depression scale (GDS) is a screening tool which may be useful for exploring an impression that an individual may be depressed. A high score on the scale should be followed up by a more thorough clinical investigation.
- The dementia assessment aid for ACATs was developed as part of the *National Action Plan for Dementia Care* and includes a range of instruments to assess cognition, functioning, depression and behaviours.

There is a wide range of assessment tools being used and developed amongst service providers and in the tertiary sector. No single tool will perform well in every conceivable situation or with every subsection of the APMHS target population. The choice of assessment tool is the responsibility of clinicians.

Completed assessments may be presented at a regular multi-disciplinary team meeting for peer review and the formulation of appropriate care plans, provided more urgent action is not required.

Following the assessment client needs are matched to workers' skills and the client is allocated a case manager. The case manager will negotiate the ISP with the relevant people (including the client and where applicable his/her carer and GP) and detail the agreed arrangements in writing.

As well as the specific disease processes, treatment of APMHS clients needs to take into account the biological and psycho-social aspects of ageing, the different presentation of mental illness in the elderly compared to younger people and the different responses to pharmacological interventions.

Client review and progress documentation will be crucial elements in clinical care and will inform review of the ISP and discharge planning.

Principles for Assessment Work

- Clients have a right to a comprehensive and expert assessment service.
- Assessment will be based on a holistic approach to client needs.
- Duplication of assessment will be avoided.
- Assessment will be culturally sensitive and appropriate.
- Assessment will be undertaken within a context of coordinated client care.
- The assessment process will be explained to the client and his or her carer.

General protocols for assessment are required for all components of APMHS. New protocols will be developed where no guidelines exist at present. The protocols will reflect mainstreaming and will include details of the referral mechanism and case management arrangements.

In addition, Psychiatric Services will develop guidelines for PGATS which will describe in more detail the full range of PGATS functions, including treatment, rehabilitation, continuing care, consultation and community education.

The Interrelationship of PGATS and Aged Care Assessment Teams (ACATs)

ACATs provide assessment, linkage and brokerage services to people over 70 years of age. They provide a gate-keeping role for Commonwealth-funded nursing homes and hostels and ensure smooth transfer for the client between different types of care and service as well as effective linkages between services.

By definition, the *target population* of ACATs is larger than that of the PGATS. This means that elderly people seeking help in relation to their mental illness in many cases also need a range of other services in relation to,

for example, their physical or social support needs. While ACATs and PGATS have a largely overlapping target population in terms of the age cohort, estimates of the level of shared clients between the two services vary greatly across the State.

A review of the Victorian ACAT program was completed in April 1995. This review provided comment upon the relationship between ACATs and PGATS in Victoria (the only State to have PGATS). A recommendation of the final report is that ACATs and PGATS should be collocated and that full integration of ACAT services and PGATS be pursued.

PGATS and ACATs clearly have different and complementary roles. As stated above, PGATS will be the first point of contact for aged persons seeking help for their mental illness. The role of PGATS complements that of ACATs in a number of important ways. PGATS

- Are a specialist service, which is better suited to treat or refer cases once the psychiatric illness is seen as the primary presenting problem.
- Are a screening service and regulate access to both acute inpatient services and, in conjunction with the ACAT, to PGNHs and hostels.
- Have a broader mandate, with treatment, rehabilitation and case management being an integral part of service provision.

Despite these different roles at the systemic level, PGATS and ACATs have significant commonality and scope for improvement at the operational level. Both services undertake a significant assessment role and control access to services within their service system. ACATs and PGATS will refer cases to each other on a regular basis and frequently consult with each other. To ensure continuity of care it is essential to derive the relationship between the assessment teams from the client-focused principles for assessment services listed in the previous section.

Key objectives therefore are to reduce duplication of assessment, to maintain psychiatric expertise and to minimise dual administrative processes.

Regional planners will also ensure that catchment areas of PGATS and ACATs are clearly defined and coincide wherever possible.

Improving ACATs/PGATS Coordination

Guidelines for Referral and Cross-Referral

The presence of an organic disorder such as dementia in itself does not necessitate a referral to mental health services.

Aged care services will continue to assist elderly clients with dementia and other organic brain disorders until such time when the client's behaviour can no longer be managed effectively in a generic or community setting. The point at which this occurs would need to be determined on a case by case basis. It may be after the client has spent several months in a generic nursing home (and on the basis that the client's behaviour has become unmanageable in that environment) or at the moment the client is first referred to the ACAT (because of risk factors which are deemed to be unacceptably high).

It is acknowledged that the following guidelines do not cover the full array of scenarios occurring in case practice. They are meant to be indicative rather than restrictive and should be reviewed in the light of individual client need, established local practices and available resources.

Direct Referral to ACATs of a Client with a Mental Illness

In some cases aged persons with a mental illness are referred to one of Victoria's 18 ACATs in the first instance. This may occur for a number of reasons including:

- The referrer did not know about the existence of the PGATS.
- The primary referral was for a problem unrelated to mental health.
- Some GPs, who may have assisted a client over a long time, are reluctant to contact PGATS because of the perceived stigma associated with involving a psychiatric service.

Cross-Referral from ACATs to PGATS

ACATs typically cross-refer a client to PGATS in the following situations:

- An older person presents with severe mental illness for the first time.
- The high likelihood or the need for early emergency intervention makes it preferable for PGATS to become involved.
- The older person's mental state impacts significantly on their physical health.
- A dementing person is exhibiting behaviours which cannot be managed by the carer (or within the generic nursing home or the hospital ward).

ACATs may refer without first meeting their own assessment requirements if it is clear that the client requires PGATS. Conversely, an older person who has been assessed by ACATs as requiring referral to PGATS for treatment should not need to undergo a very similar assessment before the PGATS will accept the referral.

Cross-Referral from PGATS to ACATs

PGATS are expected to cross-refer a client to ACATS in one of the following situations:

- The client's mental illness is no longer the primary focus for intervention because, for example, the physical care needs outweigh the client's needs for specialist psychiatric treatment or intervention. This could be at the point of referral, in the case of an inappropriate referral, or after the client's behaviour has improved to such an extent that he or she can once again be assisted in a community or generic setting.
- PGATS also refer to ACATs to obtain client access to residential care options as ACATs currently have the sole authority to sign the NH5 form, which is the nationwide Commonwealth requirement for admission to nursing homes. ACATs also control access to hostels. H&CS will request that the Commonwealth consider granting delegations to PGATS, which would enable them to complete NH5 nursing home admission forms.

Reducing Duplication of Assessment

Assessment of the elderly client is complex and often time consuming for both the case manager and the client. Given the high incidence of co-morbidity, it is often valuable to conduct a joint assessment for the sake of the client's privacy and in order to optimise use of available clinical resources.

Section 120(a) of the Mental Health Act and S.141 of the *Health Services Act 1988* set out the confidentiality requirements in relation to client information. The Acts are based on the same principles and contain exemptions relating to 'the giving of information required in connection with the further treatment of a client/patient'. ACATs and PGATS professional staff are therefore working under a compatible legal mandate and able to share clinical information which is relevant to the further treatment of a client.

Operational Integration of ACATs and PGATS

Psychiatric Services policy supports collocation and operational integration of ACATs and PGATS as the preferred arrangement between the assessment teams. This operational structure will facilitate joint assessment and cross-referral of clients according to their needs, as well as blending different organisational cultures and the cross-fertilisation of skills in both a formal and informal sense.

Operational integration means that service components work in unison at service delivery level and retain sufficient integrity at management level to maintain and foster clinical expertise and to avoid program drift.

Collocation means the housing together of the ACATs and PGATS in the same building or on the same campus.

Where collocated with ACATs, the PGATS will retain its character as a specialist and fully operational team. This reflects the fact that the PGATS provide a specialist service operating under a different legal mandate from the ACATs, with broader objectives and a strong focus upon treatment. Collocated PGATS will therefore retain a separate funding source and management structure, consistent with the mental health service having a single point of management and accountability as required in the EOI process.

This will be in the context of improved coordination in terms of information flow, referral and intake processes, joint assessment and community education. Where collocation is not pursued because of local factors, interdependent services may be acceptable provided effective linkages are established and maintained.

Respite Care

Rationale

Most aged persons with a mental illness wish to continue living in the community for as long as they can. The family is one of the best resources available for the continuing care and support of people with a mental illness. Therefore, the provision of respite care will be encouraged in order to meet the needs of both carers and consumers.

Respite care can be arranged on a planned or emergency basis to give carers a break. Good carer education combined with accessible and incremental respite care often delays or prevents admission to inpatient and residential services and reduces clients' stay in those facilities.

Generic Aged Care Respite Services

Respite care within the aged care services system is both State and Commonwealth-funded. The Commonwealth planning norm for respite in nursing homes is two beds per 1,000 persons over 70 years of age. The bed-based service may include planned or emergency respite and is provided in nursing homes or acute care settings. In Victoria, each client has access to 68 respite days per year. These are generally used in blocks or multiples of two weeks, as after this time, rent assistance and other adjustments to the aged pension are available.

Respite care in extended care centres is funded at \$130 per day for planned respite and at \$320 per day for emergency respite (1995–96 rates). Respite care in nursing homes is funded at RCI-3 level or above, plus additional SAM monies—a level comparable to that of planned respite care in a geriatric centre.

In addition to inpatient and residential respite care, other care options have been developed which target people with dementia, the confused elderly and people

with a physical disability. Funding for these services is provided from a range of sources and auspice agencies include community health services, local government, non-government agencies and aged care services. Available options may include day care, in-home respite care and attendant care. Clients and their carers are referred to these services by a variety of providers.

Respite Care Funded by Psychiatric Services

The April 1994 Framework for Service Delivery identifies the provision of respite care 'to clients who cannot be managed in aged health and community care facilities' (and to their relatives) as one of the key service requirements of extended care inpatient services.

The PGATS case manager, in consultation with the client and his/her carer, will be involved in canvassing respite care options for APMHS clients and in deciding which setting is most appropriate for the client. Planned respite as an option can be an integral part of the ISP and will generally be delivered in an extended care facility.

It is necessary to provide respite care within an appropriate setting in order to minimise trauma and to maximise the opportunity to provide optimum care. In particular, consideration will be given to the PGNH and hostel environment. These facilities provide residents with a home-like environment.

Primary Carers: Availability and Needs

Informal care for elderly persons with a mental illness is often provided within the home by a person with whom the client has a significant personal relationship such as spouse or offspring.

From a broad point of view, the size of this 'caregiver pool' may expand or shrink over time as a result of social trends in family formation and employment. Family formation trends include rates of marriage and divorce and rates of parenthood, which will affect the availability of potential caregivers. Low marriage and high divorce rates would each lead to an increase in solitary living, and a reduced parenthood rate would result in fewer siblings to share the care tasks. A recent OECD study showed that a very high percentage of care for elderly people is provided by women aged 45-64. The availability of this group to provide care may be affected by employment patterns. While paid employment does not preclude the capacity to provide care, full employment does not combine well with extensive or heavy care tasks over a long period. The availability of caregivers is also affected by declining levels of co-residence between generations while demand for care is fuelled by longevity and the growth in the aged population.

An increasingly unmet need for home care would result in increased pressure upon residential services. An existing or emerging service gap in this area would be contrary to clients' preference for living at home for as long as possible, at odds with the legislation's emphasis upon minimum intervention—in short a less appropriate alternative to early intervention.

The spouse is often the primary carer. This means that many carers are themselves elderly and may have needs of their own which may affect directly their capacity as a carer. For example, emergency respite care may be required when the regular primary carer is taken ill.

Formal support should be seen as a complement to, and not a substitute for, family-based care. Family care is unique in its capacity to meet the client's social and emotional support needs in addition to assistance with activities of daily living. In turn, family carers will be reassured that there is a formal network of supports to back them up.

In some cases, patterns of care established years ago may need to be reviewed or complemented as the carer grows older. In other cases, the sudden onset of a debilitating disease such as Alzheimer's will confront the caregiver with a rapid succession of incremental care needs—all of this in addition to the carer's own needs in finding out about the illness and coming to terms with its massive and irreparable impact upon a significant relationship.

APMHS will regard the primary carer of APMHS clients as a customer of the service. Support provided to primary carers will be determined on a case-by-case basis within the case management framework and may include:

- Information about the mental illness and its treatment.
- Financial assistance within the context of the client's ISP.
- Referral for planned respite care.
- Referral for emergency respite care.
- Referral to a caregiver support group.
- Referral for other support or assessment services (such as HACC, ACATs).
- Other innovative arrangements compatible with the client's ISP.

Recent policy initiatives and guidelines have increasingly recognised families and carers as essential partners in the redevelopment of public mental health services. The shift towards community-based service delivery opens up significant opportunities for the planning of good practice strategies and the formation of collaborative mechanisms.

In this context, families and carers are considered to be a fundamental resource in the overall provision of effective and efficient mental health services. The development of a family and other carer policy by Psychiatric Services is the first step in planning and providing a consistent response to improving the needs of families and carers in their caregiving role.

Day Program Services

Rationale

Day program services offer treatment and rehabilitation in a community setting. Multi-disciplinary teams offer living skills training, socialisation activities and behaviour management programs either linked with acute or residential psychogeriatric service components, as specialised services within a generic setting or as specialised services within their own right.

Like respite care, day program services are important in assisting aged persons with a mental illness to continue living in the community.

Psychogeriatric day program services provide services primarily to elderly persons with a mental illness who live in a hostel or a supported residential service.

Day program services within the aged care service system are provided by state geriatric centres, community health centres or local government.

In practice, clients of APMHS frequently experience difficulty in accessing or continuing to participate in mainstream day programs. Coordinators of these programs are often concerned that an increased attendance by mental health clients would change the ambience of the day centre programs. Problematic and unpredictable behaviours of mental health clients are cited as barriers to participation.

While these problems may be real, there is scope to achieve better mainstreaming by education of program managers.

Some Current Services

Some examples of day program and activity services are:

- The Oswald Street Day Program at the Dandenong Hospital Department of Psychiatry is funded by Psychiatric Services. The program offers continuing care services through a centre-based activity program and a community outreach program for people with psychiatric or behavioural disorder requiring intensive intervention. The service also aims to integrate clients into mainstream activity or day programs.
- The Southern Psychogeriatric Activity Service (SPAS). This program is jointly funded by HACC and Psychiatric Services and consists of a small team (one coordinator/occupational therapist and three psychiatric nurses) who assist with the integration of elderly clients with a psychiatric disability into community-based activity services that suit the level of functioning of the client. Prior to its recent expansion the program assisted approximately 200 clients per year and was evaluated by Monash University in 1993. The program is currently also funded as a demonstration project under the National Action Plan for Dementia Care. As part of this work, the service has produced a manual describing the SPAS method of working with clients, and staff are available to run information forums throughout the state.
- The Inner East Community Geriatric Psychiatry Service provides a rehabilitation program as part of a comprehensive service which includes the PGATS role. The aim of the program is to enable clients to function optimally within their chosen environment. The program provides a multi-faceted rehabilitation approach based on the clients' goals and needs as assessed through a collaborative process involving the client, case manager, significant others and occupational therapists. The service is provided in a variety of settings, including the client's home, and

involves the provision of a specialist rehabilitation service at Wildara Day Centre and in two neighbourhood centres as well as fostering opportunities for client integration into community services.

Key Service Links for PGATS

Apart from their links with ACATs, which have been described above, PGATS also have significant linkages with other community based services, including the following:

General Practitioners

GPs play a crucial role in providing primary consultations for elderly clients. Their role is to identify the nature of a health problem from a broad range of possibilities. They often act as a case manager, referring the client to specialist services for further assessment or treatment where necessary.

While GPs are the primary source of referrals for PGATS, there is a need for ongoing professional education about the role of PGATS and their interrelationship with ACATs in order to ensure that appropriate referrals continue. Even after referral, GPs are likely to have ongoing contact with their client. Good communication with GPs therefore remains important at all stages of the service delivery process.

With the increased occurrence of mental disorders among the increased population of elderly clients, GPs will spend more time treating these disorders and educating clients and their carers about the course of these disorders and their impact. As a result, GPs are likely to build up greater expertise in this area. They will also have an increasing need to access the resources and expertise provided by the PGATS. The PGATS will regard GPs as an integral part of their work.

Carers

Many elderly persons with a mental illness are being cared for at home or in the home of a friend or relative. Their primary carer may be a spouse who is also elderly, or a family member. The amount of care required varies according to the nature and stage of the illness but most carers would benefit from community support.

The role of PGATS comprises supporting carers through advice and information. From the point of assessment and ongoing support, carers are important as they may provide a rich source of information about the client and his/her (changed) behaviours. They also play a valuable role in maintaining the client in the community for as long as possible. Part of the case management role of the PGATS, however, will be to monitor the effect upon the carer of looking after the client, and to recommend or purchase additional support services where necessary. These may range from in-home help to planned or emergency respite care or eventual residential care.

Community Health and Support Services

Community support services such as HACC services provide valuable resources for PGATS case managers.

PGATS staff need to determine what services are available locally and to establish effective working relationships with local service providers. PGATS community education programs will include HACC service providers in their target group. PGATS staff will convene or attend case management meetings to plan and review client resourcing on an individual basis.

Private Psychiatrists and Private Psychiatric Hospitals

Private psychiatrists and private psychiatric hospitals are a valuable component of a comprehensive mental health service system. PGATS will consult with private

psychiatrists as required from the point of client care. Contact may vary from a consultation about the patient's history to a referral. H&CS is currently finalising collaborative service arrangements between public mental health services and private psychiatrists. Collaborative service arrangements will facilitate joint service provision to meet the treatment and support needs of an individual with a mental illness.

Acute Inpatient Services

Access to inpatient services provides PGATS staff with a valuable case management resource which may need to be called upon for the assessment and treatment of clients. Other treatment and psychosocial needs include the management of an acute episode or the provision of emergency respite care due to illness, support needs or unavailability of the client's regular carer.

All admissions to acute PGATS funded by Psychiatric Services will occur on the basis of a referral by the local PGATS. This is to provide continuity of care and in order to ensure that clients are managed in the least restrictive setting. Any member of the PGATS clinical team can organise an admission if required. When organising an admission, the PGATS will aim for a smooth transfer of responsibility and clear communication between themselves and the inpatient unit.

Following admission, PGATS staff will remain involved with the client. Effective communication with acute care staff presumes good information exchange between the community-based and the acute services. The contact may be in the form of client visits, case conferences, client review meetings, multidisciplinary team meetings and committee membership. The continued input and monitoring by PGATS reflects the coordinated client care model and helps to shape best practice in admission and discharge planning.

Adult Mental Health Services

CAT services, which are part of the general adult mental health system, provide a time-limited backup service for clients of PGATS who require an out-of-hours psychiatric crisis response. PGATS have a role in ensuring that CAT services are educated about the specialist nature of APMH service provision in order to ensure that clients receive expert and well coordinated assistance.

The CAT service is contacted through the senior clinician on duty at the appropriate psychogeriatric inpatient service. The client would normally be referred to local PGATS the following working day.

Residential Care

As case managers, PGATS staff will be involved in discharge planning. All admissions to psychogeriatric extended care funded by psychiatric services will occur with involvement of the PGATS in order to ensure that clients are managed in the least restrictive setting. In addition, PGATS staff will offer support to clients in making the transition to forms of accommodation funded through aged care or available within the community at large. These alternatives include supported residential services (SRS), hostels, boarding homes as well as private and public nursing homes. PGATS will also assess and treat clients in those facilities. This may be either as part of their case management work or at the request of facility staff, who may make a new referral to the PGATS. A major role for the PGATS is behaviour management in aged care settings as, for example, the majority of long-stay elderly clients with dementia are cared for in aged care nursing homes rather than in PGNHs or psychiatric hospitals.

Acute Hospitals

As described earlier, many elderly clients present with multiple needs. In line with the philosophy of coordinated client care, the dual imperative will be to ensure

continuity of care from the client perspective and to educate the contact person in the acute health facility as to how the client's mental illness may impact upon service delivery.

Non-Government Organisations

Non-government organisations (NGOs) offer a wide range of information, education and support services for APMHS clients and their carers. PGATS managers will develop effective linkages with NGOs in their area to ensure that PGATS staff are aware of all services provided by NGOs and of other resources which may be obtained through NGOs.



Acute Inpatient Services

Role of Acute Inpatient Services

The April 1994 Framework for Service Delivery identifies the following key service requirements for acute inpatient services:

- To provide an inpatient service that enables the assessment and treatment of clients' mental, physical and social state.
- To provide a short-term, voluntary and involuntary treatment service during an acute phase of a client's mental illness where this cannot be managed in the community.
- To ensure all beds are gazetted in accordance with Section 94 of the Mental Health Act and accordingly able to admit involuntary patients.
- To ensure all admissions to the unit have had involvement of PGATS.
- To ensure that clients who require a short-term secure environment and intensive support can be managed.

These hospital type units provide assessment and treatment for older people with acute symptoms who cannot be cared for effectively or supported within the community by the PGATS or the generic aged care system.

Referral for psychiatric assessment occurs within generic settings (hospitals, State geriatric centres) when a patient is admitted with physical problems and behavioural and psychological problems associated with severe mental illness.

The assessment function enables accurate diagnosis of the older person when their presentation is more complex or when their symptoms are creating acute distress or jeopardising safety.

The treatment and management function enables care management on a short term basis, offered in a safe environment. Acute inpatient services can provide or arrange access to all treatment services for APMHS clients.

Planned discharge from an acute psychogeriatric inpatient facility may be to home, a PGNH or hostel, generic nursing homes or hostels, or supported residential services. Case management follow-up is the responsibility of local PGATS in conjunction with the GP.

All psychogeriatric assessment beds are gazetted under the Mental Health Act. Bed numbers vary across regions as historical service design gives way to planning based on the needs of clients in the area mental health service. Staffing of acute inpatient services is multi-disciplinary. Total numbers and composition of staff are highly variable between services. The *Hospitals Conditions of Funding 1995-96* state that it is the responsibility of the manager of psychiatric services in each agency to ensure an appropriate mix of medical, nursing, psychology, social work and occupational therapy skills in each service team, including the use of part-time and sessional staff for specialist skills (for example, neuropsychologist).

A generic brief for the design of acute psychogeriatric units has been developed. This generic brief will be used as a blueprint for new developments in order to ensure that clients are provided with an environment which is appropriate to their needs.

Key Service Links for Acute Inpatient Services

Key service links for acute inpatient services include the following.

PGATS

This relationship is described in the section 'Key Service Links'.

Extended Care Services

This relationship is described in the section 'Key Service Links'.

ACATs

In addition to the formal cross-referrals, processes would typically comprise consultation and liaison between the two services, in particular when considering admission or discharge of a client to or from an acute inpatient service and when coordinating a package of services as part of the case management process.

Tertiary Institutions

From the point of view of acute inpatient services, academic positions in professorial units provide a focus for the cross-over between theory and case practice. Tertiary institutions make an important contribution to clinical expertise through education and research. The educative process works both ways, with the APMHS practice and service delivery framework providing a social context for research projects. Tertiary institutions play an important role in fostering excellence and expertise in psychiatric work, including the sub-specialty of aged psychiatry. The link with the tertiary sector is generally established and maintained by the director of clinical services.

Acute Hospitals

As described earlier, many elderly clients present with multiple needs. Acute unit staff may therefore need to link the client with acute health services to arrange, for example, diagnostic tests or treatment. In line with the philosophy of coordinated client care, the dual imperative will be to ensure continuity of care and to educate the contact person in the acute health service as to how the client's mental illness may impact upon treatment.

Community Health and Support Services

A range of community health and support services may need to be arranged on a case-by-case basis to assist APMHS clients, generally within the context of discharge planning. The services may range from the

provision of HACC services such as meals on wheels to in-home respite or appropriate day programs.

Many acute inpatient services now have a Royal District Nursing Service (RDNS) liaison officer on site. This person will take referrals from the client's case manager prior to discharge and ensure that appropriate services are provided. Where an acute inpatient service has no RDNS liaison officer on site, a comparable arrangement would be expected to be in place to ensure delivery of necessary services.

General Practitioners

Acute inpatient services should establish and maintain effective links with the network of local GPs in order to ensure that clients continue to have access to holistic health care following discharge. The client's GP would be advised of the discharge date and of any changes in treatment and discharge summaries should be provided promptly.

Non-Government Organisations

NGOs offer a wide range of information, education and support services for APMHS clients and their carers. Staff in acute inpatient services should develop effective linkages with NGOs in their area to ensure that they are aware of NGO services.

General Adult Mental Health Services

Staff in acute inpatient services should establish and maintain an interdependent relationship with general adult mental health services. This will ensure access of APMHS clients to modes of treatment which may not be available in the mainstreamed facility, facilitate smooth client transition from adult services to APMHS as appropriate, and expose staff in each area to expertise in another sub-specialty of psychiatry.

Extended Care Services

Role of Extended Care Inpatient Services

Extended care services are provided for APMHS clients who meet the criteria set out in the section entitled 'The APMHS Client Population'. This includes clients who cannot be managed effectively in the general aged care system due to their level of cognitive, emotional or behavioural disturbance. Residents in extended care inpatient services may have functional and/or organic disorders coupled with behavioural problems which include confusion and wandering, reduced personal and social skills, disturbed or aggressive behaviour, memory loss and difficulty in complying with requests and care because of their psychological state.

Clients in extended care inpatient services are likely to receive a combination of behavioural and social therapies and medication with the aim of enabling eventual discharge to mainstream nursing homes, supported residential services or their usual place of residence.

Extended care services must therefore be sufficiently flexible to enable long-term accommodation, ongoing assessment, treatment and care of residents and a variety of programs aimed at rehabilitation or life enhancement of clients. They will also provide respite care to clients who cannot be managed in aged health and community care facilities.

Extended care services will comprise accommodation-based services in PGNHs and psychogeriatric hostels.

As shown in figure 6, extended care inpatient services are provided primarily in PGNHs situated in community settings.

Most PGNHs are auspiced by State-funded extended care centres and their beds are governed by Commonwealth *Outcome Standards for Nursing Homes*.

Access to extended care services is through local PGATS, which have the clinical gatekeeping role through their assessment function, and the ACATs, which are instrumental in recommending client access to appropriate accommodation through completion of the NH5 form.

The Commonwealth Government has developed a resident classification index (RCI) in order to determine subsidies for nursing home beds throughout Australia. The RCI provides an extensive assessment instrument which measures client dependence for the purposes of CAM/SAM funding and is used in APMH extended care services as a mandatory tool. It is important that admission to a PGNH is followed up within the prescribed timeframe by a comprehensive assessment which establishes the RCI-rating.

The RCI was not designed to be an instrument informing ongoing clinical review. The behavioural component of the RCI relies on a single 'snapshot' assessment which establishes a client's level of dependency. Practitioners in APMH extended care services have therefore been exploring a range of instruments which can contribute to case management by facilitating regular clinical review or by being used in treatment itself (behaviour modification tools, for example). The following tools have been used in inpatient settings:

- The Revised Elderly Persons Disability Scale (REPDS), which was developed by Richard Fleming for the confused and demented elderly (CADE) units in New South Wales. The tool measures behavioural disturbance and is used in many PGNHs in Victoria as the basis for periodic review of clients.
- The Dysfunctional Behaviours Scale developed by the Queen Elizabeth Centre in Ballarat provides a basic measure of the level of wandering, restlessness and aggression of a client.

However, there remains a paucity of reliable and valid tools for assessing behavioural change in elderly people

with a mental illness. Further practice research and developmental work are required in order to produce (a range of) concise, reliable and written assessment tool(s).

PGNHs do not provide a 'whole of life' service in most cases. Recent statewide data show that the average stay in a PGNH is just under 12 months. Extended care services will transfer residents to generic aged care services when they no longer require the specialist mental health service. It is important that PGNH admission policies and information brochures developed for clients and their carers or relatives reflect the fact that the client's suitability for admission to a PGNH will be periodically reviewed within the context of the resident's ISP.

The physical layout and the staffing structure of PGNHs have gradually evolved since 1988 and present a highly variable picture.

A generic brief for the design of PGNHs has been developed in order to harness learning from recent developments which constitute best practice in this area. This generic brief is used as a blueprint for new developments in order to ensure that clients are provided with an environment which is appropriate to their needs and supportive of their care.

The Merv Irvine Nursing Home at Bundoora Extended Care Centre (BECC), which commenced operating in July 1994, presents the best format to date on which to develop a model PGNH. The nursing home is light, airy and purpose-built and designed to have a familiar, homelike atmosphere. All residents have their own room, generally with their own bathroom. Residents can participate in cooking and other supervised activities where possible.

A recent study, *Facilitating a Psychologically Supportive Environment for Residents*, has found that the design of the Merv Irvine Nursing Home contributed positively to resident quality of life and functioning. The study strongly endorsed most design features of the nursing home such as the clustering design, night cueing lights, single rooms and ensuite bathrooms.

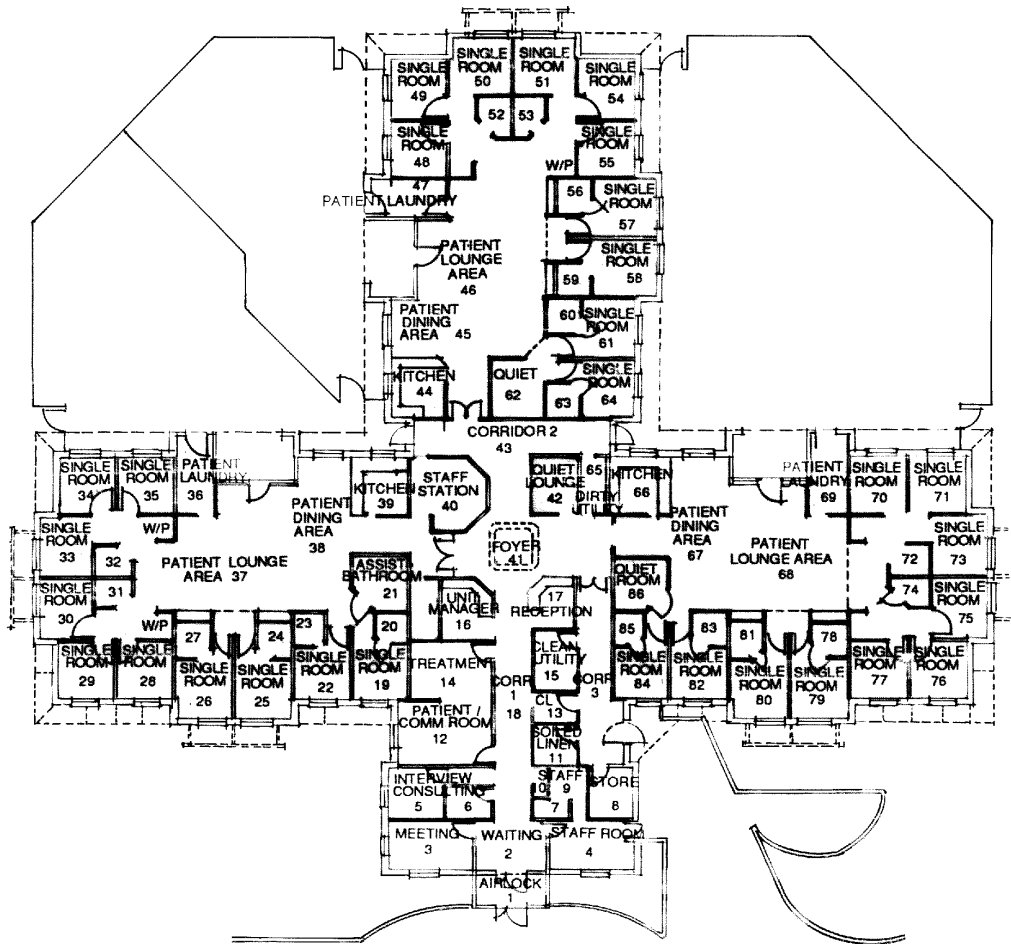
APMHS extended care services are also provided in designated beds in extended care centres or hospitals or in nursing homes auspiced by Aged Care. This arrangement is often favoured in rural areas, where the level of demand may not be sufficient to warrant the establishment of a stand-alone psychogeriatric extended care service.

Psychogeriatric hostels provide accommodation and help with daily tasks for clients who cannot live at home but who do not require full nursing care. They provide support and help clients to live comfortably and securely in a community which respects their independence, dignity and individuality. Accommodation is usually a single room, which residents can furnish with their own belongings. There is usually a private bathroom. Staff help with personal care, such as bathing, dressing and eating. Hostels are required to have staff on call 24 hours a day to help when needed. Access to psychogeriatric hostels will be governed by the Extended Care Admissions and Discharge Protocol referred to earlier in this section.

There are at present three psychogeriatric hostels in Victoria, with a combined capacity of 71 beds, all of which are non-gazetted. The most recent of these is a new 32 bed psychogeriatric hostel at Jacana which commenced operations in March 1995.

Figure 6 gives a statewide overview of psychogeriatric beds by facility type. The growth in PGNHs will continue as deinstitutionalisation continues, as will the increase in designated psychogeriatric beds.

Figure 5: Floor Plan of Merv Irvine Nursing Home at Bundoora Extended Care Centre



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BUNDOORA EXTENDED CARE CENTRE GROUND FLOOR PLAN
PSYCHOGERIATRIC NURSING HOME
DESIGN DEVELOPMENT

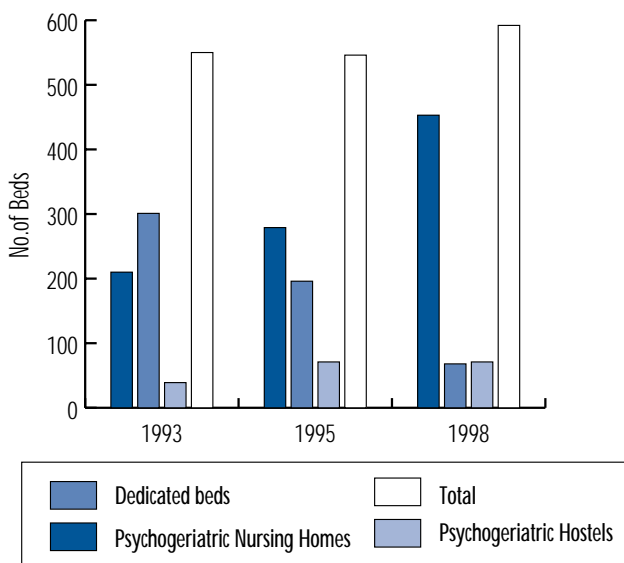
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Figure 6: Psychogeriatric Extended Care Beds by Facility Type: Trends 1993–1998.



It is not intended to develop any further hostels specifically designated for APMHS. Instead, Psychiatric Services will support the development of generic hostels and ensure that residents with a serious mental illness receive appropriate support in those settings—typically through PGATS services. This approach ensures that elderly persons with a mental illness are assisted in the least restrictive environment for as long as possible. The PGATS role will include education of hostel managers and regular consultancy as well as on-site assessment and treatment of residents.

Key Links for Extended Care Inpatient Services

Key service links for extended care inpatient services include:

PGATS

This link has been described in the ‘Key Service Links’ section.

Acute Inpatient Services

APMHS clients may be inpatients of acute inpatient services prior to their admission to a PGNH.

There will be a need to admit PGNH residents to acute inpatient services on certain occasions. Some PGNH residents, especially those with a functional mental illness, may at times become difficult to manage, placing other residents and staff at risk and/or causing a significant level of damage to facilities. The first, preventative measure, is to ensure that the physical environment of the PGNH is conducive to effective care, and that adequate life enhancement programs are in place. In further dealing with challenging residents, PGNH staff may use a number of strategies such as calling upon PGATS support, allocating extra nursing resources to challenging clients—the so-called ‘specialling’—or judicious use of a ‘quiet room’ for ‘time out’. Designated seclusion rooms are not acceptable as these would be at odds with the need to provide a home-like environment for residents. If the resident’s behaviour remains acutely disturbed, re-admission to acute inpatient services should be considered. As acute inpatient services are mandated by the Mental Health Act, they are able to access a broader range of treatment options, including seclusion. As part of their screening role for the acute unit, the PGATS may advocate admission on behalf of the PGNH. Acute inpatient services will accept all referrals which have been endorsed by the local PGATS.

ACATs

ACATs are instrumental in effecting client access to nursing homes within the context of PGATS case management. Collocation and operational integration of ACATs and PGATS will facilitate collaborative practice and lead to smoother client access to residential care services.

Auspice Agencies

APMHS extended care inpatient services have strong 'cultural' links with their auspicing body—typically an extended care centre funded by Aged Care. These links include administration, data, clinical, technical and maintenance support, reporting as well as in some cases joint staff. It is in these settings that mainstreaming becomes tangible, as discrete service components are blended into a supportive network of services. An important task of the manager of the mental health service will be to pursue the goal of mainstreaming while preserving at the same time the integrity and expertise of the psychiatric program.

Commonwealth Government

The Commonwealth Government plays a key role as the main funder of PGNHs and Psychogeriatric Hostels. Their role comprises standard development, through for example the Outcome Standards for Nursing Homes, as well as accreditation and monitoring. Commonwealth staff are available to provide support and information regarding clinical care and administrative practices and reporting.

The guidelines contained in the Outcome Standards support the APMHS case management framework by their emphasis that the individual case plan should address the full range of client needs. This holistic approach means that the range of links will have to be determined on a case-by-case basis. Other services will be required by clients in extended care services including dentistry and acute hospital services, among others.

Aged Care Nursing Homes, Hostels and Palliative Care Services

The case management framework ensures that clients receive an appropriate level of care according to need. Where it is no longer appropriate for a client to remain in an extended care inpatient service provided by

mental health services, the case manager will arrange transfer of the client to a more appropriate service.

Aged care nursing homes are sometimes reluctant to accept APMHS clients. This may create placement difficulties for the placement of older people with mental health problems from extended care facilities. It is therefore important that good links are in place and that other service providers and the client's family understand the role of extended care facilities within the comprehensive health services system. Managers of aged care nursing homes may more readily accept clients from extended care facilities if they believe that specialist resources are available, through the PGATS, to assist with the transition and ongoing management where necessary.

General Practitioners

The Commonwealth Outcome Standards specify that all residents are entitled to a doctor of their choice. While this option is not always exercised, the presence of GPs in PGNHs and hostels provides another important link with the general community. The involvement of GPs helps to break down the stigma associated with mental illness and assists the process of deinstitutionalisation.

GPs providing a service to APMHS clients are expected to visit their client(s) at least once per month. These visits and the involvement of GPs in regular case review provide important opportunities for sharing psychiatric expertise among service providers.

Psychiatrists, Psychogeriatricians and Geriatricians

Extended care inpatient services need to establish effective links with psychiatrists and psychogeriatricians in order to have access to expertise in geriatric psychiatry. As stated before, APMHS clients have multiple, complex needs. Improved links with

geriatricians are a positive outcome of the mainstreaming process.

Allied Health Staff

In accordance with the case management approach, allied health staff will be called in on a case by case basis to provide services to APMHS clients as required. Service providers called upon frequently include dietitians and physiotherapists. Life enhancement therapists are used in some facilities.

Non-Residential Disability Support Services

Psychiatric Disability and Psychiatric Illness

Psychiatric disability refers to the consequences of having a mental illness. If the definitions of the World Health Organisation (WHO) international classification system are used, mental illness includes the psychiatric condition and its symptoms as the impairment. Psychiatric disability includes both the disability and the social disadvantage (handicap). It covers the impact of the illness on a person's activities of daily living (disability) and the social disadvantages resulting from the illness itself and from being identified as a person with a mental illness (handicap). This separation of illness and disability was recognised in the other disability areas some years ago and was reflected in policy and service development and delivery for people with intellectual, physical and sensory disabilities.

Recognition of psychiatric disability services which are non-clinical and separate from clinical assessment, treatment and support services has occurred in the mental health domain in Victoria.

Non-Government Organisations' Psychosocial Rehabilitation Day Programs

These services are combinations of centre-based and community access programs. They operate according to the basic principles of psychosocial rehabilitation and those followed by the NGO psychiatric disability support sector in Victoria. All services are subject to the Commonwealth Disability Service Standards developed under the *Disability Services Act 1986*, which laid the legislative foundation for the *Commonwealth/State Disability Agreement* under which services are funded by H&CS Psychiatric Services Branch.

The actual programs may be based in a central environment, a day centre, or at other general, mainstreamed services, facilitated by the participant's

key worker. These activities may involve attendance at other day centres, neighbourhood houses, community centres, community health centres, Skillshare, TAFE programs, recreational activities, creative arts programs and/or social activities. They may also involve other day centre participants, as a group, in centre-arranged community activities. Programs differ in amount of structure to their program activities, with provision of a range of services from drop-in components to highly-structured psychosocial rehabilitation programs.

Over the past few years, there has been a marked increase in the number of people with mental illness, who also have serious psychiatric disabilities, attending NGO psychosocial rehabilitation day programs. This is a result of, not only an increased number of long-stay inpatients being transferred into community settings, but also because many people with long term mental illness are now living past the age of 65. NGO day programs have attempted to respond to the particular needs of these people, taking into account that the average age of participants is dropping because of the increase in younger, newly diagnosed Psychiatric Services clients being referred to these programs.

Increasing community awareness of mental illness and the advocacy work of key workers in NGO day programs will assist older people with psychiatric disabilities to participate in mainstream services. NGO day programs must be recognised as a critical part of the service system.

Supported Housing Programs

A range of supported housing programs exists. The most common involves linked housing and support delivered on an outreach basis. This form of support utilises the same principles outlined above and involves both in-home social and living skills facilitation and community access to mainstream programs or social and recreational activities. The focus on psychosocial rehabilitation distinguishes these specific

outreach support services from attendant care, personal care and HACC-funded services.

It is imperative that the provision of home-based outreach support to older persons with psychiatric disabilities be recognised and that the current specialist NGOs be included in the network of APMHS.

Service Development: The Next Steps

Objectives for Change and Development

A number of key objectives have been identified in order to ensure that service provision in the APMHS area incorporates the principles of Victoria's Mental Health Service: The Framework for Service Delivery. The objectives and strategies identified in this Framework for Aged Persons Mental Health Services document provide the basis for the APMHS strategic plan.

Building Comprehensive Service Networks

Regional Psychiatric Services Managers will ensure that clients have access to the full range of services in every region. They will also facilitate, monitor and review implementation of the policy framework. A review of the mix of services on a regional and area basis will be undertaken to ensure that service provision is targeted at the core client population in an efficient and effective manner.

Strengthening PGATS

The resource base of PGATS will be reviewed to ensure that the services are adequately resourced for the broad array of tasks which they undertake, in particular their case management role. Regional Managers will ensure that the interrelationship of ACATs and PGATS in their region supports the implementation of collocation and operational integration of the assessment teams in accordance with the principles outlined in this Framework. More detailed PGATS guidelines will be developed in close consultation with practitioners. These guidelines will articulate standards of care and outline the interrelationship between PGATS and other service providers.

Supporting Innovative Initiatives

Psychiatric Services will collaborate with Aged Care—both State and Commonwealth—in developing and supporting innovative initiatives which help meet the

psychogeriatric care needs of elderly people within the systemic framework outlined in this document.

Strengthening Acute Inpatient Services

Fifty-five admission and assessment beds are being developed in 1995–96. By 1998 the APMHS system will have the capacity to provide acute inpatient assessment and treatment to 250 elderly persons at any one time. This constitutes an increase of 51 per cent compared to August 1995.

Support and Expand PGNHs

As at October 1995, there were nine PGNHs, with a combined capacity of 264 beds. This will be expanded to 439 beds in 15 facilities by 1998—an increase of 59 per cent.

Psychiatric Services will monitor use and impact of current client rating scales and review the funding formula for PGNHs in consultation with the field.

Holistic and Expert Assessment

Clients will receive comprehensive and expert assessment which is culturally sensitive and undertaken within the context of coordinated client care.

Psychiatric Services will undertake a review of behavioural and mental health assessment tools in order to identify a set of tools which may be used across the field. Clinical costing mechanisms will be examined which comprise a behavioural component which is more comprehensive than the measures of dependence provided in the RCI.

Supporting Clients and Their Carers in the Community

PGATS will continue to provide in-home assessment, treatment and rehabilitation services as well as carer education and referral of clients to other support or assessment services as required. These may include

planned or emergency respite care, day programs and activity services. A range of innovative options for APMHS respite care and day programs will be developed or supported.

Continuing Partnership with Non-Government Services

Support for NGOs, which offer a wide range of information, education and support services for APMHS clients and their carers, will continue. NGO psychosocial rehabilitation day programs and supported housing programs are recognised as an integral part of the APMHS system.

Providing the Best Possible Standards of Care

Psychiatric Services will ensure that all components of the comprehensive health service have adequate access to psychogeriatric expertise. A workforce planning strategy will be developed in consultation with tertiary institutions and professional bodies to ensure that APMHS needs for qualified staff are met. Managers of psychiatric services will establish appropriate clinical consultation mechanisms to ensure that clients and/or service providers in rural, remote and isolated areas have access to the expertise of psychiatrists and/or psychogeriatricians. The consultation role of PGATS will be maintained. Psychiatric Services will monitor the impact of collocation and operational integration of ACATs and PGATS and of mainstreaming generally upon the level of clinical psychiatric expertise in APMHS.

Developing Service Standards for All Service Components

Quality assurance process and standards for H&CS purchasing of all APMHS components will be developed or reviewed. The standards will reflect the principles of mainstreaming and the need for

psychogeriatric expertise and will be specific in order to allow the establishment of benchmarks for service provision. Standards will be monitored and enforced through health service agreements.

Extended care services need to meet standards of psychiatric care, as well as the Commonwealth Outcome Standards for Nursing Homes. It is expected that they will participate in appropriate quality assurance processes such as the accreditation process of the Australian Council of Healthcare Standards (ACHS).

Improving Service Linkages

The interface between general aged care and aged persons mental health services has been enhanced through the completion of the mainstreaming of APMHS with generic aged care providers. In addition, linkages with general adult mental health services will be strengthened and strategies will be developed for clients with specific needs. Services will be required to establish appropriate mechanisms to ensure that service provision to aged persons is coordinated across program boundaries.

Training

Training of APMHS service providers is a crucial quality assurance tool. In the short term there is a need for training programs which support the redevelopment process by fostering a change in service delivery culture from institutional to community-based models of care. There is also an ongoing need for broader training in key skills areas such as assessment. Worker expertise needs to be fostered and sustained. This is particularly relevant to PGATS which have been collocated with an ACAT. Psychiatric Services will liaise with Staff Development Branch of H&CS about a training needs analysis of staff in APMHS and the development of appropriate training programs.

Data Collection and Monitoring

The Psychiatric Records Information System Manager (PRISM) will be implemented in PGNHs and hostels consistent with the mandatory conditions of the EOI process. This is to ensure that regular, reliable statewide data are available on all components of the APMHS system.

Evaluation and Research

Further research into deinstitutionalisation and a community-based service model will be encouraged. Collaborative research projects will be favoured, as will projects focusing upon client outcomes and the effectiveness of APMH service delivery structures. Practice-based research will be encouraged and models of best practice will be documented in order to maximise learning across the field. The generic briefs developed for PGNHs and for acute psychogeriatric units are being evaluated.

A funding mechanism to assess and prioritise grants for research and development initiatives will be developed. The development of a research and evaluation strategy will occur in consultation with the tertiary sector and research bodies such as the Mental Health Research Institute of Victoria and national bodies.

Conclusion

The shape of mental health services in Victoria is rapidly changing from the historical mode of service delivery, being custodial care. As a result of the redevelopment process, people with a mental illness now receive treatment and care predominantly within their community. This was a major step towards reducing the stigma traditionally attached to mental illness.

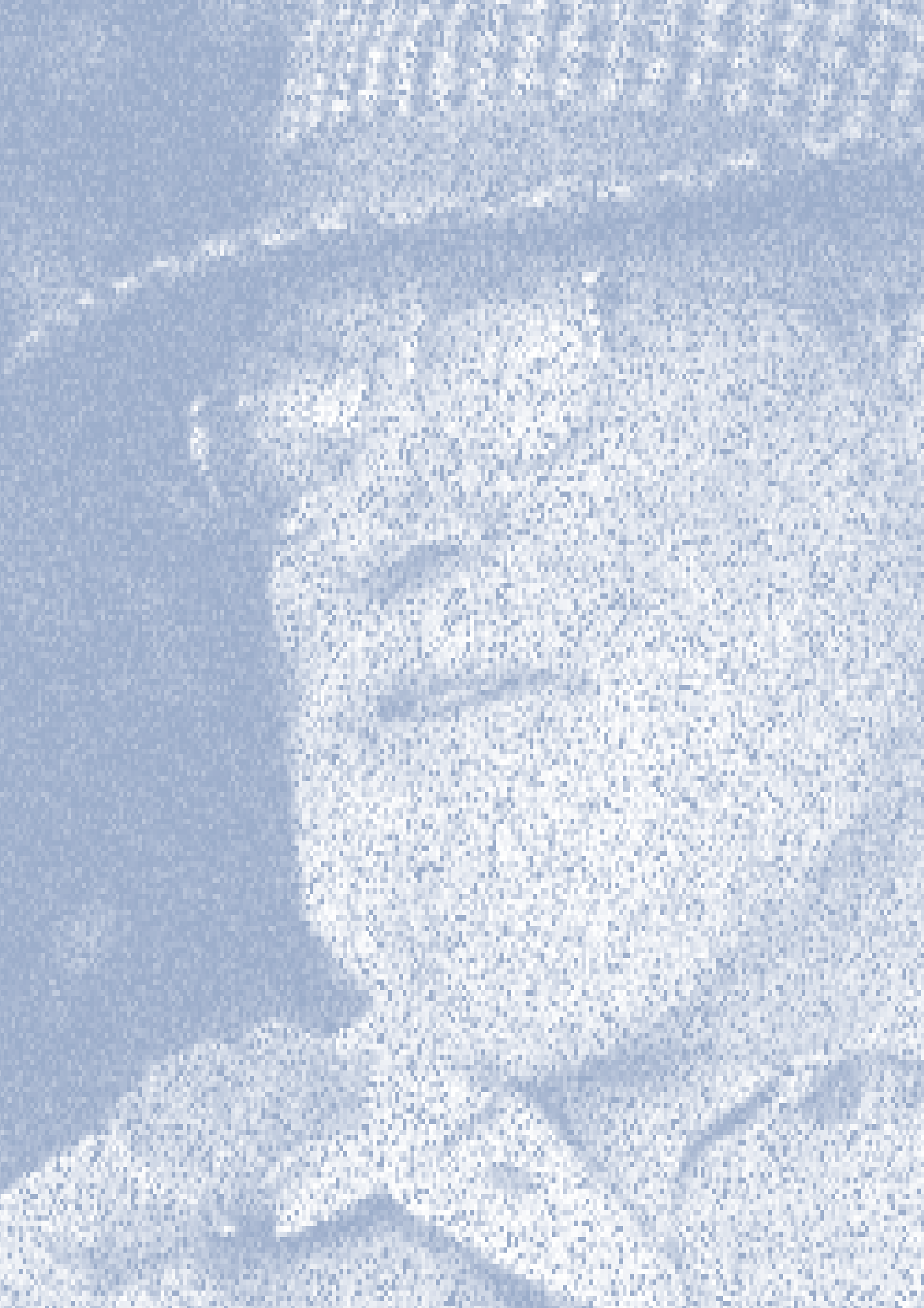
As a policy initiative, mainstreaming emphasises that APMHS are an integral part of the total package of services that are available for elderly persons (such as housing, health, social, welfare and activity services).

The principles for APMH service provision have been stated above and many key objectives and strategies have been identified to ensure that service delivery incorporates those principles.

An important objective is to maximise continuity of care by improving the interrelationship between APMHS and general aged care services. This will be partly achieved by collocation and operational integration of assessment teams and by fostering a climate of collaboration between the two service systems.

In pursuing these objectives, the primary yardstick for success will be client outcomes. Best practice will be identified through evaluation and documented, so that excellence can be examined and replicated elsewhere.

It is expected that the strategies contained in this Framework for Aged Persons Mental Health Services will provide the basis for ensuring that the best possible use is made of resources and that a growing and vulnerable group of clients receive the quality services to which they are entitled.



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Glossary

List of Abbreviations

ACAT	Aged Care Assessment Team
ACHS	Australian Council of Healthcare Standards
ADEC	Action on Disability within Ethnic Communities
ADL	Activities of Daily Living
APMHS	Aged Persons Mental Health Services
CACP	Community Aged Care Package
CAM/SAM	Care Aggregated Module/Standard Aggregated Module (the Commonwealth funding formula for nursing homes; the formula's third component is OCRE—below).
CAT	Crisis Assessment and Treatment (service)
DSM	Diagnostic and Statistic Manual for the Classification of Mental Disorders (produced by the USA Psychiatry Organisation).
ECC	Extended Care Centre (funded by Aged Care)
ECT	Electro-Convulsive Therapy
EOI	Expressions of Interest
GDS	Geriatric Depression Scale
GP	General Practitioner
H&CS	(Victorian Government Department of Health and Community Services
HACC	Home and Community Care (program)
ICD-9-CM	International Classification of Diseases
ISP	Individual Service Plan
MMSE	Mini Mental State Examination
NAPDC	National Action Plan for Dementia Care
NEMPS	North East Metropolitan Psychiatric Services
NESB	Non-English Speaking Background

NGO	Non-Government Organisation
NH5	Form required by the Commonwealth for Nursing Home admission
OCRE	Other Cost Reimbursements (part of CAM/SAM funding formula)
OECD	Organisation for Economic Cooperation and Development
PAS	Psychogeriatric Assessment Scales
PGATS	Psychogeriatric Assessment and Treatment Services
PGNH	Psychogeriatric Nursing Home
PRISM	Psychiatric Records Information System Manager
RCI	Resident Classification Instrument
REPDS	Revised Elderly Persons Disability Scale
SDB	Staff Development Branch (H&CS)
SRS	Supported Residential Service

Key Terms Explained

Case Management

Involves the monitoring and tracking of a client's progress through the service system, including ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within the integrated mental health service. Case management will vary in intensity according to client need and involve some delivery of clinical services.

Collocation

Collocation means the housing together of services in the same building or on the same campus. It is a planning measure which, if supported at the practice level, facilitates coordination of service provision without requiring amalgamation of service providers.

Continuity of Care

Integration and linkage of components of treatment and care across health service agencies according to individual need, and ensuring that the client's contact with a designated service provider or case manager is, as far as possible, continued over time. Continuity of care is both the focus and an outcome of good case management practice.

Coordinated Client Care

The case management framework adopted by Psychiatric Services.

Extended Care

The terms 'extended care' and 'extended care services' in this document refer to extended psychogeriatric care provided to APMHS clients and largely funded by H&CS Psychiatric Services. Thus defined, extended care is a type of service provided primarily in PGNHs and psychogeriatric hostels. This should not be confused with 'extended care centres' or 'ECCs' funded through the Aged Care program. The latter are State-funded public hospitals offering a mix of acute, residential and community care services.

Mainstreaming

A policy initiative which emphasises the importance of mental health services being an integral part of health, housing, social, welfare and recreational services, thereby helping to ensure that access to those services by people with mental disorders and mental health problems is equivalent to that received by the rest of the community. Administration of the mental health service system will occur in the same means as other health and welfare services.

Operational Integration

Operational integration means that service components work in unison at service delivery level and retain

sufficient integrity at management level to maintain and foster clinical expertise and to avoid program drift.

Rehabilitation

The United Nations' Standard Rules (see bibliography) define rehabilitation as 'a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.'

Treatment

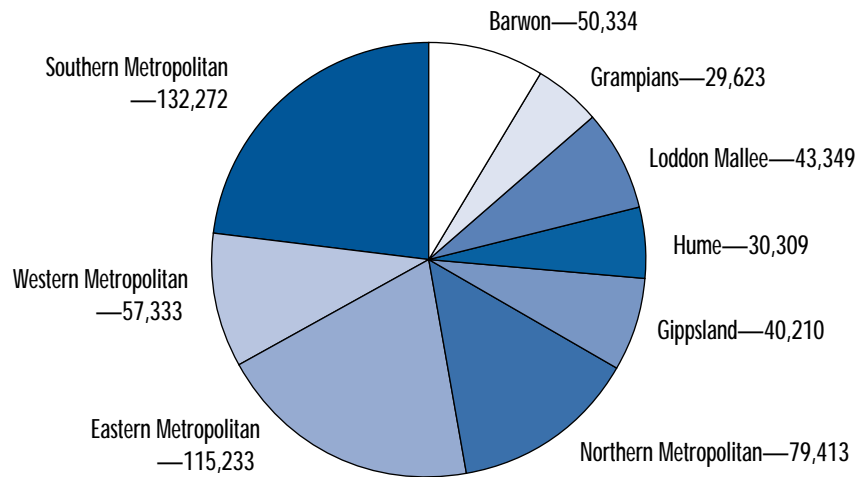
Treatment is the exercise of professional skill to remedy the disease or disability, or to lessen its ill effects or the pain and suffering which it occasions. Treatment of APMHS clients may therefore involve a broad range of clinical and personal support services, including rehabilitation, behaviour management, psychotherapy, ECT, medical treatment, diagnostic investigations, podiatry, occupational therapy, physiotherapy and respite care.

Attachment 1: Membership of the Aged Persons Mental Health Services Reference Group

Ms Jennifer Williams	Director, Psychiatric Services Branch, H&CS (chair).	Project Officers:	
Mr Andrew Stripp	Manager Service Planning and Review, Psychiatric Services Branch, H&CS.	Ms Colleen Tenni	Senior Program Advisor, Psychiatric Services, H&CS.
Dr Joan Clark	Executive Officer, Prahran City Mission.	Mr Gilbert Van Hoeydonck	Senior Project Officer, Psychiatric Services, H&CS.
Ms Kerrie Cross	Director, North West Hospital.		
Mr David Green	Assistant Director Aged Services Development, Aged Care Division, H&CS.		
Mr Alan Hall	Assistant Director, Psychiatric Services Branch, H&CS.		
Ms Phyl Halpin	Coordinator, Inner East Psychogeriatric Assessment and Treatment Team.		
Dr Anne Hassett	Senior Lecturer in Old Age Psychiatry, University of Melbourne and Clinical Director, Northern Geriatric Psychiatry Service.		
Mr Brian Joyce	Regional Director, Southern Region, H&CS.		
Dr Lyn McKenzie	Executive Officer, VICSERV.		
Ms Anne Osman	Manager, Psychiatric Services, St Vincent's Hospital.		
Prof. Daniel O'Connor	Professor of Psychogeriatrics, Academic Unit of Psychogeriatrics, Monash University.		
Ms Marilyn O'Sullivan	Director of Nursing, Aged Care Services, St. Georges Hospital and Inner Eastern Geriatric Service.		
Dr Tony Snell	Medical Director, Anne Caudle Centre, Bendigo.		

Attachment 2: Predicted Distribution of Aged Population by Region in 2001

Aged Population in 2001



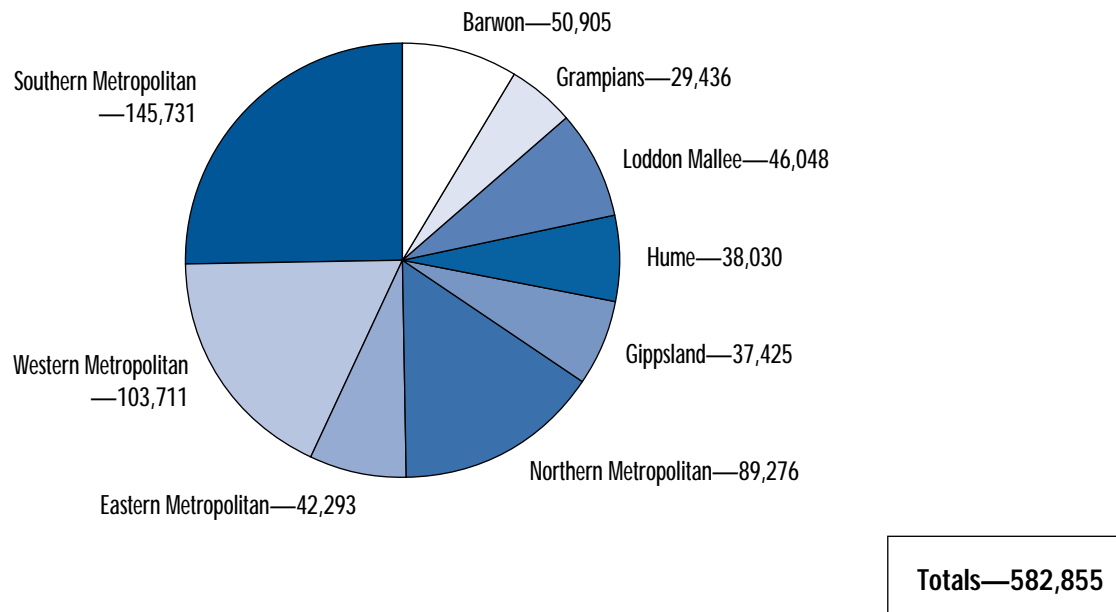
Source: Department of Planning—Preliminary Figures—November 1995

Note: The above chart is based on the actual population figures expected for 2001.

Please see attachment 3 for weighted population figures and projections.

Attachment 3: Projected Weighted Population over 65 by Region in 2000

Persons Over 65 in 2000



Source: *Masterplanning Review of Capital Expenditure Requirements for Mental Health Services in Victoria* (draft document, Pizzey Noble Pty Ltd et al, December 1994).

Important Note

Please note that the population figures in the above graph are 'equivalent estimates' based on the ABS population forecasts for the year 2000. The equivalence factors include socioeconomic, population structure and rurality factors. This means that specific local needs of a demographic nature have been incorporated into the above chart. For example, the population forecast for the year 2000 of 6,363 aged persons in Northern Mallee translates in an equivalent population forecast of 7,807 once equivalence factors have been incorporated. Conversely, the figure for Eastern Metropolitan Region is dramatically lower than the expected population figure for 2000.

Attachment 4: Nominal PGATS Staffing Profile

The notional staffing profile for a PGATS is as follows:

	EFT
Manager (VPS-4)*	1.0
Administrative Officer	0.5
Snr. Medical Officer	1.0
Consultant Psychiatrist	0.5
Registered Psychiatric Nurse (RPN-3)	2.0
Registered Psychiatric Nurse (RPN-2)	2.0
Social Worker	1.0
Occupational Therapist	1.0
Psychologist	1.0
Total staffing	10.0

* The manager’s classification is notionally VPS-4. It is expected, however, that the manager, in addition to providing leadership and management, will be able to undertake clinical duties.

meet with family members who are unavailable during normal working hours and continue with normal case work.

The indicative team profile set out above is of necessity a guide only. This is because of the following factors:

- The size of the PGATS service will need to be determined on the basis of local considerations such as size and mix of the elderly population. Factors such as the number of persons over 85 years of age, ethnic mix, disability levels and the availability of other support services may impact significantly upon service demand. Regional planners will purchase a level of PGATS services from the area mental health service.
- Managers may wish to vary the composition of the PGATS service to optimise the skills base of their team. The Hospitals Conditions of Funding 1995–96 state that it is the responsibility of the manager of psychiatric services in each agency to ensure an appropriate mix of medical, nursing, psychology, social work and occupational therapy skills in each service team, including the use of part-time and sessional staff for specialist skills (for example, neuropsychologist).
- Managers may choose to configure their teams differently in order to provide weekend cover to facilitate discharges in the latter part of the week,

Attachment 5: Aged Care Streams of Care Funding 1995–96

The table below shows the funding per occupied bed day for the *streams of care* funded through the Aged Care Division of H&CS. The daily rates listed do not apply to services funded wholly or in part through Psychiatric Services.

Stream of Care	Daily Rate
	\$
Evaluation and Management	250
Planned Geriatric Respite Care	130
Acute Care (including Emergency Respite)	320
Designated Rehabilitation Level 1	320
Designated Rehabilitation Level 2	280
Palliative Care	280
Designated Psychogeriatric	280
Nursing Home Type/Non Acute	110

Attachment 6: Existing Program Interfaces between Psychiatric Services and Aged Care Services

(Developed by both Aged Care and Psychiatric Services Divisions and associated regional staff).

Health Program and Prevention

Psychiatric Services

- Educative and preventive role of PGATS.
- Significant links with NGOs.
- Community education initiatives re mental health and the elderly commencing (for example, information brochure *Finding out about Mental Illness: Services for Persons over 65*).

Assessment

Psychiatric Services

- PGATS:
 - 17 services delivered from 23 locations.
 - Access: various sources, including self, family, GPs, ACATs and others.
 - More than 68,700 contacts involving over 4,550 clients in 1994–95.
 - Cost: approximately \$10.7 million in 1995–96.
 - Operating under Mental Health Act. Standards to be developed.

Aged Care Services

- General only—positive ageing and information programs (for example, Active at Any Age).
- HACC social support and associated programs.
- National Dementia Program education and information

Aged Care Services

- Eighteen ACATs:
 - (Jointly funded with Commonwealth Department of Human Services and Health (CDHS&H); managed by H&CS).
 - Access: referred from primary and aged care providers.
 - Approval/licensing: H&CS/CDHS&H.
 - HACC assessment services (non clinical). Seventy-eight local councils, some services being contracted out. In the context of compulsory competitive tendering (CCT), the H&CS guide suggests assessment and case management be maintained by local councils to promote continuity of care.

Acute Inpatient Services

Psychiatric Services

- Approximately 189 acute psychogeriatric beds provided in 15 locations.
- Will increase to approximately 225 beds in 17 locations.
- Access: through PGATS.
- Cost: approximately \$16.6 million in 1995–96.

Aged Care Services

- Acute Psychogeriatric:
 - 3 location: 3 ECCs.
 - 120 beds (approximately).
 - Access: assessment by geriatrician.
 - Cost: \$4 million (approximately).
- (Aged Care has acute inpatient services in a further five streams of care, which may involve services to older people with a mental illness. These inpatient services are delivered at 15 locations at a total cost of \$80 million).

Extended Care Services

Psychiatric Services

- Psychogeriatric nursing homes:
 - 279 PGNH beds in 10 facilities.
 - To be expanded to 453 beds in 17 facilities.
 - Access: PGATS assessment.
 - Cost: approximately \$6.9m in 1995–96.
 - Covered by Nursing Home Outcome Standards.
- Psychogeriatric hostels:
 - 71 beds in three psychogeriatric hostels.
 - No expansion envisaged but residents in general hostels will be able to access PGATS support.
 - Access: PGATS assessment
 - Cost: approximately \$0.7 million.
- Hospital-based extended care:
 - Predominantly in country areas where PGNH would not be viable.
 - Currently 196 beds in eight locations.
 - Redistribution will result in approximately 68 beds being provided in eight non-metropolitan locations.
 - Access: PGATS assessment.
 - Cost: approximately 10.5 million in 1995–96.

Aged Care Services

- General nursing homes:
 - 400 locations.
 - 16,000 beds.
 - Access: ACAT.
 - Cost: H&CS (\$30 million).
Commonwealth (\$700 million approximately).
 - Approval/licensing: Commonwealth and H&CS now with planning role only.
- General hostels (subsidised):
 - 200 locations.
 - 12,000 beds.
 - Access: ACAT.
 - Cost: Commonwealth only.
 - Approval/Licensing: Commonwealth and H&CS with planning role only.
- Private hostels/SRS:
 - 289 locations.
 - Beds: 8,500 approved.
 - Access: multiple sources.
 - Cost: private, no subsidy.
 - Approval/licensing: H&CS registers and regulates.
- Boarding houses:
 - 300 locations.
 - 6,000 beds (approximately).
 - Access: multiple, private housing.
 - Cost: private, no subsidy.
 - Approval/licensing: local council, minimal or no regulation.

Community Treatment and Support

Psychiatric Services

- PGATS:
 - As described above.
- Day Programs:
 - Specific psychogeriatric day programs established in four regions.
 - New ‘activity service’ model assists integration of clients into generic community-based activity services.
- Psychogeriatric respite care:
 - Planned respite can be delivered in extended care facilities.
 - Preferred setting for emergency respite is acute inpatient facility.
 - Access: through PGATS.

Aged Care Services

- Adult day services (HACC):
 - Locations: 236 (some services are dementia-specific).
 - Places: not available.
 - Access: general referrals and self-referred.
 - Cost: variable—average \$5/day.
 - Approval/licensing: H&CS, no licensing.
- Social Support (HACC):
 - Locations: 160.
 - Places: not available.
 - Access: general referrals and self-referred.
 - Cost: variable; some services are voluntary and free.
 - Approval/licensing: H&CS funding and no licensing.
- Respite care:
 - Multiple services, program rules, and overlapping provision.
- Dementia care.
- Other HACC services.
 - Home help, food services and Linkages are available for people with a psychiatric disability.

Attachment 7: Suicide Prevention Guidelines

Prevention of suicide in older people should involve the early recognition and aggressive treatment of depressive illness, the provision of support to the vulnerable bereaved, active intervention with high risk groups such as previous attempters, and intervention for alcohol abuse in later life. Gun control and careful prescribing habits are also likely to make a contribution. Health workers should routinely inquire about suicidal intent in all older depressed or emotionally distressed persons, particularly those with physical comorbidity. All older suicide attempters should be referred for urgent psychiatric assessment regardless of the apparent lethality of the attempt or the apparent absence of a classical depressed state. Early use of biological treatments including antidepressant medication and ECT in depressive disorders should be considered. As most older people who commit suicide have seen their doctor in the three months preceding their death, there is likely to be substantial scope for preventive intervention at the primary care level.

Extract from Byrne 1994, *The Recognition and Management of Mental Disorders in Older People*, NH&MRC/AGPS, Canberra.