Department Health and Families
Northern Territory Government

Report to the Director, Aged and Disability Program
on
The implementation of a psychogeriatric service for
the Northern Territory

December 2009
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Endorsed by Penny Fielding, Director Aged and Disability Program  
1 INTRODUCTION

1.1 Purpose of the Psychogeriatric Service report
The purpose of this report is to inform the Department of Health and Families, Aged and Disability Program, the outcome of a mapping exercise and community consultations across the Northern Territory (NT) from August to December 2009. Additionally, psychogeriatric (P/G) services in current use across Australian States and Territories will be identified and a best practice model suited to the Territory will be recommended. It is important to note that this project does not provide an in-depth gap analysis as the need for the P/G service has been identified in the Hospitals and Workforce Reform Plan.

1.2 Scope of the project
Sub-acute care under the terms and definitions used within the National Partnership Agreement Implementation Plan for Sub-acute Care includes geriatric evaluation, management and P/G care. This project focuses on the planning of a community P/G service in Darwin and Alice Springs, with a projected commencement date of January 2010. Within the context of the report, the term P/G also equates with the terms ‘psychiatry of old age’ and ‘mental health of older people’.

The National Health Data Dictionary defines P/G care as “care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance”. P/G services also aim to reduce hospital admissions, improve the likelihood of early discharge from hospital and reduce the risk of permanent residential care.

1.3 Objectives of the project were to:
- Map existing services and stakeholders across the NT, who service psychogeriatric clients
- Identify gaps in the service of psycho-geriatric clients
- Explore current models of psycho-geriatric service delivery across other States and Territory
- Recommend a best model of service delivery for a psycho-geriatric service in the NT
- Develop a timely implementation plan and commence recruitment processes for the commencement of the psycho-geriatric service by January 2010

1.4 Methodology
This report is the result of extensive consultation using a set of open-ended questions with NT stakeholders from acute care, mental health, community and residential care service providers from Darwin, Alice Springs and Katherine. Appendix C provides a list of those consulted. Data reports on likely target groups were accessed from relevant DHF business analysts (section 2.2), one community
care organisation, mental health data and the Department of Veteran Affairs. Supplementary to this, telephone interviews and a literature review were undertaken to identify like service models and plans, referral pathways and intake criteria (section 3).

As consultations progressed, common emerging issues were raised regarding service access and advocacy for older people with cognitive impairment, mental health disorders and those without carers. These issues are identified in section 4.

2. BACKGROUND

2.1 Literature review

P/G service delivery in Australia has developed significantly in the past 10 years. Internationally, Psychogeriatrics came of age in the 1970s with the first geriatric psychiatrists forming a specialty interest group and initiating related research. By 2007 Australia had 180 medical professionals trained in geriatric psychiatry through the Australian and New Zealand Faculty of Psychiatry of Old Age (www.fpoa.org.au).

The impact of the growth of the ageing population on health services and associated increase in the numbers of this cohort with dementia has instigated discussion and efforts to review issues related to the access to appropriate services for older people with mental health illnesses and severe and disruptive behaviours of concern related to dementia. Additionally, there is increasing concern regarding special needs groups in the age bracket 60-65 years. These include those with early onset dementia who are often more fit and agile and present with fluctuating and impulsive behaviours, Veterans with a history of PTSD, depression and alcohol-related disorders, and aged migrants with dementia and mental health problems.

The National Action Framework for Dementia states that the number of people under the age of 65 suffering from dementia will rise from 9,990 in 2005 to 14,220 in 2020. This represents approximately 3% of the estimated numbers of people with a diagnosis of dementia. While these numbers appear to be small the impact of their condition on health and support services is profound (Dept. Health & Ageing 2007). With the recent projections of dementia in Australia rising to 591,000 in 2030 (Access Economics 2009) there is an evident need for increased resources to assist with early assessment, diagnosis, research and interventions to enhance the person’s ability to remain in their own home. Evidence shows that people under the age of 65 years with mental health conditions receive 3 times more services and 4 times more office consultations than do the over 65 year olds (Draper & Koschera 2001).

The NT also has distinctive characteristics that influence service delivery planning. These include poor access to services for rural and remote clients, inadequate specialist staff, insufficient supported housing and lack of knowledge of health professionals working in this specialty field. In addition, there is insufficient information regarding the numbers of indigenous people with mental health disorders or dementia particularly in urban areas. Recent research in the Kimberley region has shown that the suggested prevalence rate of dementia could be 12.4% of the population compared to the current 2.6% rate for the rest of the nation (Smith, Flicker, Lautenschlager, Almeida, Atkinson & Dwyer, 2008).

Also, there is evidence that acquired brain injury is more prevalent in the NT, in particular in the indigenous population. This group is at higher risk of cognitive and behavioural changes, and their carers at higher risk of care-giver burden including depression and anxiety (Brodaty & Green, 2006). Other factors that create a negative effect on carers and family members include the physical changes
The number of older males in the NT over 65 years exceeds the number of females, and additionally, this population group are shown to be more likely to abuse alcohol, smoke heavily, experience more motor vehicle accidents and are less likely to exercise (ABS 2009). The majority of these men live alone with many in rural areas or in Territory housing. These negative lifestyle activities increase the risk of poor mental health especially depression, and also increase the risk of vascular dementia. Cardiac disease is also a considerable risk for this group and research shows that depressive disorders often follow clinical diagnoses related to cardiac conditions (Brodaty et al, 2005). Another group of significance in the NT is Veterans. This group historically has chronic and complex health conditions which are often exacerbated by a history of mental health. Studies (Australian Centre for Posttraumatic Mental Health, 2007) show that veterans are ageing faster than the general population and that within the next decade there will be an increase of 30% of veterans living alone, that half of the populations of veterans over 65 will have mobility problems and 85% of the veteran population will be over the age of 65.

Moreover, risk of depression and suicide are known to be higher in rural older men, in particular those without partners, those experiencing functional decline or those who suffer with painful chronic conditions (Bartlett & Davis, 2008; Fuller, Edwards, Proctor & Moss, 2000). Older patients are more likely to be successful in a suicide attempt. Studies identify that 28 males over the age of 75 (per 100,000 populace) will succeed in a suicide attempt whereas only 5 females succeed. Commonly older people do not report symptoms of mental health to their GPs and a wide gap between clinical diagnosis and self reporting occurs as people age. Early intervention, referral by the GP and follow up by P/G services has been found to be essential to improve health outcomes and reduce incidence of institutionalisation.

Some community studies have shown an incidence of 17-23 older people per 100,000 people experience paranoid disorders. Many of these are late onset and commonly not identified in early stages by GPs (Horstfall,1999; Howard & Levy, 1997).

Fifty per cent (50%) of residents of residential care facilities are shown to experience depression (15%) and other depressive disorders (35%), 5% have schizophrenia or paranoid disorders and a further group display disruptive and anti-social behaviours related to dementia (Snowden, 2007). There is generally poor assessment and treatment of this group due to inadequate funding for specialist consultancy services and paucity of knowledge of staff and attending GPs (Prince & Trebilco, 2007; Snowden 2007).

An international forum of professionals related to psychiatry of old age convened in 1997 to develop a Consensus Statement in the Organisation of Care in the Psychiatry of the Elderly (Chui, 2007). The group developed general principles of practice and chose the acronym CARITAS to promote specific principles for psycho-geriatric care. The principles are described below.

A comprehensive service: a person-centred approach - all aspects of patient’s physical, psychological and social needs and wishes
An accessible service: user friendly and readily available and minimising geographical, cultural, financial, political & linguistic barriers

A responsive service: active listening with prompt response to needs

An individualised service: focusing on the person in their family & community context & maintain the person in home environment

A transdisciplinary approach: collaborative approach and active networking with service providers

An accountable service: responsible, ethically and culturally sensitive

A systemic approach: integrative flexible model that promotes continuity of care

In the field of P/Gs, the importance of accurate diagnosis and collaboration across the health disciplines, in particular, psychiatry and neurology is emphasised (Dept. Health and Ageing 2008). In 2004 as a result of a commission by the Australian Health Ministers Advisory Council, the Centre for Applied Gerontology, Bundoora Extended Care Centre developed a guide for assessing older people in hospitals which was distributed widely throughout the State and Territories’ health services. The guide promotes evidence-based comprehensive assessment of older people and identifies relevant validated tools and resources which assist in a more efficient, effective and consistent approach to achieving better health outcomes for older people who attend hospitals.

Moreover, the Australian and New Zealand Society for Geriatric Medicine Position Statement No 15 identifies that poor hospital discharge planning for older people with chronic and complex conditions and who are at high-risk due to their psycho-social needs, frequently results in extended length of stay (LOS) in acute care, and adds to the risk of repeated admissions and permanent institutionalisation. This is supported by studies (Forero & Hillman, 2008; Williams & Botti, 2002) that describe multiple factors influencing these events such as homelessness, poor medication management, elder abuse and poor decision-making.

Temple (2008) reports that older people who live alone, and are not home owners, are at greater risk of housing affordability stress which is a contributing actor to mental health problems. They are also at risk of physical assault and financial abuse. Davis & Bartlett (2008) and Moss, Flower, Houghton, Moss, Nielsen & Taylor (2002) argue that where older people with co-morbidities are provided with community support with health services, their ability to remain living in the community increases.

CONCLUSION

It should be noted that following a report commissioned by the Hon. Justine Elliot, Minister for Ageing, in 2008, a Psychogeriatric Care Expert Reference group (ERG) was convened. The ERG is exploring innovations in treatment and care delivery for older people with mental health problems, and to develop strategies to foster collaboration across services. They report to the Ministerial Conference on Ageing. The NT is not represented on this group, however the report author has participated by teleconference on the national Older Persons Mental Health Network group and it is expected that representation on this group will continue as part of the role of the P/G CNC.

Recommendations from the 2008 report include:

- Short-term high dependency units with continued case management on discharge (reduces triggers attached to change of environment)
• Improved design for dementia management in RACFs
• Single campus to access multiple services to enhance case management ‘throughput model’ – step-up, step-down care
• Access to medical and psychiatric assessment, diagnosis & treatment to ensure appropriate pharmacological regimens are in place (usually State / Territory services)
• Access to DBMAS
• Skilled workforce
• Nurture collaborative partnerships & effective interfacing between primary, acute, mental health & aged care service systems

2.2 Related current NT services and demographics

The Northern Territory has the fastest growing population over 65 year age group in Australia. Recent figures describe the rate of growth for this cohort as eight times higher than the rest of the nation.

Existing community services for older people with organic brain disorders or newly diagnosed mental health conditions in the NT are limited. The Territory Older Persons Support Service program (TOPSS) auspiced by Frontier Services, commenced in 1999 to assist those people with dementia at risk of missing out on services due to their behaviours. In 2004 this service became the Dementia Behaviour Management Advisory Service funded by the Commonwealth through the National Action Dementia Plan and operates from Darwin, Katherine and Alice Springs with outreach services, for people with a diagnosis of dementia who exhibit behaviours of concern. The service provides clinical support, information and advice through clinical supervision, mentoring and modeling of behaviour management techniques, especially during transition to new care levels. Currently DBMAS funds a visiting Psychogeriatrician from the Gold Coast who holds a clinic every 3 months for 1 week to undertake assessments and review medications. This may include a visit to Alice Springs although due to increasing numbers in Darwin, Alice Springs had not been included in the visiting itinerary for the past 12 months. DBMAS also deliver training and workshops and have a 24 hour helpline for carers, care-workers and health professionals. Under their funding arrangement DBMAS do not provide services for people with mental health problems without a diagnosis of dementia.

Team Health is a community service provider that among other services, supplies Commonwealth funded Community Aged Care Packages (CACPs) services that assist older people with low to medium support needs to remain in their own home. This provider specialises in supporting older people with mild mental health problems through case management and they have a close working relationship with Top End Mental Health. In the past three years they have provided services to a range of non-indigenous and indigenous clients who live in the community as well as those who live in their supported housing complex “The Manse”.

The following three tables provide information about the ages and diagnostic categories serviced by this organisation from January 2006 until current time. It is interesting to note the cohort numbers with mental health problems (Table 3) between 50 to 60 years requiring home care support.
Table 1  Indigenous clients

Table 2  Non-indigenous clients
Additionally, Extended Aged Care at Home Dementia (EACHD) packages are funded by the Commonwealth for people with dementia who exhibit behaviours of concern and who live at home with a carer. The Aged Care Assessment Team (ACAT) assesses older people for eligibility for these packages which, in the NT are provided by several community care providers. They usually include about 20 hours per week of in home care delivery and required equipment that may support personal care needs, medication management and social interventions that reduce agitated behaviours. Also, there is a Dementia Support Worker (Nurse position) co-located with both Darwin urban and Alice Springs ACATs who supports the community geriatrician in assessment and medication review requirements.

The lack of support services for older people with mental health conditions or severe dementia frequently results in hospital admission following an episode of severe behavioural disturbance, a delirium related to infection or other acute physical condition, a fall or carer stress. Data from RDH, sorted by ICD codes into (a) dementia (Table 4), (b) mental health disorders (Table 5) and (c) delirium (Table 6) from 2004 – 2007, show admission numbers through Emergency Department (ED). Data from 2007-2008 is not yet available. Delirium is a major factor of the cause of disruptive behaviours, confusion, aggression and agitation in older people (Day, Higgins & Koch, 2008). Multiple studies (Ski & O’Connell, 2006; Dept. Health, Western Australia 2008) have demonstrated that the percentage of older people with delirium in acute care is often as high as 45%. From the available figures it is clear that delirium as a cause for hospital admission in the NT is under classified and including delirium as an event whilst an inpatient is undefined. Lack of detection, misdiagnosis and poor reporting of delirium exacerbate the problem, increasing the LOS and contributing to functional decline.
Table 4  Diagnoses of dementia classified at RDH

Table 5  Diagnoses of mental health at RDH
Table 6  

diagnoses of delirium at RDH

<table>
<thead>
<tr>
<th>Year</th>
<th>Indigenous 50+</th>
<th>Non-indigenous 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-05</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>2005-06</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2006-07</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

The case studies described below indicate the impact delirium can have on an older person in acute care.

M Black has spent 20 weeks in hospital to date. He is an 86 year old man who lives next door to his daughter and her family in urban Darwin and who support him with the assistance of community care. He has no history of cognitive impairment. He had a cardiac history and had a (long-term) stoma. He was admitted to RDH following a fall at home having suffered a laceration to his head and a fractured neck of femur and distal radius. He had significant pain and was treated with analgesics. He was anxious and at times agitated and within 3 days of admission a request was made for a dementia screening. Acute confusion with agitated behaviours increased and following assessment a urinary tract infection (UTI) was diagnosed. Following the anaesthetic on day 5 he exhibited increasing confusion related to delirium. He also had a fever and chest congestion. By day 14 he had developed a sacral pressure sore and had an infected elbow wound. Reports stated that he was in a depressed mood, complaining of lower abdominal pain and eating poorly. Day 26: additional pressure sore to his heel had developed with staph infection. He was also hypotensive. He experienced some minor seizures and another UTI. Medications included two benzodiazepams (not recommended in the elderly) - regular and prn, as well as a night sedation. Progress notes for next 6 weeks recorded further infected wounds, repeated UTIs, falls from his bed despite being specialised by a PCA, ‘emotional outbursts’ following bursts of aggressive behaviours, poor nutritional state, and references to depression and grief related to the recent death of his wife.

An alternative outcome may have been that when confusion first presented the P/G nurse (or an acute care CNC similar position) was contacted for to undertake a comprehensive assessment. Treatment for delirium instigated promptly, pain management and appropriate pressure relieving mattress sourced to reduce pressure sores. Nutrition and hydration monitoring would have been instigated thereby reducing tissue breakdown. Referral to mental health team to review his depressed mood would have followed with appropriate medication management. LOS would have been significantly reduced and likely respite residential care with a TCP implemented with a reasonable chance of an eventual return to home with community support.
Currently NT Mental Health services case manage a number of older people with an ongoing history of mental health problems. However when health or psycho-social problems occur that are age-related there is a service gap and this group often become long stay patients in the hospital wards or inappropriately placed in acute mental health wards for long periods of time.

The following case study describes a gentleman who spent some time in the acute mental health unit in Alice Springs and following treatment was transferred to an interstate residential care facility.

**Conclusion**

“NT Building Healthier Communities” report describes a focus on early intervention and using approaches that are culturally acceptable, sustainable and supported by
collaborative links between community and acute settings. Additionally, there is an emphasis on reducing hospital admissions by providing more care options. Through a program of education for all health service employees and a continued building of resources for the increasing numbers of older people in the NT, improved service delivery for this group will be achieved in time.

3. MODELS OF PSYCHOGERIATRIC SERVICES IN AUSTRALIA

All other States and the ACT have models of P/G services that are funded through various sources. Commonalities include the transformation of previous P/G Care Units to the DBMAS programs funded by the Commonwealth through the National Action Plan for Dementia. The NT DBMAS service is described in Section 2.2.

Additionally, in all other States and the ACT there are specialised services that target this group underpinned by mental health resources and framed by, for example, an Older People’s Mental Health Plan (WA) / Specialist Mental Health Services Older People (SMHOP) Service Plan (NSW). The focus of services such as these is to provide comprehensive clinical assessments in sub-acute care units where thorough evaluation and care planning can be undertaken. WA for example has seven state funded assessment centres operated by the area health services.

Referrals are taken from acute care (step-down) or from community and residential care (step-up). These step-up step-down units are sometimes co-located with the smaller regional or rural hospitals and thus have ease of access to medical services such as X-ray and pathology departments and also have collaborative arrangements with the local mental health services.

All units are staffed with a multi-disciplinary care team. Moreover, the units provide outreach training and education to community and residential care providers, and mentor these staff members to enable a successful transition of the older person from the unit to their home. This enhances staff confidence and increases competence in behaviour management behaviour issues. It also has been shown to reduce unnecessary admissions to both acute and sub-acute units, and improve discharge rates. Strict admission and discharge criteria policies are in place in these assessment units and families are counseled and educated throughout the admission period. Appropriate staffing selection is a crucial component of the success of these units and weekly staff meetings with either a mental health nurse or clinical psychologist are shown to reduce staff turnover and enhance recruitment.

An alternative model is the Special Care Units: 8 bed SCU at Hammond Care, NSW and in WA two 8 bed SCUs at Southern Cross Care and a 20 bed unit with Aegis. These are co-located with a residential care facility. The units are high dependency care models that enable those people with behaviours of concern or mental health conditions to be transitioned through to residential care or to their own home with a suitable community care package. The model is funded by the Commonwealth through the Aged Care Funding Instrument, with State top-up funding. Assessment, evaluation and care planning are similar to State run step-up step-down units. Regular visits by the area Psychogeriatrician are scheduled and staff are also supported by a part-time clinical psychologist.

In acute care, support teams such as Agedcare Services in Emergency Teams (ASETs), Older Persons Evaluation Review and Assessment unit (OPERA), Geriatric and Evaluation Management (GEM) wards and Nurse Practitioners in Aged Care or Psychogeriatrics assist fast tracking of older people thereby reducing access block. They also ensure clinical needs are being met and assist with best practice discharge planning.
**Recommendations**

It is recommended that future strategic planning for the NT include a step-down unit similar to the SCU models in NSW and WA. Frontier Services proposed during the project’s consultation processes that there be discussion with the Dept. Health and Families re support for a SCU wing to be added to their current high care facility at Palmerston. Top up funding similar to WA and NSW would need to be a component of the model.

Additionally it is recommended that a focus on older people at RDH be implemented to improve evidence-based practice clinical care through co-locating older people in need of geriatric assessment. This requires an increased effort to source a geriatrician to ensure better practice management.

4 FINDINGS

4.1 Target groups

Increasing numbers of older people living in their own homes impacts on carers, families and community care support services who are ill equipped to successfully manage mental health conditions and related behaviours. In the NT it is expected that there will be an increase in the age cohorts of people with organic brain disorders related to head injury, substance abuse and lifestyle related cerebral changes such as vascular dementia and Korsakoff’s syndrome. In addition, services are noting an increase in the number of older people living in squalid conditions. This group is commonly referred to as suffering from Diogenes syndrome, Collyer syndrome, Syllogomania or social breakdown. They are usually hoarders, live alone, and their living environment causes concern and often distress for families, neighbours and community services. Their condition is not viewed as a mental health condition and thus it is difficult for services to access appropriate assistance to improve their health and environment.

An additional concern is the likely increase in the number of elderly immigrants who are re-located from their home countries by local residents and the resultant emotional impact of grief and loss experienced by that cohort.

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Mr Black is a 69 year old man who was admitted to the Alice Springs Hospital Mental Health Unit under involuntary admission under section 42 due to mental disturbance. He displayed extreme and fluctuating paranoid and grandiose delusions. He had a long history of alcohol consumption with intermittent periods of intoxication and withdrawal resulting in auditory and visual hallucinations. He also suffered from several chronic medical conditions including renal impairment, hypothyroidism and anaemia. His wife was unable to continue as carer due to his difficult behaviours. Guardianship was appointed jointly to her and his son in Melbourne and he was transferred to a Melbourne aged care facility. **An alternative outcome may have been a referral from the GP or mental health team to the P/G CNC to provide psycho-social support for his wife and review their environment. This may have included access to the TCP residential care bed at The Old Timers Aged Care Facility where staff education, behaviour management and mentoring would have been provided. An alternative outcome may have been that he was admitted to the aged care facility with a 16 week program of case management to assist staff in settling him into his new environment. Carer burden would then have been lessened and he would have remained in Alice Springs.**
The target group for the NT P/G service is likely therefore to consist of people with diagnoses of depression, anxiety and affective disorders, late onset schizophrenia, Korsakoff’s syndrome, Squalor syndrome and dementia who are exhibiting behaviours of concern. Also it is likely, and according to reports from other P/G service models, carers who are receiving care or are seeking (or likely to be seeking) care and support related to anxiety and depression will constitute another target group for services. Within the target group there are subgroups with special needs such as people from a culturally and linguistically diverse (CALD) backgrounds, veterans and indigenous people.

It has been identified in other service models that potential clients are 50 years and over for the indigenous cohort and 60 years for non-indigenous cohort. This is due to the fact that those suffering from Korsakoff’s syndrome with related behavioural problems develop age-related problems earlier than other older people. Also, adults diagnosed with early onset dementia often experience a depressive illness during the early stages of the disease and benefit by support from a P/G service which can reduce the risk of at risk behaviours.

Referrals therefore, are expected to originate from multiple sources including GPs, acute care, community care service providers, mental health teams, organisations such as NT Carers and Alzheimer’s Association, and residential care providers.

4.2 Shared care

It is anticipated that health outcomes for the target group will in time be improved through collaborative partnerships between health teams, consumers and other stakeholders. This will be reliant on inter-agency protocols, clear referral pathways and intake criteria policies as well as ongoing education. Appropriate screening and risk assessment through triage will be a key component of the role of the CNC and likewise education provided to service providers, especially GPs. Past research has shown that role modelling of practitioners and education on dementia has reduced ageist attitudes of health professionals in acute care.

It must be highlighted that the current NT Guardianship Act does not enhance services to older people without carers and those with mental health problems. The Act is focused on adults with disabilities who have different needs to those with age related conditions and dementia or mental health problems. The current system of investigation and hearing is not conducive for older people to access and they and their carers are generally threatened by the process and the resultant stigma. There is a lack of understanding and knowledge about elder abuse, dementia, mental health in the older person, and communication and quality of life issues by those in the system. Historically, many of the target group are in need of guardianship and / or financial management due to risk of financial abuse or self-neglect and the need for clearer guidelines that are less daunting is evident from conversations with care providers.

In order for shared care arrangements to be successful, advocacy, recognition of the complex needs of people with dementia and their carers, and reduced ageism are paramount to success.

Recommendations:

It is recommended that compulsory education programs be rolled out to all Department health professionals to ensure there is increased knowledge and skills developed on dementia, delirium and mental health of older people and this includes subjects such as consent, capacity and advanced care planning.
4.3 Tele / video conferencing

As described in section 3 many rural and remote models of P/G service rely on a visiting Psychogeriatrician to undertake assessments, make a diagnosis and instigate an appropriate medication regime. This occurs within a case management framework with the P/G CNC, GP and other health professionals who may be involved in care support. Following this initial visit, use of video or tele-conferencing between the GP, case manager and the Psychogeriatrician is common in a rural community service, on an as needs basis, and is an effective medium to review medications or exacerbation of physical or mental health problems. Medicare funding for tele-conferencing with physicians has increased this access. Some remote services access funds to deliver telemedicine from the Medical Specialist Outreach Assistance Program funded by the Department of Health and Ageing.

In Queensland, a collaborative research project is being developed between Queensland Health’s telegeriatric and telepsychiatry service operating from the Princess Alexandra Hospital, RSL Care and the Centre for Online Health (University Queensland) to evaluate the effectiveness, efficacy and economic effect of video-conferencing that supports specialist psychogeriatric staff to improve the mental health and wellbeing of older people in residential care facilities. The difficulty older people experience accessing transport and coping with travel due to impaired mobility, sensory deficits and anxiety is well documented. It is anticipated that the opportunities to regularly case conference from the home environment will enhance the knowledge and skills of residential care staff in the management of older people with mental health conditions and behaviours of concern.

**Recommendations:**

Recent discussions between ACAT and Alzheimers Association in Darwin have identified a possible source of funding through COAG for the use of telemedicine. This needs to be investigated further.

It is recommended that the NT P/G service develop protocols to support GPs and community nurses and build capacity for these service providers through the use of telemedicine. Collaboration with Charles Darwin University may be an avenue to source grant funding through a research project to examine the effectiveness of follow up P/G services in rural and remote areas delivered by telemedicine.

4.4 Implementation plan

The tables below outline the service implementation plan.

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<thead>
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<th>Table 7</th>
<th>Implementation plan</th>
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<tbody>
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</tr>
<tr>
<td>Funding: $1.374million</td>
<td>1/7/09</td>
</tr>
<tr>
<td>Project review</td>
<td>4/8/09</td>
</tr>
<tr>
<td>Community &amp; P/G models consultation</td>
<td>5/8/09</td>
</tr>
<tr>
<td>Recruitment 2 FTE CNCs</td>
<td>31/10/09</td>
</tr>
</tbody>
</table>
4.5 Performance benchmarks

Benchmarks and reporting requirements are according to the National Partnership Agreement on Hospital and Workforce Reform (Schedule C). The expectations are that there will be an increase in P/G service of 20% to 2013. This is a conservative figure and it is expected that there will be an initial period during the first year of operation whereby referrals will need to be sifted and education regarding appropriateness will need to be undertaken.

<table>
<thead>
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<th>Table 8a</th>
<th>Benchmarks for reporting requirements</th>
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<tr>
<td></td>
<td>2009-10</td>
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<tr>
<td>Total referrals</td>
<td>20</td>
</tr>
<tr>
<td>Growth</td>
<td>4%</td>
</tr>
<tr>
<td>Ratio admitted</td>
<td>50%</td>
</tr>
<tr>
<td>Admitted P/G</td>
<td>10</td>
</tr>
<tr>
<td>ALOS per admission</td>
<td>5</td>
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<tr>
<td>Admitted days</td>
<td>50</td>
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<table>
<thead>
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<th>Table 8b</th>
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<tbody>
<tr>
<td>Non-admitted</td>
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<tr>
<td>Occasions of service per referral</td>
</tr>
<tr>
<td>Total occasions of service</td>
</tr>
</tbody>
</table>

Additionally, mental health outcome measures (MOAT) related to the National Mental Health Strategy will include HoNOS 65, LSP and possibly Kessler 10. Discussion with the Director Mental Health Program and their Business Analyst to identify additions to software required for the reporting requirements has been undertaken and an IT work project allocated to ensure, for example mandatory fields (diagnosis and source of referral) are added to the CCIS program.
4.6 Recruitment

The lack of sufficient numbers of and suitably qualified staffing in this field of health in acute, community and residential care indicates the need for experienced and well qualified professionals to be recruited to the positions in order to fulfil service objectives with regard to education and mentoring. As the service is new it is expected to be an evolving service model as target groups are identified. The position of a full-time Psychogeriatrician for the NT would greatly enhance health outcomes for the target group, reduce LOS and access block in NT hospitals and increase the capacity for older people and their carers to continue living in the community. Additionally, access to a P/G consultation service which includes staff mentoring and education would greatly improve the ability for residential aged care providers to offer sustained and appropriate care for people with behaviours of concern.

Two FTE Clinical Nurse Consultants (CNCs) at N5 level have been identified for Darwin and Alice Springs as required to initiate the service. The N5 level has been benchmarked against the Dementia ACAT CNC. Advertising through P/G networks, the Australian and Territory newspapers and positioning on the Australian P/G Nurses Association website was successful in attracting several applications. Interviews have been undertaken and the selection process is underway. The position will be co-located with the Darwin Urban and Alice Springs ACAT teams.

Recommendation

It is recommended that a full-time Psychogeriatrician be employed for the NT. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends a benchmark of 1 Psychogeriatrician for a population of 200,000. The role responsibility of the position would include consultation, comprehensive assessment, diagnosis and management, and liaison with GPs, acute and residential care and other health relevant health providers. The position would be based with the Darwin Urban ACAT alongside the P/G Clinical Nurse Consultant (CNC) and include outreach visits to Katherine and Alice Springs. There is an ability to supplement the financial resource for the position by outsourcing to DBMAS and also through Medicare rebates. In the meantime it is recommended a service agreement be made between the Dept. Health and Families and DBMAS be undertaken to broker the services of Dr Philip Morris to undertake three monthly visits of 1 week clinics to Darwin and Alice Springs to review, assess and diagnose P/G clients. This will piggyback to his service visits to DBMAS clients.

6 RECOMMENDATIONS

There is now a rapidly increasing number of older people remaining through to retirement in the NT. Government needs therefore to undertake to plan strategically for this group by examining service issues and demographics studied across the nation. Some of the future cohort (‘Baby boomers’) will be of a healthier status than previous related age groups with many choosing to continue to work well into their late 60s. However, as described throughout the report, there will be significant numbers of older people requiring health services. In order to reduce the impact on both Territory and Commonwealth resources, it is strategic to undertake planning that enhances community care and delivers proactive evidence-based practice that enhances the mental and physical wellness of older people.
The following NT specific recommendations have been drawn from current literature on P/G services, Government reports, research studies within the specialty and extensive consultations during the project time-frame within the NT sector:

- Complete Territory Dementia Framework
- Develop service plan for mental health of older people
- Develop triage system for identifying older people in ED to reduce risk of further delirium and reduce LOS and risk of access block
- Consider funding for a NT Nurse Practitioner in Psychogeriatrics who could be shared by the Top End Mental Health Team and Aged and Disability program
- Ensure fast tracking of RDH “GEM” ward to improve and speed up assessments and discharge planning for older people
- Provide training on delirium and dementia for hospital staff
- Develop training plan on capacity, consent, dementia and mental health of older people for department staff including adult guardians, investigating officers, community nurses
- Design referral pathway algorithm for use by hospital wards, GPs and service providers
- Seek additional funding to provide support e.g. through the Transitional Care Program for P/G clients living in squalor
- Promote need for accurate capture of data in community services, e.g. referral sources and diagnostic categories and hospital data including delirium
# APPENDIX A

## GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Anxiety disorder</td>
<td>State where a person has strong feelings of worry or dread, where the source is non-specific or unknown</td>
</tr>
<tr>
<td>BPSD</td>
<td>Behavioural and Psychological Symptoms of Dementia</td>
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<tr>
<td>CACP</td>
<td>Community Aged Care Package</td>
</tr>
<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<tr>
<td>Co-morbidities</td>
<td>Two or more coexisting medical conditions or unrelated disease processes</td>
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<tr>
<td>Delusion</td>
<td>False belief that misrepresents either perceptions or experiences</td>
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<tr>
<td>Dementia</td>
<td>A progressive organic mental disorder characterised by an onset of multiple changes in memory, abstract thinking, judgement and perception</td>
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<tr>
<td>Delirium</td>
<td>Acute change in a person’s level of consciousness and cognition that develops during a short period</td>
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<tr>
<td>DBMAS</td>
<td>Dementia Behaviour Advisory Services</td>
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<tr>
<td>EACH</td>
<td>Extended Aged Care in the Home</td>
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<tr>
<td>EACHD</td>
<td>Extended Aged Care in the Home Dementia</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>P/G</td>
<td>Psychogeriatric</td>
</tr>
<tr>
<td>Psychosis</td>
<td>State in which an individual has lost the ability to recognise reality</td>
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<tr>
<td>Schizophrenia</td>
<td>Mental disorder characterised by disordered thoughts, hallucinations and delusions</td>
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</table>
APPENDIX B

References


APPENDIX C

NT Stakeholders consulted

Frontier Services DBMAS
Frontier Services Regional Director
Golden Glow
COTA
Juninga Centre
Terrace Gardens Nursing Home
Tracy Aged Care
Masonic Homes (Tiwi Gardens)
Danila Dilba
Alzheimers Assoc
Tope End Mental Health A/Director
TEAM HEALTH
ACS SA/NT
OPG
RDH Discharge Planners & Remote Team
ACAT Darwin
TCP
RDH 7 CC Care Manager
NT Carers
Neuropsychologist V Garde
ACAT Katherine
CCIS Business analyst
ACAT Alice Springs
Co-director medicine RDH
NT Carers Respite program
RAPU Discharge coordinator RDH
Mental Health On Call Team
DBMAS Alice Springs
Cowdy Ward Consultants
DVA SA/NT
GPs
Wurrlie Wurrlie, Katherine
RDH Psych Social workers
Alice Springs Hospital Mental Health Liaison Officer
Dr Phillip Morris
Alice Springs Hospital Discharge Planners
RDH ED Discharge Planner
CDU Post Grad School Director
Alice Springs Dementia Worker
Psychiatrist Mental Health Top End
DoHA
Nursing Grand Rounds RDH
Old Timers RACF
Hettie Perkins RACF
Aged Care Network meeting Alice Springs