The Oakden Response Models of Care Project:

Services for behavioural & psychological symptoms of dementia

Residential services for older people with severe & enduring mental illness

Consultation Document

October 2017
### Document Information

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The SA Health Oakden Response Oversight Committee would like to specifically acknowledge the work of the Models of Care Expert Working Group as listed:

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Rosie Ratcliffe
Tarun Bastiampillai
Warwick Black
Traditional Lands of the Kaurna People

SA Health would like to acknowledge that the land all South Australian Older Persons Mental Health Services are located on is the traditional lands for the Kaurna people and we respect their spiritual relationship with this country. We also acknowledge the Kaurna people as the custodians of the greater Adelaide region and their cultural and heritage beliefs are still as important to the living people today. SA Health also acknowledges these Models of Care provide care for patients who originate from other traditional lands across all of Australia.

The term “Aboriginal” is used respectfully in this document as an all-encompassing term for Aboriginal and Torres Strait Islander people and culture.
### Abbreviations & Acronyms

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<th>Abbreviation</th>
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<tr>
<td>BPSD</td>
<td>Behavioural and Psychological Symptoms of Dementia</td>
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<td>CALHN</td>
<td>Central Adelaide Local Health Network</td>
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<tr>
<td>CAP</td>
<td>Care Awaiting Placement</td>
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<td>CHSA</td>
<td>Country Health South Australia</td>
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<td>DBMAS</td>
<td>Dementia Behaviour Management Advisory Service</td>
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<td>DSA</td>
<td>Dementia Support Australia</td>
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<td>EWG</td>
<td>Models of Care Expert Working Group</td>
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<td>FMC</td>
<td>Flinders Medical Centre</td>
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<td>IPRSS</td>
<td>Individual Psychosocial Rehabilitative Support Service</td>
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<td>LMH</td>
<td>Lyell McEwin Hospital</td>
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<td>LHN</td>
<td>Local Health Network</td>
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<td>MH-CCP</td>
<td>Mental Health Clinical Care and Prevention planning model</td>
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<td>NALHN</td>
<td>Northern Adelaide Local Health Network</td>
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<td>NBU</td>
<td>Neuro-Behavioural Unit</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NMHSPF</td>
<td>National Mental Health Service Planning Framework</td>
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<td>OPMHS</td>
<td>Older Persons’ Mental Health Service - SA Health</td>
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<td>RACF</td>
<td>Residential Aged Care Facility</td>
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<td>RAS</td>
<td>Rapid Access Service</td>
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<td>SALHN</td>
<td>Southern Adelaide Local Health Network</td>
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<td>SBRT</td>
<td>Severe Behaviour Response Team</td>
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<td>SMHSOP</td>
<td>Specialist Mental Health Services for Older People – NSW Health</td>
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<td>SRU</td>
<td>Specialist Residential Unit</td>
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<tr>
<td>SRU-EMI</td>
<td>Specialist Residential Unit for Enduring Mental Illness</td>
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<tr>
<td>TCP</td>
<td>Transitional Care Program</td>
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<td>TQEIH</td>
<td>The Queen Elizabeth Hospital</td>
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My Brother’s Voice

Here I am; I am here.
Don’t you see?
I can’t always say what I want.
But my feet stamp!
I slap my head!
The voices,
they are incessant,
they never stop;
when my head hurts they leave me alone.

I am here,
Don’t you see me?
Look at my nose; I am not a boxer; I fell.
I am falling; I don’t feel well.
I am giddy; don’t you see me.

Look at my face.
You are afraid.-
I’ve not had a shave;
One day, two, three, four and five.
Don’t you see me?
I am here and yet I am not.
Don’t you see me?
My feet stamp.
I am here.

Not always was I like this.
A laugh, a beer, a smoke.
I was an ordinary bloke;
Just like you.
I had a girlfriend; I’ve had more.
I saw the cricket,
A piece of the Pitch of the Centenary Match I have; …do you?
I liked what you have.
Comfort, care and love.
I had a Mum
I had a Dad.
I miss them.
I had dreams.
I was just like you and yet I am not.

I am here.
Don’t you see me?

Elizabeth A Owen
in honour of her brother Phillip, a former resident at the Oakden Campus
14 January 2012
1 Introduction

In April 2017, Dr Aaron Groves, South Australian Chief Psychiatrist, submitted the Oakden Report to the Chief Executive Officer of the Northern Adelaide Local Health Network (NALHN) and to the Minister for Mental Health and Substance Abuse. The Oakden Report documented the extensive and significant failures of services delivered through the Older Persons’ Mental Health Service (OPMHS) at the Oakden Campus, resulting in poor quality care of older people with very severe and extreme behavioural and psychological symptoms of dementia (BPSD) and severe and enduring mental illness.

The SA Health Oakden Response Plan Oversight Committee was established in June 2017 to provide oversight and guidance in implementing the six recommendations in the Oakden Report. Six distinct but interrelated expert working groups have been established to implement each of the recommendations.

This document presents work undertaken by the State-wide Model of Care Expert Working Group (EWG). The EWG, which was formed to respond to recommendation 1 of the Oakden Report, commenced meeting in July 2017. The EWG comprised members with lived experience, industry and community stakeholders, representatives from industrial bodies and health professionals from a variety of different disciplines from all South Australian local health networks (LHNs), excluding the Women’s and Children’s LHN.

It was identified that the Oakden Campus had provided services for three primary cohorts:

- People with extreme BPSD, including people under 65 with early-onset dementia
- People with severe BPSD, including people under 65 with early-onset dementia
- Older people with complex, enduring mental illnesses (such as psychotic or severe affective disorders).

Through a process of stakeholder consultation and best practice evidence analysis, the EWG have developed a streamed and layered service model framework for people living with dementia and presenting with BPSD, and older people living with severe and enduring mental illness. The framework outlines pathways for an older person with complex care needs to move between different levels of service provision across public health and non-government service sectors, minimising disruption to the person and their carers whilst responding to fluctuations in clinical presentation.

Stakeholder engagement identified core principles which have underpinned the development of the models, with a commitment to person-centredness and developing partnerships being at the heart of these. The importance of giving voice to consumers and carers was recognised as the most fundamental protection for future services to prevent the tragedy of the Oakden Campus occurring again in South Australia.

This document is presented for consultation to stakeholders across services and the South Australian community. It is acknowledged that the development of full replacement services for the Oakden Campus will take time, commitment and resources. It is anticipated that some of the models presented here will require further discussion and development but it is hoped that through collaboration, South Australia can move towards the implementation of services that will better meet the needs of older South Australians encountering the most challenging health, accommodation and lifestyle needs.
2 Key Recommendations

2.1 A Streamed Approach for Service Delivery for BPSD & Enduring Mental Illness

It is recommended that services for people living with dementia and presenting with BPSD and services for older people living with severe and enduring mental illness should be developed as two streamed and layered models of care. Whilst considerable commonality will exist between service providers, particularly with regards to OPMHS, consumers within these two service streams have distinct and different needs, and are disadvantaged if approaches to care are aligned together. In particular, high dependency clinical services and specialist residential services should not be provided in such a way as to combine these two cohorts as occurred previously at the Oakden Campus.

2.2 A Layered Model of Services for BPSD

It is recommended that South Australia develop a layered model of services for BPSD built around key partnerships between the Commonwealth, SA Health, aged care providers, consumers, carers and communities. The objective of a layered approach to service delivery will be to provide flexible and efficient pathways to care for people with BPSD stepping up and down between services based on clinical needs. Specifically, SA Health will take responsibility as a provider or prominent partner in the following three service strategies:

1. Development of 24 high dependency neurobehavioural beds to provide care for people presenting with extreme BPSD (Brodaty tier 7). These beds should be fully state funded, authorised under the Mental Health Act 2009 and developed within a highly skilled specialist multidisciplinary clinical framework.

2. Development of Specialist Residential Units for people presenting with very severe BPSD (Brodaty tier 6). These will be Commonwealth funded aged care beds with a state ‘top-up’ funding model, requiring partnership between SA Health, the Commonwealth and approved aged care providers. It is estimated that South Australia will need up to 120 beds for the very severe BPSD cohort by 2021. Commonwealth and State collaboration will be required to meet this need. It is recommended that SA Health initiate a first phase, in which 60 beds are developed across metropolitan Adelaide.

3. The OPMHS Rapid Access Service, as piloted and developed by SALHN OPMHS, should be implemented through the OPMHS in each LHN as an effective strategy to improve the capacity of mainstream RACFs to manage moderate to severe BPSD, reducing referrals to other layers of service provision.

2.3 Residential Services for Older People With Severe & Enduring Mental Illness

It is recommended that South Australia develop improved accommodation and care services for older people living with severe and enduring mental illness. This is a disadvantaged and vulnerable cohort within the South Australian community, for whom adequate choices and viable options are not currently available. It is recommended that three strategies be further developed to address this need:

1. Development of supported community living options, customised for older people with enduring mental illness and building partnerships between consumers, advocates, SA Health, the Commonwealth, non-government and aged care provider organisations. It is estimated that South Australia currently requires between 30-60 placements of this type.

2. Development of Specialist Residential Units for people living with severe and enduring mental illness. These will be Commonwealth funded aged care beds with a
state ‘top-up’ funding model, requiring partnership between SA Health, the Commonwealth and approved aged care providers. It is estimated that South Australia currently needs approximately 16 beds of this type.

3. Implementation of the OPMHS Rapid Access Service and the further support and development of community OPMHS across all LHNs is recommended to enhance the service provision provided to older people living with enduring mental illness in both community and mainstream residential aged care settings. This will reduce demands for other levels of service.

2.4 Interim Service Requirements

The interim period between the closure of services at the Oakden Campus and the full implementation of contemporary new services, will place increased demand on remaining acute and community OPMHS in all LHNs. An adaptable approach will be required during this period with efforts to enhance the efficiency of acute bedded OPMHS and to optimise services delivered through the mainstream residential aged care sector. There are three key strategies to support this:

1. Adaptable use of existing bedded services with a recognition that acute inpatient OPMHS will be required to provide acute and transitional care for older consumers. Additionally, the recently commissioned Northgate House will continue to provide 14-16 non-acute beds for complex consumers during the interim period.

2. Wrap around services, including targeted back-charge arrangements for partner RACFs receiving discharges of consumers with BPSD from acute inpatient OPMHS, should be developed as a strategy to maintain flow in acute services and reduce the costs associated with extended acute admissions. This strategy was developed during the closure of the Oakden Campus and was shown to support successful transfers to RACFs. It is recommended that this strategy be continued during the interim period to maintain flow from acute units across all LHNs and reduce the risk of representations.

3. Immediate development of the OPMHS Rapid Access Service across all metropolitan LHNs as a strategy to improve the capacity of mainstream RACFs to manage consumers with BPSD and enduring mental illness, reducing the risk of presentations to acute services and supporting the sustainability of placements.

2.5 Services for Regional Communities

It is recommended that partnerships between the Commonwealth, SA Health and aged care providers are developed to improve the delivery of supportive services to RACFs in regional South Australia. This will involve development of the back-charge service model for partner RACFs caring for people with severe BPSD, strengthening of Country Health OPMHS capacity to provide specialist support to regional service providers and development of collaborations with other specialist providers, particularly Commonwealth funded Dementia Support Australia (DSA) services.
3 Purpose & Scope

This document outlines new models of care for South Australian bedded and residential services for three cohorts of people:

- People with extreme BPSD, including people under 65 with early-onset dementia
- People with severe BPSD, including people under 65 with early-onset dementia
- Older people with complex presentations of enduring mental illnesses (such as severe psychotic or affective disorders)

These models will replace services previously provided at the Oakden Campus Older Persons’ Mental Health Services and reflect the South Australian Government’s commitment to implement the recommendations of the Oakden Report.

The models are embedded in an overarching framework that outlines pathways for an older person with complex care needs to move between different levels of service across public health and non-government sectors, minimising disruption to the person and their carers whilst responding to fluctuations in their clinical presentation. The models are aligned within the framework in two streams, one for people with BPSD and the second for older people with severe and enduring mental illness. The framework has been developed with recognition of the differing needs of people in these two service streams and these models are developed to provide separate and specific services appropriately.

The models are person-centred and based on contemporary, evidence-based approaches to aged care. These models will provide adaptable and sustainable service capacity to meet the complex care needs of older South Australian's now and in the future, with potential for further development across sectors to respond to the requirements of South Australia’s ageing population. Figure 1 provides an overview of the transition of services from the Oakden Campus to the new models of care.

Figure 1: Overview of transition from services at Oakden Campus to new streamed models of care
3.1 Aboriginal Consumers

The view of “mental health” for Aboriginal people is not taken in isolation but viewed in a holistic manner. It is extended beyond the individual to families and entire communities and is not separated from physical health or spirituality. Aboriginal people function from the perspective of wellness as opposed to illness. As such, the terms “mental health” or “mental illness” can be inappropriate from an Aboriginal person’s perspective.

The delivery of this overarching framework will take into account the special relationship to family, community and Country and the significant sense of loss, grief and trauma from past and current events that many Aboriginal people experience. The MOC aligns to the SA Health, Mental Health Services Pathways to Care Policy Guideline which provides specific inclusion principles and guidelines to cater for the needs of Aboriginal people, including:

- To provide diversity of choice within the design of care and treatment options for Aboriginal people, including access to Aboriginal traditional healers, translators or interpreters through the Traditional Healer brokerage program and the South Australian Aboriginal Languages Interpreters and Translators Guide.

3.2 Culturally and Linguistically Diverse (CALD) Consumers

This MOC recognises the importance of culture and the migration experience of South Australian consumers, carers and families of culturally linguistic and diverse backgrounds. This MOC will ensure that at every point of contact, services are provided in a culturally and linguistically appropriate manner, which is respectful of the cultural, linguistic, religious and spiritual needs, or other specific needs such as diet and gender, of people of CALD backgrounds. In addition, consumers and communities of CALD backgrounds are welcomed as active partners in the planning and development of culturally competent mental health care services for older South Australians.
4  Background

In April 2017, Dr Aaron Groves, South Australian Chief Psychiatrist, submitted the Oakden Report to the Chief Executive Officer of the NALHN and to the Minister for Mental Health and Substance Abuse. The Oakden Report documented the extensive and significant failures of services delivered through the Older Persons’ Mental Health Service at the Oakden Campus, resulting in poor quality care of older people with severe and extreme behavioural and psychological symptoms of dementia and severe and enduring mental illness. The report identified failures in clinical and corporate governance with systematic decline in resources and service provision over time. It identified antiquated nursing practices, negative and harmful staff culture, and high levels of inappropriate use of restrictive practices. The quality of services provided at the Oakden Campus resulted in neglect and harm to consumers.

The Oakden Report was a catalyst for a period of community outrage that responded to intense media reporting and scrutiny. The Oakden Report also triggered a range of other investigations and reviews within South Australia and nationally. The result of this was a time of challenge, reflection and change felt across state, commonwealth and non-government aged care sectors with continuing ramifications presently.

The Oakden Report made six recommendations that were accepted in full by the Government of South Australia. Specifically, recommendation 1 articulated that:

- SA Health should develop a specialised contemporary Model of Care (MOC) that addresses the State’s obligation to provide high quality care to people over 65 years of age who live with the most severe forms of disabling mental illness and for those people with the most severe and extreme Behavioural and Psychological manifestations of Dementia.

- The Model should be developed as a partnership between all Local Health Networks (LHN) across the state and be led by suitably qualified clinical experts in the field of older persons’ mental health. It should involve the full range of possible partners to such a model including, but not limited to, Consumers, Carers, Experts in Geriatric Care, referrers, staff, the Residential Aged Care Facility (RACF) sector and other providers of BPSD services.

- The Model should draw reference from the NSW plan for specialised OPMHS and by those providing similar services in Victoria and NSW. The Model should rely on detailed population-based planning, taking into consideration but not being bounded by the National Mental Health Service Planning Framework (NMHSPF) version 2.1.

- The Model should be supported by a Business Case that identifies the funding needed to implement the new model and take proper account of the need for funding to allow the transition from the current service to a future model.

- The Model should identify the range of services needed across the continuum of care; between services provided in a person’s home (including Hospital in the Home), those in other residential settings, acute inpatient services, and transitional care; that will allow for the proper care to older South Australians who experience BPSD or who have severe mental illness. It is estimated that South Australia currently has need of between 60 and 90 transitional care beds.

- The Model should identify as a priority the site(s) for a purpose built unit for people with Tier 7 BPSD and that unit(s) be constructed in consideration of the full range of services needed to provide high quality safe care. It is
predicted that the unit(s) currently requires 21 beds and will need 24 beds by 2021.

- The Model must take into account how to jointly operate services that are funded with Commonwealth Aged Care Funding and State Specialist Mental Health funding for people with BPSD, when they cannot be provided with service through the privately owned Residential Aged Care sector.

- The Review recommends this process commences immediately and that responsibility for progressing this be shared by all LHNs and should not be considered the sole province of NALHN.

An important aspect of the MOC development will be identifying the interface with existing services, including Commonwealth subsidised Residential Aged Care and how the OPMHS can be flexible to support existing services to provide appropriate care to this consumer group.

This document provides a response to recommendation 1 of the Oakden Report by describing models of care, organised in two streams, for BPSD and severe and enduring mental illness, embedded in an overarching framework that provides context within the continuum of care for replacement services for the Oakden Campus.
5 Development and Context

This section provides an overview of the development process of the framework and streamed models of care. It also provides a context for the models within relevant legislation, underpinning principles and the evidence base considered in the models’ development.

5.1 Model Development

Following the Oakden Report and acceptance of all six recommendations by the South Australian Government, an Oversight Committee was established to ensure that all recommendations were fully developed and implemented. The Oversight Committee determined that an expert working group should be established for each of the six recommendations of the Oakden Report, in order to provide focused leadership and ensure a thorough approach to developing achievable plans for each recommendation. Each expert working group was established drawing from consumers, carers, advocacy bodies, industry representatives, industrial bodies, aged care experts and SA Health clinicians from older persons’ mental health and aged care services. Timelines were developed for the working groups to report back to the Oversight Committee. The working groups were also established with considerable interrelationship with each other, recognising the need for an integrated, ‘whole of project’ approach, under the governance of the Oversight Committee.

This document is the result of the work led by the State-wide Model of Care Expert Working Group (EWG). The EWG comprised representatives from each LHN, including clinicians from OPMHS and aged care services, representatives from industrial bodies and a number of industry, community, consumer and carer representatives. Broad community and industry stakeholder consultation was undertaken through gallery walk workshops and written feedback. Interstate expert consultation was also undertaken through liaison with experts from NSW Health, Victoria Health and Dementia Support Australia.

5.2 Legislative & Policy Context

In developing these streamed and layered models, the following policies, strategic plans and legislative frameworks have been considered:

- SA Mental Health Act 2009\(^4\)
- SA Guardianship and Administration Act 1983\(^5\)
- SA Consent to Medical Treatment and Palliative Care Act 1995\(^6\)
- SA Advance Care Directives Act 2013\(^7\)
- Strategy to Safeguard the Rights of Older South Australians 2014-2021\(^8\)
- Specialist Mental Health Services for Older People (SMHOP) NSW Service Plan – 2005-2015\(^9\)
- Specialist Mental Health Services for Older People (SMHSOP) Acute inpatient Unit Model of Care Project Report, 2012\(^10\)
- Evaluation of the Mental Health Aged Care Partnership Initiative: NSW Health Policy Response, 2011\(^11\)
- Older Persons’ Mental Health Service South Australian Metropolitan Areas Model of Service, 2012\(^12\)
- SA Health Services Plan for People with Dementia (and Delirium), 2015-2018\(^13\)
5.3 Service Elements

This service framework describes bedded services for people living with severe and extreme BPSD and/or presentations of severe and enduring mental illnesses. It proposes sustainable, contemporary replacement services for the Oakden Campus.

The relevant service elements include:

- SA Health assessment services within community based and acute health services, to provide triage and inform access.
- Community-based OPMHS teams.
- Community-based geriatric medical/aged care teams.
- Acute OPMHS inpatient services.
- Acute geriatric and general medical inpatient services.
- A new, purpose built 24 bed state-wide Neuro-Behavioural Unit – for extreme behavioural presentations of dementia.
- Specialist aged-care residential services for severe BPSD delivered through a partnership model.
- Accommodation and care options for older people with severe and enduring mental illness, including supported community living options and specialist aged care residential services.
- Mainstream residential aged care services.
- Commonwealth funded services for aged and dementia care, including, but not limited to, Dementia Support Australia (DSA), comprising the Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Team (SBRT).
- Non-government aged and older persons’ mental health psychosocial and functional supportive services, including program initiatives such as the Individual Psychosocial Rehabilitative Support Service (IPRSS).

5.4 Key Principles From Stakeholder Engagement

As part of the strategy for stakeholder engagement in developing the models of care, a Gallery Walk was held in August 2017. The Gallery Walk provided an open invitation to stakeholders from across the community, industry and SA Health to attend an interactive workshop exploring key issues and collecting data to inform the development of the models of care. Data emerged from this process indicating strong stakeholder preferences around the development of a set of underpinning principles that should be used in the development of the overarching framework and streamed and layered models of care. These guiding principles are outlined as follows:

5.4.1 Right Care, Right Time, Right Place, First Time

Through a streamed, layered and multifaceted approach to service delivery, the framework reflects SA Health’s commitment to delivering ‘the right care at the right time and in the right place, first time.’ This is expanded as follows:

- Right care: ensuring the availability of staffing, skills, expertise and resource for the management of the individual’s specific health care needs.
• **Right time:** ensuring the availability and access to the required services to meet the individual’s needs in a timeframe that will minimise adverse outcomes and/or complications.

• **Right place:** ensuring that the individual’s care is provided in a health facility that will vest meet their specific needs.

• **First time:** ensuring that the required care is provided in the most appropriate place within necessary timeframes first time and that transfer to various facilities, services and personnel is not required.

### 5.4.2 Person-Centred Care

It is intended that these models should reflect a fundamental commitment to person-centred care. Person-centred care is terminology first developed in relation to dementia care by Tom Kitwood (1993)\(^4\). There is a large body of literature that describes person-centred approaches. Alzheimer’s Australia has developed useful definitions as follows\(^5\):

Person-centred care is a philosophical approach to service development and service delivery that sees services provided in a way that is respectful of, and responsive to, the preferences, needs and values of people and those who care for them.

**Key principles of person-centeredness are:**

• **Valuing people:**
  
  Treating people with dignity and respect by being aware of and supporting personal perspectives, values, beliefs and preferences. Listening to each other and working in partnership to design and deliver services.

• **Autonomy:**
  
  The provision of choice and subsequent respect for choices made. Balancing rights, risks and responsibilities. Optimising a person’s control through the sharing of power and decision-making. Maximising independence by building on individual strengths, interest and abilities.

• **Life Experience:**
  
  Supporting the sense of self by understanding the importance of a person’s past, their present-day experience, and their hopes for the future.

• **Understanding relationships:**
  
  Collaborative relationship between the service provider, service user and their carers’ and between staffing. Social connectedness through the local community through opportunities to engage in meaningful activities.

• **Environment:**
  
  Organisational values underpinned by person-centred principles. Responsive support that is responsive to individual needs. A planned, organisation-wide effort to individual and organisational learning.
5.4.3 The Triangle of Care – Consumer, Carer/Family & Clinician

Stakeholders provided resonance around the idea that care should be delivered through collaborative relationships that involved partnership between consumers, carers and families, and clinicians. This was characterised as a ‘triangle of care.’

![Relationship-centred care diagram]

Figure 2: Relationship-centred care

Nolan has developed this concept by building on the person-centred care introduced by Kitwood and exploring the principle of relationship-centred care which recognises that quality care is dependent on strong, reciprocal and interdependent relationships between the resident, family members and staff.

Key aspects of this approach are:

- The focus is on enhancing the care experience for residents, family and staff.
- Efforts are directed toward building and nurturing relationships.
- Attention is given to meeting the needs of residents, family and staff.

The Senses Framework developed by Nolan et al. (2008)\textsuperscript{16} includes six senses that support strong relationships in care. Quality care happens when the Senses Framework is experienced by all involved in the care relationship. These are outlined as follows:

- A sense of security:
  Residents feel safe and receive knowledgeable and sensitive care; staff feel safe, free from threat and work within a supportive culture; family feel confident in their ability to provide good care and have the support they need.

- A sense of belonging:
  Residents experience reciprocal relationships and feel part of a community; staff feel like they are part of a team; family maintain valued relationships and feel like they have a support network.

- A sense of achievement:
Residents have opportunities to develop and meet goals; staff and family feel they have grown because of their caring experience.

- A sense of continuity:
  Residents receive consistent care from people they know; staff have consistent positive work assignments; family and residents maintain shared pursuits.

- A sense of purpose:
  Residents have opportunities to engage in purposeful and meaningful activity; staff have clear, shared goals and direction; family have opportunities to contribute to life in the home.

- A sense of significance:
  Residents feel recognised and valued; staff feel like their work matters; family feel that their care role is valued by staff.

5.4.4 Dignity in Care Principles

Person-centred care will be further reflected through the ten dignity-in-care principles as follows:

1. Zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering personalised service.
4. Enable people to maintain the maximum possible level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people’s privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people’s loneliness and isolation.

5.4.5 Dementia Care Matters – ‘Feelings matter most’

An additional principle reflects an understanding of the impact on cognition and capacity encountered by people living with neurocognitive disorders, and also by many older people with severe and enduring mental illnesses. In keeping with this, UK dementia specialist, Dr David Sheard, developed the Dementia Care Matters program and Butterfly House Model of dementia care. The central tenet of this approach to care is that ‘feelings matter most,’ indicating that relational connectedness and understanding of a person’s emotional wellbeing may supersede cognitive understanding for these cohorts and must be a primary component of the approach to care delivery. This idea was strongly supported during stakeholder engagement and is considered an essential underpinning approach for these models moving forward.
5.5 Evidence

Evidence utilised to inform these approaches has been sourced from the following resources:

- The National Mental Health Service Planning Framework Version 2.1 (NMHSPF)\(^{18}\)
- The Brodaty et al. tiered classification model of the behavioural and psychological symptoms of dementia (Brodaty et al 2003)\(^{19}\)
- The NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015
- Dementia Care Matters Butterfly Household Model of Care.
- A national framework for recovery-oriented mental health services (2013)\(^ {20}\)
- Mental Health Coordinating Council Trauma Informed Care and Practice (2013)\(^ {21}\)

5.5.1 The National Mental Health Service Planning Framework (NMHSPF)

The NMHSPF is an excel-based planning tool that allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population. The NMHSPF builds on state and territory expertise in population-based mental health service planning and has collated expert input from over 100 service managers and planners, public and private sector clinicians, community sector professionals, consumers, carers, technical experts and academics.

The NMHSPF is the result of a commitment under the Fourth National Mental Health Plan to ‘develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models’ (Department of Health, 2009). The development of the tool has been funded by the Australian Government Department of Health and has been led by NSW Health and the University of Queensland.

In the development of the NMHSPF, as it relates to people over 65 years, there has been heavy reliance on the research undertaken by Brodaty et al (2003).

5.5.2 The Brodaty Tiered Classification Model of the Behavioural and Psychological Symptoms of Dementia

In 2003, Brodaty, Draper and Low, described a seven-tiered classification of the Behavioural and Psychological Symptoms of Dementia (BPSD) together with a description of both the prevalence and incidence of these tiers and the nature of services required to respond to these levels of behavioural disturbance.

At the time the classification was developed, services for people with BPSD in Australia were described as ad hoc and fragmented. The planning model proposed by Brodaty was based on a comprehensive analysis of the prevalence of various Dementia-related symptoms and the level of care that is considered necessary to satisfactorily assist that person.

The classification divides people with BPSD into seven tiers in an ascending order of symptom severity with corresponding bands of service intervention that are required for each tier. The seven tier classification was supported by a thorough analysis of the available literature on population prevalence rates for each tier of the classification.

This classification is now widely accepted as the best international classification of Dementia and corresponding service needs. Since 2003, Brodaty, Draper and Low and their
associates have published widely and dominated not only the national, but also international literature on epidemiological planning for people with BPSD. The model originally described by all three authors is usually referred to as the Brodaty 7 tier model and, in keeping with this, this document will refer to the model as the ‘Brodaty model’ whilst recognising the equal contributions of Draper, Low and others to Australia’s rich knowledge about BPSD.

The Oakden Report placed appropriate emphasis on the apex of the model (Tiers 6 and 7). The Brodaty model articulates that people with BPSD Tiers 2 through to 5 can successfully be managed with services from Commonwealth funded services, albeit with the support of specialised teams at Tier 5, which may include some input from state funded community based OPMHS.

Critical areas of service provision are required for those with very severe (Tier 6) and extreme (Tier 7) BPSD. The Brodaty model describes the level of interventions needed for this group of individuals as “Neurobehavioral Units” (Tier 6) or “Intensive Specialist Care” (Tier 7) that is care types that exceeds the level of care able to be provided by Dementia-Specific Nursing Homes.

Figure 3: Brodaty et al. (2003) seven-tier model of management of BPSD
5.5.3 NSW Health Model

The EWG utilised work completed by NSW Health in developing an understanding of the services required to replace the Oakden services and address the needs of the South Australian population. There was significant support for the NSW Service Plan during the stakeholder engagement process.

It is significant that both NSW and Victoria undertook large scale and detailed OPMHS planning from 2004 onward, in an effort to describe for the first time, at a State level, the full range of services needed (including Commonwealth funded services) to provide comprehensive OPMHS to their populations. Much of this was led by NSW, who had developed a state-wide Mental Health Planning tool referred to as the Mental Health Clinical Care and Prevention planning model (MH-CCP).

In 2005, NSW published a detailed 10-year State Plan for the provision of Older Person’s Mental Health Services that was based on MH-CCP and the detailed planning arising from the Brodaty model. The NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015 (the NSW Plan) is a comprehensive outline of the relevant policy, planning and demographic context, definition of the scope and functions of OPMHS, together with an OPMHS service delivery model, an implementation plan and a reporting, monitoring and evaluation framework.

In 2011, the NSW Service Plan was subjected to a mid-plan evaluation that also reviewed all additional literature that has become available since the development of the plan. In addition, NSW has also developed a very comprehensive clinician’s handbook known as the Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia to assist all clinicians working in OPMHS to understand best practice approaches to treating BPSD.

Other Australian states and territories have heavily relied on the work of NSW and Victoria to inform the way in which they provide specialised OPMHS.

The NSW Service Plan outlines an evidence based ‘severely and persistently challenging behaviours model’ and provides a framework for delivering care for people with severe and extreme BPSD and severe and complex enduring mental illness. The plan is based on the evaluation of evidence that indicates the benefits of purpose-built community based residential facilities over long-term psychogeriatric inpatient facilities for less dependent patients. These benefits include:

- Better quality of life
- More social interactions
- More privacy, choice and control
- Improvement and stabilisation of symptoms
- Improved cognition, communication, self-care skills, activity participation, mobility and behavioural disturbance
- Fewer depressive symptoms
- Less use of physical and chemical restraint.
There are four key elements to the NSW Service Plan for delivering care for older people with severely and persistently challenging behaviours:

1. **Integrated specialist behavioural assessment and intervention services (BASIS)**

   The key functions of the BASIS model are:
   - Development of formal links between OPMHS and aged care services.
   - To provide integrated assessment and intervention services for older people with severely and persistently challenging behaviours.
   - To provide consultation, liaison and case management services to identified clients in community and residential aged care settings.
   - It can also perform the gatekeeping functions to the specialist services.

2. **Special residential care service packages**

   The key functions of the special residential care service packages are:
   - To provide in-reach assessment and support for residents of aged care facilities.
   - Development of specific behavioural management protocols, and associated staff training, trialling and evaluation.
   - Monitoring of specific medications trials.
   - Short term nurse ‘specialling’ and minor environmental modifications.

3. **Interim specialist assessment and treatment facilities**

   The key elements of this service are:
   - Increased level of staffing consistent with current Australian benchmarks.
   - A multidisciplinary approach, encompassing nursing, medical and allied health input.
   - Enhanced staff psychiatric knowledge and skill in behavioural management.
   - Access to specialist psychogeriatric and geriatric medical support and advice and clear clinical governance arrangements regarding personal, medical and specialist care needs of clients.
   - Prosthetic architectural and interior design.
   - The NSW plan identified that this level of accommodation would not be suitable for people with the most extreme aggressive behaviours, recommending the development of a tertiary ‘intensive care neuro-behavioural unit’ to provide care for this cohort.

4. **An intensive care behavioural unit (ICBU)**

   The key elements of this service are:
   - State-wide specialist unit to cater for people with the most disturbed and aggressive behaviours.
   - Specialist accommodation and care for the length of time that it is required.

Key to the success of the NSW Service Plan has been the development of partnerships between OPMHS, aged care services, the residential aged care sector and NGOs.
The NSW Service Plan proposed that services for the two target cohorts be developed through the development of a state-wide ICBU of up to 50 beds and through special care units in residential care facilities, developed through partnerships between state-funded OPMHS, aged care services, and non-government aged care providers. NSW is yet to commission the state-wide ICBU and this has been acknowledged as a notable gap in service provision. The special care units in residential aged care have been implemented and evaluated through the Mental Health Aged Care Partnership Initiative.

Through the Mental Health Aged Care Partnership Initiative, NSW Health engaged with Catholic Health Care and Hammond Care, to develop purpose-designed special care units within RACFs, operated by the aged care providers but with top-up funding from NSW Health, in addition to Commonwealth aged care funding and with specialist in-reach from OPMHS and aged care teams. In the evaluated model, these services provided care for individuals with severe and very severe BPSD, in well-designed environments with multidisciplinary care teams, for the duration that behaviours continued to warrant a specialist care environment. The facilities provided supported transition to mainstream RACF placements when specialist services were no longer required. These transfers were intended to occur to the facilities, in which the special care units sat, to other RACFs or to community living where appropriate. Through these pathways, which were articulated in the residential care agreements on entry to the facilities, Commonwealth requirements relating to Security of Tenure were addressed, enabling the model to be sustainable, in that residents were able to flow through the units based on clinical need, rather than remaining in situ in a ‘bed for life.’

Evaluation of the Partnership Initiative concluded that the program provided a successful and viable model to address consumer needs and support effective functioning of services for the target populations. A number of lessons were drawn from the pilot programs which informed further enhancement of processes around admission, administration and transition through the services and will support the development of similar models in the South Australian context.

5.5.4 Butterfly Household Model of Care

Stakeholder engagement also provided strong resonance with the Butterfly Household model, developed in the United Kingdom by Dr David Sheard.

The Butterfly Household model works on the principle that we all crave human connections and this is even more important for people living with dementia. The model supports the notion of a shift from a predominantly task oriented approach to service delivery to an emotionally informed approach to care. The shift from ‘doing’ care to achieving emotional connectivity is at the heart of being person-centred and is underpinned by the model ethos which is that ‘feelings matter most’.

Approaches that support this ethos are:

- All staff are recruited and appraised on their values, attitudes and emotional intelligence.
- People living with Dementia are enabled to be in positive relationships, ‘giving’ to people as well as ‘receiving’ support from people – their contributions are extremely valued and nurtured.
- Staff are trained in observing quality interactions and, on at least an annual basis, each person undertakes a qualitative observation, feeding back their findings to the team to improve care.
- Staff demonstrate their understanding that the language of dementia is about feelings.
- Staff don’t wear uniforms – removing the concept of ‘them and us’ which promotes friendship and connectivity between residents and staff.
- People living and working together share lives, use family-like terms to refer to people living and working in the home. They eat together with no separate staff areas in the households.
- Administration of medication is personalised and administered from locked cupboards in peoples own rooms.
- ‘Going with the flow’ is how the day feels, tasks are more subtly completed in a model based on people first.
- Staff do not talk about people living in the home whilst in the household. They remove themselves to the staff areas for any necessary discussion.
- Nurses stations and other hospital-like features are removed; work areas have a ‘homely’ feel.
- The home is divided into a number of separate households or at least separate house-like living environments.
- House leaders are appointed on the basis of their values, attitudes, emotional intelligence and emotional competency.
- Housekeepers are appointed as the heart of each household ensuring that domesticity, cleaning and food preparation are a core part of the day involving everyone living and working together.
- Families are seen to be ‘at home’ in the environment and are involved in the daily life of the household as care partners. Emphasis is placed on the quality of the relationship between families, staff and the people living in the household.
- A sense of community is created by people visiting each other in their households, which maintains friendships across households.
- Staff recognise the importance of emotional memory and peoples’ treasured emotional possessions, understanding the interplay between these.
- People are free to go outside into safe enclosed areas and can do so without needing doors to be unlocked or having to be accompanied.
- Staff are not obsessed with risk prevention and excessive health and safety beliefs.
- There is limited use of anti-psychotic medication and it is used only as a last resort in episodes of acute distress.
- People living with dementia are encouraged to undertake domestic activities and maintain their own life skills.
- Sensory calming and sensory stimulating items are used at different times during the day.
- Attachment and supportive touch and the use of massage are central to the homes model of care.
- A variety of music and digital media is provided to ensure enjoyment and interest.
- Mealtime is a social occasion, not a task.
• Controlling care and labelling language is removed from care plans. For instance, words such as ‘challenging’, ‘wanderer’ and ‘aggressive’ are replaced with words that describe to person’s feelings that are leading to their expressions and actions.

• Life stories are used daily by staff to promote connectivity with people living in the households.

The Butterfly Model is particularly applicable to the Specialist Residential Units for BPSD that will be outlined in Section 6.3 below. It is recommended that aspects of the Butterfly Household model are also incorporated in the Neuro-Behavioural Unit for people with Extreme BPSD, described below in Section 6.2. It is also acknowledged that this area of service provision remains in development around the world and the redevelopment of South Australian services presents an opportunity to contribute to service evaluation and research to further inform the development of approaches, such as the Butterfly Household model, to populations living with very severe and extreme BPSD.

5.5.5 A National Framework for Recovery-Oriented Mental Health Services

The national framework for recovery-oriented mental health services brings together a range of recovery-oriented approaches developed across Australia and internationally to provide a best-practice approach to recovery-oriented mental health service delivery.

The framework supports cultural and attitudinal change and encourages a fundamental review of skill mix within the workforce of mental health services, including increased input by those with expertise through experience.

The framework defines and describes recovery and lived experience, and articulates the key capabilities necessary for the mental health workforce to function in accordance with the recovery-oriented principles and the domains of recovery-oriented practice. These are summarised as follows:

• **Domain 1: Promoting a culture and language of hope and optimism**
  A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism – this is central to recovery-oriented practice and service delivery.

• **Domain 2: Person first and holistic**
  Putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person’s life situation holistically.

• **Domain 3: Supporting personal recovery**
  Personally, defined and led recovery at the heart of practice rather than an additional task.

• **Domain 4: Organisational commitment and workforce development**
  Service and work environments and an organisational culture that are conducive to recovery and to building a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.

• **Domain 5: Action on social inclusion and the social determinant of health, mental health and wellbeing**
  Upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.
Recovery-orientation is an underpinning aspect of mental health service delivery. It has been suggested that the language of recovery-orientation may create tension for consumers, carers and clinicians in OPMHS, in relation to dementia. It has been proposed that there is a valid role for orientations such as palliative care where concepts such as ‘recovery’ may be more difficult to define (McKellar et al. 2014). Nevertheless, the underpinning principles of recovery-orientation relate to personhood, autonomy, equity and hope and, in developing the models described in this document, these were supported as important underpinning principles that would inform development of the model.

5.5.6 Trauma Informed Care and Practice

The experience of trauma and its impact on individuals, communities and society as a whole are substantial. Many consumers who engage with mental health services are trauma survivors. Responding appropriately to trauma and its effects requires knowledge and understanding of trauma, workforce education and training and collaboration between consumers and carers, policy makers and service providers.

Trauma Informed care and practice (TICP) involves not only changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic.

The eight foundational principles that represent the core values of trauma-informed care and practice are:

- **Understanding trauma and its impact.**
  Understanding traumatic stress, and how it impacts people, and recognising that many challenging behaviours and responses represent adaptive responses to past traumatic experiences.

- **Promoting safety**
  Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place particularly in relation to responding to suicidality, and provider responses are consistent, predictable, and respectful.

- **Ensuring cultural competence**
  Understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

- **Supporting consumer control, choice and autonomy**
  Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy. Providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

- **Sharing power and governance**
  Promoting democracy and equalisation of power differentials; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures.

- **Integrating care**
Maintaining a holistic view of consumers and their recovery process and facilitating communication within and among service providers.

- **Healing happens in relationships**
  Understanding that safe authentic and positive relationships can aid recovery through restoration of core neural pathways.

- **Recovery is possible**
  Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resilience and establishing future-oriented goals.
6 A Layered Model of Services for People With BPSD

6.1 An Overview of the Model

Fundamental to the proposed model, is recognition of the need to provide different and separate services for people living with BPSD and those living with severe and complex presentations of enduring mental illness in older age. Accordingly, this section of the document outlines a proposed, streamed and layered approach to services for people with BPSD, focusing on those people with very severe and extreme BPSD, but recognising the need for these services to be provided within a continuum of care from community living through to the highest acuity, specialised service for extreme presentations. Services for people with enduring mental illness will be described separately, in section 7.

The model also recognises that partnerships between the Commonwealth, State and non-government sectors are essential to providing a cohesive and sustainable range of services for the South Australian population.

A diagrammatic overview of the model is provided in figure 3, indicating the layering of services and pathways that facilitate transfer between service units. Transfers would be brokered by developing strong relationships between the range of services, utilising clearly articulated criteria for admission and discharge and fostering enhanced capacity of community based OPMHS and geriatric medical services to work collaboratively and proactively in assessing, triaging and facilitating movement between layers. In this way, the layered model will support reduced presentations by people with BPSD to emergency departments and acute medical units, which are well-described as negative and potentially traumatising environments for this cohort.

Figure 3 also depicts the relationship of Commonwealth funded services, such as Dementia Support Australia (DSA), which provides services including the Dementia Behaviour Management and Advisory Service (DBMAS) and the Severe Behaviour Response Team (SBRT). These services provide an essential additional resource for residential aged care facilities.

![Layered Model of Services for BPSD](image)

Figure 3. A layered model of services for BPSD
The three components of the model which will be provided with support from SA Health are the state-wide Neuro-behavioural Unit, Specialist Residential Units developed in a partnership model and Rapid Access Services operating from Community OPMHS teams in each LHN.

6.2 Neuro-Behavioural Unit for Extreme BPSD (NBU)

The NSW Service Plan described the development of an Intensive Care Behavioural Unit to cater for the most severe and aggressive presentations of BPSD. In the NSW model, it was anticipated that many of these individuals would present with frontal lobe pathology due to a range of causes, including previous acquired brain injury, harmful substance use, and progressive neurocognitive disorders. It was proposed that this level of care would provide specialist accommodation in a highly skilled, multidisciplinary environment for the time it is required. The NSW Service Plan, which was first authored in 2005, recommended the development of up to 50 beds of this type in a highly specialised state-wide unit.

The South Australian experience is similar to the NSW description, with the Oakden Campus and acute OPMHS inpatient services having previously worked with individuals presenting with neurocognitive disorders of this type, with extreme behaviours, including aggression. There has been predominance of males with frontal lobe presentations in this cohort. Previously this cohort was accommodated in Makk House, which was identified as not fit for purpose by the Oakden Review, with inadequate built environment, overcrowded spaces and limitations in the approaches to care. It is agreed that these factors contributed to the perpetuation of problematic behaviours.

Based on the NSW Service Plan, it is recommended that South Australia develop 24 specialist high dependency beds to meet the needs of this population, with capacity for growth over the coming decade. This unit is proposed as a Neuro-behavioural Unit (NBU), developed with a positive, person-centred, specialist approach to care. The determination of 24 beds is based on modelling supported by the NMHSPF and use of the Brodaty model contextualised to South Australia’s current and predicted dementia prevalence.

In assessing the needs for this cohort of people, the EWG considered how best deliver this service in South Australia. Analysis was undertaken comparing the merits of developing one single unit, two units located in the North and South of metropolitan Adelaide or three units located within each of the metropolitan LHNs.

Advantages of developing three units across the metropolitan LHNs were acknowledged by the EWG. Development of three units would provide increased access for individuals with BPSD and their families across metropolitan regions. Aligning units within LHN would address governance within current LHN structures, which may be advantageous, providing consistent approaches to the purpose and function of units could be assured. A number of potential disadvantages were also acknowledged with this option, including the costs of developing the units, developing staffing profiles across regions, maintaining operating costs for up to three units, and potentially diluting the highly specialised nature of the units, addressing the rare and high acuity presentation of extreme BPSD.

In keeping with this analysis, the NBU has been conceptualised as a single state-wide service, to provide an economy of scale and optimise the highly specialised skills and resources required to support the service.

Reflecting strong stakeholder engagement, it is recommended that the unit be collocated on another SA Health site, with access to mental health and geriatric medical services. The unit should be developed with reference to best-practice design principles for dementia care and safe environments, built around a podded design of 6 bedded pods, which should be gender specific. Podded units should provide areas with easy access to spacious indoor and
outdoor areas, with areas of low-stimulation and capacity for sensory modulation provided throughout the units.

It is recommended that the unit be commissioned as an Authorised Treatment Centre under the South Australia Mental Health Act 2009, providing a legislative framework for management of the most complex presentations, including risk of harm to self and others.

6.2.1 Governance

It is recommended that a clinical governance framework be developed for the unit, reflecting its status as an Authorised Treatment Centre, but also promoting collaborative management between Older Persons’ Mental Health Services and Aged Care Services. It is considered essential that consumer and carer perspectives are strongly represented within the governance of the unit. It is also recommended that the articulation with other layers within the service model, particularly the second layer of Specialist Residential Services, addressed in 5.3 below, be described within the governance framework. The SA Health Oakden Response, Safety and Quality Expert Working Group will provide a full description of governance arrangements that will provide greater detail for the full implementation of the conceptual model described in this document.

6.2.2 Staffing Profile

Similarly, full details of an appropriate staffing profile will be developed by the SA Health Oakden Response, Staffing Profile Expert Working Group. Nevertheless, it is acknowledged in this document that the service will require development and recruitment of a contemporary multidisciplinary staffing profile. This will include medical staffing including qualified consultant old age psychiatrist, consultant geriatrician and junior medical officers; nursing staff with a mix of older persons’ mental health and specialist dementia care nurses and a full complement of allied health disciplines. Staffing profile will also describe requirements for administrative and hotel services.

Staff within all clinical craft groups will develop specialised skills in management of BPSD. It is anticipated that the service will operate with an increased ratio of nursing hours per patient day, in keeping with the complexity of the clinical presentation and associated risk. The advantage of a single state-wide service is an enhanced specialisation in the clinical team, enabling the development of a centre of excellence in the management of extreme BPSD.

6.2.3 Infrastructure

The Oakden Response Infrastructure EWG will lead a process of developing site options and a full project plan to implement the SA Government’s commitment to development of the NBU, as an important aspect of the replacement for Oakden services.

A number of principles emerged from the stakeholder consultations to inform the development of new infrastructure. As a result of this engagement process, it was recommended that the unit should be developed as a collocated health service, rather than a stand-alone service as was the case with the Oakden Campus. The service should be accessible for families accessing admitted consumers and a single unit should be situated in as centralised a location as possible or close to transport options. There was strong support for the service to have access to geriatric medical services. Stakeholders also identified that collocation with a major general hospital was not preferred. Stakeholders also provided support for ideas that the unit should be built upon best-practice dementia design principles, including being a ground floor building with abundant space available both inside and in safe garden areas.
6.2.4 Pathways to Care

The NBU will admit people with a confirmed diagnosis of dementia who present with extreme BPSD. The service is not intended to provide care for consumers with enduring mental illness and appropriate care and accommodation will be provided in other settings. Presentations of BPSD appropriate for the NBU will include symptoms such as severe agitation, aggressive behaviour, severe vocalisations, psychosis, depression, anxiety and suicidal behaviour secondary to a primary dementia diagnosis. Dementia is an overarching syndrome caused by a number of disorders including Alzheimer’s disease, Lewy body dementia, fronto-temporal dementia, substance use related dementia, vascular dementia, acquired brain injury and other less common causes.

Referral pathways will primarily be from acute OPMHS inpatient services and acute aged care medical services. The service will also provide streamlined step-up admission from specialist BPSD residential aged care services. Referrals will also be accepted from mainstream residential aged care services where there has been engagement with OPMHS community teams and/or community geriatric service teams and the referrals have been brokered by these teams.

A principle of the service will be promoting streamlined transitions between layers of service delivery, reducing the number of disruptions for consumers with dementia. Referral pathways will be developed to minimise consumers presenting through emergency departments or being placed in acute medical units that are unsuitable environments for people with dementia, as much as possible.

The length of stay for the service will, in most instances, be between three and 12 months, although this will be indicated by clinical presentation. Utilising a definition of sub-acute services representing length of stay of up to 12 months, the NBU will be classified as a sub-acute service. This should not lead to misunderstanding of the acuity or complexity of consumers cared for, or the highly skilled and specialised clinical services provided.

Discharge from the service will be to a Special Care Residential Unit for BPSD, mainstream residential aged care service or the community, in a step-down approach, when the presentation of admitted consumers enables them to be cared for in a less restrictive and specialised environment. Discharge processes will be organised in consultation with families, guardians and other service providers, supported by the clinical team in the NBU.

6.3 Specialist Residential Units for BPSD (SRUs)

A priority under the NSW Service Plan was the development of community based residential care services for appropriate longer-term management and accommodation for people with severely and persistently challenging behaviours associated with dementia and/or mental illness, and older people with complex and persistent psychiatric symptoms with severe functional impairment, such as people living with chronic schizophrenia experiencing the onset of age related problems. It is noteworthy that the facility developed in NSW through partnership between NSW Health and Hammond Care provided services for individuals with BPSD and advocated that consumers with enduring mental illness be provided services in other locations.

It is recommended that South Australia develop capacity across all metropolitan LHN regions to address the accommodation and care needs of individuals with very severe BPSD by developing a number of Specialist Residential Units (SRUs) through focused partnerships between the Commonwealth Department of Health and Ageing, SA Health and non-government, approved residential aged care providers. This model reflects the viability of the state ‘top-up’ funding model in other jurisdictions.
Based on modelling supported by the NMHSPF and analysis of South Australian current and predicted dementia prevalence, it is anticipated that South Australia will require 120 beds to meet the needs of this sector by the year 2021.

It is recommended that an initial phase of development be undertaken to enable capacity for 60 specialist BPSD residential beds across metropolitan Adelaide. A second stage of development should subsequently enable capacity for the remaining 60 beds. These services will be developed as advanced, secure, memory support units in residential aged care settings in community locations where consumers can be accommodated close to their families and carers. It is recommended that a person-centred nomenclature be adopted for these units such as ‘Safe Neighbourhoods.’

Identification and selection of potential partners within the residential aged care sector will be carried out through a public tender process. Infrastructure will remain the property of the partner organisations and partner organisations will provide the capital investment for new build facilities. Full development of services will require collaborative partnership between the Commonwealth, SA Health, and partner organisations.

The EWG reviewed existing South Australian partnerships between similar partner bodies, assessing the varying merits of the Transitional Care Packages (TCP), the Care Awaiting Placement (CAP) program and the ViTA Daw Park rehabilitation model. The EWG expressed caution regarding the TCP and CAP approaches to partnership development and strongly advocated for a partnership for BPSD services that mirrored the structural, funding and governance arrangements of the ViTA Daw Park model, in which expert SA Health clinical staff are embedded within the service model.

The details of the staffing model for this service will be determined by the SA Health Oakden Response, Staffing Profile Expert Working Group. Medical staffing to support the service will be provided through GPs with the addition of specialist old age psychiatry resources provided by SA Health. The Oakden Response Staffing Profile EWG will also provide recommendations for the appropriate skill mix for nursing staff and determination of nursing hours per patient day, as well as the appropriate quota of allied health staff within the units to meet the needs of residents.

6.3.1 Governance

The Oakden Response Quality and Safety EWG will provide a framework for governance of the model. Governance will reconcile the responsibilities to the Commonwealth Department of Health and Ageing, the Commonwealth Aged Care Quality Agency, SA Health and the participating partner aged care provider organisations. Whilst this document provides a conceptual overview of the model, the Quality and Safety EWG will describe governance arrangements in detail in a subsequent technical business rules document. The relationship between the partner components of Commonwealth, SA Health and approved partner aged care provider will be described in a negotiated Memorandum of Understanding (MOU).

6.3.2 Pathways to Care

Admission to the SRUs will be based on criteria outlined in the MOU. The partner aged care provider will provide admission to the unit but in most instances the relevant OPMHS will provide a facilitating ‘gate-keeper’ role, both when ‘stepping-down’ from the NBU or an acute inpatient unit, or ‘stepping-up’ through an OPMHS community or rapid access service from a community based setting. It is recommended that the processes for admission be managed by OPMHS within each LHN in consultation with the partner aged care provider.

On entry to the service, residential care agreements will be confirmed between the resident’s carers or guardians and the SRU, acknowledging that accommodation in the service is based on clinical need and that when the clinical team provides advice that the resident’s
presentation has moderated, such that a specialist residential service is no longer required, the service will provide a supported process to transfer the resident to a mainstream residential aged care bed, either with the same provider or an alternative aged care provider, as agreed by the carer or guardian. It is essential that the specialist and transitional nature of the service is clearly articulated to carers and guardians, to support the flow through the service which is critical to meeting population needs. The Commonwealth, SA Health and partner organisations will need to collaborate in order to develop a security of tenure model that supports the transitional requirements of this cohort whilst meeting aged care legislation.

It is acknowledged that the initial phase of service development, for a proposed 60 beds will not meet South Australia’s population needs across this sector. A commitment to further service development will be required, including consultation and collaboration with the Commonwealth, through a national process of reform in service provision for people with BPSD. This will underpin a second phase of development, building on the initial implementation of the model proposed here, utilising Commonwealth aged-care funding reforms and initiatives. It is postulated that a model of shared responsibility between State and Commonwealth governments is required for successful service provision for this aspect of aged care.

Further, it is the consensus view of the EWG that success of this proposed partnership model is essential for the provision of BPSD services in South Australia. It is unlikely that reforms in other layers of services for this sector will be successful if SRUs are not implemented to provide sustainable specialist care to the cohort of people with very severe BPSD.

6.4 OPMHS Rapid Access Service (RAS)

The Rapid Access Service (RAS) was developed by the SALHN OPMHS, initially as a pilot program, which was evaluated, shown to have achieved significant service benefits and subsequently implemented as a continuing core strategy for SALHN OPMHS to respond to service demands from the mainstream residential aged care sector. The RAS was developed as a specialised team to function within the wider OPMHS aiming to achieve systemic change with improved early intervention, and reducing the need for crisis response within the target population in residential aged care facilities (RACFs).

The RAS was developed with a number of aims and objectives, outlined as follows:

- Provide a quality, timely service to clients and care providers of RACFs.
- Reduce the rate of transfer to hospitals and emergency departments, for clients with recognised or probable psychiatric illness, &/or a diagnosed dementia with complex, severe and persistent difficult behaviours, through assessment, intervention, support and education.
- Streamline care pathways.
- Improve the quality of life for residents of RACFs who have either a recognised or probable psychiatric illness, &/or a diagnosed dementia with complex, severe and persistent difficult behaviours.
- Build skills in managing psychiatric illness and dementia with complex, severe and persistent difficult behaviours via education and training for staff of RACFs.
- Provide services using short term involvement with clients and RACF staff.

The RAS was developed with a primary staff of mental health nurses with training and skills in older persons’ mental health and assessment and management of BPSD, supported by a clinical coordinator and nurse practitioner. Additionally, the service was developed with a
consultant old age psychiatrist embedded in the team part-time and structured access to allied health practitioners.

During the pilot program the RAS achieved hospital avoidance in 90% of referrals received during the pilot period. 88% of referrals were seen within 24 hours during normal working hours. The pilot program also demonstrated capacity to improve direct admissions to hospital when required for the target population, avoiding emergency department presentations. The program also provided more than 50 education sessions to over 600 residential aged care staff during the pilot period. Since the pilot period, the SALHN OPMHS RAS has continued to build on this initial success as a core service strategy for both people with enduring mental illness living in RACFs and, significantly, also for people presenting with BPSD.

Fundamental to the success of the recommended layered approach to services for people presenting with BPSD, is recognition of the need for effective targeted services to support function at each layer of the system. The RAS has been shown to be an effective and efficient intervention that has enhanced the capacity of state-funded OPMHS to respond to BPSD, as well as presentations of mental illness, improving the capacity of RACFs to manage more complex problems and reducing demands on higher acuity bedded services.

It is recommended that this strategy be developed across each metropolitan LHN OPMHS, modelled on the service developed in SALHN, as an important capacity builder to moderate demand for beds in acute services and in SRUs, through early, targeted and skilled intervention.

It is acknowledged that the Commonwealth is also a stakeholder in this sector through Dementia Support Australia (DSA) which provides the Dementia Behaviour Management Advisory Service (DBMAS) and the Severe Behaviour Response Team (SBRT). It should be noted, however, that the clinical demands of the sector and the service model of DSA is not sufficient to fully and sustainably meet population needs. The development of the RAS across all metropolitan LHNs will be an important and proactive contribution to a layered and partnership approach to address the issue of BPSD.

It is recommended that the RAS be developed as an ongoing strategy to improve service provision for people presenting with BPSD, but that this work commence immediately in NALHN and CALHN, which currently do not have the RAS embedded within OPMHS teams. This will form part of the immediate interim response to service delivery post-Oakden as well as being part of an ongoing long-term strategy.
7 Residential services for older people with severe & enduring mental illness

7.1 An Overview of the Model

Older people with severe and enduring mental illness are identified as a disadvantaged population. People with severe mental illness at all ages are more likely to encounter difficulties in accessing health care, accommodation and positive lifestyle options. This is accentuated for older people with severe mental illness who may also have an earlier onset of age, lifestyle and treatment related health difficulties. Mental health services across adult and older persons’ sectors currently provide services to a cohort of consumers aged 60 and older who present with emerging age-related issues and who encounter difficulties accessing high quality options for accommodation and care. This cohort presents both mental health and general health services with challenges in achieving appropriate pathways to long-term accommodation and care, subsequently using acute health services inappropriately. These health service consumers may find themselves discharged to inadequate accommodation options in order to preserve ‘flow’ in acute services.

Until the present time, older people with severe and enduring mental illness with increasing support needs have been recommended to seek accommodation in RACFs which may be unsuitable environments for them. There is a common narrative of this group of consumers failing aged care placements for this reason. Whilst this population may present with neurocognitive and executive changes associated with long-term mental illness and treatment with psychotropic medications, they do not present with dementia or BPSD and are not appropriately supported by being placed in memory support units, particularly in environments where staff do not have adequate orientation and training to support people with mental illness.

It is difficult to capture quantitative data regarding the size of this population. A point-in-time survey undertaken by the EWG of metropolitan mental health services, suggested that there is a population of approximately 30 mental health consumers who receive care from public mental health services that meet these criteria. In addition to this cohort, it is acknowledged that there are other older people with enduring mental illness who experience homelessness and require consideration in planning of accommodation and care services. There are also other individuals who currently live in supported residential facilities (SRFs), which are managed as private accommodation services under the disability sector with limited regulation of quality standards, who may not currently receive care through public mental health services, but may be at risk of their accommodation not being sustained, particularly with increasing age and may therefore present unexpectedly to acute health services with complex difficulties, resulting in them becoming ‘stranded’ in the acute sector. These cohorts may be very difficult to sustainably support in mainstream residential aged care placements, due to the nature of their illnesses and associated difficulties, or due to their age, level of disability and personal preferences.

The EWG estimates that South Australia currently has between 30-60 people who should be considered in the planning of accommodation and care services for this sector. The needs of this group are complex but very different to the cohort of people presenting with BPSD. Nevertheless, a similar layered approach to services is also recommended, providing options for people to step-up from community-based living options, with flexible supports, to higher levels of residential care as needs increase with age.

A layered approach to accommodation and care will require allocation of resources utilising partnerships between the Commonwealth, SA Health and non-government agencies. Some individuals with severe and enduring mental illness, associated disabilities and emerging age-related issues, may be eligible for services through the National Disability Insurance Scheme (NDIS). These individuals should be identified by health services and referred
appropriately. It is also acknowledged that there are individuals within the target cohort who are either outside NDIS age boundaries, or do not meet criteria, yet still present with significant service needs.

An overview of a conceptual model for enhanced services for this cohort is presented in figure 4. The EWG presents this model with an acknowledgement that robust service planning and allocation of resources is required for this cohort who remain at risk of missing out on services. It is also acknowledged that there are many older people living with mental illnesses, who are accommodated successfully in mainstream RACFs with or without services from community OPMHS. This conceptual model recognises the need to strengthen and support the continued provision of these services with available services from well-resourced community OPMHS, including development of the RAS across all regions.

The EWG recommends that further development of this model occur beyond the initial period of consultation around this document in order to clarify required service needs and viable pathways to implementation. It is proposed that a sub-group of the EWG be formed to undertake this work, with focused consumer and advocate representation.

Figure 5: a layered model for older people with severe and enduring mental illness

7.2 Supported Community Living

SA Health developed the Housing and Accommodation Support Partnership (HASP) Program to enable people with severe and enduring mental illness to access an affordable place to live, linked with psychosocial and clinical support services. The purpose of the program was to support South Australians with a mental illness to lead their lives within the community and avoid repeated hospital admissions. The HASP program has a number of housing clusters across the metropolitan area with varying levels of supportive services available to residents, depending on need, with up to daily assistance. HASP housing provides safe, secure and affordable housing with security of tenure.
HASP is currently the most intensively supported mainstream community living program for people experiencing serious mental illness in South Australia. It is targeted to people whose need for psychosocial rehabilitation and support cannot readily be met by less intensive options.

The HASP Program was developed as a partnership model, with each partner having their own roles and responsibilities, described as follows:

- **Consumer** – decides on their recovery pathway and works with service providers to get the support they need to be successful in living independently and engaging in their recovery journey.
- **Psycho-social Rehabilitation Support Services (PRSS) provider** – provides psychosocial rehabilitation and support services, operating in extended hours, 7 days a week. A key worker works on an individual basis with people in the HASP Program. PRSS providers in the HASP Program are MIND Australia, Life Without Barriers and Neami National.
- **Housing provider** – owns, manages and maintains properties, manages the Residential Tenancy Agreement and provides a Tenancy Manager or other staff contact who will engage sensitively with each consumer. Housing Providers in the HASP Program are Unity Housing and Junction Housing.
- **SA Health Community Mental Health Service** – provides clinical assessment, treatment and rehabilitation, crisis intervention, a care coordinator and a care plan.

The HASP program provides security of tenure within a model that supports consumers to manage their own care needs over time, including issues relating to ageing. Community aged care packages can be added to residents’ care plans, through access to Aged Care Assessment Teams, as well as there being opportunity for negotiated transfer from adult services to OPMHS and access to geriatric medical community teams when indicated.

Other models requiring consideration are the Community Recovery Centres (CRC) which provides clustered supported housing in a rehabilitative framework, with staff present on site 24 hours daily. Disability sector models of community housing with 24-hour staff providing care within small communities of consumers resident in a domestic environment also warrants further consideration for this cohort.

A key problem is that there are currently insufficient supported housing resources to meet the needs of this cohort of South Australians living with severe and enduring mental illness. It is notable that current accommodation models, such as HASP have been focused on a younger adult cohort, whilst older people have been referred towards residential aged care, which, as noted previously, may be inappropriate for a variety of reasons. There is opportunity and need to develop a strategy for older people with enduring mental illness, whose preference is for community based living, to have increased opportunity to access similar resources.

It is recommended that a partnership model, uniting older consumers, approved aged care provider organisations, non-government psychosocial service providers and community OPMHS, be explored in order to address this population need. There is opportunity to develop partnerships built around participating residential aged care providers to develop options that will enable older people with enduring mental illness to access a continuum of care enabling ‘ageing in place’ that would facilitate stepping up from supported community housing to higher levels of care when needed.
Such communities should be developed as safe environments, with person-centred, recovery and trauma-informed orientations from service providers. Such services will require development of a supportive, skilled NGO workforce with clinical partnerships from community OPMHS.

7.3 Specialist Residential Units for Enduring Mental Illness (SRUs-EMI)

Older people with severe and enduring mental illness have a right to access Commonwealth funded residential aged care accommodation. It is acknowledged that many people with mental illness are provided accommodation and care successfully by a range of approved mainstream aged care providers who have developed appropriate environments and staffing skills mixes to provide quality care for this cohort. These providers may variably draw on supportive resources available through existing community OPMHS. The EWG does not propose any change to this current level of service provision and recommends that adequate community OPMHS be made available to provide robust support for aged care providers caring for older people with severe and enduring mental illness.

A small cohort of older people with enduring mental illness, particularly primary psychotic disorders, present with particularly challenging behavioural presentations, impaired capacity and functional needs related to ageing. This cohort requires the level of care provided in residential aged care but are unsuitable for these care environments, because of their behaviours and difficulty integrating. Specifically, consumers in this cohort may have spent many years in institutional settings and may have been part of the population previously resident at the Glenside Campus prior to the ‘Returning Home’ program. A residual cohort of residents from the Oakden Campus fit this profile and are unlikely to be able to be supported in mainstream residential aged care environments because of the nature of their psychiatric symptoms and behavioural dysregulation. It is anticipated that there are a number of other older people currently residing in supported residential facilities (SRF) who may be provided more appropriate care in a specialist aged care environment.

The EWG recommends that a number of specialist residential beds be developed in a partnership model, analogous to the partnership model proposed for SRUs for BPSD. The EWG currently estimates that there is a need for approximately 16 beds of this type across South Australia. Further detailed evaluation is required regarding this and the conceptual model is proposed here for consultation, with the EWG enduring mental illness sub-group to work further on quantitative detail as the model development continues.

It is recommended that these services be developed as small, homelike environments. Consideration should be given for men and women to be accommodated in separate areas. This reflects an understanding that many of these residents, particularly women, will have had histories of personal trauma. In order to promote a trauma-informed approach to service delivery, creating safe communities that minimise the risk of re-traumatisation is considered best-practice.

It is recommended that these specialist residential beds have nursing staff available with mental health training to support residents and provide a leadership and up-skilling role for other aged care staff. The Oakden Response Staffing Profile Expert Working Group will provide detailed advice about the specific staff requirements required to support adequate service provision.

Governance of this service will be described by the Oakden Response Quality and Safety Expert Working Group, taking into consideration the critical partnerships required for success, across the Commonwealth, State and non-government partners. The importance of security of tenure described under the Commonwealth Aged Care Act, is acknowledged for this cohort of consumers, who are more likely to have had disrupted histories of tenancy throughout their lives due to illness. This is in contrast to people presenting with very severe
BPSD who would be accommodated in SRUs in the BPSD model, for whom an understanding of security of tenure must be moderated around an understanding of the progressive and changing nature of their clinical presentation.

7.4 OPMHS Rapid Access Service & Community Teams

The EWG acknowledges the importance of adequately supporting the capacity of the OPMHS community teams to deliver Rapid Access Services into mainstream RACFs for this cohort of consumers, as well as being resourced to provide in-reach for multidisciplinary assessment, management support and care coordination for consumers with ongoing needs. In parallel to OPMHS provided in the BPSD model, there is recognition that OPMHS in each LHN will be required to provide responsive care within this proposed model for older consumers with severe and enduring mental illness.
8 Interim Service Requirements

With the closure of services at the Oakden Campus, there has been a significant reduction in the number of sub-acute and non-acute/residential beds available for South Australian OPMHS. Previously the Oakden Campus provided up to 64 beds for consumers with severe enduring mental illness or very severe and extreme BPSD. The inadequate quality of these services was clearly described in the Oakden Report and led to the closure of the service in September 2017.

This document presents plans to replace the Oakden Campus with sustainable, contemporary services that can be built upon in the context of an ageing South Australian population. It is acknowledged that during the interim period, between the current reduced service capacity and future implementation of replacement services, there will be increased pressure on remaining services requiring adaptability. There are a number of components and strategies that need consideration to ensure that this interim period is able to meet population need to an adequate level.

8.1 Bedded OPMHS Services

Currently, South Australia has 66 acute OPMHS inpatient beds, with a further four beds at the Queen Elizabeth Hospital (TQEH) able to be flexed up during periods of increased demand. During the interim period, the acute OPMHS services at Lyell McEwin Hospital (LMH), TQEH and the Flinders Medical Centre (FMC) will continue to provide acute and transitional care for consumers presenting with very severe and extreme BPSD, and episodes of acute mental illness.

Northgate House, was commissioned in June 2017, as part of the Oakden closure process, as a state-funded neurocognitive support and older persons’ mental health residential service. It will continue to operate during the interim period, providing accommodation and care to the residual population who were not suitable for mainstream RACF placement at the closure of the Oakden Campus, until these residents are able to be appropriately transferred to other services. Northgate House provides 14-16 state funded beds, operating within a residential aged care framework. Northgate House has limited capacity to admit new residents to further support flow in the acute sector, however, it is recommended that this should not occur until a period of service and staff development and practice reform has been fully operationalised. If this is achieved, Northgate House may provide a basis for appropriate development of a skilled workforce for the commissioning of the neuro-behavioural unit.

8.2 Wrap Around Services & Back Charge Arrangements

During the staged closure of the Oakden Campus, a strategy of wrap-around services has been developed for discharges of residents with BPSD to mainstream residential aged care in order to support the sustainability of the transfers. This has provided an opportunity to begin developing partner relationships with non-government aged care providers. The wrap-around services have included follow-up from community OPMHS teams, referrals to NGO psychosocial support services where applicable to provide increased meaningful engagement for transferred residents and a back-charge arrangement whereby receiving facilities have been able to employ increased staffing capacity around the specific needs of residents. This has been supported through supplemental payments invoiced back to SA Health from receiving RACFs. For instance, where a resident has required increased staffing to assist with activities of daily living, this has been able to be provided above the level supported with Commonwealth funding.

It is recommended that SA Health support the use of this strategy to provide sustainable discharges of individuals with BPSD who would previously have been referred to the Oakden Campus, from acute OPMHS inpatient units to partner organisations in mainstream aged
care during the interim period. It is recommended that a mechanism is developed to facilitate partner RACFs to access these resources on a case by case basis for consumers who are transferred to mainstream care, but require a period of increased supports. This will assist acute services from each LHN to provide adaptable responses during the interim period that will enable service flow to be maintained. Whilst this strategy requires input of a financial resource, the saving through reducing bed days in the acute sector will result in considerably reduced overall costs and enable service flow to be maintained.

8.3 Full Implementation of the OPMHS Rapid Access Service

A further development that will support successful management of service demands during the interim period, as well as laying a foundation for the robust functioning of future services, are service reforms and focused increased resourcing for OPMHS community teams. In particular, it is recommended that the Rapid Access Service model, piloted by the SALHN OPMHS community team, and described earlier in this document, be developed across all metropolitan LHNs. The Rapid Access Service was developed to provide timely, skilled and focused engagement for RACFs with residents presenting with BPSD or severe mental illness. The service has provided an effective and efficient service that has been shown to reduce presentations to emergency departments and acute admissions to hospital. It is considered essential that this service model be supported in all regions; through redeployment of existing community FTE as well as allocation of new resources to expand capacity and assist services to manage increased demand during the interim period, where there is a loss of bedded services.

8.4 Partnerships between OPMHS, Geriatric Medicine & DSA

In addition to the development of Rapid Access Services across all OPMHS regions, it is recommended that a period of consultation be undertaken in each LHN, to explore enhanced co-operation between OPMHS and geriatric medical services and community teams. to explore how both inpatient and community resources might be optimised to respond to the needs of people presenting with BPSD.

Similarly, further consultation with Commonwealth funded services provided by DSA, presents an important opportunity to ensure that sustainable and efficient responses to BPSD are provided. It is recommended that a state-wide forum be established between OPMHS, geriatric services and DSA.
9 A strategy for services to support regional communities

A theme emerged through the MOC stakeholder engagement process, emphasising the need for service development to not neglect the needs of communities in rural and remote South Australia. A key idea expressed in this stakeholder feedback was the importance of keeping people within their home communities as much as possible. This was viewed as consistent with a person-centred approach to service delivery.

The EWG deliberated over the possible merits of establishing SRUs within existing regional RACFs. Based on the experience of the Integrated Mental Health Inpatient Units in Whyalla, Berri and Mt Gambier the working group acknowledges the challenge faced in recruiting and retaining the specialist medical, nursing and allied health staff that would be required to support these beds. Additionally, the low density population of South Australian regions presents further challenges in determining the locations and size of SRUs.

The EWG supports the notion of further building on the concept of partnerships between the Commonwealth, SA Health and aged care providers to support enhanced capacity in regional South Australia. It should also be noted that SA Health is currently the largest provider of Commonwealth funded aged care beds in regional South Australia, creating unique opportunities to maximise the impact of partnerships.

It is recommended that lessons learned from the wrap around and back charge strategies used during the process of closing the Oakden Campus, should be developed further as an ongoing strategy to support regional RACFs in sustaining care for people with BPSD and/or enduring mental illness in placements in their own community settings. This strategy is recommended as a cost-effective way of preventing transfers to metropolitan acute treatment settings or alternative metropolitan placements, with disruption for consumers, carers and service providers. The EWG recommends that a mechanism be developed to make this resource available to regional aged care providers, in partnership with Country Health OPMHS, with a structure for appropriate governance to be applied to protect the integrity and sustainability of the strategy. It is recommended that this strategy be employed through a case-by-case approach, where a supplemental support be provided to sit around a specific consumer based on clinical need and supported by appropriate assessment, management support and clinical review provided by the Country Health OPMHS team. It would, for instance, be appropriate for a consumer with BPSD to receive increased staffing within the RACF for a period of time to provide increased assistance for with behavioural management during activities of daily living, or to provide increased meaningful engagement beyond routine service capacity. These represent a moderately simple level of intervention that may have significant benefits for the consumer and care providers. The Oakden Response Quality and Safety Expert Working Group will address the approach to governance in order to facilitate a viable model.

Consideration of providing focused resource allocation to the Country Health OPMHS would also be an appropriate strategy in ensuring older South Australian’s in rural and remote regions are not disadvantaged. It is recommended that a review of current funding to this service be undertaken in order to ensure equity across sectors.

Partnerships are a critical factor in addressing the needs of older people presenting with BPSD and/or enduring mental illness. Further discussion with Commonwealth funded Dementia Support Australia (DSA), encompassing the DBMAS and SBRT is recommended to explore how supports for regional RACFs managing residents with BPSD can be improved. Increased access to tele-health consultations should be considered for organisations such as DSA as well as state-funded Country Health OPMHS. Whilst services, such as DSA, currently exist with availability to all South Australian regions, it is acknowledged that rural and remote services have much greater difficulty in utilising these services in a timely and accessible manner. This requires discussion, collaboration between
partner services, service planning and consideration of both Commonwealth and State funding.

The EWG recommends that a sub-group of stakeholders continue to facilitate further development of a viable service model to better meet the needs of rural and remote communities and support management of older people in situ, without having to leave their homes, families and communities.
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