Wintringham
SPECIALIST AGED CARE

CARE AND MANAGEMENT OF YOUNGER AND OLDER AUSTRALIANS LIVING WITH DEMENTIA AND BEHAVIOURAL AND PSYCHIATRIC SYMPTOMS OF DEMENTIA (BPSD)

WINTRINGHAM SUBMISSION TO THE
Senate Standing Committees on Community Affairs

OPTIONS · DIGNITY · RIGHTS

Contents

PREFACE

Wintringham welcomes the opportunity to comment upon aspects of the care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD). In this paper we will address those terms of reference with direct bearing on our experience in this area.

Wintringham's response will concentrate exclusively on the elderly homeless, about whom we have widely acknowledged expertise. We will demonstrate that many in our client group exhibit the behavioural and psychiatric symptoms of dementia. Some of the responses that we have developed to the problem of delivering services to aged men and women who are homeless have clear implications to the development of a range of programmatic policy settings for the delivery of aged care services to all elderly people who do not fit neatly into existing mainstream groups.

It is well documented that excessive drinking over a period of years may lead to Alcohol Dementia, which can cause problems with memory, learning and other cognitive skills, all of which present as similar to BPSD. These same clients tend to be atypical of the traditional aged care client in that they are often younger, though with early onset of ageing. There are few care options available in the community for this group and yet quite often this same group has such significant care and behavioral needs that support is required from aged care, disability, mental health and drug and alcohol services to successfully house and provide care for this client group.

Wintringham's experience in working with such clients, regularly rejected elsewhere in the aged care sector, will be shared with the Senate in this submission, highlighting our model for successfully integrating clients with severe BPSD into the aged care environment.

We welcome this opportunity to look specifically at the financial and care implications of severe and complex behaviours and assist in finding workable solutions to the care and treatment of older individuals with BPSD.

In considering better systems and supports for clients with significant behaviours of concern, the key issues for Wintringham are:

- The need for supporting programs to understand and avoid the obvious systemic resistance to dual funding, ie the need for agreement amongst services and across government departments that clients with significant behaviours of concern require extra support that may indeed involve duplication across service programs;
- The potential to develop a Wicking Respite/Reintegration model as a gateway for the placement or re-integration into aged care facilities of people whose BPSD have become otherwise unmanageable;
- Consideration of a funding program for extra recreational support that we believe clients experiencing BPSD require since, in our extensive experience, recreational support minimises the need for any form of restraint.

Wintringham: some background information

Wintringham was established in 1989 as an independent not-for-profit welfare company to provide high quality aged care services to frail elderly homeless men and women. Today we provide a range of services to approximately 1,300 elderly people who are homeless or at risk of becoming homeless each night, including low and high care residential homes, Federally-funded community care packages, State-funded support packages, a range of housing services and options, street based outreach work, advocacy services, as well as our work representing the interests of the homeless elderly on a variety of State and National ministerial advisory committees. More details about these services and further background to the company can be found at www.wintringham.org.au .

Wintringham is today the largest provider of services to the elderly homeless in Australia. Of the approximately 700 residential aged care beds in Australia, Wintringham has more than 200 reserved exclusively for the homeless. In addition to the four Registered Aged Care Facilities (both low and mixed care) Wintringham has designed and build the first nursing home for homeless people in Australia, and quite possibly the first one in the world.

In 2011, Wintringham was award the United Nations Habitat Scroll of Honour, the first time an Australian organisation has achieved this award which is the highest award for human settlement provided by UN-Habitat.

The vision at the start of Wintringham was simple. The company would be a social justice organisation that would care for older homeless people whom the aged care industry had turned its back on.

Our view of social justice, and the rights that flow as a result of social justice, is that aged care and housing are basic and fundamental rights and should not be consequential on the personal values of a worker or an organisation. So, for Wintringham, older homeless people have a right to decent aged care services and housing simply because they are Australian citizens.

Commencing in 2008 with funding from JO & JR Wicking Trust, Wintringham has undertaken a major research project on 'Older People with Acquired Brain Injury and Associated Complex Behaviours: A Psychosocial Model of Care That Supports Long-term Residential Care Needs'). The Wicking Project has yielded major insights into a successful model of care for the BPSD client group. Its findings inform our response here. (http://www.wintringham.org.au/Research/TheWickingProject.aspx)

The elderly homeless remain one of the most disadvantaged and powerless groups in Australian society. At a time of life when most people would be enjoying their retirement, elderly homeless men and women live outside mainstream society making do with inadequate food, clothing and housing.

Elderly and homeless: shifting the paradigm

At the time of the formation of Wintringham, many hundreds of elderly men and women were living and dying in homeless persons' night shelters unable to access mainstream aged care services even though these services were often run by Church and charitable organisations who received tax concessions in order to provide for the disadvantaged.

The prevailing view in the 1970's and 80's was that as these elderly folk were homeless, it was appropriate that they were in a homeless service. In short, these aged people were being seen as homeless and elderly and as such it was the responsibility of the homeless sector to provide for them. Wintringham reversed that expression, arguing that aged homeless people were elderly and homeless.

Changing the description of aged homeless people from being homeless and elderly to elderly and homeless is not merely semantics: it creates a new paradigm and a new way of thinking about the elderly homeless. It involves acknowledging that the person is aged and therefore entitled to normal aged care services. If we say they are homeless it perhaps makes some sense of the fact that they are living in a homeless persons' night shelter, but if we say that they are aged (and just happen to be homeless) then the next question surely is "why are they not part of the aged persons' service system?"

The principle that Wintringham has operated on from its inception is that the aged homeless should have the same right as any other elderly Australian to access mainstream aged care services.

The aged care system is not allowed to discriminate against any minority group on the basis of their ethnicity, religion or personal views. Why then should they not be required to make welcome the elderly homeless?

Unable to place our elderly homeless clients in mainstream aged care services, Wintringham resolved to build its own.

Is there a typical Wintringham Client?

Wintringham's residents and clients do not fit the profile of a 'typical' mainstream aged care resident who is around 87 years of age, female, likely to have been referred to a care option by an Aged Care Assessment Service and originating from a middle class background. On the contrary, Wintringham residents are predominantly male, the median age is 66 years and they are almost exclusively from the working class.

As a consequence of a homeless lifestyle, Wintringham clients and residents have an over-representation of people with the following characteristics:

- No regular contact or support from family and friends and no record of a next of kin.
- A need for guardianship support through the Office of the Public Advocate (OPA). Approximately 50% of newly admitted Wintringham residential aged care residents receive guardianship support.

- A need for administrative and financial support. Approximately 70% of newly admitted residents to Wintringham residential aged care services are under Administration Orders.
- High incidence of psychological illness and/or acquired brain impairment and or social/behavioural issues (various forms of dementia / intellectual disability). Acquired brain injuries can cause symptoms similar to psychosis and dementia, as well as significant problems with impulse control, social skills and self-awareness.
- Premature ageing – it has been demonstrated that homeless populations have a higher rate of serious morbidity and premature mortality compared to the general population, with westernised countries reporting an average age of death between 42 and 52 years.
- Poor skills in activities of daily living leading to domestic mismanagement.
- Unwillingness to readily engage with services and participate in communal activities.
- High prevalence of issues relating to gambling, drug and alcohol addiction and abuse.
- High prevalence of challenging, difficult and anti-social behaviours. Challenging behaviours are generally described as behaviours that, either directly or indirectly, seriously disrupt or affect the lives or routines of other people or services. In the residential setting these include other residents, neighbours, support services, staff, families and communities. Frequently the presence of these behaviours interferes with the resident's ability to learn, and may place the person, others or property at risk of injury or damage.
- It is well documented that people who are homeless have higher rates of illness, drug dependency and injury than the general population.
- The majority of our clients have some sort of diagnosable condition including mental illness, drug and alcohol disorders, behaviour disorders, and intellectual disability as well as chronic health problems. Many have had multiple and uncoordinated interactions with a variety of services, including emergency services.
- There are also significant health problems generally linked to poor nutrition occurring secondarily to alcohol addiction.

It is well documented that excessive drinking over a period of years may lead to a condition known as Alcohol Dementia, which causes problems with memory, learning and other cognitive skills. Alcohol has a direct effect on brain cells, resulting in poor judgment, difficulty making decisions and lack of insight. Nutrition problems often accompany long-time alcohol abuse and can be another contributing factor, since parts of the brain may be damaged by vitamin deficiencies.

Wintringham clients suffering from dementia may have very little ability to learn new things, while many of their other mental abilities are still highly functioning. Along with the decline in cognitive skills, sometimes noticeable personality changes take place. As many of our clients who drink may have a concurrent mental health issue,

it is not uncommon for them to have a diagnosis of Alcohol Related Brain Injury or Alcohol Related Dementia as well as other mental health issues.

'Dual diagnosis' describes people who have coexisting substance abuse (drug and/or alcohol problems) and mental illness or psychiatric disability. Homeless persons who are dually diagnosed with severe mental illness and substance use disorders constitute a particularly vulnerable subgroup with complex care needs. These patients have been shown to have a poorer prognosis than patients with exclusive substance addiction, with a higher incidence of hospitalisation, medication non-compliance, criminality, homelessness, and suicide. Because of such complicated diagnostic and morbidity issues, patients identified as having dual or multiple diagnoses require specialised treatment for a successful outcome. In turn, individuals with multiple care needs require a wider suite of service provision for longer periods of time.

Residents and community clients coping with these health and social issues have posed many unique challenges to services such as Wintringham that are only occasionally experienced by other aged care providers.

TERMS OF REFERENCE (a): (i) (ii) & (iii)

In this section, Wintringham's experience with models of community, residential and acute care for Australians living with dementia and BPSD will be discussed. As will be noted in discussion, the vast majority (approximately 70%) of Wintringham's services are funded through the Commonwealth Department of Health and Ageing: this includes all of our Residential Care beds, Community Aged Care Packages and a portion of our Outreach service, funded as Assistance with Care and Housing for the Aged (ACHA).

The State government funds another of our Outreach services – Older Persons Outreach Program (OPOP) – as well as some support services for our independent living units.

Importantly, the Wicking Project, our major research undertaking of direct relevance to optimizing the care of older people with dementia and BPSD, has been funded by a private philanthropic trust. We will argue in this paper that the Wicking model of care offers care solutions that warrant policy development and on-going government funding.

Wintringham's experience with dementia and BPSD in Residential Care

Acquired brain injuries can cause symptoms similar to psychosis and dementia, as well as significant problems with impulse control, social skills and self-awareness. These problems may manifest as agitated, difficult, disruptive, inappropriate and/or aggressive behaviour which may or may not be associated with a serious mental illness or disorder. A person with such a condition, who may be typically 50 years of age and who is no longer able to live independently within the community has very limited care options. In the past, most people in this category were found to be ineligible to enter most Commonwealth funded residential aged care facilities as they were perceived as too young by **Aged Care Assessment Teams**.

Wintringham have enjoyed an excellent relationship with the Department of Health and Ageing over the years, and this has seen an increasingly flexible approach by most ACAS teams for referral of younger vulnerable clients with Alcohol Dementia.

Recommendation 1

Wintringham further encourages a more consistently flexible approach of all ACAS teams to consider younger more vulnerable homeless clients for access to Aged Care Services.

Wintringham prides itself on advanced behavioral management strategies and models of care developed over 20+ years focused on managing the care needs of older, homeless people. While there are many paths leading to homelessness (or risk of homelessness) one common factor is isolation due to anti-social behaviours. We have also found that our models of care and behavioural management strategies can be successfully applied to a much wider care recipient group and as a result, we have become the organisation of choice for those with difficult behaviours. These residents do not always come from a financially disadvantaged or homeless background. Many are referred to Wintringham by other aged care providers; many have a diagnosed mental health disorder.

Because so many of our clients require extra support Wintringham has developed strong partnerships with external support organisations such as: RDNS Homeless Persons' Program, Aged Psychiatric Assessment Team, Mobile Aged Psychiatry Service, Carer Links, Carer Respite Services, Community Connections Programs, Assistance with Care and Housing for the Aged (ACHA) program, Drug and Alcohol Services, Mental Health Services, arbias, Public Hospitals and Hospital Admission Risk Program (HARP). And at times ….police services!

The following case study illustrates the support culture at Wintringham whilst also demonstrating the difficulties faced in linking much needed services around a typical client with behavioural and psychiatric symptoms of dementia (BPSD).

Case Study - Val

This case study was written by our high care facility Manager. It was actually written to try to describe the difficulty we have, on occasion, in accessing mental health services but seemed appropriate to include here.

Val, who was 66 at the time, came to our Ron Conn nursing home after failing accommodation services because of acute mental health episodes where he had trashed his housing. (As an aside he received a notice for costs of approximately $13,500 from the Department of Housing for the damage he caused that we were able to settle on his behalf for about $1,100 through a supported conciliation meeting at VCAT.)

Following his eviction from his housing he was treated for a brief period as an acute mental health inpatient (at Broadmeadows) and discharged with a high care ACAS to a bed at Ron Conn. (They could not find another aged care provider who would take Val). When he arrived he was not well at all: paranoid, pacing, yelling, talking to himself constantly, in tears and 'minor' episodes of self harm. It was dreadful to see him so tortured within himself. He was also quite frightening to other residents and some staff. Apart from

his tortured mental health condition, he was a very unstable diabetic, morbidly obese and had several other health co morbidities that one associates with rough living. In short, he was a mess! (His life history is one of immense tragedy – Children's Home, fostered, abused, children's correction services, mental health admissions +++).

Despite the extensive experience at Ron Conn in dealing with challenging behaviors, we found Val very difficult to manage. Several calls to and from the Aged Psychiatric Assessment Team (APAT) prompted a couple of quick visits and reviews but a usual theme was "these are behavioral issues – not psycho geriatric issues" and "keep up the good work". It was like a pat on the head was what we were being offered. This is despite the fact that Ron Conn has a fairly regular liaison with APAT services – so one would reasonably expect that if we were asking for help – we probably needed it!

We called for help on several occasions over a two or three week period, with Val's doctor offering various "as necessary medications" to help control his behaviours. Staff were at their wits' end. They were spending so much time with Val who would only engage with a few staff; he was very distrusting. On one particular day Val decided to sit in the middle of the road outside Ron Conn. His Care Manager had been sitting with him trying to coax him back to Ron Conn and I went out to relieve her. The Care Manager told me that APAT services had been informed but they again indicated that we should continue to try and do what we were doing. Eventually I decided to call APAT myself. So there I was, sitting with Val, in the middle of the road, Val yelling at someone / something (who was not there) telling his imaginary friends to "Fuck off and leave him alone" – all of this occurring whilst I was talking on the mobile phone with APAT. It was not until I used APAT's language – indicating that he was a danger to himself and others, that we finally got a response that we needed. "We will organize a CAT team to be with you ASAP! – please also call the police" - (Sometimes it has appeared, unless we have police involvement – we can not "get the attention" of the services - Police involvement and training for police in "less assertive" techniques is another whole story!)

After a prolonged discussion with the CAT team, Val's "Case Manager" and the police we were able to coax Val into the ambulance and he was readmitted to acute psychiatric care. (Picture them all standing around Val and I sitting on the road for about 30 minutes. The police trying to forcefully pick Val up [it was after all at the end of their shift], me asking them to just give us a second so we could talk Val into the ambulance, Val now telling the police and his imaginary friends to fuck off together!!! – Sad but true).

On admission to psych care Val had a complete review of medications over a 7 day period. We requested a case conference at the acute unit with Val involved, prior to his readmission to Ron Conn. This all occurred. Val was readmitted back to Ron Conn. He had some behaviours of concern but we were able to manage those. We were also able to get Val to eat a good diet.

Years later he is now a very healthy weight, his diabetes is controlled and he is off insulin and most importantly he is very content and helping many of our

other residents – he calls Ron Conn home. He is a great success for Wintringham. Prior to admission to Ron Conn his life was a total mess.

This case study typifies what Wintringham has found to be the reluctance within health systems to support a client exhibiting behaviours of significant concern with dual (or more) funding options. Val clearly required extra mental health support but there was reluctance to offer the extra support as he was believed to be an "aged care client" not a client that required assistance from both sectors.

Paradoxically, people like Val are exactly the clients for whom dual support and/or funding is the most cost and time efficient approach. When clients like Val are 'deferred' until a crisis, they bleed more resource support from an over-stretched system (police response, CAT response, Emergency Department response), than would have been the case if the appropriate dual supports were offered prior to the crisis.

Recommendation 2

Clients with significant BPSD need easier access to specialist care providers who are able to access support from a variety of services (aged care, disability and mental health). Resistance to 'dual assistance' needs to be better understood and priority supports should be offered to specialist providers to prevent unnecessary crisis and tertiary hospitalisations of complex behavioural clients.

Wintringham's experience with dementia and BPSD in Community Care

The difficulty that specialist providers have in delivering financially viable residential aged care services to elderly homeless people with BPSD is replicated with community or home care services.

Home based care is built around central concepts of 'home' and 'family', neither of which are likely to have much direct relevance to homeless people, or indeed to those elderly people who are at grave risk of becoming homeless.

Wintringham's community care services have their roots in our Outreach teams who search out or follow up on leads concerning elderly people who are homeless. Our aim has always been to develop a suite of services that are instantly available to our outreach workers which they in turn can offer to their homeless clients. These services range from advice and support to housing and aged care services whether community based or residential.

The commonalities which unite most of our community clients are their experiences of absolute poverty, their consistent lack of family contact or support, and the instability of their housing.

In our experience, the incidence of BPSD is as likely to occur with our Community clients as with our Residential care clients. The additional time and financial burden occasioned by caring for clients with BPSD is as likely to be incurred in either setting.

We believe that the Dementia Supplement currently under consideration by the Department of Health and Ageing will, if implemented, go some way to assisting Providers in funding an appropriate model of care in both the Residential and Community settings, although we have expressed elsewhere our concern that an additional supplement to cover Severe Behaviours may be necessary.

In relation to the BPSD Terms of Reference, we are anxious that issues for Community clients are given equal consideration to the better known issues relating to Residential care.

Recommendation 3

Wintringham stresses the need to develop and appropriately support successful models of care for older people suffering BPSD in both Residential and Community settings.

Wintringham's Wicking Project: a Model of Care to address dementia and BPSD

Wintringham's Wicking Research Project came about through a Major Strategic Initiative Grant from The JO & JR Wicking Trust which is managed by ANZ Trustees. The four year Project, fully titled, 'Older People with Acquired Brain Injury and Associated Complex Behaviours: A Psychosocial Model of Care That Supports Long-term Residential Care Needs' investigated, designed and trialled a purpose-designed 'Specialised Model of Residential Care' specifically aimed at providing long-term care options to older people with dementia resulting from severe acquired brain injury. Residents admitted to Wicking had a long history of behaviours which had led to them being deemed extremely challenging or inappropriate for care by a number of services.

The Wicking Project finished in December 2009. One of its finding was that we were able to successfully reintegrate many clients back into mainstream aged care by providing intense focused care and support and developing care plan options that would successfully support the resident in an aged care facility. We identified this as Complex Respite for the aged care facility – allowing the resident to reintegrate into an aged care setting. The following case study is a good example of the model.

Case Study - Jim

Jim first came to Wintringham's notice when he was referred to our Wicking Research Trial. He was admitted to the Wicking trial in June 2009 and remained there until the Trial ended in December 2009, at which time he transferred to Wintringham Williamstown Hostel.

Jim's background is vague as he has had minimal contact with health and community services over the years and is estranged from his family. He was born in Timboon and raised in the Northern Suburbs of Melbourne. Apparently his father had a history of heavy alcohol use. Jim appears to have led a relatively itinerant lifestyle following the death of his parents with failed attempts at living in private rental accommodation, public housing, Ozanam House (homeless shelter) and Darebin Lodge (rooming

house), interspersed with episodes of primary homelessness. Jim has no children and has never been married.

He came to the attention of Royal District Nursing Homeless Persons' Services after his rental home was lost to a fire in 08/2007. The source of the fire was apparently a lit cigarette Jim had himself discarded. It is suspected that he sustained some level of carbon monoxide poisoning during the fire. He was referred to Merri Outreach Support Services (MOSS) in 2008, who assisted him to obtain a Disability Support Pension and transitional accommodation with North East Housing Services.

It became evident that Jim was using alcohol quite heavily and that his behaviour was becoming progressively more odd and erratic. Direct observations included persecutory beliefs concerning others following or spying on him, ideas of reference about the radio communicating with him, visual hallucinations regarding the changing size of his hands and possibly olfactory hallucinations relating to foul odours. Continuing complaints from Jim's neighbours noted shouting at 'imaginary' people and constant door slamming throughout the night.

On Jim's move to Wicking, he demonstrated a wide range of challenging behaviours including: absconding; agitation/verbal aggression; reduced participation in tasks within the home environment and exhibiting psychotic symptoms. Over the first few weeks of residency at Wicking he increasingly made references to ideas and sensations relating to his body (e.g., expressing beliefs about his menopausal symptoms, enlarged hands and feet). There was an increase in agitation, episodes of absconding and multiple instances of an unusual behaviour which appeared to be volitional, whereby he stood/sat with arms outstretched in front of him while explaining to others that he needed to assume this position in order to assist his 8-month menstrual cycle and to assist with his poor circulation.

However, over the ensuing months, the intensive Wicking support model led to a significant reduction in these behaviours with increased socialization and participation in activities within the home. This was attributed to a number of factors including:

- *decreased alcohol intake and the provision of an alcohol and cigarette program,*
- *an intensive Recreation program tailored progressively to his interests, as they emerged,*
- *the provision of a safe home environment,*
- *consistency of staff who nurtured a trusting relationship and rapport,*
- *the provision of routine and structure around daily chores,*
- *the provision of a comprehensive health (mental and physical) assessment,*
- *availability of someone who would listen to his concerns and act on them accordingly.*
- *improved nutrition,*
- *the commencement of anti-psychotic medication.*

By December, with Jim's transfer out of Wicking imminent, staff had established a clear and sustainable care plan which eliminated or reduced behaviours to a level that could easily be managed at a Wintringham Hostel, provided, of course, that identified strategies and interventions were implemented and implemented consistently.

In addition, a staff member from Wicking, who had established a good rapport with Jim was also transferred to the Williamstown Hostel with him to provide 1:1 support for 10 hours per week during the transition period.

During his time at Wicking staff had pushed very hard for psychiatric assessment. [similar to our previous case study Val, this required extreme assertion from staff] This was eventually done, although reluctantly. Psychiatric services believed that all Jim's behaviours could be explained through continual alcohol intoxication. This was despite the fact that, during his residency at Wicking, his alcohol intake was closely monitored to ensure he did not become intoxicated.

Following psychiatric review, a provisional diagnosis of schizophrenia was given, although there was insufficient data for this diagnosis to be confirmed. As a result, the psychiatric team provided a general mental health diagnosis of 'psychosis' and 'mental and behavioural disorders related to substance abuse'. In addition, Jim has ABI (hypoxia), ARBI, Epilepsy and Arthritis.

Once he'd transferred to Wintringham's Williamstown Hostel the behavioural interventions developed in Wicking were reviewed and adapted to the new environment.

This change management program (specialised BPSD Respite/Reintegration) worked well for Jim and Hostel staff. Jim exhibited few behaviours of concern and those behaviours that did occur were infrequent and Jim's reactions quite moderate. Jim's 'respite' allowed for a comprehensive behavioural plan to be developed that allowed him to be successfully integrated back into an Aged Care Facility.

Recommendation 4

Wintringham recommends that support for a new Wicking Respite/Reintegration Model gateway be considered for clients with significant BPSD, with the aim of integrating the individual back into main stream aged care with a tailored suite of care and behavioral strategies.

Please note that the Wicking study, a multi-year research project, was entirely funded by a philanthropic trust. For the full value of its findings into a successful model of care for the Respite/Reintegration of clients with significant BPSD into residential aged care, ongoing government funding is needed. We strongly believe that the toll on services dealing with catastrophic behaviours in residential and community settings is such that the Wicking Respite/Reintegration gateway model could be justified on a financial basis, as well as in terms of best practice in care.

TERMS OF REFERENCE (b)

Resourcing the Wintringham Model of Care for Clients with BPSD

Wintringham's argument that the elderly homeless were entitled to access services delivered from the Commonwealth Age Care Program was accepted by the then Government in the late 1980's and, importantly, has been reaffirmed by all subsequent Governments and Aged Care Ministers.

There are, however, major financing problems arising from that decision as the Aged Care Act has essentially been designed around the needs and resources of an elderly Australian who has little in common with a homeless person. Homeless people cannot pay Accommodation Bonds (except in the most unusual circumstances), rely solely on the Aged Pension and usually have no additional financial resources with which to make any additional contribution, and in the main, have no family upon whom they can rely for either emotional or financial support.

Organisations such as Wintringham, who work exclusively with the elderly homeless, can therefore rely on no income stream other than government recurrent funding. Up until 2008, this was delivered by the RCS (Resident Classification Scale).

Under ACFI (Aged Care Funding Instrument), however, our income dramatically fell largely due to the different weighting the instrument placed on ADLs (Activities of Daily Living) as distinct from behavioural interventions.

The specifics of our problems with ACFI have been addressed elsewhere, but the following case study illustrates the issues around funding for BPSD in an aged care setting.

Case Study - Jason

Jason has a very significant brain injury which results in extremely violent outbursts which have seen him oscillate between homelessness and a variety of care facilities all of which have been unable to cope with his behaviours resulting in his eviction.

Through setting a strict regime of routines that Jason was comfortable with, Wintringham has successfully provided for his needs within the aged care program and importantly given him a safe home – probably the first time this has happened to Jason.

In spite of this apparent success, Jason's temper flairs violently if he perceives that he has been wronged. Usually this will occur if there has been an unintentional change to his routine.

On one occasion, when Jason's medication was not provided to him at the agreed time, he became violent and charged our young (female) worker. Terrified, she retreated into a staff room. Jason punched his way through the glass door and was only subdued when the police arrived. Three divisional vans, 7 police and 3 cans of capsicum spray were needed to bring Jason under control. Jason is not the kind of client the aged care industry usually sees.

Upon an internal investigation as to what prompted the outburst, we discovered that Jason had become violent because we had failed to change the clock in his room when day light saving finished, thereby confusing him as to the real time. When Jason's routine was disrupted, he lacked the cognitive ability to see anything other than that his rights had been violated.

Wintringham calls these events 'catastrophic' but they can all be managed and usually prevented. By having a routine in place that keeps Jason calm, staff are able to effectively work with him in a relatively safe environment. Jason requires nothing more than a regular routine – but he requires a regular routine for all ADLs, Medication and Complex Health Care needs.

Under the RCS system, the routines that we developed for Jason were claimable under a wide range of RCS Questions, but under ACFI the only claim that can be made is a 'Low' claim for the one-off violent outburst and the claim is only applicable to the ACFI Behavioural Domain.

It is also worth noting that if, on the other hand, Jason had a mild form of Alzheimer's that presented itself as gentle confusion requiring hourly minor prompts from staff, these interventions would be eligible for a 'High' claim under this same domain.

We believe that the financial gap that has opened up since the introduction of ACFI is unintentional and has not been introduced to penalise homeless providers, where the incidence of BPSD is disproportionately high. Nevertheless, the burden that this has placed on homeless aged care providers threatens our ongoing viability and our capacity to provide care to the elderly homeless.

TERMS OF REFERENCE (c)

As will already be apparent, Wintringham has highly developed care practices for older Australians with BPSD and some specific recommendations based on the Wicking Research model.

Access to appropriate respite care

For clients with BPSD, Wintringham would like the Senate to consider a very different model of respite to those which are currently understood in aged care.

We believe that the Wicking Respite/Reintegration Model could act as a gateway to have individuals with BPSD in the community successfully placed in a residential setting. Equally, it offers people whose residential care placement is failing a program in which their behaviours of concern can be intensively addressed, with the real option of successful reintegration back into their residential care facility.

For these reason, we reiterate Recommendation 4:

> Wintringham recommends that support for a new Wicking Respite/Reintegration gateway model be considered for clients with significant BPSD, with the aim of integrating the individual back into mainstream aged care with a tailored suite of care and behavioral strategies.

Reduction in the use of both physical and chemical restraints

It is well recognized that exercise is one of the best stress-relievers for both dementia patients and carers. Regular walking, movement, or seated exercises can have a positive effect on many problem behaviours, such as aggression, wandering, and difficulty sleeping.

Simple activities can also be a way for clients with behaviours of concern to reconnect with their earlier life. Someone who used to enjoy cooking, for example, may still gain pleasure from the simple chore of washing vegetables for dinner. Wintringham strives to involve the clients in as many productive daily activities as possible.

It is Wintringham's experience that residents demonstrating challenging behaviours require a disproportionate amount of service resources. These include the provision of special residential units which create a harmonious environment that minimise potential behavioural triggers while adequately meeting occupational health and safety requirements. Specialist workers are trained to work effectively and intensively in such environments.

All Wintringham care staff receives training in behaviour management techniques, and maintain and deliver individualised behavioural management care plans. It is well recognised that a lack of engagement and activity can contribute to the loss of already limited abilities through lack of use and can also trigger challenging behaviours resulting from boredom, loneliness and disempowerment. An important component of Wintringham's care plans is the implementation of appropriate, individualised recreational and lifestyle opportunities.

Recommendation 5

Wintringham recommends that consideration be given to ensuring specialist providers are further supported to provide ongoing annual advanced behavioral training in the area of BPSD.

Recommendation 6

Wintringham recommends that consideration be given to ensuring specialist providers are financially supported to provide best practice recreational therapies that are seen to reduce reliance on chemical and physical restraints.

SUMMARY

Wintringham, together with the Federal Government, established in 1989 the right of Elderly Homeless people to access the mainstream aged care program. While that victory for homeless people is still resonating around the aged care community, a fundamental problem continues to plague the delivery of these services. The problem is that the aged care program and all of the various alterations, additions,

reforms and innovations are designed around the needs of an elderly person who has little in common with a homeless person, nor indeed with any client or resident suffering from a BPSD.

Wintringham welcomes the Senate's undertaking to understand and address the policy and financial implications of caring for older people with BPSD in both Residential and Community settings. We are eager to be involved in the many system refinements unquestionably needed. We particularly hope that the Wicking Respite/Reintegration model will be investigated as a policy innovation for older people with BPSD.

Bryan Lipmann, AM
Chief Executive Officer
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