



# Dementia and the take-up of residential respite care

## Summary

People caring for those with dementia have identified respite care as one of their critical care needs. Their low use of respite care, however, appears to belie this stated need.

Evidence about respite use patterns for people with dementia and their carers has to date largely been based on small-scale studies and qualitative research. A recent systematic review of the literature on transitions in care of people with dementia found little that described common pathways and transitions between care types, including the use of respite care (Runge et al. 2009).

This study aims to fill part of this evidence gap using nationally linked administrative data to quantify the extent to which residential respite care is taken up by those with and without dementia. The study is based on 32,000 members of the Pathways in Aged Care (PIAC) cohort who had an approval for residential respite care use from an Aged Care Assessment Team (ACAT) in 2003–04.

The nature and the size of the data set lets us draw robust conclusions on factors that affect the take-up of residential respite care among those with an approval. In particular, this bulletin reports findings about the influence of dementia status, carer status and English proficiency on the take-up of respite care. The main findings are summarised below.

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## Take-up of residential respite care

- Only about a quarter (27%) of people approved for residential respite care (RRC) actually used it within 12 months of their approval.
- A somewhat greater proportion of people with dementia (32%) took up RRC than those without dementia (25%). The difference was statistically significant.
- Having a carer increased the likelihood of a client taking up RRC. Among those recommended to live in the community, a person with a co-resident carer was more likely to take up respite than those with a non-resident carer (31% and 25%, respectively).
- Dementia status and carer status acted independently on the probability of taking up respite care; that is, there was no interaction between dementia status and carer status.
- For people recommended to live in the community, those born in non-English speaking countries had a lower take-up rate (24%) than those born in Australia or other English-speaking countries (28%). This difference was statistically significant.
- Dementia status and English proficiency acted independently on the probability of taking up respite care; that is, there was no interaction between dementia status and English proficiency.

## Movement into permanent residential care after using respite care

Current literature shows that dementia is a key predictor of institutionalisation. Statistical modelling confirmed that if a person had dementia or no carer, there was an increased likelihood of admission into permanent residential care within 12 weeks of take-up of RRC.

## Background

Respite care, which can take a variety of forms, is a key service designed to provide support for carers and the people they care for, by giving carers a break from providing assistance. It is also important for people who need a higher level of care for a short period.

Respite care is especially important for people caring for someone with dementia. The demands of caring for those with dementia are heavy, involving the provision of increasing amounts of physical, psychological, cognitive and social support as dementia severity increases. Dementia is sometimes also accompanied by behaviour changes which add to the complexity of caring (e.g. Brodaty & Hadzi-Pavlovic 1990, Bindoff et al. 1997, Schofield et al. 1998, Luscombe et al. 1998, LoGiudice et al. 1999, Leong et al. 2001, Draper 2004, Bruce et al. 2005, AIHW 2007). Caregivers of people with dementia are particularly at risk of high carer stress often associated with lower levels of psychological wellbeing (Brodaty & Hadzi-Pavlovic 1990, Bruce & Paterson 2000, AIHW: Hales et al. 2006).

Respite care is highly valued by carers, including those caring for someone with dementia, as a way of sustaining them in their caring role. Increased availability and flexibility of respite care are common requests in carer studies (House of Representatives Standing Committee on Family, Community, Housing and Youth 2009; Kosloski & Montgomery 1993, Adler et al. 1995, AIHW: Hales et al. 2006; Lee & Cameron 2004, Bruen & Howe 2009).

Patterns of use of respite care by carers of people with dementia appear, however, to belie this stated need. Reasons for generally low levels of service use in the face of high need have been explored in a number of studies (e.g. Kosloski & Montgomery 1993, Leong et al. 2001, Brodaty et al. 2005, Bruen & Howe 2009, AIHW: Hales et al. 2006). These studies note concerns by carers in relation to the usefulness, quality, convenience, cost, flexibility and responsiveness of respite care.

Current Australian evidence about respite use patterns by people with dementia and their carers is largely based on small-scale studies, qualitative research or analysis of data from single programs. A systematic review of the literature on transitions in care of people with dementia found that there is little evidence describing common pathways and transitions between care types, including the use or efficacy of respite care (Runge et al. 2009).

This study is funded by the Dementia Collaborative Research Centre for Assessment and Better Care Outcomes, which aims to strengthen evidence in this area. The study uses national-level aged care data from the Aged Care Assessment Program (ACAP) and residential aged care. These data have been linked as part of the Pathways in Aged Care (PIAC) cohort study (AIHW 2009b).

### Residential respite care

The focus of this study is on patterns of residential respite care (RRC) use among a cohort of people eligible to use the service. Residential respite care provides emergency or planned care in a residential aged care home on a short-term basis. The provision and use of RRC is highly regulated by the Australian Government. An approval from an Aged Care Assessment Team (ACAT) is required to access RRC and, during the period covered by this study, an approval remained valid for up to 12 months.

A person with a valid approval may use up to 63 days of respite care in a financial year. This care may be taken in 'blocks' (often one or two weeks) subject to the availability of services. Extensions of residential respite care for periods of 21 days can be approved by an ACAT, based on considerations such as carer stress, the severity of the care recipient's condition or absence of the person's carer (DoHA 2009). Respite residents pay the *basic daily fee* at the minimum rate but do not pay an accommodation charge or bond.

## Hypotheses

Some service characteristics of RRC—including relative inflexibility, cost, possible lack of available places and system complexity—may act as barriers to take-up by carers. Factors specific to people with dementia may further increase their reluctance to use RRC. These include concerns about its usefulness if it results in increased levels of confusion, disorientation and deterioration of cognitive function and behaviour (Bruen & Howe 2009) and lack of confidence that RRC will provide care sufficiently appropriate to the complex care needs of care recipients (AIHW: Hales et al. 2006, Bruen & Howe 2009). Therefore this study hypothesised:

- that people with dementia would be less likely to take up ACAT recommendations for residential respite care than people without dementia (Hypothesis 1).

A key aim of respite care is to provide support to carers. In addition to providing assistance with daily activities and giving emotional and practical support, carers may also engage in service-seeking behaviour on behalf of the care recipient, thus acting as a conduit to formal service intervention (AIHW: Hales et al. 2006). Therefore this study hypothesised:

- that people with dementia who had a carer were more likely to take up respite care recommendations than those without a carer, and that the effect of having a carer on take-up was different for those with and without dementia (that is, there was an interaction effect) (Hypothesis 2).

The limited evidence available about dementia in persons from culturally and linguistically diverse (CALD) backgrounds suggests that some CALD migrants regard dementia as part of normal ageing and hence may be less likely to seek support or assistance (Runge et al. 2009, Low et al. 2009). They may also face barriers to accessing services, such as language proficiency, family and cultural attitudes to the appropriateness of formal care assistance and stigma associated with dementia (Low et al. 2009). In addition, usage rates of permanent residential care are typically lower among people born overseas in a non-English speaking country than among those born in Australia or in other English-speaking countries (AIHW 2009c). Therefore this study hypothesised:

- that people with dementia who were born overseas in non-English speaking countries were less likely to take up respite care recommendations than those born in Australia or in English-speaking countries, and that the effect of English proficiency on take-up was different for those with and without dementia (that is, there was an interaction effect) (Hypothesis 3).

Residential respite care plays an important role in care pathways, sometimes acting as a stepping stone towards permanent RAC placement (AIHW: Karmel 2006, Adler et al. 1995, Cohen & Pushkar 1999, Butler et al. 2002). In addition, there is consistent evidence that dementia and cognitive impairment are strongly associated with, or predictive of, institutionalisation (e.g. Miller & Weissert 2000, Banaszak-Holl et al. 2004, McCallum et al. 2005). Therefore this study hypothesised:

- that people with dementia were more likely to move from respite care to permanent residential care within 12 weeks of admission than people without dementia (Hypothesis 4).

People with dementia are less likely to be able to continue living at home on their own than other frail older people. For example, 89% of Extended Aged Care at Home (EACH) package recipients have a carer available, while the figure for EACH Dementia package recipients is 95% (AIHW 2009a). Similarly EACH Dementia package recipients are less likely to live alone (22%) than EACH package recipients (29%). The stepping-stone effect of RRC may therefore operate more strongly for people with dementia who do not have a carer in their usual accommodation. Therefore this study hypothesised:

- ♦ that people with dementia who did not have a carer were more likely to move from respite care to permanent residential care within 12 weeks of admission than those with a carer, and that the effect of having a carer on movement into permanent residential aged care was different for those with and without dementia (that is, there was an interaction effect) (Hypothesis 5).

## Methodology

### Data

This study builds on and uses the capacity and data infrastructure created through the National Health and Medical Research Council-funded Pathways in Aged Care (PIAC) project being undertaken by the Australian Institute of Health and Welfare (AIHW), La Trobe University and the University of Queensland. The PIAC project linked aged care program data sets, including residential aged care (RAC) data, for the years 2002–03 to 2005–06, to ACAP data for 2003–04 (AIHW 2009b).

The PIAC cohort consists of 105,000 people who had at least one completed ACAT assessment in 2003–04 reported on the client level ACAP National Minimum Data Set Version 2. Out of the full cohort, 77,400 people had not previously used programs which required an ACAT assessment (Figure 1). These people comprised the PIAC new-pathways cohort, as they can be considered to be starting out on their aged care pathway.

### Study groups

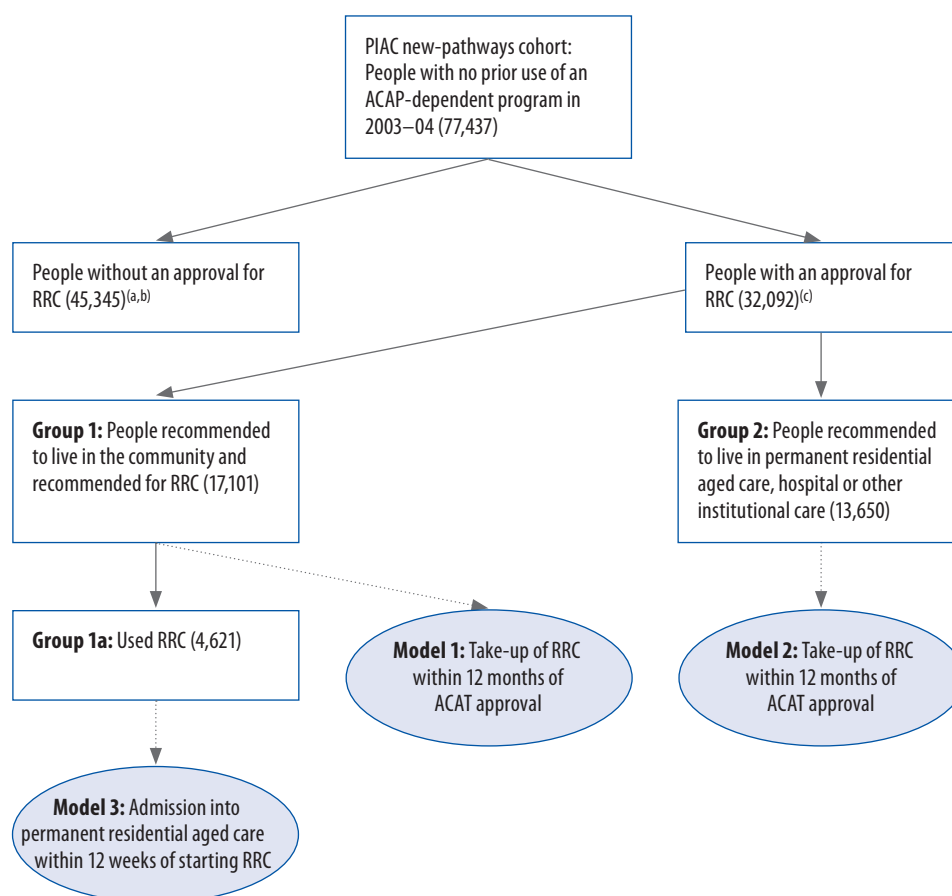
This study focuses on those people in the PIAC new-pathways cohort who were approved for RRC by an ACAT during 2003–04, before they had used any programs requiring an ACAT approval (32,000 people). An ACAT approval is required in order to access either low- or high-level residential respite care and, during the period covered by this study, an approval remained valid for up to 12 months.

A completed ACAT assessment results in recommendations for long-term care (community care or residential aged care) and program support, as part of a care plan that may include approvals to use certain programs. In particular, an ACAT can provide recommendations and approvals for respite care which includes RRC, non-residential respite care or both residential and non-residential respite care. ACATs do not make any recommendations on the use of respite care for people recommended to live long-term in residential care, hospital or other institutional care. However, those clients may still get an approval for RRC.

There was an expectation that there would be different take-up rates and different factors affecting the take-up of RRC for people recommended to live long-term in residential care compared with those recommended to live long-term in the community. Hence for analytical purposes, the population of those approved for RRC was split into two main groups (Figure 1):

- Group 1: people recommended to live long-term in the community and recommended for residential respite care (17,100 people). The subset of this group which took up RRC (Group 1a: 4,600 people) was used to examine the movement from RRC to permanent residential aged care.
- Group 2: people recommended to live long-term in residential care, including residential aged care, hospital or other institutional care (13,700 people).

Note that people who were recommended to have non-residential respite care or had a missing recommendation for respite care were excluded from the analysis (1,300 people).



(a) Includes 8,920 records from South Australia where the RRC approval item was missing.

(b) Includes people who used another ACAP-dependent program before their first ACAT approval for RRC.

(c) Includes 1,341 people that could not be assigned to Group 1 or 2 since they were recommended to have non-residential respite care or had a missing recommendation for respite care.

**Figure 1: Study groups used in modelling take-up of respite care**

## Methods

The hypotheses were examined using cross tabulations and logistic regression modelling. Variables considered in the logistic regression covered a range of areas including: client demographics, health conditions, care needs and assessment characteristics. The regression analysis allowed investigation into the effects of each of the variables included in the model, while controlling for the effects of the other variables. Separate analyses were carried out for the two study groups. For a full explanation of the logistic regression model and results see AIHW: Powierski et al. 2010.

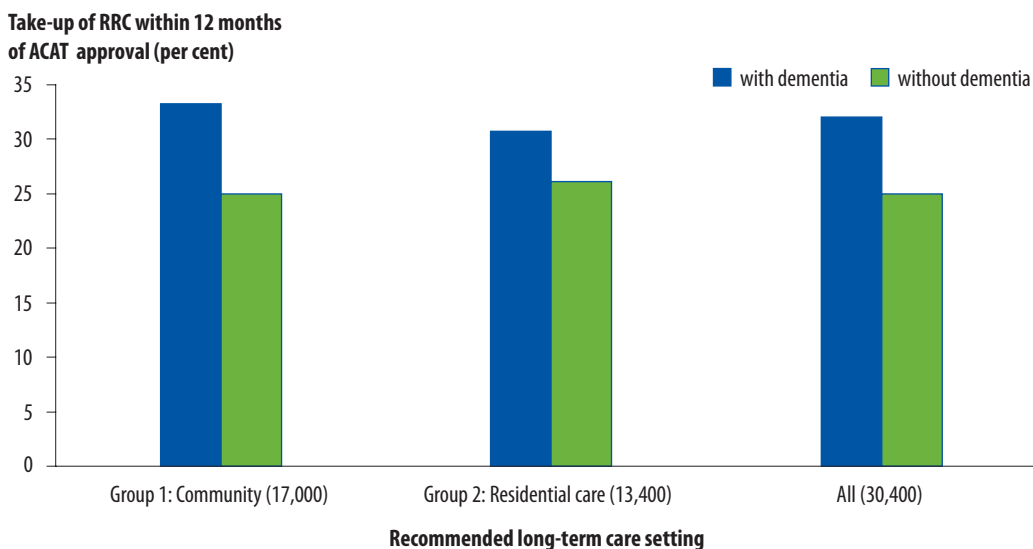
## Results

### Take-up of residential respite care

Just over a quarter (27%) of people approved for RRC used it within 12 months of their approval. This was true for both those recommended to live in the community and those recommended to live in residential care.

### Dementia

Overall, a greater proportion of people with dementia took up RRC (32%) than those without dementia (25%) (Figure 2). Dementia affected the take-up of RRC both among those recommended to live in the community and those recommended to live in residential care.



Note: Figure excludes observations where no health conditions were stated.  
Source: Table 1

**Figure 2: Take-up of residential respite care within 12 months of ACAT approval, by dementia status and recommended long-term care setting (per cent)**

## Recommended to live long-term in the community

Of those recommended to live in the community, people with dementia were more likely (rather than less likely, as posed in Hypothesis 1) than those without dementia to use RRC within 12 months of their ACAT approval. More specifically, a third of people with dementia took up RRC within 12 months of ACAT approval, compared with only a quarter of those without dementia. Logistic modelling verified that people with dementia were more likely than others to take up RRC, even when controlling for a range of other factors (Hypothesis 1 rejected).

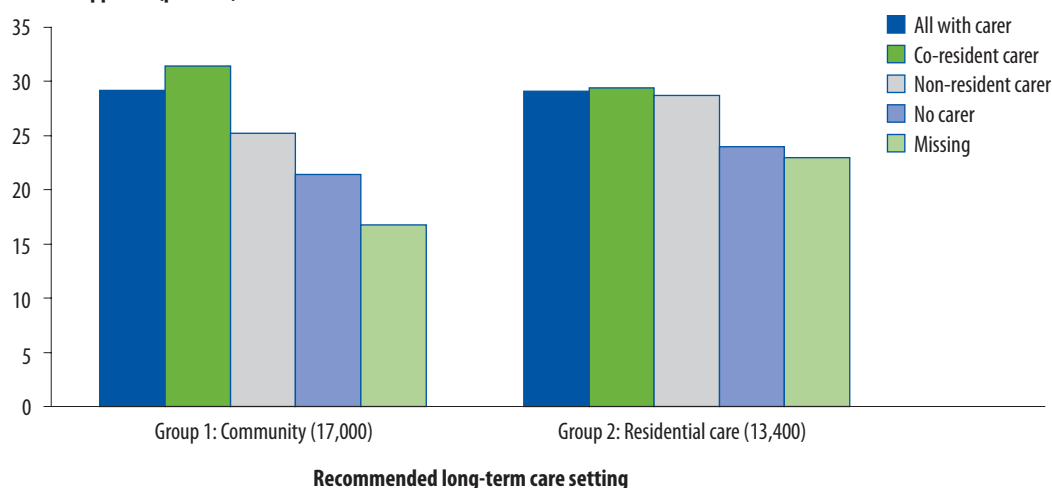
## Recommended to live long-term in residential care

Among those recommended to live in residential care, people with dementia were again more likely than those without dementia to use RRC within 12 months of their ACAT approval. The effect was not as strong as that for people recommended to live long-term in the community: 31% of people with dementia took up RRC within 12 months of ACAT approval, compared with 26% of those without dementia (Table 1). Modelling confirmed these results even when controlling for a range of other factors (Hypothesis 1 rejected).

## Carer

Having a carer increased the likelihood of a client taking up RRC. This was seen for both those recommended to live in the community and those recommended to live in residential care (Figure 3).

**Take-up of RRC within 12 months of ACAT approval (per cent)**



Note: Figure excludes observations where no health conditions were stated.  
Source: Table 2

**Figure 3: Take-up of residential respite care within 12 months of ACAT approval, by carer status and recommended long-term care setting (per cent)**



## Recommended to live long-term in the community

### *Carer versus no carer*

Among those recommended to live in the community, people with a carer were more likely to take up RRC (29%) than those who did not have a carer (21%) (Table 2).

The carer effect was apparent even when taking other factors into account.

### *Co-resident carer versus non-resident carer*

Of those with a carer, 31% with a co-resident carer took up RRC within 12 months of ACAT approval, as opposed to a 25% take-up rate among those with a non-resident carer. The fitted logistic regression model also found that people with a co-resident carer generally had a higher likelihood of taking up RRC than those with a non-resident carer.

### *Dementia and carer status*

Hypothesis 2 posed that the presence of dementia and availability of a carer had an interactive effect on the take-up of RRC. Cross tabulations suggest that among people with dementia, those who had a carer were more likely to take up respite than those without a carer (34% versus 24%, Table 4). A similar pattern was seen for those without dementia, although the differences were not as marked.

These results provide little evidence of an interaction effect. When a dementia–carer status interaction term was added to the regression model to test the presence of an interaction, it was not statistically significant. Consequently, this analysis suggests that dementia status and carer status acted independently on the probability of take-up of respite care (Hypothesis 2 rejected).

## Recommended to live long-term in residential care

### *Carer versus no carer*

Overall, of those recommended to live in residential care, people with a carer were more likely to take up RRC than those without a carer (29% and 24%, respectively) (Table 2). This effect was statistically significant even after taking other factors into account through regression modelling.

### *Co-resident carer versus non-resident carer*

Unlike those recommended to live in the community, cross tabulations did not show any effect of carer residency. Take-up of respite care was the same for those with either a co-resident carer or a non-resident carer (29%). Such effects were also not evident from the regression modelling.

### *Dementia and carer status*

Cross tabulations showed that for people with dementia, those with a carer were more likely to take up RRC care than those without a carer. For example, 33% of people with dementia and a co-resident son as carer used RRC, compared with 25% of those who did not have a carer (Table 5). However, similar effects were also seen for those without dementia.

Furthermore, when a dementia–carer status interaction term was added to the regression model it was not statistically significant, indicating that the dementia status and carer status were acting independently on take-up of RRC (Hypothesis 2 rejected).

### English proficiency

The problem of finding suitable services is particularly challenging for people from CALD backgrounds (House of Representatives Standing Committee on Family, Community, Housing and Youth 2009). This study used the English Proficiency (EP) Groups Classification as a measure of cultural and linguistic diversity. The EP classification indicates a migrant's level of English proficiency using an index based on the person's country of birth and the number of that country's immigrants living in Australia (DIMA 2003). Under this classification, people in EP1 are those born in English-speaking countries other than Australia; groups EP2–4 include all others born overseas. In the discussion below, people born in 'English-speaking countries' include those born in Australia or EP1 countries.

### Recommended to live long-term in the community

#### *English proficiency*

For people recommended to live in the community, those born in non-English speaking countries had a lower take-up rate (24%) than those born in English-speaking countries (28%) (Table 3). The modelling results also indicate that people in the lower proficiency groups were less likely than those born in English-speaking countries to take up RRC.

#### *Dementia and English proficiency*

Hypothesis 3 posed that the take-up of RRC among those with dementia also depends on their CALD background. Cross tabulations by dementia status and English proficiency showed no statistically significant difference in RRC take-up for people with dementia by EP group, but significant differences for people without dementia, suggesting a possible interaction effect (Table 6). However, after controlling for other factors, logistic modelling showed no statistically significant interaction effect between dementia status and English proficiency (Hypothesis 3 rejected).

### Recommended to live long-term in residential care

#### *English proficiency*

Overall, there was no statistically significant difference in the take-up of RRC by people born in EP2–4 countries and those born in Australia or EP1 countries (25% versus 28%, the difference not being statistically significant at the 95% level) (Table 3). This result was replicated in the modelling phase where EP was not a statistically significant term when other factors were taken into account.

### *Dementia and English proficiency*

Overall, for people with dementia there was less take-up of RRC by those born in non-English speaking countries (28%), compared with those born in Australia or EPI countries (32%) (Table 7). Similar differences were also seen for those without dementia, suggesting no interaction between dementia status and English proficiency. The modelling phase also provided no evidence of an interaction effect on take-up of RRC (Hypothesis 3 rejected).

### **Other factors**

Dementia status, carer status and English proficiency were the main variables of interest in this study. However, many other variables can also affect the probability of taking up RRC, including client demographics, other health conditions, care needs and assessment characteristics. Evidence from the ACAP National Data Repository show that variables of this type are associated with different recommendations for long-term care settings and program support (ACAP NDR 2006). Logistic regression showed that the factors associated with the take-up of respite care were not always the same according to whether people were recommended to live in the community or in residential care.

Factors associated with take-up of RRC for those with either long-term living recommendation included:

- ♦ having care needs for *activities of daily living*—that is, care needs with activities that people tend to do everyday, such as eating and bathing
- ♦ particular health conditions—for example, having a neoplasm or a disease of the musculoskeletal system and connective tissue
- ♦ locality of residence—for example, people residing in New South Wales were more likely to take-up RRC than those living elsewhere in Australia.

However, some factors were associated with take-up for only one of the study groups. For example:

- ♦ for those recommended to live long-term in the community, previous use of government services was associated with an increased likelihood of taking up RRC—however, this factor was not significant for those recommended to live in residential care
- ♦ diseases of the blood and blood-forming organs affected take-up of RRC for those recommended to live in the community, and having had an eye or adnexa condition affected take-up for those recommended to live in residential care.

## Movement into permanent residential care after using respite care

The study analysed the movement into permanent residential care within 12 weeks of take-up of RRC by people recommended to live in the community (4,600 people out of Group 1).

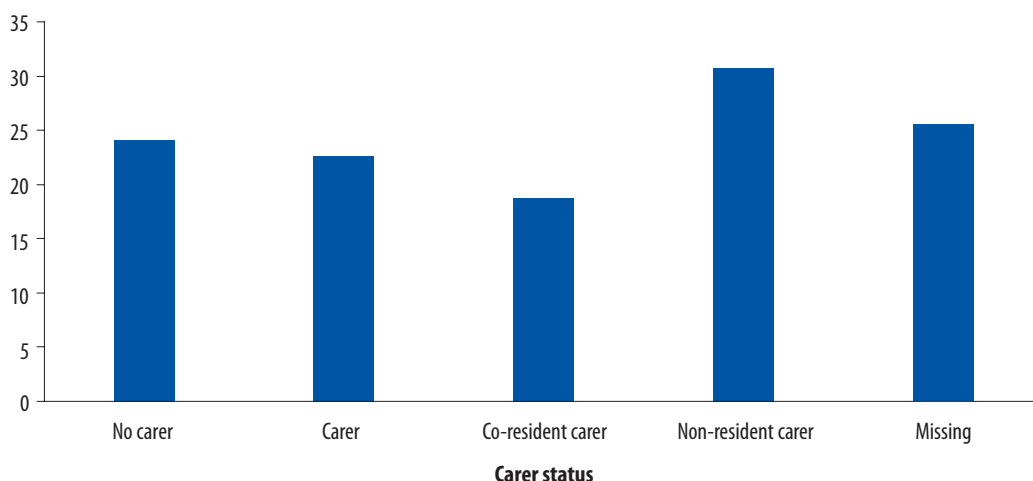
### Dementia

Overall, among people recommended to live long-term in the community, a higher proportion of those with dementia were admitted into permanent residential care within 12 weeks of starting RRC (30%) than of those without dementia (20%). The fitted regression model also indicated that people with dementia were more likely to be admitted into permanent residential aged care within 12 weeks of starting RRC than those who did not have dementia, even taking into account other factors (Hypothesis 4 accepted).

### Carer

Overall, similar proportions of those with and without a carer were admitted into permanent residential aged care within 12 weeks of starting RRC (23% and 24%, respectively) (Figure 4). However, cross tabulations suggested that carer availability and residency should be considered together. Those without a carer were more likely (24%) to be admitted into permanent residential aged care than those with a co-resident carer (19%) and less likely than those with a non-resident carer (31%). Results from the regression modelling supported this finding.

**People moving from RRC to permanent RAC within 12 weeks of starting RRC (per cent)**



*Note:* Figure excludes observations where no health conditions were stated.  
Source: Table 8

**Figure 4: People moving from residential respite care to permanent residential aged care within 12 weeks of taking up residential respite care, by carer status (per cent)**

### Dementia and carer

Among people with dementia, the apparent difference in the overall admission rate into permanent residential aged care for those with and without a carer was not statistically significant (30% and 36%, respectively) (Table 9). However, a significant carer availability and residency effect was again seen—36% of people with dementia and without a carer used permanent residential care within 12 weeks of starting RRC, compared with 26% among those who had a co-resident carer and 43% of those who had a non-resident carer. A similar pattern (but at a less dramatic level) was also seen for people without dementia, suggesting no interaction effect. When the dementia–carer status interaction term was added to the regression model it was not statistically significant (Hypothesis 5 rejected).

The above results indicate that carer availability and residency affected the likelihood of entering permanent residential aged care within 12 weeks of respite admission; however, the extent of this effect did not vary with dementia status.

### Other factors

Further to dementia status and carer status, many other variables may affect the probability of admission into permanent residential aged care within 12 weeks of starting RRC, including client demographics, other health conditions, care needs and assessment characteristics. For those recommended to live in the community, other factors associated with admission into permanent residential aged care included various health conditions, such as having diseases of the skin and subcutaneous tissue.

## Discussion

For the first time, large-scale administrative data from the Pathways in Aged Care (PIAC) cohort provide researchers with an opportunity to explore care transitions and care pathways of older people living in Australia. In this study, the data allowed us to quantify take-up rates of RRC and explore factors affecting the use of RRC, as well as analyse the movement of people from RRC to permanent residential aged care.

### Take-up of respite

Irrespective of whether a person had dementia or not, the data show a low take-up of residential respite care among those approved to use such care. Only about a quarter (27%) of people approved for RRC used it within 12 months of their approval. Low usage rates of respite care are consistent with the findings presented in the Parliamentary Inquiry into Better Support for Carers and with earlier research studies. Possible reasons for the low rates of take-up of residential respite care are indicated by carer submissions to the inquiry. While carers indicated that respite care is of critical importance to them, they also cited issues such as shortage of respite places in their local area, affordability, insufficient flexibility in respite care options and difficulties in understanding and accessing available services (House of Representatives Standing Committee on Family, Community, Housing and Youth 2009).

This study's hypothesis that people with dementia would be less likely to take up ACAT recommendations for residential respite care than people without dementia (Hypothesis 1) was not supported. The results show that people with dementia were more likely to take up residential respite care compared to people without dementia, irrespective of their recommended long-term care setting. This possibly reflects their higher care needs and associated potential for high levels of carer stress (AIHW 2007, AIHW: Powierski et al. 2010).

The role of RRC in providing support to carers is exemplified in the study's finding that people with a carer were more likely to take up RRC compared to those without a carer. This outcome aligns with the anecdotal evidence provided in the recent Parliamentary Inquiry into Better Support for Carers, which stated that 'the overwhelming evidence received by the community indicates that respite services are an essential support for sustaining carers in their caring role' (House of Representatives Standing Committee on Family, Community, Housing and Youth 2009). However, the analysis indicates that carer status and dementia status independently affect the likelihood of taking up RRC; that is, there was no interaction between dementia and carer status.

Consistent with the expectation that people from non-English speaking backgrounds face numerous barriers in taking up formal care assistance (Low et al. 2009), of people recommended to live in the community, those born in a non-English speaking country are statistically less likely to take up RRC than those born in Australia or another English-speaking country. However, the effect of English proficiency on take-up was similar for those with and without dementia. That is, dementia status and English proficiency acted independently on the likelihood of taking up residential respite care.

Many other variables—in addition to dementia status, carer status and English proficiency—may affect the probability of taking up RRC, including client demographics, other health conditions, care needs and assessment characteristics. Study results showed there were some similarities in the factors affecting take-up of RRC for those with different long-term living recommendations. These included:

- having care needs for activities of daily living
- particular health conditions (e.g. having a neoplasm or a disease of the musculoskeletal system and connective tissue)
- locality of residence (e.g. people residing in New South Wales were more likely to take up RRC than those living elsewhere in Australia).

However, some factors associated with the take-up of respite care varied according to whether people were recommended to be living in the community or in residential care. For example, diseases of the blood and blood-forming organs affected take-up of RRC for those recommended to live in the community, while having had an eye or adnexa condition affected take-up for those recommended to live in residential care.

## Transition from respite care to permanent residential aged care

Research has shown that RRC plays an important role in care pathways, sometimes acting as a stepping stone towards permanent RAC placement (AIHW: Karmel 2006) and sometimes delaying entry. However, there is little evidence about the nature of care transitions for people with dementia (Runge et al. 2009).

The results of this study support the hypothesis that people with dementia, despite being recommended to live in the community, are more likely to move from residential respite care to permanent residential care than those without dementia. These results align with previous research which has shown that people with dementia who use short-term care, such as dementia day services, respite services and hospitals, are more likely to be institutionalised (Adler et al. 1995, Butler et al. 2002, Cohen & Pushkar 1999).

The study tested if people with dementia who do not have a carer are more likely to move from respite care to permanent residential care within 12 weeks of admission than those with a carer (Hypothesis 5). As seen above, a person with dementia was more likely to move from RRC to permanent residential aged care compared with a person without dementia. Furthermore, a person without a carer was more likely to move from RRC to permanent residential care than a person with a carer. However, there was no evidence that the effect of the availability of a carer on movement from residential respite care to permanent residential aged care was different for people with and without dementia.

Other factors associated with admission into permanent residential aged care within 12 weeks of starting RRC included various health conditions, such as having a disease of the skin and subcutaneous tissue.

## Benefits of study

This study makes an important contribution to the evidence about the take-up of residential respite care using the PIAC linked cohort to quantify the take-up rate of residential respite care amongst those who had been approved to use the service. Furthermore, it provides evidence about respite use patterns for people with dementia and their carers, which in current literature is largely based on small-scale studies and qualitative research.

## Tables

**Table 1: Take-up of residential respite care by dementia status and recommended long-term care setting (per cent)**

Dementia status	People with an ACAT approval for RRC: per cent who took up respite within 12 months of ACAT approval			Number
	Recommended to live in the community	Recommended to live in residential care	Total	
With dementia	33.3	30.7	32.0	8,170
Without dementia	25.0	26.1	25.4	22,231
<b>Total</b>	<b>27.0</b>	<b>27.5</b>	<b>27.2</b>	<b>..</b>
<b>Total (number)</b>	<b>16,963</b>	<b>13,438</b>	<b>..</b>	<b>30,401</b>

Note: Table excludes 350 observations where no health conditions were stated.

**Table 2: Take-up of residential respite care by carer status and recommended long-term care setting (per cent)**

Carer status	People with an ACAT approval for RRC: per cent who took up respite within 12 months of ACAT approval			Number
	Recommended to live in the community	Recommended to live in residential care	Total	
Carer	29.2	29.1	29.1	22,502
Co-resident	31.4	29.4	30.7	13,308
Non-resident	25.2	28.7	26.9	9,194
No carer	21.4	24.0	22.8	5,359
Missing	16.8	23.0	19.4	2,540
<b>Total</b>	<b>27.0</b>	<b>27.5</b>	<b>27.2</b>	<b>..</b>
<b>Total (number)</b>	<b>16,963</b>	<b>13,438</b>	<b>..</b>	<b>30,401</b>

Note: Table excludes 350 observations where no health conditions were stated.

**Table 3: Take-up of residential respite care by English proficiency (EP) group and recommended long-term care setting (per cent)**

English proficiency group	People with an ACAT approval for RRC: per cent who took up respite within 12 months of ACAT approval			Number
	Recommended to live in the community	Recommended to live in residential care	Total	
Australia/EP1	27.8	27.9	27.9	24,451
EP2–EP4	24.2	25.4	24.7	5,015
EP group unknown	21.7	26.1	23.6	935
<b>Total</b>	<b>27.0</b>	<b>27.5</b>	<b>27.2</b>	<b>..</b>
<b>Total (number)</b>	<b>16,963</b>	<b>13,438</b>	<b>..</b>	<b>30,401</b>

Note: Table excludes 350 observations where no health conditions were stated.



**Table 4: Take-up of residential respite care by dementia status and carer status for those recommended to live long-term in the community (per cent)**

Carer status	People with an ACAT approval for RRC					
	With dementia		Without dementia		All	
	Take up (%)	Number	Take up (%)	Number	Take up (%)	Number
Partner co-resident	35.2	1,788	25.4	3,112	29.0	4,900
Partner non-resident	14.3	14	25.0	24	21.1	38
Daughter co-resident	39.8	497	33.2	1,189	35.2	1,686
Daughter non-resident	28.7	502	25.0	2,047	25.7	2,549
Son co-resident	35.8	187	27.9	530	30.0	717
Son non-resident	28.6	217	21.1	811	22.7	1,028
Other co-resident male	39.7	116	36.7	373	37.4	489
Other non-resident male	23.5	132	25.1	590	24.8	722
Other co-resident female	25.9	27	26.5	102	26.4	129
Other non-resident female	23.5	34	22.8	123	22.9	157
Unknown co-resident	37.6	93	45.2	283	43.4	376
Unknown non-resident	41.9	31	32.2	233	33.3	264
<b>Co-resident carer</b>	<b>36.3</b>	<b>2,708</b>	<b>29.1</b>	<b>5,589</b>	<b>31.4</b>	<b>8,297</b>
<b>Non-resident carer</b>	<b>28.0</b>	<b>930</b>	<b>24.5</b>	<b>3,828</b>	<b>25.2</b>	<b>4,758</b>
<b>Carer</b>	<b>34.2</b>	<b>3,638</b>	<b>27.2</b>	<b>9,417</b>	<b>29.2</b>	<b>13,055</b>
<b>No carer</b>	<b>24.2</b>	<b>244</b>	<b>21.1</b>	<b>2,193</b>	<b>21.4</b>	<b>2,437</b>
<b>Missing</b>	<b>28.0</b>	<b>161</b>	<b>15.4</b>	<b>1,310</b>	<b>16.8</b>	<b>1,471</b>
<b>Total</b>	<b>33.3</b>	<b>4,043</b>	<b>25.0</b>	<b>12,920</b>	<b>27.0</b>	<b>16,963</b>

Note: Table excludes 138 observations where no health conditions were stated.

**Table 5: Take-up of residential respite care by dementia status and carer status for those recommended to live long-term in residential care (per cent)**

Carer status	People with an ACAT approval for RRC					
	With dementia		Without dementia		All	
	Take up (%)	Number	Take up (%)	Number	Take up (%)	Number
Partner co-resident	31.2	1,158	22.4	1,404	26.3	2,562
Partner non-resident	9.1	11	33.3	18	24.1	29
Daughter co-resident	37.4	417	31.9	692	34.0	1,109
Daughter non-resident	29.2	664	28.6	1,540	28.8	2,204
Son co-resident	33.3	231	28.7	369	30.5	600
Son non-resident	32.1	271	26.7	688	28.3	959
Other co-resident male	33.3	123	28.6	273	30.1	396
Other non-resident male	31.8	223	26.4	516	28.0	739
Other co-resident female	25.7	35	33.3	75	30.9	110
Other non-resident female	26.7	60	27.8	144	27.5	204
Unknown co-resident	37.2	78	36.5	156	36.8	234
Unknown non-resident	34.2	73	32.9	228	33.2	301
<b>Co-resident carer</b>	<b>33.0</b>	<b>2,042</b>	<b>27.0</b>	<b>2,969</b>	<b>29.4</b>	<b>5,011</b>
<b>Non-resident carer</b>	<b>30.3</b>	<b>1,302</b>	<b>28.1</b>	<b>3,134</b>	<b>28.7</b>	<b>4,436</b>
<b>Carer</b>	<b>31.9</b>	<b>3,344</b>	<b>27.6</b>	<b>6,103</b>	<b>29.1</b>	<b>9,447</b>
<b>No carer</b>	<b>24.7</b>	<b>538</b>	<b>23.8</b>	<b>2,384</b>	<b>24.0</b>	<b>2,922</b>
<b>Missing</b>	<b>26.5</b>	<b>245</b>	<b>22.0</b>	<b>824</b>	<b>23.0</b>	<b>1,069</b>
<b>Total</b>	<b>30.7</b>	<b>4,127</b>	<b>26.1</b>	<b>9,311</b>	<b>27.5</b>	<b>13,438</b>

Note: Table excludes 212 observations where no health conditions were stated.

**Table 6: Take-up of residential respite care by dementia status and English proficiency (EP) group for those recommended to live long-term in the community (per cent)**

English proficiency group	People with an ACAT approval for RRC					
	With dementia		Without dementia		All	
	Take up (%)	Number	Take up (%)	Number	Take up (%)	Number
Australia/EP1	33.8	3,109	26.0	10,349	27.8	13,458
EP2	34.4	253	24.9	711	27.4	964
EP3	30.2	540	19.7	1,410	22.6	1,950
EP4	28.6	14	25.0	48	25.8	62
EP2-4	31.5	807	21.5	2,169	24.2	2,976
EP unknown	32.3	127	18.4	402	21.7	529
<b>Total</b>	<b>33.3</b>	<b>4,043</b>	<b>25.0</b>	<b>12,920</b>	<b>27.0</b>	<b>16,963</b>

Note: Table excludes 138 observations where no health conditions were stated.

**Table 7: Take-up of residential respite care by dementia status and English proficiency (EP) group for those recommended to live long-term in residential care (per cent)**

English proficiency group	People with an ACAT approval for RRC					
	With dementia		Without dementia		All	
	Take up (%)	Number	Take up (%)	Number	Take up (%)	Number
Australia/EP1	31.5	3,259	26.4	7,734	27.9	10,993
EP2	26.3	251	23.9	457	24.7	708
EP3	28.8	469	23.9	811	25.7	1,280
EP4	23.1	13	26.3	38	25.5	51
EP2-4	27.8	733	24.0	1,306	25.4	2,039
EP unknown	24.4	135	26.9	271	26.1	406
<b>Total</b>	<b>31.5</b>	<b>4,127</b>	<b>26.1</b>	<b>9,311</b>	<b>27.5</b>	<b>13,438</b>

Note: Table excludes 212 observations where no health conditions were stated.

**Table 8: People admitted into permanent residential aged care within 12 weeks of starting residential respite care, by carer status and recommended long-term care setting (per cent)**

Carer status	People with an ACAT approval for RRC and admitted into permanent RAC within 12 weeks of starting RRC			
	Recommended to live in the community	Recommended to live in residential care	Total	Number
<i>Carer</i>	22.6	44.1	31.6	6,557
Co-resident	18.8	40.1	26.5	4,083
Non-resident	30.7	48.8	40.0	2,474
No carer	24.1	48.1	37.9	1,222
Missing	25.5	50.4	37.9	493
<b>Total</b>	<b>22.9</b>	<b>45.3</b>	<b>32.9</b>	<b>..</b>
<b>Total (number)</b>	<b>4,577</b>	<b>3,695</b>	<b>..</b>	<b>8,272</b>

**Table 9: People admitted into permanent residential aged care within 12 weeks of starting residential respite care, by dementia status and carer status for those recommended to live long-term in the community (per cent)**

Carer status	People with an ACAT approval for RRC				All	
	With dementia		Without dementia			
	Admission (%)	Number	Admission (%)	Number	Admission (%)	Number
Partner co-resident	27.9	630	14.7	791	20.5	1,421
Partner non-resident	50.0	<8	33.3	<8	37.5	8
Daughter co-resident	19.7	198	12.9	395	15.2	593
Daughter non-resident	43.1	144	26.4	511	30.1	655
Son co-resident	25.4	67	15.5	148	18.6	215
Son non-resident	51.6	62	31.6	171	36.9	233
Other co-resident male	30.4	46	12.4	137	16.9	183
Other non-resident male	29.0	31	25.7	148	26.3	179
Other co-resident female	57.1	7	14.8	27	23.5	34
Other non-resident female	25.0	8	25.0	28	25.0	36
Unknown co-resident	28.6	35	15.6	128	18.4	163
Unknown non-resident	46.2	13	26.7	75	29.5	88
<b>Co-resident carer</b>	<b>26.4</b>	<b>983</b>	<b>14.2</b>	<b>1,626</b>	<b>18.8</b>	<b>2,609</b>
<b>Non-resident carer</b>	<b>43.1</b>	<b>260</b>	<b>27.3</b>	<b>939</b>	<b>30.7</b>	<b>1,199</b>
<b>Carer</b>	<b>29.9</b>	<b>1,347</b>	<b>19.0</b>	<b>2,565</b>	<b>22.6</b>	<b>3,808</b>
<b>No carer</b>	<b>35.6</b>	<b>59</b>	<b>22.7</b>	<b>463</b>	<b>24.1</b>	<b>522</b>
<b>Missing</b>	<b>28.9</b>	<b>45</b>	<b>24.8</b>	<b>202</b>	<b>25.5</b>	<b>247</b>
<b>Total</b>	<b>30.1</b>	<b>..</b>	<b>19.9</b>	<b>..</b>	<b>22.9</b>	<b>..</b>
<b>Total (number)</b>	<b>..</b>	<b>1,347</b>	<b>..</b>	<b>3,230</b>	<b>..</b>	<b>4,577</b>

Note: Table excludes 44 observations where no health conditions were stated.

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## Abbreviations

ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
AIHW	Australian Institute of Health and Welfare
CALD	culturally and linguistically diverse
DoHA	Department of Health and Ageing
EACH	Extended Aged Care at Home
EP	English proficiency
PIAC	Pathways in Aged Care
RAC	residential aged care
RRC	residential respite care

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