Guideline

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Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care Guideline

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Summary This Guideline articulates a good practice model of care for NSW SMHSOP community services. It is intended to promote recovery-oriented care and good practice in SMHSOP community services, guide service improvement, re-orientation and development of existing services, and inform planning for new services. This Guideline is a summarised version of the project report, and contains key supporting information and recommendations to guide local service planners, managers and clinicians in the development and delivery of SMHSOP community services.

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GUIDELINE SUMMARY

SPECIALIST MENTAL HEALTH SERVICES FOR OLDER PEOPLE (SMHSOP) COMMUNITY SERVICES MODEL OF CARE GUIDELINE

PURPOSE

The purpose of this Guideline is to outline a good practice model of care for NSW Specialist Mental Health Services for Older People (SMHSOP) community services. This model of care explains how community mental health services for older people should be delivered. The aims involve providing the right care to people at the right time, by the right team in the right place, with care directed by the consumer and carer with expert clinician assistance alongside. It is intended to guide policy makers, service planners, service managers and clinicians in improving and re-orienting SMHSOP community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified from consumer, carer, clinician and stakeholder consultations.

Both the SMHSOP community and Behavioural Assessment and Intervention Services (BASIS) teams across NSW are in the primary scope of the model of care.

The Guideline focuses on the model of care and relevant recommendations for SMHSOP community teams. Additional detailed information is available in the SMHSOP Community Model of Care Project Report.

KEY PRINCIPLES

This Guideline is guided by the principles of recovery, consumer-directed care and partnering with the consumer, carer(s), GP, and other key services and supports.

The SMHSOP community model of care has been informed by work being done at the state and national level in the mental health and / or aged care space. It aligns with key national and state standards and policy frameworks.

USE OF THE GUIDELINE

This Guideline should be used by SMHSOP community services to assist them to make improvements in service delivery which are based upon the best available evidence. It is to be developed in collaboration with consumers, carers, clinicians, managers, health care partners and other key stakeholders. It will also provide guidance to existing community services and new services, to inform planning and promote the best use of available resources.

REVISION HISTORY

Version	Approved by	Amendment notes
January 2017 (GL2017_003)	Deputy Secretary, Strategy and Resources	New guideline

ATTACHMENTS

1. Specialist Mental Health Services for Older People (SMHSOP) Community Services Model of Care – Guideline.

Specialist Mental Health Services for Older People (SMHSOP) Community Services - Model of Care Guideline

NSW GOVERNMENT Health

GUIDELINE

Issue date: January 2017

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FOREWORD

Like people of any age, older people may experience problems with their mental health, like I have. Most of my life I have suffered from depression. It has often affected my career, my hopes, my plans and our family's fortunes. In recent years my partner has also been troubled by depression, and I continue to be his carer. Both of us have been helped by advances in mental health treatment and by the fine services available in our local area, and in particular our local **Community Specialist Mental Health Services for Older People** or 'SMHSOP'. The community SMHSOP clinicians see us in our own home and have provided us with care and support.

As a carer and consumer of SMHSOP community services, I was pleased to hear of the development of the *SMHSOP Community Services Model of Care.* The model of care places us as consumers and carers at its heart. The things that consumers and carers see as important when receiving care – including supporting us in our own recovery journey and in directing our own care; providing good communication; ensuring easy access to care; and involving a range of services to ensure that our needs and goals are met - are at the centre of the model of care. I believe implementing it will lead to improvements in SMHSOP community services across NSW and the way care is delivered.

It is also pleasing to see a focus on peer work included in the model of care. My partner and I recently commenced working as peer workers in a SMHSOP service. We have undergone training and we continue to work under the guidance of well trained professionals. The basic idea of the program is that if people like my partner and I share the experience of depression, if we know what people with depression are going through, we can lead a conversation among small groups of consumers in which we can reflect on our experiences. We can see we are not alone in our problems, that some ways of coping work better than others, and that there is a way ahead. These peer group conversations allow us as consumers of these services to share our experience of what we have found helpful, and what not. It is still early days, but I would say we have had a few successes and have been able to help other consumers in their recovery journey.

I encourage all clinicians in all SMHSOP community services across NSW to adopt the SMHSOP community services model of care. With your help, SMHSOP community services can better meet the needs of older people with mental illness, their carers and families.

Vicki Schramko
Consumer, carer and peer worker of SMHSOP community services
Dip .Community Org. Management

ACKNOWLEDGMENTS

The Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care Guideline is the result of the work of many people. Broad consultation informed the development of this guideline and the accompanying project report, and the project team acknowledge the participants in the consultation workshops and other organisations and individuals who provided feedback and guidance. The NSW Health SMHSOP Advisory Group and Older People's Mental Health (OPMH), Aboriginal OPMH and Culturally and Linguistically Diverse (CALD) OPMH Working Groups also significantly contributed to the development of this model of care.

The SMHSOP Community Model of Care Project has been conducted by the OPMH Policy Unit of the Mental Health Branch, NSW Ministry of Health, with advice and input from the project's Expert Reference Group. The NSW Ministry of Health would particularly like to thank the members of the Expert Reference Group for their guidance and dedication to the project. See Appendix for membership of the Expert Reference Group.

CONTENTS

1 INTRODUCTION

1.1 Purpose of this guideline

The Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care (MoC) is about older people with, or at risk of, mental illness, their needs, and the needs of those who care for and support them. It also is about the role of clinicians within SMHSOP community services, and the way these clinicians work with a range of partners, including consumers, families, carers and relevant services and supports, to improve the lives of older people with mental illness and their carers.

Like people of any age, older people can be vulnerable to mental illness. Some older people develop a mental illness as they age, while others grow older with a continuing experience of a mental illness that developed earlier in their lives.[1] Such illnesses include depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, alcohol and substance misuse disorder and Behavioural and Psychological Symptoms of Dementia (BPSD). In some circumstances, the presence of mental illness in older people is more common, including in those with chronic illnesses[2] and in residential aged care facilities.[3] Men aged 85 and over persistently have the highest suicide rate in Australia.[4] Mental illness and dementia, however, are **not** an inevitable part of ageing.

The **SMHSOP Community Model of Care (MoC) Guideline** articulates a good practice model of care for SMHSOP community services. It is intended to guide policy makers, service planners, service managers and clinicians in improving and re-orienting SMHSOP community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified from consumer, carer, clinician and stakeholder consultations. The guideline contains key supporting information, an outline of the NSW SMHSOP community MoC, and recommendations to support local implementation of the MoC (whilst recognising that there are variable starting points in terms of current care delivery across NSW SMHSOP community services, and local service context will also vary).

This guideline has been developed as part of the SMHSOP Community MoC Project. A SMHSOP community MoC project report has been developed to accompany this guideline. This is a report on the project overall and contains detailed information on: the process followed in developing the model of care; the supporting consultation advice, evidence and policies; current practice within SMHSOP community services; and an outline of the SMHSOP community MoC in the form of recommended features of SMHSOP community services. An information booklet will also be developed to provide information for consumers, carers and the broader community about how to access SMHSOP community services, what to expect (including key philosophies and principles of care), and the key directions in which SMHSOP community services are heading. In addition, a template for a local service brochure will be developed.

1.2 Scope of the model of care

SMHSOP are a specialist clinical stream of public mental health services targeted specifically at older people with mental illness, and include inpatient, community and community residential services (generally delivered in partnership with non-government residential aged care services). SMHSOP community clinicians work primarily in the community including residential aged care facilities. The SMHSOP community MoC articulates how community mental health services for older people should be delivered, aiming for the right care to be provided to people at the right time, by the right team and in the right place, with care directed by the consumer and carer with expert clinician assistance alongside.

Both SMHSOP community and Behavioural Assessment and Intervention Services (BASIS) teams are in the primary scope of the model of care. This recognises that in many LHDs, the BASIS function is incorporated into an integrated SMHSOP community service, while some LHDs operate a separate BASIS team. The MoC applies to SMHSOP community and BASIS teams located in metropolitan, regional and rural areas.

1.3 Why develop a SMHSOP Community Model of Care?

The MoC has been developed with consumers, carers and clinicians to provide a key reference point in improving the mental health care of older people at a time of fundamental changes in the mental health and aged care service landscapes. It recognises and supports the shift occurring in NSW mental health services towards recovery-oriented care and practices, and the need for mental health services to actively support an individual in their personal recovery journey. It supports a focus on the individual defining their own recovery goals and directing their own care. It also recognises that there is currently significant variation in practice and governance in SMHSOP community services across NSW and a need to promote consistent good practice.

SMHSOP community services are part of the broader system of care and support for older people with mental health problems, providing specialist clinical services for older people with mental health problems in the community setting. Other key partners in this complex system include families and carers; the broader community; primary health care services including General Practitioners (GPs); community care and support services; residential services; specialist private practitioners and facilities; community managed / non-government organisations providing counselling, crisis services, community care, rehabilitation and psychosocial support services, and NSW Health services, including mental health services (non-age specific and SMHSOP, community and inpatient).

The SMHSOP community MoC is required to guide development of SMHSOP services in a manner that complements partner services, and assists those services to interface effectively with SMHSOP community teams to meet the needs and preferences of the

older person. The features in the model are intended to prepare SMHSOP community services to meet current key challenges including:

- The capacity of providers (public mental health, primary care and other providers) to respond to increasing demand generated by a growing older population that is distributed unevenly across NSW
- Reform of the mental health, aged care and disability systems that will generate a significant period of constant change in an already complex system of care and support. SMHSOP community services will need to evolve to ensure that they are integrated with these systems in a manner that is transparent to consumers, carers and other providers
- Economic and community demands, coupled with reform initiatives, that contemporary mental health care is readily available in the community, with hospital care reserved only for those whose needs cannot be met in the community, requiring SMHSOP to have systems and staff equipped to provide increasingly specialised care
- Variation in existing service development, service models and clinical practice within SMHSOP community services across NSW.

1.4 Principles underlying the SMHSOP Community Model of Care

Consumers have indicated that they see community SMHSOP as one part of a complex system of care that supports their recovery journey. The SMHSOP community MoC has been developed to match this consumer perspective, as shown in Figure 1.

The SMHSOP community MoC is guided by the principles of recovery, consumer-led care and partnering with the consumer, carer(s), GP, and other key services and supports. This reflects the expressed desires of consumers, carers and clinicians in consultations, and the clear focus on recovery principles and recovery-oriented practice in mental health policy in Australia.[5,6,7,8.9]

The *Australian National Framework for Recovery-Oriented Mental Health Services* defines recovery as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.[5] Research with older consumers has found that "continuing to be me" may capture the essence of what this means for older people.[10] Recovery is much broader than clinical recovery and the interconnectedness between 'personal' and clinical recovery is well recognised.[5,11] Figure 1 shows the interface between clinical and personal recovery and the centrality of the consumer, their carer/s and GP. While recovery is unique to the individual, it is likely to involve some or all of the 'domains of a meaningful life'. A range of health and community providers – of which community SMHSOP services are one - will be required in order to meet the complex physical, social, behavioural and psychological needs of the older person with mental health issues. The exact supports offered will be driven by a

person's unique values, goals and needs, thereby supporting that person's journey of recovery.

While the established evidence base and expert consensus drive clinical practice of SMHSOP community services and are a key component of this project, each element of the SMHSOP community MoC should be consistent with (or at least not impede) personal recovery. All elements of the SMHSOP community MoC have been considered and developed in relation to the five personal recovery processes of Connectedness, Hope and optimism, Identity, Meaning in life, and Empowerment, commonly represented using the acronym CHIME.[12]

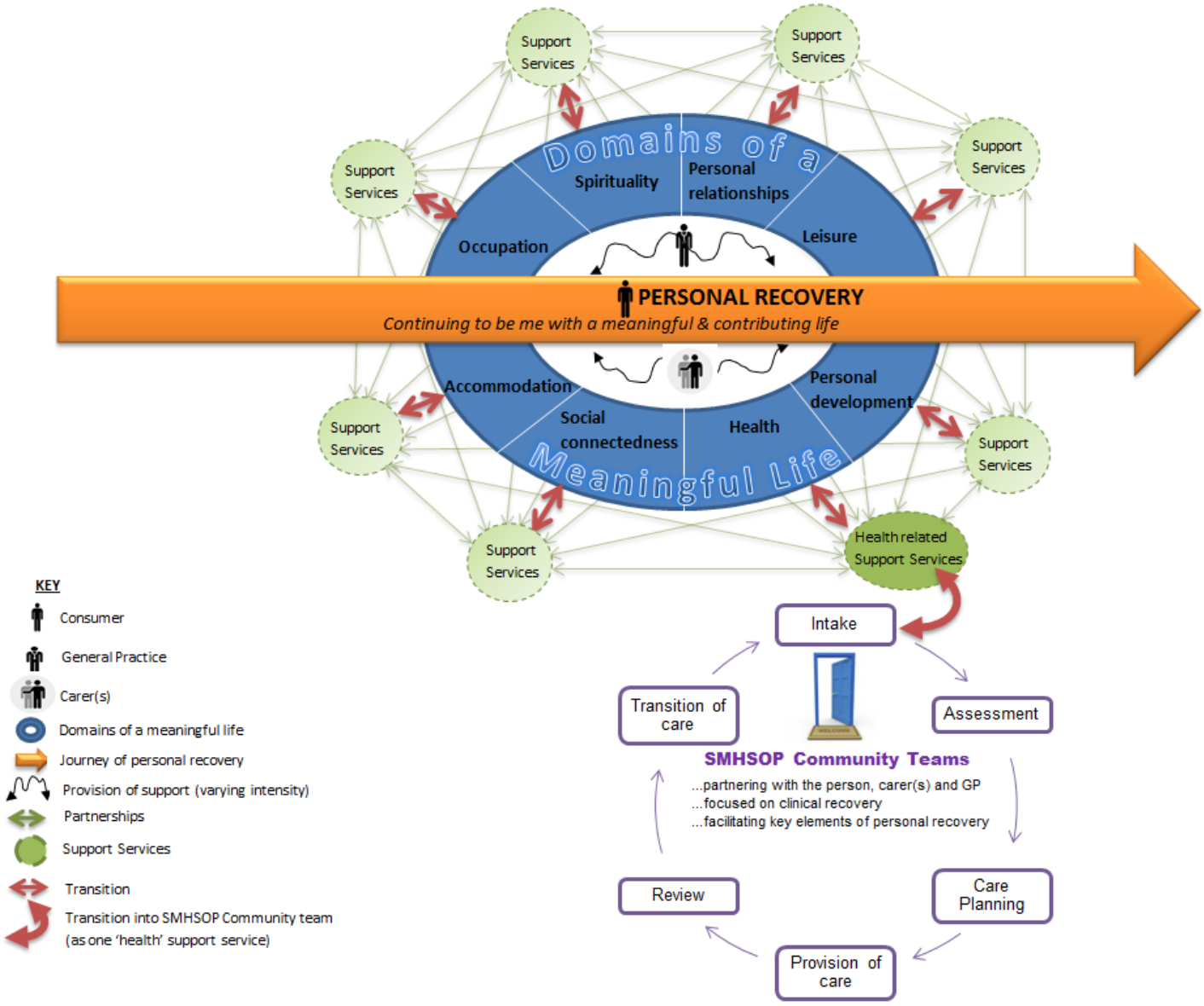
The SMHSOP community MoC has also been informed by work being done at the state and national level in the mental health and/or aged care space, including the NSW mental health reforms,[13] the Commonwealth mental health reforms,[14] the Commonwealth *Living Longer Living Better* aged care reforms,[15] the introduction of activity based funding into public mental health services, and the establishment of Primary Health Networks from 1 July 2015.

The SMHSOP community MoC aligns with key national and state standards and policy frameworks including the NSW Mental Health Strategic Plan *(Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*[6]), *NSW 2021: A Plan to Make NSW number one*,[16] *NSW Health Community Mental Health Strategy 2007-2012*,[17] NSW Integrated Care Strategy, *NSW Carers Strategy 2014-2019*,[18] *National Standards for Mental Health Services (NSMHS)*,[19] *National Safety and Quality Health Service (NSQHS) Standards*,[20] *National Framework for Recovery-Oriented Mental Health Services*,[5] *Fourth National Mental Health Plan 2009-2014*[7] (noting that work has commenced on a Fifth Plan),*COAG Roadmap for National Mental Health Reform 2012-2022*,[21] *Contributing Lives, Thriving Communities* - National Mental Health Commission's Review of Mental Health Programmes and Services[22], the *NSW Aboriginal Health Plan 2013-2023*[23] and the *NSW Aboriginal Mental Health and Wellbeing Policy* (currently under review).[24]

The *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015*[25] is the current guiding document for SMHSOP in NSW. The *SMHSOP Service Plan* is currently being reviewed and a new plan developed to guide service development in SMHSOP across NSW over the next ten years. SMHSOP community services, and this MoC, will be guided by this new service plan (however titled) once developed.

The NSW SMHSOP Recovery-Oriented Practice Improvement Project commenced in 2015 and has significantly informed the development of the SMHSOP community MoC.

Figure 1: The role of community SMHSOP from the consumer's perspective: one of many supports in a personal journey of recovery



1.5 Methodology for model of care development

The following has been undertaken to guide the development of the SMHSOP community MoC:

1. Establishment of the SMHSOP Community MoC Expert Reference Group, with representatives from consumer and carer peak organisations, OPMH policy and program areas, Clinical Directors of Mental Health and SMHSOP Coordinators in rural and metropolitan LHDs, clinicians from various disciplines including an inter-state senior SMHSOP clinician, relevant non-government organisations, Aboriginal and Culturally and Linguistically Diverse (CALD) committees and organisations, aged health services and Primary Health Networks. This group provided assistance and guidance with progressing the project and developing the draft MoC. See Appendix A.
2. A review of relevant policy and practice guidelines and the international literature.
3. Consumer, carer and clinician consultation workshops held in August, September and November 2014 to identify the primary vision and values for SMHSOP community services and the key principles and elements of the older consumer's journey. 120 people participated in the consultation workshops (54 from rural or regional locations, 38 consumers and 20 carers) with an additional 60 people attending the public forum.
4. Consultation with relevant NSW Ministry of Health branches, SMHSOP community services, and the NSW Health SMHSOP Advisory Group, Older People's Mental Health (OPMH) Working Group, CALD OPMH Working Group, Aboriginal OPMH Working Group and General Practice Clinical Advisory Group (Agency for Clinical Innovation).
5. Dissemination of the draft MoC guideline for comment to NSW LHDs, relevant NSW Ministry of Health branches and other key stakeholders, supported by the draft project report for reference.

1.6 Key themes arising from consultation, literature review and expert consensus

Consultations for this project made it clear that people highly value the work of clinicians in NSW mental health services, but also identified key inconsistencies in the delivery of care by services, particularly with regards to access to care and access to clinicians who understand and respond to those needs of people that may change with age.

The consultations also made it clear that expectations are changing, and will keep changing. There is an increasing expectation by older people that self-determination continues throughout life. Older people want to be informed about what they should expect from services, and then to demand it occurs. But more than informed, older

people, and those who care for or about them, expect to be involved in deciding how they receive care, and how care systems work.

Whilst the way recovery should be interpreted or communicated with older people has not been extensively explored, consultations made it clear that recovery remains just as important for older people as for younger people. Recovery may require assistance from individuals with specialised knowledge, but fundamentally it requires the maintenance of hope: by the person, their family and carers. And when that hope requires building up, an older person with mental illness requires support from professionals with knowledge and skills in working with older people, and an ability to 'come alongside' them. Consumers and carers made it clear that this is required from the point of first contact with mental health services, and throughout their involvement with services.

The following elements of care emerged from the consultations as priorities for consumers and carers, as well as SMHSOP clinicians and key stakeholders, and have provided the key points of reference in the development of the SMHSOP community MoC. The quotes included in this document were made by participants of the consultation workshops.

- Good communication and engagement with older people from initial contact
- Easy and timely access to appropriate assessment
- Recovery-oriented, consumer-led care, involving partnering with a consumer and their carer(s) and GP and supporting consumers in their personal recovery journeys
- Short-term mental health care/treatment for older people with acute, severe and/or complex mental health problems (including moderate-severe BPSD)
- Joint care planning and coordination with GPs and other key services and health care providers, with a focus on recovery
- Supporting planning and management of transitions/transfer of care from inpatient to community settings (including residential aged care) and community to inpatient, with a focus on clinical and personal recovery.

The key themes identified through a review of the literature, including relevant state and national policies, and supported by expert consensus, are outlined below. Many of these are consistent with the priorities identified during the consultations, and have further provided direction to the MoC.

- Recovery-oriented care and practice. This is reflected in the development of the *National Framework for Recovery-Oriented Mental Health Services*[5] and the *National Standards for Mental Health Services 2010: Principles of recovery-oriented mental health practice*[8] and in revisions to the *NSW Mental Health Act*.[9] The importance of recovery is also emphasised in *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*.[6] The NSW SMHSOP Recovery-Oriented

Practice Improvement Project provides a good overview of the recovery literature and considers this in the OPMH context (report due late 2016).

- Multidisciplinary care of older people with mental health problems. There is considerable and growing evidence to support this as best practice.[26,27,28,29]
- Integrated care across settings and with service providers both within and external to NSW Health to ensure that the complex needs of older people with mental health problems, and their clinical and personal recovery goals, can be addressed. The NSW Health policy document, *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs*,[30] is a key reference. Research from the UK highlights an emerging focus on integrated care – bridging the gaps between physical and mental health care[31].
- The important link between physical and mental health and the need for appropriate linkages with other healthcare providers. The *Physical Health Care of Mental Health Consumers Guidelines*[32] and the *Physical Health Care within Mental Health Services Policy Directive*[33] (both currently under review) provide guidance to SMHSOP community services.
- A stepped care approach to service provision, with the level of service provided matched to each consumer's needs, including 'wrap around' coordinated care for those with severe and complex mental illness. This is a key focus of the national mental health reform agenda.[14]
- No major new developments were identified regarding the evidence for individual therapies.

1.7 The model of care at a glance

The SMHSOP community MOC places the consumer, their carer(s) and GP at the centre of **recovery-oriented, person-centred, biopsychosocial** care.

There are seven key components in the SMHSOP community MoC:

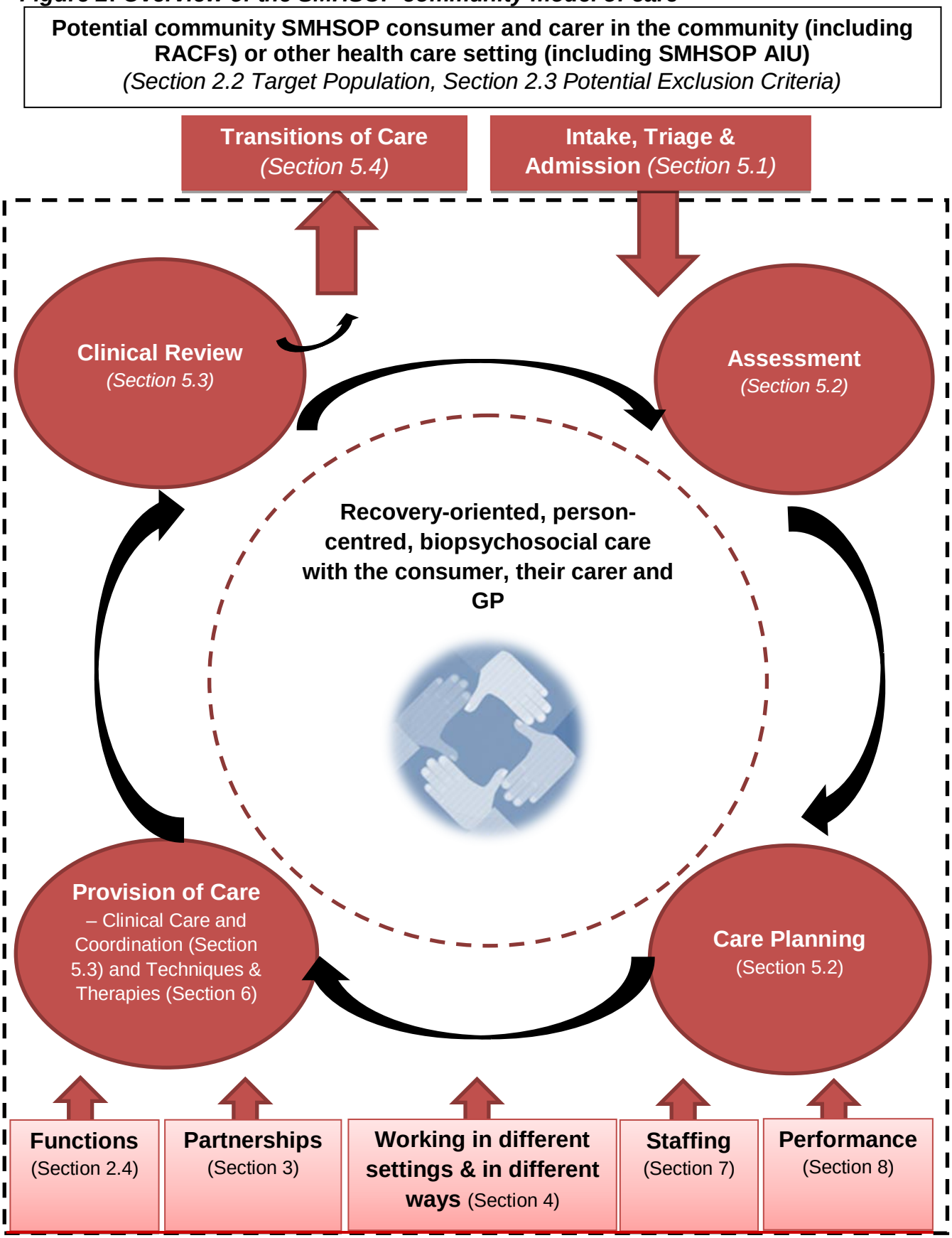
- Philosophy of care, target population and functions
- Partnerships
- Working in different ways and in different settings
- Key processes
- Techniques and therapies
- Staffing
- Performance.

In each of these areas, 'good practice features' of the MoC are presented to guide practice in SMHSOP community services.

The relationships between key service model components are outlined Figure 2. The philosophy of care - recovery-oriented, person-centred and biopsychosocial – lies at the centre of the model, emphasising its importance. The joining of hands represents the shared approach of a multidisciplinary service working with the SMHSOP consumer, carer/s and family, and GP on common goals. The consumer and carer should move in and out of SMHSOP community services with minimal barriers to transition. There is a close relationship between the SMHSOP community service's key processes / provision of care and its philosophy of care. Underpinning the model are the cornerstones of clear functions, strong partnerships, ways of working in settings and modalities, appropriate staffing and good performance, which integrate with and support the delivery of the model.

The SMHSOP community MoC is closely aligned to the *SMHSOP Acute Inpatient Unit (AIU) MoC*[34], reflecting the importance of continuity of care and maximising integration between inpatient and community settings. The two models of care have the same philosophy of care and similar components. Ideally, SMHSOP AIU and community teams are part of the one service. When governed separately, clear protocols are required to support integration between the two services. The SMHSOP community MoC supports integration with SMHSOP AIUs, where present, by recommending SMHSOP community clinicians work in accordance with the AIU MoC and are involved in SMHSOP AIU intake processes, clinical review and transitions of care. Further, community mental health assessment should occur prior to inpatient admissions where possible.

Figure 2*: *Overview of the SMHSOP community model of care



2 PHILOSOPHY OF CARE, TARGET POPULATION AND FUNCTIONS

2.1 Philosophy and principles of care

Reflecting the importance of continuity of care across SMHSOP service elements, the SMHSOP community MoC adopts the same philosophy of care recommended in the *SMHSOP Acute Inpatient Unit (AIU) MoC.*[34]

Person-centred and individual-based models of care are common modes of service provision which are considered to be central tenets that contribute to the concept of recovery in older people's mental health. Key national and state policies and standards, including the *National Standards for Mental Health Services*[8] and the *National Framework for Recovery-Oriented Mental Health Services*,[5] recommend mental health services incorporate recovery principles into service delivery, culture and practice. The RANZCP's *Position Statement 22* advocates for a holistic, age- and culturally-appropriate approach to addressing mental illness in older people, informed by the principles of recovery, independence, dignity and quality of life.[35]

> *'It is important to be treated as an individual, not as an age-specific condition'*
>
> *'Never underestimate the power of listening'*

The value that consumers place on being treated as an individual and having control over their own care were strong and consistent messages throughout the project consultations. This requires clinicians to be able to listen effectively and to spend time with consumers and carers in order to get to know the person and their situation. Understanding a consumer's background, considering each person's needs and preferences from a holistic perspective including any physical health issues and psychosocial needs, recognising the strengths and abilities of a consumer, sharing decision making, and delivering services in collaboration with consumers and carers are paramount within a person-centred and recovery-focused philosophy of practice. Person-centred and recovery-oriented approaches are also influenced by a consumer's cultural and social context, and this is particularly important for Aboriginal people, culturally and linguistically diverse (CALD) people and lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Culturally determined help-seeking can be enabled through a recovery-oriented, person-centred, biopsychosocial philosophy of care.

Using a recovery-oriented approach recognises the uniqueness of the individual, provides real choices to consumers, supports consumers to undertake the journey of individual recovery, focuses on the rights of consumers and carers including self-determination, provides dignity and respect, and recognises the importance of partnerships (with consumers, carers, GPs, other service providers) and

communication.[36] Wellness planning, collaborative consumer care planning, life stories work, and shared decision making are all well-recognised recovery-oriented practices.[37]

SMHSOP community clinicians often work with older people who experience complex physical and psychological conditions or co-existing mental illness and substance misuse. People experiencing co-existing conditions frequently live with multiple and complex needs, experienced in an entirely individual way.[38] A recovery-oriented approach remains relevant, and clinicians should support consumers to determine and address their own recovery goals, which will be influenced by their particular circumstances and the impact of their co-existing conditions on their lives. While 'recovery' language may seem inappropriate, especially if the consumer has BPSD or there is a poor prognosis associated with the physical illness, it must be remembered that recovery is not synonymous with 'cure' but rather on supporting the consumer to live a meaningful life as determined by them. People with BPSD and co-existing conditions require multiple and specialist expertise and service delivery will need to be collaborative and focused on the same recovery goals.

In addition to the growing focus on recovery-oriented care, research and practice direction support an emphasis on trauma informed care and practice (TICP), positive ageing and enablement, consumer directed care, and the involvement of people with lived experience of mental illness in guiding service design, development, evaluation and improvement. TICP is an 'approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. It is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment'.[39] Further work is required to support practice development in relation to TICP in an OPMH context.

SMHSOP community services have traditionally held a person-centred, biopsychosocial philosophy of care, with a limited specific focus on recovery concepts. In recent times, there has been a growing focus on implementing a recovery-oriented approach to care, associated with the National Recovery Framework and NSW SMHSOP Recovery Practice Improvement Project, and through local initiatives.

The starting presumption for all people is that they have capacity to consent to treatment. Any concern about an individual's capacity to understand or participate in health-related decision making must be assessed on an individual basis. A lack of capacity cannot be assumed based on the person having a mental illness. Assessments relating to capacity should be repeated at different times and a person may have capacity in respect of one decision, but not another.[40] See the *Guardianship Act 1987 (NSW)*[41] for further information on substitute consent provisions when a person loses or lacks the capacity to make decisions about their medical treatment.

Where a person is an involuntary patient, or detained, under the *Mental Health Act,*[9] that Act allows an authorised medical officer to provide non-surgical treatment, regardless of the person's consent. However, the *Mental Health Act* and good clinical practice, require that patients/consumers be involved in their care and recovery and that their views should be considered in the development of treatment plans.

The *Mental Health Act* also recognises the role of carers and the importance of involving them in the care and recovery of mental health consumers, and providing them with key information in regards to a consumer's treatment. See *Mental Health Act* and *Mental Health Carers NSW* brochure for further information on carers, including types of carers (designated carers and principal care providers), nominating carers including during times of incapacity and excluding people from being provided with information and/or consulted about a consumer's treatment.

The concepts of consumer self-determination, personal responsibility, self-management and reclaiming control and choice are pivotal to recovery-oriented practice regardless of a person's legal status.[36] Mental health workers can work in a recovery-oriented paradigm with involuntary consumers by maximising their opportunities for sustaining hope, for promoting agency for recovery, for supporting relationships and for redefining self.[42]

Good practice features – Philosophy and principles of care

1. SMHSOP community services adopt a recovery-oriented, person-centred, biopsychosocial philosophy of care. This may be demonstrated as follows:
    a. Respecting a consumer's autonomy and incorporating substitute consent only when absolutely necessary.
    b. The use of open, transparent, honest and clear communication with consumers, with clinicians actively listening to, learning from and acting upon communications from the consumer and carer(s).
    c. This philosophy is evident in all policies and procedures.
    d. Key features of the philosophy and principles of care are included in orientation material for staff, consumers and carers.
    e. All clinical staff have completed training in the application of recovery-oriented practice to the mental health care of older people, including the interface between this practice and the principles of person-centred and biopsychosocial care.
    f. The Consumer Wellness Plan is completed prior to the care plan and informs the development of the care plan.

2.2 Target population

The target population for SMHSOP services, including community services, is defined in the *SMHSOP Service Plan*[25] and/or its successor. This is currently defined as older people (65 years and over) who:

- Develop or are at high risk of developing a mental health disorder at the age of 65 years and over, such as depression, psychosis, anxiety or a severe adjustment disorder;
- Have had a lifelong or recurring mental illness, and now experience age-related problems causing significant functional disability (i.e. become 'functionally old');
- Have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by SMHSOP but is guided by consumer preference, and/or
- Present with moderate-severe behavioural or psychiatric symptoms associated with dementia (BPSD) or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. Older consumers with moderate-severe BPSD are included in the SMHSOP target population.

The *SMHSOP Service Plan*[25] also highlights a number of population groups that require specific attention including Aboriginal peoples, CALD communities, LGBTI people, people living in residential aged care facilities, 'functionally old' younger people with mental health needs, people with recurrent or life-long mental illness who are ageing and older people with co-existing mental illness and intellectual disability. Other groups that may require special attention due to disadvantage and other factors include older people living in rural and remote areas, people living in squalor or who are homeless or at risk of homelessness, and people in contact with the criminal justice system. Families and carers of older people with mental illness are also part of the broader target group for SMHSOP.

It is recognised that SMHSOP community services will need to prioritise access to services according to clinical need, risk and a range of other factors. The *SMHSOP Service Plan* provides guidance regarding prioritising access to SMHSOP community services if required.

The impact of physical health conditions upon older people with mental illness, and the appropriate role of SMHSOP community services in ongoing physical health care, is complex. For people already in contact with mental health services, co-existing medical conditions are common and providing or facilitating physical health assessment and care is core business of all mental health services. For people entering SMHSOP for the first time, there are two competing drivers regarding physical health status. In general, the Australian population is 'ageing well' and SMHSOP can expect to see more people with

no or minimal physical co-existing conditions in the future, especially in the 'young old'. However, the presence of physical health illness and associated disability substantially increases the risk of mental health problems and the complexity of their management, and these illnesses are more common in later life. Therefore, the demographic drive to more 'old old' Australians is likely to lead to increased numbers of people being referred to SMHSOP with complex co-existing conditions. The SMHSOP target group is therefore likely to be more diverse with time, and services will need to plan for this.

The number of referrals to SMHSOP community services for people aged less than 65 years with a lifelong mental illness is increasing.[43] Some adult mental health services see SMHSOP services as better placed to accept consumers aged 55 to 65 years who have co-existing physical health conditions, even when they are not age-related; whilst other consumers have early ageing issues and may be seen as 'functionally old'. SMHSOP may be the most appropriate service for this latter group, but the term 'functionally old' is broad and open to interpretation. As with the related term 'frailty', it is difficult to apply a uniform definition or tool to measure this group.[44] Factors that should be considered include the presence of frailty, multiple complex problems, complex disease, reduced mobility, continence problems, and/or cognitive impairment that appears related to an age-related neurocognitive disorder.

SMHSOP services should apply flexibility in seeing consumers who are under 65 years with potentially age-related problems causing significant functional disability. Decisions should be focussed upon the capacities of SMHSOP and adult mental health teams to meet the consumers' needs, together with the wishes and desires of consumers and their carers.

It is recognised that some adult mental health clinicians may find it difficult to determine when or if a consumer should be transferred to the care of the SMHSOP community service, and written or phone communication may not always be able to resolve this. The following example shows how referrals from adult mental health teams are managed in one LHD. This is a person-centred process that is guided by the needs and desires of the consumer and carer(s). This collaborative approach is based on joint respect and appreciation of the skills and expertise of both the adult mental health and SMHSOP clinicians, and has been successful in reducing the number of inappropriate referrals, improving communication between the two services, and better meeting the needs of the individual consumer.

Elements of a person-centered approach to the management of referrals from adult mental health teams, Central Coast Local Health District SMHSOP

- *A SMHSOP clinician is rostered on daily as the 'SMHSOP duty officer', and receives and actions all referrals from the State Mental Health Telephone Access Line (SMHTAL) and all internal referrals for other mental health teams.*
- *The SMHSOP duty officer discusses all referrals from the local adult mental health service with the adult mental health clinician.*
- *If it is clear that the referral is appropriate for SMHSOP, the referral is accepted by the SMHSOP duty officer.*
- *If it is unclear if the referral is suitable for SMHSOP, the SMHSOP duty officer will accept the referral and the allocated SMHSOP clinician will propose a joint home visit with the adult mental health clinician. This face-to-face assessment with the consumer and carer(s) and involving the adult mental health clinician will help determine suitability for ongoing SMHSOP services.*
- *Following the joint assessment, the SMHSOP and adult mental health clinician will discuss and negotiate on which service is most appropriate to provide ongoing care to the older person, taking into account the preference of the consumer/carer(s). This may be the adult mental health service, SMHSOP or adult services with short-term SMHSOP involvement to provide consultation, advice or management of specific issues relevant to the needs of the older person. For instance, advice regarding physical health care needs or aged care services / placement.*
- *Where an older person is assessed as not appropriate for ongoing care by SMHSOP, this is presented at a clinical review meeting and discussed with the SMHSOP Clinical Director to ensure appropriate access to the SMHSOP service is maintained.*

Consultations revealed a lack of awareness and understanding within primary health, aged care services and the general community with regard to the existence, functions and target population of SMHSOP community services, resulting in denied and/or delayed referral and impacting on access to services. The role and target population of SMHSOP community services should be clearly defined and communicated to key service partners and referral services.

> *'So, this gentleman rang the local mental health team to seek services for his wife. He was told that this wasn't the right service; he needed to contact BASIS in the regional centre 3 hours away. When he finally made contact with them he was told that he should be contacting the SMHSOP worker from the team he originally contacted. Not a good introduction to our service'.*

In consultations, some consumers and carers indicated that they have experienced barriers in trying to find support and access the appropriate mental health service within the NSW health system. Some had contacted (or been referred following triage) to one mental health team only to be told that they need to be referred to another team, even for secondary triage and/or initial assessment. It was strongly communicated in consultations that no matter which NSW mental health team people present (or are referred) to, they want this service to assess their needs and then provide care and/or facilitate access to other services as required, to address their range of mental health and other clinical and social needs.

Consumers and carers want easy access to the mental health services they need, and SMHSOP community services should support this by accepting any person referred to community SMHSOP for secondary triage and/or initial assessment following triage, thereby translating the principles of the 'no wrong door' approach into practice. Following secondary triage/initial assessment, a consumer should be supported to access the most appropriate services, including SMHSOP, for ongoing care and other clinical and community supports, to address their particular needs in a timely manner.

Good practice features – Target population

1. SMHSOP community services have a clearly defined target population, service criteria and prioritisation criteria, consistent with the *SMHSOP Service Plan* and/or its successor.
2. The above criteria are distributed to key service partners and referral services.
3. To support timely access to care and support and the guiding principles of the 'no wrong door' approach, any person who presents or is referred to SMHSOP community services following triage will be accepted for secondary triage and/or initial assessment (see Section 5.1 for further discussion of intake processes). This will be supported by the following practices:
   a. Older people with mental health problems* (including those with and without dementia) will have access to SMHSOP community services.
   b. Where an older person with mental health problems is referred following

triage, they will have a secondary triage and/or initial assessment by a SMHSOP community clinician.

c. Determining if a secondary triage and/or an initial assessment is undertaken will be done on an individual basis by the local service in consultation with a consumer and carer(s), and as appropriate given agreed local service functions and staffing arrangements. See Key Definitions for definition of secondary triage and initial assessment.

d. The carer will be involved in the secondary triage and/or initial assessment process with consumer consent.**

e. The secondary triage and/or initial assessment process is inclusive of the GP with consumer consent.** This may include having a system to ensure the consumer's GP is contacted as part of the initial assessment process, for instance to be advised on the outcome of the initial assessment and be involved in joint care planning.

f. Following assessment, the older person will be supported to access the most appropriate services, including SMHSOP, for ongoing care and other clinical and community supports, to address their particular needs in a timely manner.

4. SMHSOP community services will develop and implement local policies and processes that support them to provide secondary triage and/or initial assessment for all people referred to SMHSOP community services following triage. This may be demonstrated by:

a. Reorienting the philosophy, functions and practices of the service as required.

b. Accepting the State Mental Health Telephone Access Line (SMHTAL) as having a low threshold for forwarding referrals for older people to SMHSOP services. See Section 5.1 for further discussion of SMHTAL.

c. Inclusion of older people with mental health problems (including those with and without dementia) in the service criteria of the SMHSOP community service.

d. Inclusion of older people with complex and unclear aetiology potentially suggestive of mental illness in the target population for secondary triage and/or initial assessment by SMHSOP community services.

e. Exercising appropriate flexibility in regards to people who are under 65 years old with age-related problems causing significant functional disability.

f. Provision of an integrated service for older people presenting with a mental health problem (including those with and without dementia). Within a community service, clinicians may have specialised skills and functions, but they will form part of one team with a shared target population and common access points.

g. An agreed approach to managing the care of older consumers with severe BPSD, considering the role of other service providers who have a remit to provide BPSD support such as Dementia Behaviour Management Advisory Services (DBMAS) / Severe Behaviour Response Teams (SBRT), with key resources available to support this approach. See Section 3 for further discussion on DBMAS/SBRT.

h. Where local prioritisation results in SMHSOP community services not providing ongoing care to a subset of older consumers in the *NSW SMHSOP Service Plan* target group, there are clearly documented pathways to alternate care providers.

i. Effective partnerships between SMHSOP community services and other providers of services to older people.

** Mental health problems includes BPSD*

*** See Key Definitions for further discussion of 'consent'.*

Specific population groups

Of the population groups with specific needs that were identified (see Section 2.2), the SMHSOP Community MoC Project highlighted some specific considerations in providing care regarding two groups – older Aboriginal and culturally and linguistically diverse (CALD) people with mental health problems. These considerations are highlighted below.

Aboriginal people

Target population

Aboriginal people have a shortened life expectancy[45], associated with a history of dispossession, poor community and social capital, low socioeconomic status, impaired access to and quality of health and other services, health-related behaviours and environmental factors. Given this, and the earlier onset of illnesses and conditions usually associated with ageing in this population, SMHSOP should be able to provide care to Aboriginal people from the age of 50 years if they identify as older people and/or with the specific needs of older consumers, and if this is their preference. Aboriginal people with a mental health issue who are aged 50-64 years may reasonably choose to be seen in adult mental health or SMHSOP services.

Philosophy of care

Aboriginal people generally have a holistic view of mental health and prefer the term 'social and emotional wellbeing' to mental health.[46] The holistic view incorporates the physical, social, emotional, and cultural wellbeing of individuals and their communities, and includes domains of health and wellbeing such as connection to land or Country, culture, spirituality, ancestry, family and community. Service provision that reflects this definition of social and emotional wellbeing and the factors that influence it best meets the needs of Aboriginal and/or Torres Strait Islander people.[47]

In the case of an older Aboriginal person, there needs to be an understanding of: their connectedness to family, community and Country; their role within family and community, particularly the significant and special place an older Aboriginal person or Elder may have within one or many communities, and the burden of grief, loss and trauma experienced by many Aboriginal people.[24,46,47,,48] Aboriginal people are also adversely

affected by multilayered discrimination, marginalisation, and stigma in ways that are relevant to recovery and need to be considered in recovery-oriented practice.[49,36]

Key processes, techniques and therapies

A full appreciation of the holistic notion of health and mental health (and the language used to express this) and an older Aboriginal person's contribution to, and inclusion within, culture, family and community is important in working with older Aboriginal people with mental health issues, and may be particularly relevant to assessment, therapy and family/carer education. Clinicians also need to have an understanding that older Aboriginal people may experience mental health not only at an individual level but at the community level, and should appreciate the impact of transgenerational traumatisation for both the older Aboriginal person and their family/community.

There are a number of factors to consider when implementing standardised assessments with Aboriginal people,[46] including any cultural views and taboos regarding signs and symptoms being assessed, the cultural and political context of the assessment and setting, and inherent cultural factors of the assessment tool itself (e.g. language, terminology). A number of mental health assessment tools have been developed / adapted that are culturally appropriate and validated for use with Aboriginal people.[46]

Mental health services should ensure the cultural safety of Aboriginal people throughout all stages of care,[50,23,51] including facilitating access to an Aboriginal mental health and/or health worker. Aboriginal community organisations and Aboriginal Community Controlled Health Services (ACCHS) including Aboriginal Medical Services are well placed to develop innovative forms of service delivery and may act as advocates for older Aboriginal people with mental health issues, carers and families, and SMHSOP should seek to develop effective partnerships with ACCHS to facilitate culturally competent assessments, treatment and care planning. Treatments and therapies should be culturally appropriate. See *Activity guidelines for health professionals working with Indigenous Australians with dementia in rural and remote Australia*[52] for suggested culturally appropriate activities for Aboriginal people with dementia, and *Behaviour Management: A Guide to Good Practice: Managing Behavioural and Psychological Symptoms of Dementia*[51] for further information on cultural considerations for service provision to Aboriginal people with dementia.

Good practice features – Aboriginal people

1. The Aboriginal target group for SMHSOP community services includes Aboriginal people aged 50 years or older who develop, or are at high risk of developing, a mental health disorder and identify themselves with the older population and/or the specific needs of older consumers. The preference of Aboriginal people aged 50-64 years to be seen in adult mental health or SMHSOP services should be

facilitated.

2. SMHSOP community services make the most of formal partnerships and/or partnership arrangements in place between the LHD Mental Health Service and Aboriginal service providers including ACCHS and/or communities (see page 32).
3. SMHSOP clinicians are supported to work in a range of settings including Aboriginal health services (see page 35).
4. SMHSOP clinicians appropriately adapt their practice to meet the needs of Aboriginal people. This may be demonstrated as follows:
   a. All consumers are asked if they are Aboriginal (recognising that it is the person's choice if they choose to identify or not).
   b. All community SMHSOP services have access to Aboriginal liaison/health workers and cultural consultants where required (see page 65).
   c. Staff actively contact and seek involvement of Aboriginal health/mental health workers in preadmission processes (see page 39), during assessment (see page 44) and during treatment where required.
   d. Assessment processes for Aboriginal people are trauma informed and culturally appropriate, and consider the potential for complex family and community relationships.
   e. Carer(s), other health care providers and community support services participate in the process of planning for transition of care/discharge as appropriate (see page 54).
   f. Staff are trained in cultural awareness and are knowledgeable about local services for Aboriginal people.

Culturally and Linguistically Diverse (CALD) consumers

An older person from a CALD background is likely to have specific needs depending on individual experiences/factors and migration circumstances, and the extent to which cultural traditions have been maintained.[53] Older people from refugee backgrounds are particularly vulnerable to mental health issues. Psychological health concerns of older refugees include isolation, depression and cognitive decline. Evidence suggests that the multiple impacts of severe traumatisation can persist for many years after the traumatic events took place.[54] There is great diversity within all cultures and clinicians should never assume that people from the same cultural heritage are any more similar to each other than members of the general community.

Philosophy of care

Person-centred care approaches for culturally and linguistically diverse (CALD) consumers may emphasise the role of family and cultural belonging. Alternative approaches may be required for older people from CALD communities experiencing

isolation and/or loneliness and for those who do not have extended family networks for support, are ageing in an unfamiliar cultural environment, and/or are experiencing grief, loss, shame, stigma and discrimination associated with migration or displacement.

Community and cultural traditions, beliefs and values play a significant role in and have a significant influence on a person's experience of recovery. Cultures vary in their emphasis on individuality, personhood, gender, kinship and family ties. Deference to community leaders—traditional healers, priests, elders and community leaders— and family members regarding personal decision making is a strong tradition in some communities.[36] For some people spiritualty is defined by formal religion, while for others spiritualty is a more individual construct.

The concept that cultural beliefs and practices flow through generations should be acknowledged in the way that generational influence is accepted in Aboriginal culture. At the same time, individuals and families bring with them (into clinical and related settings) a range of varying and shared perspectives. The 'Key processes, techniques and therapies' then provides tools for exploring individual perspective(s).

Key processes, techniques and therapies

Research and policy reform initiatives clearly articulate the importance of, and expectations for, delivering culturally competent mental health services. The *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*[55] assists mental health services to evaluate their cultural responsiveness and enhance their delivery of services for CALD communities. Cultural differences in verbal and non-verbal communication will have implications for practice and service delivery,[36] including provision of culturally appropriate written mental health information and the use of direct or indirect questioning styles as appropriate. Service providers will also need to have specific skills in working with interpreters and cultural advisers, and seek collaboration with trans/multicultural health services when required. Concepts of confidentiality are understood differently in many communities. Signs and symptoms may be expressed in spiritual or behavioural ways and by other symbolic and somatic references by some CALD consumers.[55] See *Behaviour Management: A Guide to Good Practice: Managing Behavioural and Psychological Symptoms of Dementia*[51] for further information on cultural considerations for service provision to people with dementia living in CALD communities.

Mental health services should ensure the cultural safety of consumers through the assessment process.[50] The *Transcultural Assessment Checklist*[56] can be used to support culturally appropriate assessments. The multicultural MH-OAT tool may assist in addressing the cultural implications arising in the care of CALD consumers.

Good practice features – CALD consumers

1. SMHSOP community services engage in relevant partnerships to address local demography and needs and supports of CALD communities, which may include transcultural and/or multicultural services and other agencies where relevant (page 33).
2. SMHSOP clinicians appropriately adapt their practice to meet the needs of CALD consumers. This may be demonstrated by:
   a. All community SMHSOP services access interpreters and cultural consultants where required (see page 65).
   b. Staff actively contact and seek involvement of bilingual counsellors, cultural consultants and other cultural brokers in preadmission processes (see page 39), assessment and care planning processes (see page 44) and treatment where required.
   c. Staff access and appropriately use validated culturally sensitive assessment tools and resources with CALD consumers (see page 44).
   d. The specific cultural customs and values, religious beliefs, and other beliefs and practices of a consumer are considered as part of the consumer's assessment, care and discharge/transition planning, with the *Transcultural Assessment Checklist* used to support culturally appropriate assessments as relevant.
3. Staff are trained in cultural awareness and cultural competency, and working with interpreters.

2.3 Potential exclusion criteria

SMHSOP community services will exercise appropriate flexibility in providing assessment for older people with complex and unclear aetiology and, where possible and appropriate, will provide care for consumers who are under 65 years old with age-related problems causing significant functional disability. While the 'typical' SMHSOP client is aged 65+, age should not be considered a unique exclusion or inclusion criterion for accessing SMHSOP services.

Providing advice on the services not provided by SMHSOP community services (exclusion criteria) assists older people, carers and GPs to more easily access appropriate services and care. Easy access can be promoted if clear exclusion criteria are distributed to key service partners and referral services.

SMHSOP services[25], including community services, will not generally provide services for older people with a primary diagnosis of drug and alcohol disorder or delirium. If an older person with delirium or drug and alcohol disorder presents to or is referred to a SMHSOP community service following triage the SMHSOP clinician will, following secondary triage

and/or initial assessment, refer and/or assist the person to obtain assessment and management of these issues from a different service provider. This might include directly arranging for the consumer to be assessed by that service or ensuring that the consumer has achieved access to the service to which they were referred. Also, SMHSOP community services should have or develop some capacity to provide assessment and care for older consumers with co-existing drug and alcohol and mental health issues, working in collaboration with drug and alcohol services. There is a general need for more collaborative arrangements with drug and alcohol services. The *NSW Health Older People's Drug and Alcohol Report*[57] provides some guidance for mental health services and SMHSOP.

Existing NSW Health services, including mental health crisis teams and Emergency Departments, will continue to provide emergency response services for older people with acute mental health care needs 24 hours a day.

Good practice features – Potential exclusion criteria

1. SMHSOP community services have clearly defined potential exclusion criteria, consistent with the *SMHSOP Service Plan* and/or its successor and informed by the local needs of the target population.
2. Potential exclusion criteria are distributed to key service partners and referral services.
3. SMHSOP community services exercise appropriately flexibility in providing assessment for older people with complex and unclear aetiology and, where possible and appropriate, provide care for consumers under 65 years old with age-related problems causing significant functional disability.
4. Where referral information is suggestive of delirium or acute medical illness, the person is referred for and/or assisted to obtain assessment and management of these issues. This should be accompanied by clear information regarding how to re-contact the SMHSOP community service if this still appears indicated after management of delirium/acute medical illness.

2.4 Functions

SMHSOP must be able to conduct specialist mental health assessment, diagnosis and treatment tailored for older people[2], given that the needs of older people with functional mental illness and/or organic diseases such as dementia and their associated physical and social issues are often distinct from those of younger people with mental illness.[58]

The principles of recovery-oriented care should drive the practice of SMHSOP community services. Whilst the functions of SMHSOP community services are geared

primarily towards clinical recovery, they must be framed in a broader recovery context, thereby supporting and facilitating personal recovery.

Functions of all SMHSOP community services include specialist mental health assessment, care planning, short and longer term clinical management (involving clinical care and coordination, treatment, clinical review and transitions of care) and consumer advocacy. Other functions may include specialist consultation and liaison, crisis care (intensive community treatment), and specific mental health promotion, illness prevention and early intervention activities. For detailed discussion of these different functions see Section 5.2 for coverage of assessment and care planning, Section 5.3 for clinical care and coordination, Section 5.4 for recovery-oriented risk assessment and planning, Section 5.5 for clinical review, Section 5.6 for transitions of care, Section 5.7 for consultation liaison, Section 5.8 for crisis care, Section 5.9 for promotion, prevention and early intervention and Section 6 for techniques and therapies.

Interagency cooperation is crucial to successfully resolving and managing cases of severe domestic squalor. SMHSOP community services should work in partnership with other agencies on squalor/hoarding issues, as required. It is likely that FACS will take the lead responsibility in such instances, with SMHSOP providing advice and assistance when requested. SMHSOP should provide a comprehensive mental health assessment for any person referred with squalor and/or hoarding problems. Additional information on squalor and hoarding, including assessment tools and suggested resources, is available on the *Pathways through the Maze* website.[59] The document *Hoarding and squalor: A practical resource for service providers,*[60] developed by the health department in Victoria, may provide additional information and advice for NSW SMHSOP services. Local Councils may have protocols on managing squalor/hoarding in the local area, and SMHSOP community services should be aware of and guided by these.

Prioritisation of different functions

Some functions of SMHSOP community services need to be prioritised over others, other functions will be prioritised depending upon local context, and some functions are appropriate for some services only. However, core functions of all SMHSOP community services in relation to a) all consumers referred to SMHSOP, and b) consumers prioritised for ongoing care, are outlined below.

Stepped care

Establishing a ‘stepped care’ model for primary mental health care is a key action area identified in the Australian Government’s mental health services reform agenda.[14] Under these reforms, it is proposed that a mental health system built on a stepped care approach will comprise a full continuum of services, from low intensity, early intervention through to high levels of care requiring ‘wrap around’ coordinated care for those with severe and complex mental illness. Primary Health Networks will have the flexibility to commission regionally delivered primary mental health services suited to local needs within the stepped care model, and will lead mental health planning and integration at a

local level. The development of a regional approach to suicide prevention and the improved coordination of care for people with severe and complex mental illness who are being managed with primary care will be priorities. The impacts of these reforms on prioritisation of functions with SMHSOP and how partnerships are formed/maintained is not yet clear, but will need consideration in the implementation of the SMHSOP community MoC.

Good practice features – Functions

1. In undertaking the functions of their service, staff of SMHSOP community services will:
   a. Promote the individual clinical and personal recovery of older consumers.
   b. Undertake joint care planning and coordination with consumers, and carers, GPs and other key services and health care providers with consumer consent.*
   c. Advocate where required on behalf of the consumer and/or carer, including on a consumer's right to physical health care.
   d. Work with consumers and carers in undertaking a 'positive risk taking' approach to risk assessment and planning, including complying with other relevant guidance including the NSW Health policies Clinical care of people who may be suicidal[61]and Transfer of care from mental health inpatient services.[62]
   e. Comply with relevant legislative requirements and NSW Health policy.
   f. Meet the specific requirements of the *NSW Mental Health Act* and the *NSW Guardianship Act,* and access or support appropriate hearings and inquiries.
   g. Undertake the development and maintenance of appropriate partnerships with primary care services and residential aged care facilities (RACFs).
   h. Be supported to access appropriate education, training and/or research activities.
   i. Participate in ongoing monitoring and improvement of practice and performance.
2. For all referred older consumers, the following functions are provided by all SMHSOP community services:
   a. Timely assessment.
   b. Planning initial steps of care with the consumer, and carer(s) and GP with consumer consent*
   c. Facilitation of easy and appropriate transitions in and out of care between providers and settings, including collaborative care arrangements.
3. Where a consumer meets local prioritisation criteria for ongoing SMHSOP community care, then the following functions may be provided directly by SMHSOP community services or in collaboration/by arrangement with other

health teams/services or partner organisations:

a. Ongoing care planning with the consumer, and carer(s) and GP with consumer consent.*
b. Provision of specific mental health techniques and therapies with the consumer, carer(s) and their GP.
c. Ongoing clinical care and coordination with the consumer and their carer(s).
d. Working with the consumer, their carer(s) and other professionals to assist in management of relevant co-existing conditions as required.
e. Individualised prevention and promotion activities that are complementary to clinical care.
f. Clinical review.
g. Facilitation of easy and appropriate transitions in and out of care between providers and settings, including collaborative care arrangements.

Indicated features – Functions

1. Functions which may be appropriate for some services include:
   a. Inpatient consultation liaison.
   b. Involvement in crisis care management in conjunction with broader adult crisis mental health response.
   c. Innovative models of more intensive follow-up and assertive outreach.
   d. Specific promotion, prevention and early intervention activities and programs, including working in partnership with other service providers

** See Key Definitions for further discussion of 'consent'.*

3 PARTNERSHIPS

From the perspective of the consumer, SMHSOP community services are one partner in a range of services that support their clinical and personal recovery. It is only by working in partnership with a range of health and community providers that the complex physical, social, behavioural and psychological needs of the older person can be met. SMHSOP play a key role in the provision of continuity and coordination between other mental health services and services outside of mental health, ensuring the provision of integrated care. There has been further development of key SMHSOP service partnerships over the last 10 years as these services have expanded and developed across the State under the *SMHSOP Service Plan*[25] and as

Working with a vast range of agencies is seen as essential to the core work of SMHSOP.

there has been an increasing emphasis in health policy and practice on partnerships, collaboration and integrated care and on primary health networks.

SMHSOP community services must ensure clinical practices, service structures and service partnerships facilitate integrated and coordinated care that will meet the particular needs of the individual older person. Linkages and referral pathways should be developed, with a range of service partnerships and formal processes in place to develop inter-agency and inter-sectoral links and collaboration. Organisations that provide care to an older person are distinct from those relevant to younger people, and SMHSOP clinicians need to be aware of the range of these services.[58,2,63,64]

The NSW Health policy document, *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs*,[30] outlines a number of system design principles which support integrated healthcare across settings. Having agreed goals and a clear vision, confidence in other service providers, clear roles and responsibilities, joint care planning, clarification and agreement in relation to expectations around communication, opportunities for information sharing, and shared or mutual access to documentation are considered key for successful collaboration with other service providers.[65,66, 67,68]

Clinical service partners

SMHSOP community services rely on and acknowledge the need for strong partnerships with other key services to support *clinical* recovery, particularly GPs and SMHSOP inpatient services. In particular, working in partnership with GPs is seen as central to the way in which SMHSOP operate,[2] and GP involvement is recommended in various key process of SMHSOP care (intake and admission, assessment including physical examinations, care planning, clinical review and transition of care).[25] Ideally, SMHSOP AIU and community teams are part of the one service. If managed differently, clear protocols to support integration between the two services are required. Where relevant, SMHSOP community clinicians should be involved in SMHSOP AIU intake processes and in multidisciplinary reviews of AIU consumers, and community mental health assessment should occur prior to inpatient admission where possible.[34] The high rates of physical health conditions experienced by older people with mental illness necessitate joint working and service delivery that can address both physical and mental health needs. Therapies may be provided by SMHSOP or by partnering with, or linking to, other service providers.

Where geriatric medical services have a substantial role in the community, close liaison and coordination would be beneficial, and close working relationships should be promoted.

Other key community SMHSOP service partners considered critical in supporting clinical recovery include: T-BASIS units; adult mental health services;[58] private mental health professionals;[69] aged health and geriatric medical services[70,58] including ACAT; dementia

services including Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRT); community and residential aged care services; drug and alcohol services;[57] other health services; other hospital services and emergency departments; pharmacy services; ACCHSs and Aboriginal health and mental health workers; multicultural/transcultural health and mental health services; LGBTI service providers; community managed mental health services (CMOs), NGOs, and legal partners including the Mental Health Review Tribunal and Public Guardian. Most SMHSOP community services have a relationship with local residential aged care facilities. In some LHDs, SMHSOP community clinicians provide clinical consultation/liaison support to specialist transition units within residential aged care facilities or Specialist Residential Aged Care Facilities. These specialist mental health-residential aged care partnerships models are currently being expanded under the NSW Health *Pathways to Community Living Initiative*.[71]

Community service partners

Social needs of older people with chronic mental illness are often an area of unmet need.[72] Whilst joint involvement between OPMH services and social/community services isn't always required, it should be available when it is.[58] SMHSOP community services should follow an integrated care approach across services to promote consumer independence[2] and maximise effective service and care coordination, including at times of discharge/transition of care.

> *Having knowledge about and interacting productively with services such as those that support social connectedness was seen as important.*

Key partners for SMHSOP considered critical in facilitating *personal* recovery include the consumer, their carer(s) and/or family and their community networks such as social clubs and organisations; spiritual supports; and other community supports such as Housing NSW and other housing and squalor services, Centrelink, and community managed organisations and programs. A number of service partners considered critical for enhancing clinical recovery may also be important for an individual's personal recovery, including ACCHSs.

Consumers should be recognised as partners in the management of all aspects of treatment, care and recovery planning[73,74,22,6, 75] A partnership with a consumer involves providing care that is respectful, sharing information in an ongoing manner, and supporting and encouraging consumers' roles in their own care including in the development and monitoring of individual care plans goals, thereby supporting personal recovery.

The value of carer engagement is underpinned in both legislation and policy, including the *NSW Carers (Recognition) Act 2010*[76] and the *NSW Carers Strategy 2014-2019*.[18] Mental health services should implement and maintain 'ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care'.[8] However, it must be acknowledged that a consumer may not always have a carer(s), or the carer(s) may be ageing limiting their capacity to provide support and advocacy. Some consumers are reluctant or unwilling to nominate a carer or are socially isolated. In some cases, health providers such as mental health workers or GPs are the main contact, especially if the person is isolated. Working with a consumer early, including through provision of in-reach services, may help those without carer(s)/advocate(s) to access care as early as possible. This may help prevent the need to substitute consent at a later date due to deterioration. Further information on substitute consent, include a definition of 'person responsible' and appointment of guardians, can be obtained from the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT).

National Disability Insurance Scheme (NDIS) providers may be key partners as NDIS implementation progresses, particularly in relation to SMHSOP consumers who are under 65 and older people with mental illness who are transitioning from NDIS to aged care supports.

Partnerships and Aboriginal communities

Development of formal inter-agency linkages is considered an extremely effective way to support Aboriginal consumers and enhance service delivery and treatment outcomes.[46] The *NSW Health Partnership Agreement 2015-2025*[77] and the *NSW Aboriginal Health Plan 2013-2023*[23] recognise the importance of working in collaboration with, and developing strong partnerships between, LHDs and Aboriginal communities including ACCHS and Aboriginal health/mental health workers, and requires LHDs to have local partnerships with ACCHS. At the local level, many SMHSOP have developed informal connections with the local ACCHS/regional ACCHS consortia where available and the ability to access Aboriginal health workers if requested. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*,[46] *Aboriginal Older People's Mental Health Project Report*[47] and *Aboriginal Older People's Mental Health: Resources for LHD SMHSOP Services*[78] provide information to assist mental health services to improve collaboration and partnerships with ACCHS.

Partnerships and CALD communities

The most effective strategy in meeting the needs of diverse CALD communities is to have partnerships with different types of organisations that provide services to CALD communities,[79] including trained bilingual workers, specialist transcultural mental health services (including the *Transcultural Mental Health Centre*'s specialist consultative service and the *Service for the Treatment and Rehabilitation of Torture and Trauma Survivors),* Community Managed Organisations/NGOs and multicultural agencies.

Constructive partnerships with CALD communities, health practitioners and organisations may generate referrals to SMHSOP and/or support SMHSOP in assessment and management of older people with mental health issues from CALD backgrounds. Given the great variation across NSW in the composition of the local CALD population, SMHSOP services need to be cognizant of the specific needs of the local CALD population and any local non-health services that may provide support, such as Migrant Support Services offered by local Councils.

Good practice features - Partnerships

1. SMHSOP community services value partnerships and recognise that effective partnerships require concerted focus and effort in a complex system of care and support where there are many health and community service providers (see Figure 1).

2. SMHSOP community services prioritise partners according to the needs of the local community to ensure that investment in partnership activity is directed appropriately.

3. SMHSOP community service clinical and management processes recognise key partners, promote effective partnerships and optimise relationships. This includes:
   a. the following key services *in particular*:
      - General Practitioners/ Primary care providers
      - SMHSOP acute inpatient units, where present
      - Other NSW Health community mental health teams
      - NSW Health aged health community services
      - Aged Care Assessment Teams (ACATs)
      - Residential aged care providers (including specialist service providers where available, and equivalent community aged care package providers)

   b. relevant *inpatient* clinical services such as:
      - Adult mental health inpatient units
      - Geriatric medical units (or other medical inpatient units in rural areas)
      - Emergency Departments
      - Other relevant units specialising in the care of older people (such as acute medical behavioural units, T-BASIS units or other SMHSOP sub- or non-acute inpatient units)
      - Justice Health and Forensic Mental Health Network

   c. relevant *community* services such as:
      - Acute (crisis) teams and other adult mental health community teams
      - Community managed mental health providers (CMOs) and NGOs

- Community aged care services
- Dementia services including DBMAS and SBRTs
- Drug and alcohol services
- Pharmacy services
- Mental Health Review Tribunal, Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT) and NSW Trustee and Guardian
- Emergency services (police and ambulance)
- Primary Health Networks
- Commonwealth Home Support Programme services
- Housing and squalor services
- Justice Health and Forensic Mental Health Network
- Aboriginal Medical Services and other Aboriginal Controlled Community Health Services/ Aboriginal-specific services
- Multicultural and transcultural service providers
- LGBTI service providers.

d. the private sector, including private hospitals and psychiatrists.

4. SMHSOP community services maximise integration with SMHSOP Acute Inpatient Units (AIUs), where present, by working in accordance with the *SMHSOP AIU Model of Care* and particularly in regards to admission, clinical review and transitions of care.

5. SMHSOP community services have clear processes to facilitate optimisation of care integration with GPs. This may include:
   a. provision of information to GPs on SMHSOP, including information about pathways for access;
   b. close involvement and communication with the GP throughout a person's care episode, and
   c. consideration being given to arrangements that allow provision of SMHSOP clinical services in primary care settings.

6. SMHSOP community services have mechanisms in place to support effective partnership arrangements such as: shared care arrangements; workforce development in partnership skills and inter-professional practice; clear expectations around communication and information sharing; joint case conferences / case sharing; joint assessments, cross referrals or joint assessments; consistent management approaches; clear governance arrangements; consultation-liaison services; joint involvement in planning of services and/or review of processes; and formal agreements outlining service roles and responsibilities.

7. SMHSOP community services maximise the benefits of formal partnerships and/or partnership arrangements in place between the LHD Mental Health

Service and Aboriginal service providers including ACCHS and/or communities.

8. SMHSOP community services engage in relevant partnerships to address local demography and needs and supports for CALD communities, and identify community supports, which may include transcultural and/or multicultural services and other agencies where relevant.

4 WORKING IN DIFFERENT SETTINGS AND IN DIFFERENT WAYS

Settings

> *'SMHSOP need to be willing to go where older people are'*

The preference of the consumer must be considered when determining where and how to deliver services.[58] A consumer may prefer to receive care 'in situ' or in their normal place of residence (private residence, residential aged care facility or supported accommodation), in a clinic or in a primary care or social setting, and this choice should be supported as much as possible.[25] For some consumers, their particular circumstances will dictate where they are seen by SMHSOP community clinicians. Although there is significant evidence to support a person's home as the optimal service delivery setting in terms of effectiveness and healthcare costs,[80,81,27] not all consumers and/or carers welcome services provided in their home, preferring to keep home separate from the care and services environment. This may be a way of maintaining some control in their recovery journey and their choice of preferred setting should be supported where possible.

The location of care may be negotiated with a consumer, but often a consumer is told where contact will occur. This may mean consumers feel obliged to see the SMHSOP clinician in their home, or have to travel significant distances.

SMHSOP community services must be willing and able to work in a range of service settings. However, it is noted that the availability of resources, including staffing, and partners in care will impact on choice of location.[82] All SMHSOP community services provide home visits to some extent, and outpatient clinics are offered in all LHDs, but with variable integration into community teams. All SMHSOP community services provide some in-reach to residential aged care facilities. Provision of consultation-liaison services and in-reach to SMHSOP inpatient units or other mental health or geriatric units is undertaken rarely, although some SMHSOP community services are beginning to develop models and pathways to support this. Similarly, provision of SMHSOP services in primary care settings would be undertaken very rarely. To work in some settings (including residential aged care facilities and general practices), SMHSOP community clinicians will be required to work closely with other service providers, providing consultation, liaison and joint care planning and coordination.

Whatever service setting is decided upon, SMHSOP clinicians must promote the optimal safety and wellbeing of the consumer, carer(s), families, visitors and staff.[8] Staff must be supported to make home and residential visits, including provision of adequate transport for staff.[58]

Different ways of working

Relevant literature and expert opinion suggest that SMHSOP community clinicians should utilise different methods of communication as required to meet the needs of older people. Consumers' preferences regarding face-to-face care and telehealth/video link/telemedicine should be considered and supported if possible and practical. While face-to-face contact is desirable in terms of relationship building and reduction of social isolation, more equitable access to services may be facilitated by the effective use of electronic communications.[2] Telemedicine should be used as an adjunct to face-to-face services but not as an alternative to these services. SMHSOP services are mostly provided face-to-face, with tele-psychiatry used to supplement these by some rural teams, primarily providing assessment and case conference functions. There are differing views amongst clinicians about the acceptability and effectiveness of tele-psychiatry for older people. The resource *Guidelines for the use of telehealth for clinical and non-clinical settings in NSW*[83] provides a common standardised communications framework for 'clinician to patient' and 'clinician to clinician' usage groups.

There is a growing evidence base supporting the role of online technologies and the effectiveness, including cost-effectiveness, of e-mental health solutions.[84,85,86] E-mental health services provide access to information, treatment and support to people with mental health issues and their carers through telephone, computer and online applications. E-mental health services are accessible, offer an effective alternative to conventional treatments,[85] and can empower individuals with choice and enable self-management through early stages of illness to recovery.[84] For many mental illnesses, including depression and anxiety, the outcomes for older people who participate in online therapies are broadly comparable to those of face-to-face services using similar treatment techniques.[87,88,89] Technology must meet the needs of older adults and also be accepted by them, and older people should be provided with time to establish confidence with the technology prior to undertaking computer-based on online therapies.[2]

Good practice features - Working in different settings and in different ways

1. SMHSOP community services provide care in the location preferred by the consumer and carer wherever feasible. Where this is not known, or unclear, care should occur in the person's normal place of residence unless there are specific reasons for it to occur elsewhere.
2. Where a consumer prefers to receive care in an outpatient clinic or other setting outside their normal place of residence, SMHSOP community clinicians support

this preference and provide and/or arrange assistance as required, including considering any mobility needs of the consumer and/or carer(s).

3. SMHSOP clinicians are supported to work in a range of settings including a person's normal place of residence (which may be a residential aged care facility or a private residence), outpatient settings, inpatient hospital units, primary health settings and Aboriginal health services. Consideration should be given to the following:
   a. Appropriate staff resourcing.
   b. Access to appropriate clinical information, e.g. EMR, results of investigations.
   c. Logistical arrangements such as access to transport and allocation of time for travel and making other necessary arrangements.
   d. Work health and safety considerations.
   e. Formalising partnership arrangements and/or linkages with other service providers as required to ensure continuity of care for older people.
   f. Credentialing and governance requirements.
   g. Skillset and modes/styles of care that SMHSOP staff need to provide services in different settings.
   h. Clear processes for raising issues in settings such as residential aged care and primary care settings.
   i. A single / consistent set of governance arrangements across all settings.
4. Where care is provided through consultation and/or liaison style services, guidance is available to clinicians on the agreed multi-sector arrangements in each setting, including:
   a. the roles and responsibilities of the services involved in the provision of care,
   b. arrangements for the management of medical records, and
   c. the agreed expectations around communication (including handover of clinical details and discharge/transition of care information).
5. SMHSOP community services utilise a variety of modalities as required to provide treatment (including face-to-face, telehealth and/or e-health), in order to improve access to services by older people with mental health problems, and/or provide support to clinicians (including GPs and primary health clinicians).
6. When utilised, SMHSOP clinicians undertake telehealth with regard to the NSW Agency for Clinical Innovation *Guidelines for the use of Telehealth in Clinical and Non Clinical Settings in NSW.* In particular the following is noted:
   a. Telehealth should augment existing services, not replace face-to-face services.
   b. There are administrative considerations and technical support requirements that need to be taken into account.
   c. Sufficient space is required for equipment and conferencing.
   d. Interpreters should be utilised where required to meet the needs of CALD

consumers.

e. Staff training will be required.

f. Agreed protocols should be developed/maintained for consumer referral, selection, prioritisation, preparation, reporting, prescribing and record keeping.

5 KEY PROCESSES

The NSW SMHSOP community benchmarking Self-Audit Tool (SAT)[90] outlines a set of agreed standards to improve and maintain the various key processes of SMHSOP community services, including intake and bed management (and intake criteria), assessment, care planning, clinical review and community discharge. Utilising the SAT, SMHSOP community services have been undergoing review through the processes of benchmarking since 2009. The 'good practice features' identified in this section of the guideline build on the standards included in the SAT, and the SAT will be revised to align with the SMHSOP community MoC (see Section 9).

Consultation with consumers, carers and clinicians identified a number of key points that are relevant across all key SMHSOP processes and the spectrum of care. The importance of taking the time to listen; having a person-centred focus; working in partnership with the consumer, carer and GP; communication with the health professional that is open, honest, transparent and two-way; and the provision of information, including written information, were highlighted as particularly important.

5.1 Access and intake

Access

National standards[19] clearly identify that mental health services must support access and entry through provision of information to the community, including GPs, regarding the availability and range of services and the method for establishing contact. A lack of awareness by the community and GPs of SMHSOP services and what they do is a key obstacle to access to services that must be overcome.

> Consultation revealed that there is a general lack of knowledge and anxiety about mental health services - *'like a black box, but one that is vaguely fearful'*

Stigma was identified as an impediment to care. This may be associated with poor mental health literacy regarding ageing and/or mental illness, and regarding service options. Aboriginal and CALD people have additional barriers to access and care,[47,79 ,91] and enhancing their engagement in the mental health system requires a culturally sensitive approach and specific strategies. This may include collaboration with ACCHS and/or Aboriginal health/mental health workers and trans/multicultural health services, having

multiple entry points to facilitate access to services, and provision of culturally sensitive mental health information.

Older people living with mental illness and intellectual disability have unique barriers to accessing mental health services, and the document *Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers* provides advice on improving access.[92]

Intake

The primary entry point for all new referrals is the NSW centralised mental health intake service - State Mental Health Telephone Access Line (SMHTAL). SMHSOP community services should look at mechanisms to facilitate ease of access consistent with this approach. To support easy and timely access and limit 'closed doors', SMHSOP administrative and/or clinical staff will facilitate good communication and liaison with the SMHTAL in regards to any referral made directly to the service. People can self-refer or referral can be made by others including family members, GPs, private psychiatrist, geriatrician, RACFs or healthcare providers.

Mental Health telephone triage in NSW is guided by the *NSW Mental Health Triage Policy*[93] and *NSW Health Mental Health Clinical Documentation*[94] triage module. A key difference between the triage of older people and that of younger age groups is the higher likelihood of co-existing medical conditions which may imitate, exacerbate or mask psychiatric symptoms[95] and physical (e.g. hearing) impairments. Screening for acute medical deterioration or delirium, including any potential underlying clinical cause of delirium, is essential for assessing risk in older people and must be undertaken as part of the triage process.

Following initial triage and where appropriate, consumers should be referred to SMHSOP for a more comprehensive secondary triage and/or initial assessment. Processes for admission will vary, but all SMHSOP community services should have some process for secondary triage / initial assessment before acceptance for admission. The criteria for admission should be based on the agreed target population (see Section 2.2).

As discussed in Section 2.2, consumers and carers want timely, easy access to care and services. To support this, SMHSOP community services should accept any person referred to the service following triage for secondary triage and/or initial assessment (see Good Practice Feature, page 17). This requires an acceptance of SMHTAL's role in forwarding referrals of older people to SMHSOP. The secondary triage and/or initial assessment undertaken by SMHSOP community services should consider a consumer's particular needs, in order to support them to access the most appropriate services for ongoing care, including SMHSOP, and other clinical and community supports as required (see Good Practice Feature, page 18).

Mental health services have a responsibility to recognise and support the rights and needs of consumers and carers throughout the intake and admission processes

(including language and cultural needs), and involve the carer and/or GP where possible and with appropriate consent. [19,96,25]

Currently, in most services maintaining intake through SMHTAL, any consumer discharged from mental health services (including SMHSOP) can only re-access services through recontacting SMHTAL for a full re-triage. However, some SMHSOP services informally allow re-referral through direct contact with the previous clinicians involved, and 'registering' the consumer either directly in the electronic record, or by the clinician calling SMHTAL. Consumer, carer and expert opinion informing this guideline supports SMHSOP community services having processes that promote easy re-access to services for SMHSOP consumers following discharge, where required.

Good practice features – Access and intake

1. SMHSOP community clinicians communicate in a non-judgemental, culturally appropriate way, utilise recovery-focused language, listen well, clearly explain any decisions and make allowances for the specific sensory, communication and cognitive needs of older people.

2. To promote awareness of, and support access to, SMHSOP community services:
   a. Ensure information on community SMHSOP is available from a range of health and non-health sources, including referral directories, relevant websites, SMHTAL and other service settings (e.g. adult mental health wards, geriatric medical wards, ACCHSs and multicultural services).
   b. Establish/further develop linkages with local Primary Health Networks
   c. Link to the new national centralised mental health digital gateway (see Section 4) as appropriate.

3. SMHSOP community services accept SMHTAL having a low threshold for forwarding referrals regarding older people to SMHSOP services.

4. SMHSOP community services have rigorous processes for initial assessment and/or secondary triage which focus on ensuring the person accesses the most appropriate service(s) in a timely manner (see Good Practice Features 3 and 4 in Section 2.2). This includes:
   a. Having an intake phone line answered directly by a clinician (including through diversion of phone).
   b. Having documented admission and intake procedures and ensuring all staff are aware of these procedures.
   c. Ensuring that the intake system operated or used by the SMHSOP community service prioritises referrals for SMHSOP assessment from different sources.
   d. Ensuring referral information can be communicated via phone, secure fax, email and/or mail.
   e. Making available a proforma to assist referrers in providing appropriate

information with referrals and having clear processes for its use.

f. Establishing or facilitating robust hand-over strategies for all internal referrals received from other mental health teams.

g. Provision of phone advice within working hours to support Aged Care Services Emergency Teams (ASET) / staff of Emergency Departments, and other general and mental health services, as required.

h. Involving carers and families in intake processes with consumer consent*

i. Screening for likely delirium or acute medical deterioration as part of preadmission processes.

j. Staff actively contacting and seeking involvement of GPs in preadmission processes, wherever possible

k. Staff actively contacting and seeking involvement of Aboriginal health/mental health workers in preadmission processes wherever possible and relevant.

l. Staff actively contacting and seeking involvement of bilingual counsellors and other cultural brokers in preadmission processes wherever possible and relevant.

m. Staff making initial contact with the referred consumer (usually by phone) within 1-2 business days (Monday-Friday) of accepting triage referral.

n. Staff completing assessment within agreed urgency of response timeframes as per *NSW Mental Health Triage Policy*.

o. Older consumers and carers being informed of the nature of the SMHSOP community service and what to expect if accepted for treatment.

p. Notifying referring agency when a referral is not accepted, advising of the reasons for non-acceptance and giving advice or actions to facilitate access to appropriate ongoing care.

q. Where local prioritisation results in SMHSOP not catering to a subset of older consumers, clearly documenting and communicating pathways to alternative care providers.

5. SMHSOP community services have processes that support easy re-access to SMHSOP services by consumers who have been discharged in the previous 6 months. This includes actions such as:

   a. Guidance for mental health intake services, and

   b. Agreed processes for the consumer or their carer(s) to contact the SMHSOP service directly.

*** See Key Definitions for further discussion of 'consent'.*

5.2 Assessment and care planning

The initial triage process determines if a comprehensive mental health assessment is required. Comprehensive assessment of the older person is a 'multidimensional process that considers the whole life situation of an older person'.[97] It aims to diagnose the exact

nature of the person's difficulties in order to 'plan and deliver appropriate prevention, intervention and management strategies'.[98] Assessment and care planning should be recovery-focused, person-centred and consumer-led, with the consumer, carer and GP active participants in assessment and care planning processes.

Assessment must be comprehensive and multi-dimensional, considering a range of psychological, functional, physical and social attributes of the person in the context of their environment, as well as the risks and vulnerabilities for the person's family and/or carers. [97] It should also consider what is important to the consumer (e.g. social activities, pets). A comprehensive assessment process should be undertaken by SMHSOP community clinicians, at admission and at other times where required, utilising the *NSW Health Mental Health Clinical Documentation* suite.[94] Core modules include Triage, Assessment, Care Plan, Review, and Transfer/Discharge, with additional assessment modules used as required. People at risk of suicide should receive a comprehensive mental health assessment incorporating a psychiatric evaluation, a culturally and developmentally appropriate psychosocial assessment including current stressors and a detailed assessment of suicide risk, in accordance with the requirements of NSW Health policy directive *Clinical Care of People Who May be Suicidal*.[61] The use of suicide risk measurement tools or checklists in isolation is not recommended.[61]

> The essential tasks of establishing rapport, listening, and establishing trust were highly valued by consumers, carers and clinicians - *'forms and measures don't tell the whole story'*

Nationally mandated assessment tools for older people include the Health of Nation Outcome Scale 65+ (HoNOS 65+), Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL), LSP-16 (an abbreviated version of the Life Skills Profile), and K10+-LM and K10-L3D (two versions of the Kessler-10). The 3MS and RUDAS are also supported in the NSW Mental health documentation suite. There are currently no mandated or agreed instruments for assessment behaviour beyond sub-scale 1 included in HoNOS 65+. The Montreal Cognitive Assessment (MoCA)[99] is a state-supported tool for use in ECT pre-post assessment and in drug and alcohol services. The MoCA is a brief cognitive screening tool developed to detect mild cognitive impairment as a precursor to dementia, but has also been validated with regards to frontal lobe (executive) impairment, including substance use disorders.[100] The MoCA has been validated for 55-85 year olds, and is available in different languages and has variants for people who are blind or who have limited educational skills. The MoCA is free to download and use, and quick to administer.

There are many other tools available to assist with assessment of older people. The *Dementia Outcomes Measurement Suite (DOMS)* includes a range of annotated assessment measures and tools for the commonly rated constructs within dementia such as cognition, behaviour, function and quality of life.[101] The NSW Agency for Clinical Information has developed a Cognitive Screening for Older Adults form.[102] Two key resources - *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia: A Handbook for NSW Health Clinicians*[103] and *Behaviour Management: A guide to good practice: Managing Behavioural and Psychological Symptoms of Dementia*[51] – also provide advice on assessment tools for use with people with dementia. An example of a broader tool looking at the functioning and needs of older people is the Camberwell Assessment of Need in the Elderly (CANE). A number of mental health assessments tools have been developed / adapted that are culturally appropriate and validated for use with Aboriginal consumers. See *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*[46] for further information. RUDAS is recommended for use with people from CALD backgrounds.[102] While clinicians can make use of a wide range of assessment tools, these must supplement rather than replace the mandated tools as listed above.

There are a number of tools available for evaluating recovery-oriented practice and measuring recovery outcomes with consumers. These were assessed as part of the SMHSOP Recovery-Oriented Practice Improvement Project for their suitability for use in an Australian OPMH context (report due late 2016).

The *Physical Health Care of Mental Health Consumers Guidelines*[32] and the *Physical Health Care within Mental Health Services Policy Directive*[33] (both currently under review) outline the responsibilities of mental health services in relation to providing physical health care for consumers with a mental illness. Guidance is provided regarding undertaking an initial assessment and consent. Assessment of older people should also consider drug (non-prescription and prescription) and alcohol use, falls risk[104], pain, elder abuse/domestic violence[105] and suicidal risk.[61]

In NSW, people aged over 65 are most likely to drink daily, and to have an alcohol-attributable hospitalisation or death.[106] As outlined in the *NSW Health Older People's Drug and Alcohol Report*[57] and recognising that drug and alcohol misuse is a significant co-existing issue for some people with mental health problems, SMHSOP community services should provide routine screening and assessment of consumers with regards to substance use issues, including prescription drug misuse, utilising recommended screening tools. A screen for cognitive impairment should be undertaken if there is a positive screen for substance misuse/alcohol misuse. Mental health services may also be requested to provide expertise and support to drug and alcohol services in cognitive screening and assessment.

A range of resources are available to support assessment of consumers with specific needs, including people with BPSD[103,51] and people from Aboriginal and CALD

backgrounds. Cultural and spiritual needs are to be considered, including requirements for interpreters and Aboriginal mental health/health workers, and mental health services should ensure the cultural safety of consumers through the assessment process.[50] For Aboriginal people, mental health is holistic, bound up within the social, emotional, spiritual and cultural life of people and communities. A full appreciation of this holistic view of health and mental health is absolutely vital as part of the contextual matrix within which assessment takes place.[46] The *Transcultural Assessment Checklist* was developed to support mental health clinicians to conduct culturally appropriate clinical and psychosocial assessments for consumers from CALD communities.[56] The Multicultural MH-OAT tool assists in addressing the cultural implications arising in the care of people of CALD background. Validated translated assessment tools are also available in some languages and should be accessed where appropriate. Where translated assessment tools are not available, application in the cultural context should be considered in completing the assessment.

Based on the information gathered during the assessment, clinicians should complete the HoNOS65+ and other relevant outcome measures. HoNOS65+ is designed to be used by clinicians before and after interventions, so that changes attributable to interventions can be measured. The *Care Plan* module of the *Mental Health Clinical Documentation Suite*[94] should be used to summarise the goals and clinical issues that are the targets for the episode of care.

Care plans should be recovery-focused and consider clinical and personal recovery, and be developed in partnership with the consumer and carer. Goals and plans should not be imposed on a consumer, but rather clinicians should support consumers to make decisions about their care and communicate their hopes and plans for recovery. Social needs are often key unmet needs[72] and should be considered by services as central in care planning and coordination.

The *Consumer Wellness Plan* module of the *Mental Health Clinical Documentation Suite*[94] facilitates consumer involvement in their own care, supports self-determination and serves as a recovery aid. Cultural and spiritual needs, as well as mental and physical needs can be considered in the Wellness Plan. One way to support self-determination is for the consumer's Wellness Plan to be completed before the care plan, so that the Wellness Plan can contribute to the development of the care plan. Clinicians should support consumers in completing their own Wellness Plan wherever possible.

Advance care planning should be considered where appropriate. See NSW Health *Dignity, Respect and Choice: Advance Care Planning for end of life for people with mental illness*[40] for further information.

Good practice features - Assessment and care planning

1. Assessment and care planning is recovery-focused and consumer-led. This may be demonstrated by:
   a. Conducting the initial assessment at the location of the consumer's preference, wherever possible.
   b. An expectation that elements of the wellness plans are explored with the consumer as early as feasible in contact with the consumer, and inform the care plan.
   c. Assessments being appropriately inclusive of carer(s), family and friends.
2. Assessment and care planning are inclusive of the GP with consumer consent*. This may include having a system to ensure the consumer's GP is contacted as part of the initial assessment and care planning process including the negotiation of frequency of contact.
3. The SMHSOP community service has clear governance expectations regarding the application of more general assessment guidelines to consumers of the SMHSOP community service. This may include:
   a. The expected timing of relevant assessments.
   b. The responsibilities and skills sets of staff who are conducting assessments.
4. Assessment domains that are considered include:
   a. Strengths of the consumer (including resources and protective factors)
   b. Goals of care and recovery
   c. Risk of delirium, or acute medical conditions
   d. Key risk issues including harm to self or others, pain, allergies, falls, pressure areas, polypharmacy, substance use issues, physical health issues, abuse, and advance care planning
   e. Medications
   f. Relevant past mental health history and current mental health state, including cognitive assessment and experiences of trauma, loss and grief
   g. Relevant past and current medical and family medical and mental health history
   h. ADL and IADL functioning - including providing advice/contributing to the assessment process relating to managing finances and driving, and in relation to Power of Attorney and Enduring Guardianship considerations
   i. Sensory impairment
   j. Language, cultural and spiritual and social needs
   k. Current and past social, residential and occupational situation, to inform a person-centred approach and planning for transitions of care
   l. Carer's needs.

5. There is clear reference to, and availability of, relevant professional and policy standards as outlined in this guideline.

6. Local guidance reinforces the use of mandated and state supported assessment instruments where relevant. If other instruments are recommended locally these should supplement and not replace mandated instruments, and only replace state-supported instruments after LHD-level review. Currently areas where this is relevant are:
   a. Complexity of assessment (mandated): HoNOS65+
   b. Distress (mandated): K10
   c. Functioning (mandated): LSP
   d. Cognition (state-supported): RUDAS, 3MS (and MoCA as relevant, particularly in ECT pre-post assessment and in the context of substance use issues)

   In recognition that there is no recommended tool for assessing *behaviour* beyond sub-scale 1 in HoNOS65+, services will utilise tool(s) based on best-practice and supported in the evidence base. See Section 9.

7. Initial community assessment includes a screening assessment for falls risk, and care planning includes relevant actions if a community consumer is identified as at high falls risk.

8. Mechanisms are in place for consumer-led multidisciplinary care planning that is as collaborative as possible with older consumers and carers. Such care plans must be reviewed at defined periods.

9. There is a process in place to ensure that Aboriginal consumers are provided with the option of having an Aboriginal Health / Mental Health Worker present during the assessment, and this is arranged where required.

10. SMHSOP community services appropriately adapt assessment and care planning for the needs of CALD consumers. This may include:
    a. Interpreters being accessed when required
    b. Staff access and appropriately use validated culturally sensitive assessment tools and resources with CALD consumers.

11. Care planning includes factors relevant to transitions of care such as post discharge follow-up, review and support.

** *See Key Definitions for further discussion of 'consent'.*

5.3 Clinical care and coordination

In this MoC, the term 'clinical care and coordination' is broadly taken to include the range of activities involved in providing and/or organising clinical treatment and psychosocial interventions, including helping arrange access to a range of different services across the

health and community care sectors, to meet an individual's treatment and recovery goals. This may include: building therapeutic relationships, providing and/or facilitating access to a range of biopsychosocial therapies, fostering community connections and participation, liaison with other professionals/services/agencies including referrals, coordinating various services and providers of care, case conferencing, transition/discharge planning and ensuring continuity of care. Under the recovery-oriented approach, the duration of clinical care and coordination will be negotiated with the consumer with clinician guidance. The prioritisation of the team's functions (see Section 2.4) is also relevant.

However, it is recognised that each LHD and/or SMHSOP community service will need to use their understanding of local consumer needs and the presence of other relevant services to prioritise functions and define what constitutes 'clinical care and coordination' locally.

Shared care arrangements may be progressed and are most likely to be established with GPs, private psychiatrists or Aboriginal Community Controlled Health Services (ACCHS). Each consumer may be allocated one or more key contact(s) within the SMHSOP community service to act as their care coordinator, in accordance with local processes and the *National Mental Health Core Capabilities* and discipline-specific standards, competencies or curricula.

The development of links and partnerships with specialist drug and alcohol services for referral and joint care management of consumers with significant substance misuse problems should be progressed when indicated.

The care management of suicidal older people in a community setting should be undertaken in accordance with the NSW Health policy directive *Clinical Care of People Who May Be Suicidal*.[61]

Care coordination has the potential to deliver a more person-centred response to the complex multi-level health and social needs experienced by older adults with severe and persistent mental illness[107,108] A key function of OPMH services is coordinating a range of services across the spectrum of care required by older people with mental illness.[58] In line with recovery-oriented care and practice, the exact supports arranged will be driven by the unique needs and recovery goals of the individual and will maximise the choice and control of the consumer and carer(s).

While care coordination has a consultation/liaison component, it should not be confused with specialist consultation and liaison, which is discussed following. The *SMHSOP Service Plan*[25] recognises the role of SMHSOP community services in provision of assessment, referral and training with primary care workers and GPs, residential service providers and others to address the needs of older people with mental health problems. The literature supports community mental health care for older people being undertaken within residential aged care.[58,109]

Good practice features – Clinical care and coordination

1. Each LHD and/or SMHSOP community service defines what constitutes 'clinical care and coordination' locally, based on their understanding of local consumer needs and the presence of other relevant services, and with reference to the prioritisation of functions as outlined in Section 2.4.

5.4 Recovery-oriented risk assessment and planning

The development of a recovery-oriented approach to working with consumers and the successful management of risk may appear contradictory to many. Recovery-oriented care is associated with the development of hope, facilitation of self-determination and choice, and the provision of opportunities. Risk management in health services is traditionally a clinician led activity that is focused on avoiding danger and reducing harm to the consumer and others, and often includes implementing restrictions of some form.

The *NSW Mental Health Act* both provides guidance, and highlights the tensions, in working in this area. The *Act* clearly promotes the provision of care that promotes the recovery of people with mental illness, the involvement of those persons in treatment and recovery plans, and maximising the involvement of people in consenting to such plans.[9] The Act also states '*any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances'*.[9]

However the *Act* also includes within its objects:

> *'while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others'.*[9]

The objects of the *Act* also include that 'those who care for them' be involved in decisions involving appropriate care and treatment.[9]

These objectives capture the tension that is inherent in mental health care between maximising personal autonomy and at times restricting this autonomy to promote safety of the individual or others. All clinicians must work in a way that promotes the recovery of the person they are working with but cannot ignore the responsibilities inherent in being able to utilise the *Mental Health Act* to 'provide treatment' for the protection of the person or others from harm. In addition, clinicians have a responsibility to ensure that consumers are warned of risks so as to enable consumers to make an informed decision about treatment options.

This means that all clinicians must work in a manner that identifies and advises consumers of potential risks and ensures the response to such risks is clear; but does not assume all risks must, or can, be eliminated. There is increasing exploration in the

literature regarding how to manage this tension, supporting a focus on recovery-oriented risk assessment and care planning based on shared decision making.[110,111,112,113] In this way, risks are assessed and managed in a way that is supportive of individual recovery. Within such approaches, consumers with capacity may choose to make a decision regarding their own treatment (or lack of), and this could potentially include choosing voluntarily to live within a level of risk, or, most commonly, involve decisions regarding which risks they prefer to live with. Of course, clinicians must advise consumers of the risks of treatment or not accepting treatment. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status (voluntary or involuntary, receiving treatment in hospital or in the community). The *Mental Health Act*, and this guideline, encourages the active involvement of others involved in the care of a consumer in collaborating to attain these goals.

A clinician needs to consider how best to support the consumer in their choice, which may involve implementing risk mitigation strategies, or engaging in positive risk taking.[36] *Positive risk taking* refers to a way of working that enables clinicians to support people in taking risks as a route to positive outcomes. It may be defined as:

> *'weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes'.*[114]

This approach links the risk assessment with the subsequent planning for safety, learning and personal growth, aligning closely with recovery-oriented practice. A consumer's confidence, capacity and resilience may be improved through carefully considered and appropriately supported engagement with risk. Clinicians must advise consumers of the risks and benefits of the options available to patients. An example of this in practice is shown in the following box.

Consumer story: Balancing safety and positive risk taking

Joan is a 75 year old woman who is a consumer of her local community SMHSOP service for severe depression. She is quite frail and has been assessed by her clinician as a high falls risk. When depressed, she has taken large overdoses of medication, but has not had any suicidal ideation for over two years. As part of her Wellness Plan, Joan has identified joining a local walking group as important for her personal recovery. However Joan has been told that her medication increases her risk of falls, and she would like to reduce the dose slowly. Her clinician agrees that the medication has some impact upon Joan's risk of falling, but is worried that Joan may have a deterioration in her depression with a change in medication, and discusses this with her. Joan understands the risk, but decides that she prefers to take this risk rather than the increased risk of falling, especially as she feels that joining the walking group will have such a positive impact on her recovery. Joan has been assessed as having capacity, and is therefore has a right to self-determination. The clinician and Joan together discuss what can be done to help her join the walking group and how best to monitor for any deterioration in her depression. They decide to involve her adult children in helping with this.

A collaborative, person-centred approach is fundamental to recovery-oriented risk assessment and planning.[110] Other important considerations include the following:[115,116,5,110]

- Joint or supported decision-making about the management of risk and promotion of safety, in the pursuit of the consumer's identified recovery and treatment goals.
- Recognition that the level and type of risks associated with a consumer can change over time. Each consumer requires a consistent and individualised approach that is clearly articulated within clinical reviews, management and recovery plans.
- Discussions with consumers regarding their treatment and recovery options, and the risks and benefits of the options, should be undertaken and appropriately documented. Further details can be found in *Consent to Medical Treatment – Patient Information PD 2005_406*.[117]
- Decisions are based on evidence; knowledge of the consumer, their social context and the consumer's own experience; and clinical judgement.
- Inclusion of family and carer(s) in opportunities for positive risk taking and learning.

- Assisting people to take responsibility for themselves and for ensuring their safety with appropriate supports.
- A focus on helping people to do the things they want to as safely as possible and supporting 'positive risk taking'.
- Knowledge and understanding of mental health legislation.

The use of recovery-oriented language, such as replacing the concept of 'managing risk' with 'promoting safety', can also often assist maintain a recovery oriented approach in this difficult area of practice.

Good practice features – Recovery-oriented risk assessment and planning

1. All SMHSOP community clinicians should be aware of the tension between recovery orientation and a focus upon maintaining safety, and should seek advice from a more senior clinician when unsure about the implications for care or recovery planning with an individual consumer.
2. All SMHSOP community services should have processes in place that support clinicians, consumers and carers in undertaking a 'positive risk taking' approach to risk assessment and planning, including support to comply with other relevant guidance including the NSW Health policies *Clinical care of people who may be suicidal*[61] and *Transfer of care from mental health inpatient services*[62] (see page 26).

5.5 Clinical review

Clinical review is undertaken by individual clinicians during regular consumer contacts, as well as through a formal structured process undertaken by the multidisciplinary SMHSOP community team and other clinicians involved in the care of the consumer as appropriate. National and state standards and policy[19,94] require review of a consumer's treatment, care and goals to occur at least every three months. Information for the review will be presented by the relevant clinician using the Mental Health Outcomes Assessment Tools (MH-OAT) assessment or review format.[94] The clinical review meeting may consider new admissions, discharged/transitioned consumers, any consumer with a change in presentation and those consumers requiring a '13 week' review.

Clinical reviews should clearly relate to identified clinical and personal goals, and should actively involve the consumer, carer and GP. Clinical reviews are usually informed by all available information, including clinical observations, the consumer's own assessment, carer and other informant reports. A review of physical health status should also be undertaken. Use of clinician and/or consumer outcome rated measures from the latest assessment is recommended and research has found the use of routine outcome

measures to be beneficial to multiple stakeholders including consumers, carers and clinicians.[118]

There are a range of behaviour outcome measures that are useful in the context of BPSD. The *Dementia Outcome Measurement Suite (DOMS)*[101] lists a number of recommended tools that assist in monitoring behavioural and/or psychological symptoms of dementia (also called non-cognitive symptoms, neuropsychiatric symptoms and challenging behaviours) and for evaluating the effects of interventions.

Clinicians may choose to monitor a consumer's progress towards personal goals through the use of tools designed to measure recovery outcomes. A review of safety (risk management) plans should be considered as part of the clinical review process, balanced against dignity of risk considerations.

Following Clinical Review, the care plan should be updated in collaboration with the consumer and signed by the consumer. The consumer has a right to seek a second opinion if there are concerns regarding treatment or procedures after they have been discussed with the treating team.[96]

Good practice features - Clinical review

1. The consumer is clearly involved in review processes and decisions. This may involve:
   a. Direct involvement of consumer and/or carer(s) in the review process.
   b. Explicitly considering the perspectives, concerns and wishes of the consumer as part of the review process.
   c. Monitoring and consideration of consumer-rated outcome measures.
   d. Updating with, and provision of, collaborative care plan to the consumer.
2. With consumer consent*, the consumer's carer(s) and GP are involved in review processes and decisions. This may involve:
   a. Direct involvement of the carer(s) in the review process, particularly when the consumer is preparing to exit the community SMHSOP service.
   b. Explicitly considering the perspectives, concerns and wishes of the carer(s) as part of the review process.
   c. Actively engaging the GP and inviting participation in the review process when it would assist with the consumer's care management.
   d. Provision of new and revised care plans to the carer and/or GP.
3. Clinical reviews clearly relate to identified clinical and personal recovery goals. This may include:
   a. Recognising the strengths and uniqueness of the individual consumer and supporting the recovery desired by the consumer and their carer(s).
   b. Treating each consumer with dignity and respect, supporting self-

determination and providing real choices to a consumer.

c. Monitoring and measurement of progress towards the consumer's agreed treatment goals.
d. Review and discussion of the recovery/ wellness plan.
e. Review of physical health care requirements and other needs outside the direct remit of the SMHSOP community service.
f. Discussion of the level of consumer and carer/involvement in care planning.
g. Recognising and supporting the importance of partnerships (with consumers, carers, GPs and other service providers) and communication.

4. SMHSOP community services clearly identify expected standards for monitoring progress at reviews. This may include:
   a. Outcome measures (including agreed ones for BPSD and MH-OAT).
   b. Meeting milestones in goals of care.

5. SMHSOP community services have clear internal guidelines or procedures with regards to multidisciplinary clinical review of older consumers. The following are to be considered:
   a. Incorporation of processes above into the review.
   b. Frequency of multidisciplinary team clinical review meeting.
   c. Process for ensuring that all consumers have an 'in person' clinical review no less than 3 months or more frequently when required.
   d. Current relevant standards and policies including those outlined in this guideline.
   e. The makeup of the clinical review team (including a 'senior' clinician and any other clinicians outside of the SMHSOP community service).
   f. The competencies or levels of experience required of staff to *supervise* a clinical review.
   g. Use of relevant MH-OAT documentation.
   h. The expected preparation required by clinicians prior to clinical review.
   i. Review of key admission goal achievement against milestones, or against a documented instrument.
   j. Reviews due to change in presentation or clinical incidents.
   k. Tasks for follow up are allocated.
   l. Completion of tasks set during previous reviews.
   m. Process for contacting GP (and follow up provider) to feedback review outcome at 3 monthly reviews.

6. Consumer progress is reviewed by a SMHSOP community clinician during regular contacts / visits and will consider:
   a. Mental state review
   b. Outcome measures and progress towards goals (including personal recovery goals) utilising relevant tools as required

c. Physical observations
d. Review of risk assessments (e.g. suicide, falls, delirium, violence)

7. SMHSOP community services regularly review relevant data from clinical reviews to evaluate service effectiveness and guide future development.

** See Key Definitions for further discussion of 'consent'.*

5.6 Transitions of care

Successful transition of care between services for older people is dependent upon a well-planned, coordinated process that maximises the choice and control of the consumer and carer(s) and facilitates continuity of care. Aspects of clinical and personal recovery should be considered, and linkages made with other service providers and agencies as required. This should include safety assessment and planning (balanced against dignity of risk considerations), and escalation of care by transition to inpatient settings from community settings when required.

> *'Good if you are ready for discharge, but only if it's true'*

Communication between the SMHSOP community service and the consumer, carer and consumer's GP is critical in the transition of care process, and includes the provision of written discharge summary/exit plan or letter.[19] The Transfer/Discharge Summary module of the *Mental Health Clinical Documentation Suite*[94] should be used to document the current episode of care and its outcomes.

The *NSW Mental Health Act 2007*[9] outlines the actions that mental health services must undertake when planning for transitions of care to ensure best practice. This includes consulting with the consumer and carer(s), consulting with agencies involved in providing services to the consumer, carer(s) or family members, and providing appropriate information on follow-up arrangements to the consumer and carer(s). The NSW Health policy *Transfer of care from mental health inpatient services*[62] also provides principles for ensuring the quality, safety and efficiency of transfers of care that are relevant to SMHSOP community services. This policy is currently under review and its successor should be referred to once released.

SMHSOP community clinicians can support successful discharge from inpatient units,[17] and may also initiate transfer of care of a consumer to an inpatient mental health unit or for general health care if required. SMHSOP community clinicians may also have a role in supporting consumers who are transferred from inpatient care into residential services (for instance, under the *Pathways to Community Living* initiative[71]). Processes must be in place to facilitate seamless transition of care both in and out of inpatient care.

At community transitions of care, the person usually remains in the same environment with the same people supporting them, including their GP. SMHSOP processes should empower that person to maintain this goal. Any unmet needs outside the remit of the SMHSOP community service should be considered and contact made with other service providers and partners as required to ensure that post-discharge supports are in place.

Planning for transition of care should begin at the time of admission to SMHSOP. Barriers to transition of care should be identified at the time of admission and specific planning initiated to address these. In planning a transition of care for an older person with mental illness, particular consideration should be given to the complex interaction of physical health and mental health problems, level of physical impairment, risk of elder abuse, impacts of BPSD (e.g. on the consumer's accommodation arrangements or community participation), role of any guardian, and requirements for referrals to specialist care and support services such as RACFs or ACATs.[62]

It is recognised that consumers will move in and out of SMHSOP depending on their needs at a particular point in time. For a particular consumer, the intensity of SMHSOP involvement will vary over time and easy transition out and back in as required needs to be supported and facilitated.

T-BASIS units are short-medium stay specialist inpatient facilities providing multidisciplinary assessment, care planning and intensive treatment for older people with severely and persistently challenging behaviours associated with dementia (and/or mental illness). There are currently five T-BASIS units in NSW. An important component of the T-BASIS model is the provision of outreach services to residential aged care facilities and community care providers (particularly in rural areas) to enhance the capacity of these services in the care of older people with severe behavioural disturbance and promote discharge from and reduce unnecessary admissions to the units. It should be clear if this function is performed by SMHSOP community services or the T-BASIS staff.

Good practice features - Transitions of care

1. Planning for transition of care commences from the first contact with the SMHSOP community service, and is regularly reviewed in collaboration with the consumer and carer(s). This may involve:
   a. Setting and regularly reviewing progress towards discharge goals, and estimated date of transition (discharge)
   b. Criteria for transition/discharge from the SMHSOP community service, including when it is appropriate to 'disengage' and when there should be ongoing involvement (even when clinical recovery has occurred but there are ongoing unmet needs that could be best met by SMHSOP).
2. Transition of care planning maximises the control of the consumer and carer(s),

and facilitates continuity of care. This may involve:

a. Consumers and carer(s) are consulted in the development of discharge/transition of care plans, including around the exact timing of transfer.
b. Transition of care/discharge planning includes reviewing the Wellness Plan, ensuring it includes elements of relapse prevention planning, and as actions to take if re-entry to the SMHSOP service is required. If a service utilises separate safety plans, these should also be reviewed
c. Carer(s), other health care providers and community support services participate in the process of planning for transition of care/discharge as appropriate.
d. SMHSOP community clinicians work with consumers to obtain consent that if they are admitted to hospital unexpectedly, the clinician may contact the treatment team to provide advice as appropriate on the consumer's mental health history, thereby supporting continuity of care.
e. Electronic communication (including electronic medical records) are utilised as appropriate to maximise sharing of information and coordination of ongoing care and services.
f. A system is in place to ensure that contact with the GP, private psychiatrist where relevant, and any other follow-up providers has occurred, and been documented, prior to discharge.
g. Discharge decisions and plans being informed by SMHSOP community clinicians with a good knowledge of the services available locally that can provide support for older consumers relevant to personal recovery goals. This may include: accommodation support; employment and education; leisure and recreation; family support and carer programs; self-help and peer support; helpline and counselling services, and information, advocacy and health promotion
h. A Discharge Summary is completed for all older consumers at the time of discharge and is written in a manner the consumer (or carer if most appropriate) can read and understand.
i. Discharge communication includes relevant information regarding the older consumers' mental health, medical, functional and behavioural support needs, current mental state and medications (as per *NSQHS Standard 4: Medication Safety*[20]. In addition, advice is provided on how to contact SMHSOP community service for advice or guidance if required.
j. A system is in place to ensure that the discharge summary is dispatched to the consumer's GP and private psychiatrist where relevant, as soon as possible, and no later than 1 week following transition of care.
k. Where a consumer is transferred to an inpatient mental health or general health unit, a system is in place to ensure that verbal communication occurs with, and the transfer summary is dispatched to, the primary follow-up service provider on the day of transfer.
l. There is a team review of planned, or actual, ambulatory

discharges/transitions of care.

3. The SMHSOP community service has clear expectations regarding planning for transition of care or discharge that are consistent with relevant standards and policies as outlined in this guideline.

4. The SMHSOP community service has clear internal guidelines or procedures for transition of care/discharge, including:
   a. Criteria for consumer transfer to more acute mental health or medical care, and procedures to facilitate this
   b. The roles of various members of the multidisciplinary team in regards to transition of care/discharge planning and making arrangements for transition of care/discharge
   c. A clear mechanism within the team to determine who is responsible for decisions about when a community consumer is discharged, and for ensuring that the clinician responsible for making this decision has appropriate skills and qualifications
   d. A clear mechanism for managing any conflicting views of the consumer/carer and the senior clinician regarding timing and readiness for transition of care
   e. A specific staff member (but not necessarily the one person) being responsible for coordinating each transition/discharge. This person ensures the discharge plan is fulfilled but does not necessarily make all the arrangements themselves.

5.7 Specialist consultation and liaison in the inpatient setting

Within this MoC, consultation and liaison services refer to specialist clinical mental health services provided by community SMHSOP staff to people under the care of a non-SMHSOP team **within inpatient settings**. This is a developing area for SMHSOP community services in NSW, and it is a function that may be integrated with either community or inpatient SMHSOP services. Further information regarding such services may be found in the *SMHSOP Acute Inpatient Unit Model of Care Project Report*.[34]

As reported in the *SMHSOP Service Plan*[25] there is some evidence for the effectiveness of liaison-style SMHSOP consultation-liaison services in medical wards, particularly in relation to recognition of and treatment outcomes for depression. Two RCTs have also demonstrated reduced length of stay and costs, and one of these has demonstrated fewer nursing home admissions.[119]

Indicated features – Specialist consultation and liaison

1. Functions which may be appropriate for some services include: (a) inpatient consultation liaison (see page 27).

5.8 Crisis care

The role of community SMHSOP services in crisis care will depend on local arrangements. In most LHDs, crisis care functions and dedicated staffing / teams are the remit of adult mental health services. However community crisis services or intensive community teams for the care of older people with mental illness have been found to reduce the need for hospital admission for some older people, support earlier discharge, reduce the length of stay of hospital admissions, and reduce referrals to residential care. [120,2 121]

Good practice features - Crisis care

1. SMHSOP community services have agreed process in place with partners for the appropriate provision of care to consumers during periods of crisis and after-hours. These process are discussed with the consumer and carer(s) and outlined in care plans where required.

Indicated features – Crisis care

1. Functions which may be appropriate for some services include: (b) involvement in crisis care management in conjunction with broader adult crisis mental health response (see page 27).

5.9 Promotion, prevention and early intervention

The importance of promotion and prevention in mental health is recognised in a number of key policy documents.[7,122,6,17] Mental health promotion and prevention initiatives focused on older adults are particularly significant given that mental illness is often under recognised, and is frequently misrepresented as a normal part of the ageing process.[123] Prevention of major depression in later life may be efficiently accomplished by targeting older people who experience risk factors, particularly functional limitations as a result of illness or medications prescribed, have a small social network, and/or have subthreshold (i.e. subsyndromal) symptoms (see definitions). [124,125]

The *SMHSOP Service Plan*[25] indicates that prevention and early intervention strategies should be part of the SMHSOP community service's activity, including promotion of self-care and peer support approaches (see Section 7.4 peer workers), capacity building with families, carers and communities to recognise early warning signs and to support older people with mental health problems, and education and training with relevant services to promote early and effective response to mental health problems in older people. These would generally be progressed through a primary health care model, in partnership with primary health and aged care services, community support services and GPs. The extent of specific prevention and early intervention activities conducted by SMHSOP community

services will be influenced by resource levels, the work of other organisations in this space, and recent national and NSW policy directions and initiatives regarding mental health promotion, prevention and early intervention,[14] and suicide prevention. [126,127,128,129,130,131] However, a focus on early intervention and relapse prevention is integral to SMHSOP clinical practice, and this should be done in a culturally relevant and safe way.

Indicated features – Promotion, prevention and early intervention

1. Functions which may be appropriate for some services include: (d) specific promotion, prevention and early intervention activities and programs, including working in partnership with other service providers (see page 27).

6 TECHNIQUES AND THERAPIES

In line with the principles of recovery-oriented practice, an individualised plan should be tailored to the consumer's preferences. This will be driven by evidence based practice, and the clinician's clinical reasoning alongside the consumer's unique values, goals, needs and types of support identified, and will be developed with the consumer and carer(s).

A variety of techniques and therapies are available to address the recovery and treatment goals of the consumer and carer(s). SMHSOP community services have a primary responsibility for facilitating clinical recovery, while supporting consumers in other aspects of their recovery goals, (e.g.by referrals to and partnerships with appropriate health and community care services and psychosocial supports). Optimal 'clinical' interventions involve a biopsychosocial approach and this will often involve the SMHSOP community service supporting the consumer to manage their self-care, improve social and relationship skills and achieve a broader quality of life (including in the areas of physical health, social connectedness, housing, education and employment). See consumer story following. Clinicians will utilise a variety of tools in undertaking therapies and to facilitate consumer and /or carer self-management, recovery, resilience and empowerment.

Consumer story: SMHSOP influence on clinical and personal recovery

Steve is a 79 year old man who became involved with SMHSOP services after an attempt to end his life. Whilst medication and cognitive behavioural therapy were important in resolving symptoms of Panic Disorder, re-engagement in volunteer activities was essential for Steve to regain a sense of purpose in his life. His SMHSOP clinician both responded to Steve's concerns about having lost his role in life and helped Steve plan steps to address this, but his family provided the main practical supports in achieving his goal.

Therapies may facilitate clinical and/or personal recovery and may be provided directly by SMHSOP or by SMHSOP partnering with, or linking to, other service providers. Local factors determine who should have primary responsibility for providing a particular therapy on a particular occasion. Many therapies, techniques and tools are supported by a good evidence base (particularly clinical therapies), while others (particularly in personal recovery domains) are new or evolving approaches for which there is limited research conducted to date, but which may still provide good outcomes for individuals. SMHSOP community clinicians should support consumers to maximise their autonomy in directing care and accept the consumer's right to engage in therapies or supports without an evidence base, balanced by respectful discussions about limitations in evidence or any potential for harm associated with the consumer's decisions.

Many techniques and therapies used are more traditional in approach (clinician-led) and clinicians need to be mindful of this in practice and make adaptations as required to ensure recovery-oriented practice. Processes such as fostering self-determination and personal responsibility, promoting shared decision-making and working in partnership with the consumer, carer(s) and GP, supporting the development of consumer motivation, self-management and self-empowerment, providing dignity and respect including gaining appropriate consent, managing and sharing risk, ensuring adequate time for consultations and utilising good communication, should be incorporated routinely into practice.

> The focus within the consultations, as emphasised by consumers and carers, was very much on '*what I can do to improve and maintain my mental health'* and what clinicians can do to facilitate and support this process.

There are many ways that mental health clinicians can support the empowerment of consumers. These may include: supporting consumers to choose from a range of options and to participate in all decisions; fostering exposure to people in recovery who can model empowerment and demonstrate experience in self-management; and supporting access to self-management resources including support groups. [132,133] Consultation participants strongly emphasised the need to address social factors, especially isolation and loneliness.

Most therapies that are effective in younger people remain effective in later age, including medications and a range of psychotherapeutic approaches, even in the presence of cognitive impairment.[58] However specialised knowledge or skills may be required to adapt them appropriately to an older person or someone with cognitive impairment. Psychotherapy can be adapted to meet consumer needs. This may include increased number of sessions, slower presentation of material, increased use of behavioural activation and other similar techniques, use of memory aids and environmental cues, and

including a role for the carer in therapy.[58] Psychotropic medication use in the older person may cause diverse outcomes including changes in sensitivity, benefits, and a variety of side effects.[58]

It is considered beyond the scope of this guideline to develop specific guidance regarding the management of particular conditions. However, the project expert reference group and other experts consulted agreed that sufficient guidance should be provided to support LHDs and community SMHSOP services to develop the necessary clinical governance and organisational supports for their clinicians to use appropriate therapies, tools and techniques. Consultation participants expressed concern that some clinicians were unable to provide a range of biopsychosocial therapies, which placed too much focus on pharmacotherapy. Where consumers live in areas with small teams, or individual clinicians supported by general mental health services, there may be limited options for therapy, and sometimes a more biological oriented approach from SMHSOP services, although sometimes complemented by other supports from other services. Decisions regarding the range of therapies offered are highly dependent upon clinical preferences, skills and/or availability of staff within a SMHSOP service. There is limited guidance available to SMHSOP community services regarding adaptation of therapies for age, or non-biological therapies.

SMHSOP community services should have some capacity to provide clinical care for consumers with substance use issues, as outlined in the *NSW Health Older People's Drug and Alcohol Report*.[57] This may involve provision of brief interventions and education where appropriate and/or close collaboration and joint working with specialised drug and alcohol services.

Where consumers require access to highly specialised biological treatments such as clozapine, outpatient and maintenance ECT, or some depot antipsychotic medications, this usually requires involvement of mental health services primarily focussed upon the needs of non-older adults.

While there are currently no national clinical standards on the clinical care of older people with mental illness, there are a number of resources available to guide SMHSOP clinicians. Examples of these are included in the table below. International resources need to be considered and applied (if used) within the Australian context, especially in line with application to the Aboriginal population and CALD communities. The *MyLink Mental Health of Older People website* of the Hunter New England Local Health District shares information and knowledge about OPMH, and is a good information source for staff within SMHSOP as well as health staff in other areas caring for older people.

Table 1: Example resources to guide SMHSOP clinicians

Scope	Australian Guidance	International Guidance
Adaptation for Age		American Psychological Association: *Psychotherapy and Older Adults Resource Guide*
Depression	RANZCP: *Clinical practice guideline: Mood disorder* RANZCP: *Position statement: Use of antidepressants to treat depression in dementia* Beyond Blue: *What works to promote emotional wellbeing in older people*	NICE: *Depression in adults: recognition and management* NICE: *Depression in adults with a chronic physical health problem: recognition and management*
Anxiety	RANZCP: *Clinical practice guideline: Panic disorder and agoraphobia* Beyond Blue: *What works to promote emotional wellbeing in older people*	NICE: *Generalised anxiety disorder and panic disorder in adults: management* NICE: *Post traumatic stress disorder: management*
Schizophrenia	RANZCP: *Clinical practice guideline: Schizophrenia and related disorders*	NICE: *Psychosis and schizophrenia in adults: prevention and management*
Bipolar	RANZCP: *Clinical practice guideline: Mood disorder*	NICE: *Bipolar disorder: assessment and management*
BPSD and dementia	NSW Health and RANZCP: *Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD): A handbook for NSW Health clinicians* NHMRC Partnership Centre for Dealing with Cognitive and Related Functional Decline in Older People: *Clinical Practice Guidelines and Principles of Care for People with Dementia* Alzheimer's Australia/DBMAS: *Reducing behaviours of concern* DCRC-ABC: *Behaviour Management: A Guide to good practice: Managing BPSD*	IPA: *The Complete Guides to Behavioural and Psychological Symptoms of Dementia (BPSD) – 3 volumes* NICE: *Dementia pathway*
Suicide	NSW Health: *Clinical care of people who may be suicidal*	NICE: *Self harm in over 8s: short-term management and prevention of*

Scope	Australian Guidance	International Guidance
	RANZCP: *Clinical practice guidelines for the management of adult deliberate self-harm*	*recurrence* NICE: *Self harm in over 8s: long-term management*
Occupational therapy	Osborne Park Hospital, WA: *Dementia: Osborne Hospital Guide for Occupational Therapists in Clinical Practice*	NICE: *Mental wellbeing in over 65s: occupational therapy and physical activity interventions*
Mental wellbeing in RACFs	Beyond Blue: *What works to promote emotional wellbeing in older people*: *A guide for aged care staff working in community or residential aged care settings*	NICE: *Mental wellbeing in older people in care homes*
Promoting mental wellbeing	Hunter Institute of Mental Health: *Prevention First: A prevention and promotion framework for mental health* NSW Health: *Wellbeing in Later Life: Your Guide to Programs and Activities*	NICE: *Older people: independence and mental wellbeing* University of Toronto/Toronto Public Health, Canada: *Best practice guidelines for mental health promotion programs: Older adults 55+*
Social interventions		NICE: *Social care for older people with multiple long-term conditions pathway* Mental Health Foundation UK: *An Evidence Review of the Impact of Participatory Arts on Older People*
Optimising consumer experience of service		NICE: *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*
Drug and Alcohol		NICE: *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*

Note: Every effort has been made to ensure the accuracy and reliability of the information in the table above at the time of publication. Links to internet sites and resources are identified; however these represent only a selection of those available. Links to internet sites are provided for information purposes only. Due to the changing nature of internet content, it is the responsibility of users to make their own investigations, decisions and enquiries about any information retrieved from internet sites.

Good practice features - Techniques and therapies

1. SMHSOP community services embed actions to facilitate clinical recovery within approaches that promote personal recovery by:
   a. Actively working with consumers to facilitate access to a range of biopsychosocial therapies that are evidence-based in regards to clinical recovery, and
   b. Assisting the consumer to access a range of services and supports identified as supportive of the individual's personal recovery.
2. SMHSOP community services will ensure carers have access to a range of information, therapies and services that support their biopsychosocial needs and the consumer's recovery, either through direct service provision where appropriate or through facilitating access to other services.
3. A range of mechanisms are in place to support staff in fulfilling (1) and (2) above, which may include:
   a. Approval of the range of biopsychosocial therapies that may be provided by staff (including any therapies that are precluded).
   b. Identifying how staff will work with the consumer, carer and other providers when therapies not provided by staff are needed/wanted.
   c. Supporting access to, and guidance about, the evidence base and other tools and reference material.
   d. Provision of self-help tools to consumers and carer(s).
4. SMHSOP community services provide easily accessible information to inform the local community, including GPs, about the range of therapies they offer.
5. SMHSOP community services promote relationships and arrangements with mental health services providing highly specialised services (e.g. clozapine dosing, outpatient and maintenance ECT and depot antipsychotic medications) to ensure age is not a barrier to access and appropriate care.

7 STAFFING

7.1 Staffing mix of SMHSOP community services

Leadership and governance

During consultations, there was strong support and expressed need for specialist SMHSOP leadership both clinically and organisationally.

SMHSOP community services should be supported by clear operational and clinical leadership

and governance arrangements. Clinicians consulted for this project considered that the SMHSOP role continues to require development, and this would be supported by specialist leadership as well as specialist clinical supervision. Research highlights the importance of leadership in recovery-oriented service delivery at both the service management and individual practitioner level.

Leadership and governance of mental health services is driven by a number of key national policies including the *National Standards for Mental Health Services 2010*,[19] the *National practice standards for the mental health workforce*[50] and the *Fourth National Mental Health Plan*[7] (noting that the development of the *Fifth National Mental Health Plan* recently commenced). The specialty associations, and other specific OPMH sub-groups, play a key leadership role with their members and in the specialty area of old age mental health. At the state level, governance and leadership of mental health services are provided by the Mental Health Branch of the NSW Ministry of Health. A number of statewide committees also provide strategic guidance across SMHSOP and OPMH more broadly, including the SMHSOP Advisory Group, OPMH Working Group, Aboriginal OPMH Working Group and CALD OPMH Working Group. Workforce development and support is a key focus of a number of state policy documents, both mental health specific and broader documents, including *Living Well: A Strategic Plan for Mental Health Services in NSW 2014-2024*,[6] *Health Professionals Workforce Plan 2012-2022*,[134] *Aboriginal Workforce Strategic Framework 2011-2015*[135] and the *NSW State Health Plan: Towards 2021*.[122] The development of a *NSW Mental Health Workforce Plan* is due for completion by June 2016.

SMHSOP are a clinical service of LHD Mental Health Services and are therefore operationally responsible to the LHD Mental Health Service and supported by local clinical and corporate governance arrangements. The clinical and corporate governance arrangements of SMHSOP vary between the LHDs, with most having a SMHSOP Clinical Director (usually a psychiatrist) providing clinical leadership and/or a Clinical Coordinator providing strategic leadership. In some LHDs, some or all of the functions of the Clinical Coordinator are undertaken as part of other strategic leadership roles.

Multidisciplinary staffing

A multidisciplinary staffing profile and approach was identified in the literature review, expert opinion and consultation for this project as most appropriate, in order for community SMHOP services to be able to address consumers' unique values, goals and needs and enable a range of therapies to be offered.

The literature suggests that community mental health teams for older people should comprise of mental health nurses, consultant psychiatrists, social workers, occupational therapists, psychologists and support workers and have direct access to other specialties such as physiotherapy and dietetics[29] (see Section 7.4 for discussion of peer workers). Community OPMH services should be multidisciplinary in nature,[26,29] in order for consumers to access appropriate multidisciplinary assessment and ongoing care.

Multidisciplinary care is when professionals from a range of disciplines work together to delivery comprehensive care that addresses as many of the consumer's needs as possible.[136]

> *During the consultations, the need for older people to receive care from mental health professionals with specialist skills working with older people, including those with BPSD, was frequently stated.*

Interdisciplinary team approaches are characterised by a high degree of collaboration and communication among health professionals and the establishment of comprehensive treatment plan to address the biological, psychological and social needs of a consumer.[137] The membership of the interdisciplinary health care team will depend on the needs of the consumer. National and state policies and standards require mental health services to have formal processes in place to support and sustain interdisciplinary care.[134,19,50] Core competencies for inter-professional collaborative practice include competencies relating to values/ethics for inter-professional practice, communication, team functioning and role clarification, and inter-professional conflict resolution and reflection.[138,139]

Professional diversity within teams must be respected and valued.[8] Staff from different disciplines offer unique perspectives and specialised skills, and in larger teams a range of disciplines is desirable. In all teams, large and small, each team member should have an area of professional expertise that is recognised and utilised. However, particularly in small or rural teams, innovative inter-professional practice will be required. Such practice respects discipline strengths whilst supporting staff development to meet identified consumer needs across some traditional discipline roles (e.g. structured brief psychotherapy by any discipline). Active use of skills and services in partner organisations can increase the access of consumers to appropriate services and therapies, especially in social domains.

Staff working in SMHSOP community services will have core skills as outlined in the *National Mental Health Core Capabilities*, and discipline-specific skills, as per the discipline-specific standards, competencies or curricula. There is an area of overlap between core and discipline-specific skills.

The number and range of staff and their skill levels vary across SMHSOP community services. The skill mix in a team may be a result of the types of clinicians available. Some services, particularly in rural locations, have very small teams. The majority of staff

working in SMHSOP community services have a nursing background, followed by allied health (social worker, psychologist, occupational therapist), and medical. There is no agreed definition of what is a reasonable caseload in SMHSOP community service.

Staff may work across inpatient and community SMHSOP and it is recognised that such horizontal integration may support transitions in care and maximise continuity.

Good practice features - Staffing mix of SMHSOP community services

1. Staff have the skills to work with older people with mental illness and a desire to further develop the specialist skills in OPMH.
2. Recruitment and staffing mix of teams are focussed upon enabling teams to have the range of skills required to meet the needs of local consumers. Teams should support innovative inter-professional practice and utilisation of partnerships to meet these needs.
3. Staffing supports the provision of biopsychosocial therapies, either through direct provision or in partnership, which meet the needs of older people with mental illness and their carers.
4. All SMHSOP community services have a core staffing of dedicated medical and nursing staff with specialist skills in both mental health and care of older people.
5. SMHSOP community services access skills from other disciplines (including allied health) to provide a broader range of therapies, and
   a. Staff from these other disciplines have specialist OPMH skills.
   b. LHDs with smaller teams aim to have staff available/accessible within the LHD, including via telehealth.
6. All community SMHSOP services access interpreters and Aboriginal liaison/health workers, and access cultural consultants where required.
7. Mechanisms are in place to support and sustain the multidisciplinary team and ensure the provision of interdisciplinary, high quality and appropriate care. Consideration should be given to the following:
   a. A dedicated team leader.
   b. Established and dedicated clinical leader(s).
   c. Flexible staffing arrangements as per relevant policy directives and Awards, including out-of-hours service delivery/access.
   d. A team culture that supports interdisciplinary team functioning.
   e. Caseloads.
   f. Access to administrative support, data managers, and quality and WHS staff as required.
   g. Access to telecommunication equipment, transport, office space and IT

equipment.

LHDs with smaller teams should consider arrangements across the LHD as appropriate.

8. SMHSOP community services should develop and implement succession planning strategies, especially for senior positions. This may include arrangements across the LHD.
9. Staffing structures are in place to facilitate staff and career development within SMHSOP, including arrangements across the LHD. Consideration should be given to the following:
   a. Specialist promotional positions within different disciplines.
   b. Dedicated student positions and/or new grad positions.
10. There are established operational and clinical leadership and governance processes in place that support the integration of SMHSOP service elements (inpatient, community and residential) and quality improvement. Consideration should be given to the following:
    a. Clear, well communicated arrangements for SMHSOP clinical leadership and strategic leadership, and the line management of SMHSOP staff
    b. A local leadership group (either community SMHSOP specific or including community SMHSOP representation) which provides both clinical and strategic leadership for SMHSOP across the LHD
    c. Training in clinical leadership for senior staff members
    d. Support for clinicians to promote and undertake practice/service improvement
    e. Representing the interests of SMHSOP community services, staff and consumers at LHD and/or state level where required.

7.2 Clinical supervision

The *NSW Health Clinical Supervision Framework*[140] provides guidance to community SMHSOP services in undertaking clinical supervision, and defines what clinical supervision is in practice. Clinical supervision should focus on issues relating to, or impacting on clinical practice and the delivery of care,[141] with the clinician supported to critically reflect on professional practice and take responsibility for their clinical practice.[142]

Clinical supervision should be a clinician-led activity, with the clinician choosing their own supervisor.[141] However, this does not always occur, with the type of supervision, how it is provided, and whether it is SMHSOP specific varying across SMHSOP community services. Some services have a SMHSOP-specific Clinical Nurse Educator who offers specialist SMHSOP supervision to SMHSOP community nurses. Other clinicians, particularly allied health workers, may be supervised by their relevant discipline senior who often has no experience in working in SMHSOP. Clinical supervision around

SMHSOP-specific issues may be provided from different disciplines. Some staff access supervision external to the LHD. All supervisors should be fully conversant with recovery principles and philosophy of practice.

For some disciplines, clinical supervision is a requirement of professional association membership/registration and is embedded in professional standards.[143,144,145,146] The *National Practice Standards for the Mental Health Workforce*[50] can guide clinical supervision and assist individual practitioners to identify their own level of knowledge and skill to practice mental health care, and these are a useful tool in supervising practice.

In some locations, particularly in rural areas, accessing clinical supervision can be challenging, with some teams utilising videoconferencing although this is rare.

Good practice features - Clinical supervision

1. SMHSOP community services support the local implementation of the *NSW Health Clinical Supervision Framework*.
2. The focus of clinical supervision is on clinical practice in the context of OPMH, with reference to the core skills required as outlined in the *National Mental Health Core Capabilities,* and on the specific skills required for working with older people with mental illness.
3. Cross-discipline supervision is considered, and supported, to ensure appropriate access to supervisors with skills and experience in OPMH, including supervision from external to the LHD where required. Where this occurs, establishing formal linkages between this process and appraisal processes are encouraged.
4. For those SMHSOP community staff who receive clinical supervision from a discipline-specific supervisor without specific OPMH experience/skills, staff are encouraged to network with other OPMH clinicians in their discipline as part of 'communities of practice'.
5. Capacity building within SMHSOP is supported, with supervisors and supervisees supported to access training on providing/receiving clinical supervision.

7.3 Workforce development

The *National Mental Health Core Capabilities*,[64] together with the *National Practice Standards for the Mental Health Workforce*,[50] the *National Standards for Mental Health Services*[19] and discipline-specific standards and competencies provide guidance to mental health clinicians on knowledge and skill development. The *Core Capabilities* document[64] identifies and describes expected workforce behaviours across the range of mental health workforce roles and services and has a specific focus on the essential values, attitudes and behavioural skills required of all people working in mental health.

The *SMHSOP Core Competencies and Measurement Criteria for Beginning Clinicians*[63] was developed in 2011 to guide professional development, clinical supervision and performance review for beginning SMHSOP community clinicians in particular. An evaluation of the *SMHSOP Core Competencies* found them to be a positive workforce development strategy, assisting with processes such as recruitment and orientation, performance development and educational initiatives, and that they had been implemented widely within SMHSOP services.[121]

The *Intellectual Disability Mental Health Core Competencies Framework: A Manual for Mental Health Professionals* describes the specific skills and attributes required by mental health professionals when working with people with an intellectual disability, identifies the Core Competencies required by workers and provides examples of resources that support professional development in intellectual disability mental health.[147]

While recognising that workforce development is an individual practitioner's responsibility, the extent to which staff of SMHSOP community services are supported to access work-related training and skill development within work time is variable, affected by factors such as staffing levels, backfill, funding and availability of appropriate training, although online education is a mitigating factor to some extent. SMHSOP community clinicians also access on-the-job upskilling and 'in-service' training sessions and participation in clinical reviews can be a good learning opportunity for staff.

All staff working in NSW Health services are required to undertake mandatory training across a range of areas, including cultural competency. Cultural competency is a key strategy for reducing inequalities in healthcare access and improving the quality and effectiveness of care for Aboriginal people[148] and CALD people. The *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* provides clinicians with practical and achievable strategies to increase the cultural responsiveness of their practice.[149] The *National Cultural Competency Standards for the Australian mental health sector* were introduced in 2010[150] and informed a revision of the *SMHSOP Core Competencies* in 2011.

Within state-wide SMHSOP benchmarking processes and workforce surveys, SMHSOP community managers and clinicians have identified a number of priority areas for education and training that are aligned with SMHSOP core competencies and current practice priorities, including: delivering person-centred, recovery-oriented care; working with Aboriginal families and consumers; working with CALD/diverse needs consumers and carers (cultural background, ethnicity, religion, LGBTI status), including accessing interpreters and providing culturally appropriate care; understanding patient legal rights, guardianship and financial management orders, and legal documentation; understanding the *Mental Health Act* in practice; providing end-of-life care; managing risk and polypharmacy; and patient file documentation.[151] Another potential area for staff development is delivering trauma-informed care and practice.

Good practice features - Workforce development

1. Staff are enabled to access workforce development opportunities that support life-long learning in accordance with relevant NSW Health policies and further develop the specialised skills, competencies and knowledge required to work in the SMHSOP setting.

7.4 Peer workers

Consumers regarded the opportunity to receive support from others who have a lived experience as very valuable.

Peer workers have a lived experience of mental illness (as a consumer or carer), personal knowledge of the mental health service (as a consumer or carer) and a consumer/carer perspective. Job titles and related tasks vary, but responsibilities may involve peer support, individual and/or systemic advocacy, coordination and management of programs/activities relevant to their role, health promotion, education and training, and involvement in quality improvement processes/projects and research. Some peer workers facilitate peer support groups.

Research supports the contribution of peer workers generally, but there are only a few studies[152,10] that support the effectiveness and role in an OPMH context. The available (non-OPMH specific) evidence suggests that the employment of peer workers may provide benefits to consumers including hope and role modelling for recovery, [153,6] a minimisation of the power differential in the professional-consumer relationship,[154] and effective peer support[153] and advocacy.[155] There is also reported benefit to the service[153,6] and the peer worker.[154] Grey and O'Hagan (2015) reviewed 33 peer-reviewed papers and associated literature and found consumer-run services are effective in supporting recovery.[156] It must be recognised, however, that not every consumer will want access to a peer worker and consumers' choices must be supported.

Support for peer worker development is outlined in a number of key national and state policy directives, reports and standards,[7,19,22,6] where peer workers are recognised as a key component of recovery-oriented mental health services. Both the Commonwealth and NSW health departments have a current focus on growing and supporting the consumer workforce and have implemented specific initiatives to this end.[14,157,158]

In NSW, the majority of peer workers are employed within adult mental health services. Although they may provide limited support to SMHSOP consumers, they often have no specific skills, knowledge or personal experience of ageing or SMHSOP.

There are a number of barriers and challenges relating to the peer workforce that are consistently highlighted in projects,[159,158] the literature[160,161,156] and by consumer groups. These include: poorly defined jobs and unclear roles and responsibilities; variability of roles between mental health services; inconsistent (and often insufficient) support and supervision structures; inconsistency in salary and conditions; negative attitudes from non-peer workers; managing sometimes conflicting interests of the consumers and the service in which they are employed; career paths and limited access to education and training. Progress has been made to address training requirements and the national *Certificate IV in Mental Health Peer Work*[162] was endorsed in 2012. There are also a number of LHD-based recovery colleges that offer education and training programs to support peer workers. In Australia, peer workers mostly operate within existing mental health services, often working as team members alongside mental health workers. 'Integrated' peer work can bring about tensions and conflicts such as role strain and role confusion, where peer work may sometimes be indistinguishable from other aspects of the workforce, and where there is a higher potential for co-option.[163] However, having peer workers work as part of the team has many benefits including facilitating closer collaborative relationships between peer and non-peer workers[163] and may also enhance the recovery-orientation of services.

The gap in SMHSOP-focused peer workers has been recognised, and a number of SMHSOP community services are currently exploring the development of a peer workforce in SMHSOP to provide peer support and consumer advocacy and support recovery-oriented practice. SMHSOP consumers have advised that peer workers working with older people should be mature in age, as it is felt that peer workers working with older people should also have personal experience of ageing not just a personal experience of mental illness. This theory was supported in a small US study by Chapin et al (2013)[152] and is being tested in a pilot mental health peer work model for older people currently underway in a community SMHSOP service in NSW.

There is a complex, and to date poorly explored, interface between the concepts of volunteers, who provide valuable services throughout NSW mental health services, and peer workers. Volunteers in mental health services may or may not have past experience or exposure to mental health services and may undertake similar tasks to peer workers, may work 'behind the scenes' or alongside health professionals and other healthcare staff, and may be involved in fundraising efforts.

Good practice features - Peer workers

1. SMHSOP community services should seek to increase the involvement of peer workers within SMHSOP community services, building on the evidence that comes from adult services, and seeking to build on the evidence base regarding peer work with older people.

2. The important role played by volunteers working with SMHSOP services is recognised and promoted.
3. In those SMHSOP community services that employ peer workers, peer workers can function as integral team members and engage in all team activities relevant to their roles.

8 PERFORMANCE

Quality is driven by local systems and the individuals within them, supported by state and national systems to maximise consistency in performance and standards, and reduce duplication of effort in developing systems.

Standards

The *National Standards for Mental Health Services (2010) (NSMHS)*[19] and the *National Safety and Quality Health Service (NSQHS) Standards*[20] provide health services with a framework for the implementation of systems to deliver safe care and continuously improve the quality of the services they provide. Implementation of both sets of standards is seen as important in meeting the safety and quality requirements for people with lived experience of mental health issues accessing the mental health sector, with neither set of standards able to stand alone.[164]

Indicators of performance and benchmarking

SMHSOP community services are required to comply with mandated data collections including the Key Performance Indicators (KPIs) outlined in the *National Mental Health Performance Framework*[165] and the KPIs included in the Service Performance Agreements[166] between the NSW Ministry of Health and LHDs. Relevant KPIs include Acute Readmission within 28 days, Acute Post Discharge Community Care (7 day follow-up post inpatient discharge), HoNOS Completion Rates, and Consumer Experience Measure (YES) Completion Rate. The YES Measure is a nationally developed questionnaire based on the recovery standards of the National Mental Health Service Standards.[167] The *NSW Health Performance Framework*[168] includes the performance expected of NSW Health services and organisations to achieve the required levels of health improvement, service delivery and financial performance.

The SMHSOP benchmarking model continues to be an effective model for promoting quality and practice improvement in SMHSOP community services across NSW. See Section 5. Benchmarking allows SMHSOP community services to learn from each other and improve understanding of current service delivery, determine best practice and improve care. Benchmarking in NSW has led to significant and sustained improvements in SMHSOP community services.

Data collection

NSW public community mental health services data collection comprises a number of types:

- Client clinical outcomes reporting through standard outcome measures (MH-OAT data collection) – for which the required tools for older people include the HoNOS 65+, RUG-ADL, LSP-16 and K10+-LM/K10-L3D. See Section 5.2.
- Activity reporting through the Mental Health Ambulatory (MH-AMB) collection.
- Mental Health Service Entity Register (MHSER) and Mental Health Establishment data (NMDS)
- Financial reporting and monitoring.

The NSW Health data collection and reporting systems link to relevant national collections such as the National Outcomes and Casemix Collection[169] and the National Mental Health Minimum Data Sets.[170]

Systems for monitoring and improving performance

At the national level, the *Australian Commission on Safety and Quality in Health Care* and the *Australian Institute of Health and Welfare* have a whole-of-health system focus, providing direction for the mental health sector. There is also activity occurring in relation to mental health reform, particularly under the direction of the *National Mental Health Commission* and the *Roadmap for National Mental Health Reform 2012-2022*[21], with the Fifth National Mental Health Plan currently under development. In NSW, the NSW Health pillar organisations - *Clinical Excellence Commission*, the *Agency for Clinical Innovation* and the *Bureau of Health Information* – support clinicians and managers to improve performance and provide safe and effective healthcare. The NSW Ministry of Heath also leads a number of quality and safety initiatives including the *Whole of Health Mental Health Project*. NSW Health policy provides direction to health services on employee performance management and annual performance appraisals. [171]

Research

All health services in NSW are guided by the strategies outlined in the *Health and Medical Research Strategic Plan for NSW*.[172]

Good practice features - Performance

1. Relevant routine activity, outcome and performance data and other relevant Key Performance Indicator data are made available to staff of SMHSOP community services.
2. At the SMHSOP community service level, data is examined and used to monitor performance, evaluate the care being provided, and identify opportunities for clinical practice improvement, and to improve the outcomes and experiences of

consumers and families.

3. There is a continued emphasis on quality improvement through benchmarking, with SMHSOP community services supported to participate in benchmarking processes and encouraged to use benchmarking findings to guide local service improvement.

4. Implementation of this SMHSOP community MoC will be particularly supported by a focus on the following areas, which align with the key directions of the MoC with SMHSOP community services monitoring their performance in these areas, investigating marked differences from historical or expected performance or the performance of benchmarked services, and promoting quality improvement as required.
   a. Recovery-oriented services/practice
      i. SMHSOP community services monitor if the care and services provided are recovery-oriented, with clinicians working in partnership with consumers and carers. Monitoring may be through:
         - Routine measures (e.g. K10 and YES completion rates), and
         - Additional measurement (e.g. consumer and service measures as per SMHSOP Recovery Project recommended evaluation tools)
      ii. SMHSOP community services undertake specific quality improvement activities to improve recovery orientation.
   b. Access
      i. SMHSOP community services monitor the understanding of SMHSOP amongst key referral partners and service accessibility. Monitoring should include:
         - 'Source of admission' (referral source) to ensure key referral partners are appropriately represented, and investigation if markedly different from historical or expected performance or the performance of benchmarked services.
         - Timeliness of response against the following timeframes:
            - initial contact with referred consumer (usually by phone) within 24 business hours of accepting triage referral
            - completion of assessment within agreed urgency of response timeframes as per *NSW Mental Health Triage Policy*
         - Proportion of consumers who are Aboriginal and reasons investigated for marked variation from catchment demographics, historical performance or the performance of benchmarked services
         - Proportion of consumers with CALD background and reasons investigated for marked variation from catchment demographics, historical performance or the performance of benchmarked services
   c. Care coordination with GPs, in recognition that improved collaboration and engagement with GPs is a key direction of this MoC (but not diminishing the importance of partnerships with other health and community care services):

i. There are clear processes in place to actively seek the involvement of the consumer's GP during key phases of the care process
ii. SMHSOP community services monitor GP involvement in assessment, care planning, clinical review and transition of care processes
iii. Timeliness of the provision of discharge summary to GP is monitored as per the following timeframe:
    - Discharge summary provided to GP within 1 week following transition of care

These principles should also be considered in working with private psychiatrists.

d. Capabilities
    i. SMHSOP community services monitor the service's ability to provide a mental health service for older people based on appropriate skills and knowledge of its staff, and adherence to relevant national standards and frameworks including the *National Mental Health Core Capabilities*
    ii. Staff communication and engagement with consumers and carers is monitored through:
        - Consumer and carer feedback (including completion of the YES survey)
        - Performance review processes
e. Responsiveness
    i. SMHSOP community services monitor consumer outcomes participation and feedback (including consumer feedback about communication) through completion of the Your Experience of Service (YES) survey, and act upon survey findings as required
    ii. SMHSOP community services monitor K10 or other consumer completed measurement data and investigated if markedly different from historical or expected performance, or the performance of benchmarked services

9 SUMMARY AND NEXT STEPS

This guideline articulates a good practice model of care for SMHSOP community services. It is evidence-based, framed by the key themes identified through consumer, carer, clinician and stakeholder consultations, and responds to the changing mental health landscape (including the reforms of the mental health and aged care systems and the establishment of PHNs). The guideline contains key supporting information and presents 'good practice features' of the MoC to support the further development of SMHSOP community care in seven key areas. Some priorities of the MoC are highlighted below.

Philosophy of care, target population and functions

Under the SMHSOP community MoC, SMHSOP community services should adopt a recovery-oriented, person-centred, biopsychosocial philosophy of care. This is perhaps

the most significant component of the MoC and underpins other good practice features of the MoC. This key direction in philosophy has implications for many aspects of practice and service delivery, and will require significant commitment and effort to implement. The guideline suggests ways that SMHSOP community services may embed this philosophy of care into organisational processes, including staff orientation, training and policies.

Promoting timely access to care and support, and thereby translating the principles of the 'no wrong door' approach into practice, is another key theme of this MoC. To support this, each SMHSOP community service will need to review their current processes, and make changes as necessary, so that they are able to accept any person referred to community SMHSOP for secondary triage and/or initial assessment following triage. Older people with mental health problems (including those with and without dementia) will have access to SMHSOP community services. SMHSOP services will need to recognise that age is not a unique exclusion or inclusion criterion for accessing SMHSOP services, and they will need to apply some flexibility in providing assessment and care to consumers who are under 65 years with age-related problems causing significant functional disability. Families and carers of older people with mental illness are also part of the broader target group for SMHSOP.

Partnerships

Effective collaboration and functional relationships with a range of health and community services and providers are critical to the implementation of this MoC. Each SMHSOP community service should prioritise relationships according to the needs of their local community and local priorities, and develop strategies for improving / maintaining these relationships. However, all services should have a focus on the key partners highlighted in this MoC, namely GPs and SMHSOP AIU where present, and should aim to improve relationships with them to promote integrated and continuous care. This is particularly relevant in those LHDs where SMHSOP inpatient and community teams are managed separately and not as an integrated service. Many SMHSOP community services may need to improve the integration with local community/social services including Aboriginal and trans/multicultural services.

Working in different ways and in different settings

In order to deliver person-centred, recovery-focused care, SMHSOP community services should ensure processes and procedures support clinicians to work in a range of settings including a person's normal place of residence and to utilise a variety of modalities (including face-to-face, telehealth and/or e-health). In particular, SMHSOP community services should consider logistical arrangements such as access to transport and telehealth facilities and appropriate staff resourcing.

Key processes

Each SMHSOP community service will need to review their current processes against the good practice features outlined in this MoC, and prioritise strategies to address any gaps.

This will be assisted through benchmarking processes, following a review of the Self-Audit Tool to align it with the MoC. Key processes are to be undertaken in a way that is recovery-focused and consumer-led, and this may mean significant practice development in some SMHSOP community services. It is also anticipated that meeting the requirements of the *Physical Health Care of Mental Health Consumers Guidelines*[32] and the *Physical Health Care within Mental Health Services Policy Directive*[33] will require concerted effort in some services. Other key processes that may require significant service reorientation in some services include intake and admission (particularly the interface between SMHSOP and SMHTAL, and GPs), care planning (including a focus on wellness planning) and assessment and review (particularly the focus on recovery goals). Local guidance and leadership should reinforce the use of mandated and state-supported assessment instruments where relevant. If other instruments are recommended locally, these should supplement and not replace mandated instruments and only replace state-supported instruments after LHD-level review.

Techniques and therapies

The range of biopsychosocial therapies provided directly by each SMHSOP community service is likely to be quite variable, associated with clinical preferences and skills, team staffing mix and size of team. However, this MoC emphasises that to support evidence-based good practice and equity of access to a range of therapies for SMHSOP consumers, each SMHSOP service should develop appropriate clinical governance processes, service delivery arrangements and organisational supports for the provision of appropriate therapies, tools and techniques. This should include guidance on the range of biopsychosocial therapies that may and may not be provided by staff, and the process for accessing therapies that are not provided by staff including through inter-professional practice and utilisation of partnerships. Under the MoC, consumers should have access to very specialised, non age-specific services (e.g. clozapine dosing, maintenance ECT and depot antipsychotic medications) and each SMHSOP community service will need to negotiate access to these services as appropriate.

Staffing

The implementation of this MoC will need to be supported by strong service culture, orientation, clinical supervision and workforce development processes, and multidisciplinary staffing and approaches. In some SMHSOP community services, the implementation of this MoC will require changes to practice and this may be challenging to some staff. Ongoing support of clinical leaders will be required along with programs that support change management and quality improvement.

It is recognised that not all SMHSOP community services will be in a position to increase the involvement of peer workers within their service. However, as the evidence supporting peer work in the OPMH context increases, and with the impetus from state and national initiatives focused on increasing the peer workforce, it is envisaged that the number of SMHSOP peer workers will increase over time. Where there are SMHSOP

peer workers, they will need to be treated as members of SMHSOP community teams and engaged in all team activities relevant to their roles.

Performance

LHDs have responsibility for monitoring and improving their SMHSOP community services(s). It is important that SMHSOP community services continue to participate in benchmarking and that data and KPIs are examined and used to improve the outcomes and experiences of consumers, carers and other care providers. A number of areas of performance are highlighted under the MoC – namely, recovery-oriented services/practices, access, care coordination with GPs, capabilities and responsiveness. These areas align with the key directions of the MoC. SMHSOP community services will need to review their current procedures against the highlighted performance measures.

Gaps/limitations in the research and practice

A number of issues arose during the course of the SMHSOP Community MoC Project that were not able to be addressed within this guideline but are identified for further work. Some of these are the focus of current national projects, for example: the impact on SMHSOP community services of the implementation of the stepped care model; the expanded role of PHNs in regional mental health planning and integration, and current and future reforms within the aged care sector. Electronic health information systems will continue to evolve, and future revisions of this MoC will need to consider engagement of SMHSOP clinicians with the electronic medical records (eMR) system, and any interface between eMR and *My Health Record* and eMR and the medical record systems used by GPs, and how this can help promote continuity and coordination of care.

Others issues, such as quantifying staffing profiles and benchmarks and reasonable caseloads, are outside the scope of the project although various national and state planning frameworks provide some guidance.

A number of issues require much more extensive and detailed work than could be achieved in this project, in particular, recommending outcome and assessment tools for behaviour / BPSD for standardised use across NSW.

There are a number of areas of practice, particularly recovery-oriented practice in an OPMH context, peer work in OPMH, and the recovery / trauma-informed care and practice (TICP) interface, which will continue to evolve as more evidence becomes available, and will need to be considered in future revisions of the SMHSOP community MoC. In addition, the role of e-therapies in the care and treatment of older people with mental health and their carers, and the provision of low intensity early intervention services have not been considered in a detailed way at this stage. The potential implication of Activity Based Funding is likely to result in services looking at their models of efficiencies and this guideline/MoC may assist with this process. There may be an evolving role for SMHSOP in relation to squalor/hoarding, as part of the interagency response.

Next steps

It is intended that this guideline will guide the implementation of the SMHSOP community MoC in LHD SMHSOP community services across NSW, thereby promoting service improvement, consistency and good practice within SMHSOP community services and improving care for older consumers. It is recognised that some SMHSOP services, particularly in rural locations, have very small teams, and an innovative approach will be required in the implementation of, and continued adherence to, the MoC. This may require small teams to work together across the LHD. The following example of a SMHSOP network model is provided as an illustration of how one rural LHD supports small SMHSOP teams/sole workers, including district-wide implementation of service improvements.

Elements of a rural hub-and-spoke model, Western NSW Local Health District SMHSOP

- *Within the LHD, sole SMHSOP workers / small SMHSOP teams in rural and remote towns are networked with a larger SMHSOP team based in a regional centre, both clinically and strategically.*
- *The network is not operational by nature, with all SMHSOP workers having their own local operational management. However, operational managers are supported by the LHD SMHSOP Coordinator, in areas such as recruitment, advice on clinical supervision, education, performance review, etc.*
- *All community SMHSOP workers are part of the SMHSOP Clinical Stream.*
- *A LHD-wide meeting of the SMHSOP Clinical Stream is compulsory, and helps keeps all community SMHSOP workers engaged and the direction of the service aligned across the LHD. Discussion at the meeting would include such things as benchmarking findings, education and service development issues. It is anticipated that this meeting would consider how to support the implementation of the new MoC. The meeting is held six times per year, chaired by the SMHSOP Coordinator and face-to-face attendance is emphasised (location is rotated). These meetings are supported by the LHD MHS Management.*
- *In addition, regional meetings (one in Dubbo, one in Orange) are held on the alternate months, focusing on more local matters.*

- *There are only two SMHSOP Clinical Reviews held in the LHD, and all sites that host a SMHSOP worker or team (currently ten sites) link in to one of these weekly clinical reviews by video link. This means that, even though a SMHSOP worker may sit as part of an adult mental health team in their town, their clinical review is done with their SMHSOP colleagues from across the LHD. They are chaired by the SMHSOP Clinical Director and another Psychogeriatrician. These reviews are also used for clinical training and ensuring clinical governance.*
- *The final component of this networked model is the existence of senior SMHSOP clinicians who have regional roles across all of the sites. They travel to all the sites where there are SMHSOP workers and they co-manage some of the more complex consumers, but they also educate, supervise and capacity build in those smaller communities. This is a key feature, ensuring that sole SMHSOP workers / small teams are well supported.*

The Mental Health Branch of the NSW Ministry of Health will work with LHD mental health services to support, monitor and evaluate implementation and service redesign in line with the MoC. This will include revision of the SMHSOP benchmarking self-audit tool completed by SMHSOP community (and inpatient) services across NSW to align with the SMHSOP community MoC. The revised self-audit tool will be informed by the good practice features of the MoC which relate to SMHSOP clinical processes, in particular. It is intended that the revised SAT will be completed once per year and the findings used at both local level and state benchmarking.

A self-assessment checklist against other good practice features of the MoC has been developed (see Attachment 1 for checklist) to assist local SMHSOP community services in assessing current practice against the MoC and developing a local implementation strategy. This is intended as an internal document, and not part of formal state benchmarking processes.

It is envisaged that performance of SMHSOP community services (and implementation of the performance section of the MoC) will be monitored through benchmarking, the SMHSOP Advisory Group and other monitoring and evaluation processes. In addition, the SMHSOP community services model of care will be formally evaluated, in the period following initial implementation.

A brief ‘plain English’ information booklet will also be developed to provide information for consumers, carers and the broader community about how to access SMHSOP community services, what to expect (including key philosophies and principles of care and practice) and the key directions in which SMHSOP community services are heading. In addition, a template for a local service brochure will be developed.

APPENDIX A: MEMBERSHIP OF THE EXPERT REFERENCE GROUP

Project Lead

Dr Roderick McKay – Clinical Advisor, OPMH Policy Unit, NSW Health Mental Health Branch

Project Team

Ms Kate Middleton – Senior Policy Officer, OPMH Policy Unit, NSW Health Mental Health Branch
Ms Deborah Hoban – Senior Policy Officer, OPMH Policy Unit, NSW Health Mental Health Branch
Dr Kate Jackson – Manager, OPMH Policy Unit, NSW Health Mental Health Branch
Mr Ian Rawson – SMHSOP Clinical Coordinator, Western NSW LHD
Ms Elizabeth Grist – SMHSOP Clinical Coordinator, Hunter New England LHD

SMHSOP Community Model of Care Expert Reference Group

Dr Roderick McKay (Chair) – Clinical Advisor, OPMH Policy Unit, NSW Health Mental Health Branch
Ms Kate Middleton - Senior Policy Officer, OPMH Policy Unit, NSW Health Mental Health Branch
Dr Kate Jackson - Manager, OPMH Policy Unit, NSW Health Mental Health Branch
Ms Deborah Hoban - Senior Policy Officer, OPMH Policy Unit, NSW Health Mental Health Branch
Mr Richard Baldwin – Policy Officer, Mental Health Carers NSW
A/Prof David Burke – Director of Psychogeriatrics, St Vincents Hospital
Ms Maria Cassaniti - Manager, Transcultural Mental Health Centre
Mr Andrew Clement – Program Manager SMHSOP, Northern Sydney LHD
Ms Natalie Cook - NSW Primary Health Network State Coordinator
Ms Nadia Garan - Program Leader, Service Development, Planning & Evaluation, Transcultural Mental Health Centre
Ms Samantha Gray – Senior Advisor, NSW Mental Health Commission
Ms Raichel Green – Service Manager SMHSOP, Central Coast Mental Health Service
Ms Elizabeth Grist – SMHSOP Clinical Coordinator, Hunter New England LHD
Mr Jonathan Harms – Chief Executive Officer, Mental Health Carers NSW
Dr Johan Havenaar – Clinical Director, Area Mental Health Service, Northern NSW LHD
Mr Robert Hearn – Senior Social Worker/Case Manager, SMHSOP Hunter Valley Team
Ms Corinne Henderson - Senior Policy Advisor, Mental Health Coordinating Council
Dr Neil Jeyasingham –Royal Australian & New Zealand College of Psychiatrists (RANZCP) NSW Faculty of Psychiatry of Old Age (FPOA)
Mr Stephen Kay – Acting Program Manager SMHSOP, Northern Sydney LHD
Ms Jennifer Kelly – Clinical Nurse Consultant, St Vincent's Psychogeriatric team
Dr Deborah Koder – Senior Clinical Psychologist SMHSOP, Sydney LHD

Associate Professor Stephen MacFarlane - Director of Aged Psychiatry, Alfred Health (Victoria)
Associate Professor Peter McGeorge – Director, Inner City Health Program, St Vincent's Hospital
Mr Bryan McMinn – Clinical Nurse Consultant SMHSOP, Hunter New England LHD
Ms Anne Moehead - Nurse Practitioner Psychogeriatrics / Dementia, Northern NSW LHD.
Ms Ka Ki Ng – Senior Policy Officer, BEING
Mr Trevor Perry - Service Director Forensic Mental Health, Justice Health & Forensic Mental Health
Mr Ian Rawson – SMHSOP Clinical Coordinator, Western NSW LHD
Ms Laura Ross - District Coordinator Mental Health Drug & Alcohol Aboriginal People, Murrumbidgee LHD
Ms Julie Strukovski – Program Manager SMHSOP, Northern Sydney LHD
Ms Lynda Walton – Policy Officer, Mental Health Carers NSW
Ms Jacqueline Wesson – Senior Occupational Therapist, SMHSOP and Memory Disorders Clinic, Prince of Wales Hospital

LIST OF ATTACHMENTS

Attachment 1: Implementation checklist

LHD:		**SMHSOP community service:**	
Assessed by:		**Date of Assessment:**	

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
Philosophy and principles of care			
Please refer to relevant good practice features and the revised benchmarking Self-Audit Tool	❑	❑	❑
Notes:			
Target population			
1. There are clearly defined target population, admission criteria and prioritisation criteria, consistent with the *SMHSOP Service Plan* and/or its successor.	❑	❑	❑
2. The above criteria are distributed to key service partners and referral services.	❑	❑	❑
3. To support timely access to care and support and the guiding principles of the 'no wrong door' approach, any person who presents or is referred to the SMHSOP community service following triage is accepted for secondary triage and/or initial assessment.	❑	❑	❑
4. Local policies and processes that support the provision of secondary triage and/or initial assessment for all people referred to the SMHSOP community service following triage are developed and implemented.	❑	❑	❑
Notes:			
Aboriginal people			
1. The target population includes Aboriginal people aged 50 years or older as appropriate. The preference of Aboriginal consumers aged 50-64 years to be seen in adult mental health or SMHSOP services is facilitated.	❑ ❑	❑ ❑	❑ ❑
2. Formal partnerships and/or partnership arrangements in place between the LHD Mental Health Service and Aboriginal service providers and/or communities are supported, promoted and utilised.	❑	❑	❑

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
3. SMHSOP clinicians are supported to work in a range of settings including Aboriginal health services.	❑	❑	❑
4. Clinical practice is appropriately adapted to meet the needs of Aboriginal people.	❑	❑	❑
Notes:			
CALD consumers			
1. Relevant partnerships are in place and utilised to address local demography and needs and supports of CALD communities.	❑	❑	❑
2. Clinical practice is appropriately adapted to meet the needs of CALD consumers.	❑	❑	❑
3. Staff are trained in cultural awareness and cultural competency, and working with interpreters.	❑	❑	❑
Notes:			
Potential exclusion criteria			
1. There are clearly defined exclusion criteria, consistent with the *SMHSOP Service Plan* and/or its successor and informed by the local needs of the target population.	❑	❑	❑
2. Potential exclusion criteria are distributed to key service partners and referral services.	❑	❑	❑
3. Appropriate flexibility is exercised in providing assessment for older people with ***complex and unclear aetiology*** and, where possible and appropriate, in providing care for consumers ***under 65 years old with age-related problems*** causing significant functional disability.	❑	❑	❑
4. Where referral information is suggestive of delirium or acute medical illness, the person is referred for and/or assisted to obtain assessment and management of these issues. This is accompanied by clear information regarding how to re-contact the SMHSOP community service if this still appears indicated after such management.	❑	❑	❑
Notes:			
Functions			
1. In undertaking the functions of their service, staff:			
a. promote the consumer's clinical and personal recovery	❑	❑	❑
b. undertake joint care planning and coordination	❑	❑	❑
c. advocate where required on behalf of the consumer/carer, including on right to physical health care'	❑	❑	❑

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
d. undertake a 'positive risk taking' approach to risk assessment and planning	❑	❑	❑
e. comply with relevant legislative and policy requirements	❑	❑	❑
f. meet requirements of *Mental Health and Guardinship Acts* and access or support appropriate hearings and inquiries	❑	❑	❑
g. develop and maintain appropriate partnerships with primary care services and RACFs	❑	❑	❑
h. are supported to access appropriate education, training and/or research activities	❑	❑	❑
i. participate in ongoing monitoring and improvement of practice and performance	❑	❑	❑
2. For all referred older consumers, the following are provided:			
a. timely assessment	❑	❑	❑
b. planning initial steps of care (jointly)	❑	❑	❑
c. facilitation of transitions in and out of care between providers and settings.	❑	❑	❑
3. For consumers who are prioritised for ongoing SMHSOP community care, the following are provided directly or in collaboration/by arrangement with other teams/services/partner organisations:			
a. ongoing care planning (jointly)	❑	❑	❑
b. provision of specific therapies and techniques	❑	❑	❑
c. ongoing clinical care and coordination	❑	❑	❑
d. assistance with management of relevant co-existing conditions as required	❑	❑	❑
e. individualised prevention and promotion activities that are complementary to clincial care	❑	❑	❑
f. clinical review	❑	❑	❑
g. facilitation of transiitions in and out of care between providers and settings.	❑	❑	❑
Indicated Features 1. The following functions may be appropriate for some services:	❑	❑	❑
a. Inpatient consultation liaison			
b. Involvement in crisis care management	❑	❑	❑
c. Innovative models of more intensive follow-up and assertive outreach	❑	❑	❑
d. Specific promotion, prevention and early intervention activities and programs	❑	❑	❑
Notes:			

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
Partnerships			
1. Partnerships are valued and it is recognised that effective partnerships require concerted focus and effort.	❑	❑	❑
2. Partners are prioritised according to needs of local community to ensure that investment is directed appropriately.	❑	❑	❑
3. Clinical and management processes recognise key partners, promote effective partnerships and optimise relationships. This includes: a. *Key services* (GP, SMHSOP AIU where present, other community MH teams, NSW aged health community services and ACATs, residential aged care providers)	❑	❑	❑
b. Relevant inpatient clinical services	❑	❑	❑
c. Relevant community services	❑	❑	❑
d. Private sector	❑	❑	❑
4. Integration with SMHSOP AIUs, where present, is maximised by working in accordance with the AIU MoC (particularly in regards to admission, clinical review, transitions of care).	❑	❑	❑
5. Clear processes are in place to facilitate optimisation of care integration with GPs.	❑	❑	❑
6. Mechanisms are in place to support effective partnership arrangements.	❑	❑	❑
Notes:			
Working in different settings and in different ways			
1. Care is provided in the location preferred by the consumer and carer wherever feasible.	❑	❑	❑
2. The preference of a consumer to receive care in an outpatient clinic or other setting outside of their normal place of residence is supported and assistance is provided and/or arranged as required.	❑	❑	❑
3. Clinicians are supported to work in a range of settings.	❑	❑	❑
4. Where care is provided through consultation and/or liaison style services, guidance is available to clinicians on the agreed multi-sector arrangements made in each setting.	❑	❑	❑
5. A variety of modalities to provide treatment and/or provide support to clinicians are utilised as required.	❑	❑	❑
6. When utilised, telehealth is undertaken with regard to the *Guidelines for the use of Telehealth in Clinical and Non Clinical Settings in NSW.*	❑	❑	❑
Notes:			
Key Processes: Access and intake			

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
Assessment and care planning Clinical care and coordination Recovery-oriented risk assessment and planning Clinical review Transitions of care Specialist consultation and liaison in the inpatient setting Crisis care Promotion, prevention and early intervention			
Please refer to relevant good practice features and the revised benchmarking Self-Audit Tool	❑	❑	❑
Notes:			
Techniques and therapies			
1a. Staff actively work with consumers to facilitate access to a range of biopsychosocial therapies that are evidenced-based in regards to clinical recovery.	❑	❑	❑
1b. Consumers are assisted to access a range of support and services identified as supportive of the individual's personal recovery.	❑	❑	❑
2. Carers are assisted to access a range of information, therapies and services that support their biopsychosocial needs and the consumer's recovery, either through direct service provision where appropriate or through facilitating access to other services.	❑	❑	❑
3. A range of mechanisms are in place to support staff to fulfil 1a, 1b and 2 above.	❑	❑	❑
4. Easily accessible information on the range of therapies offered by the SMHSOP community service is provided and available to the local community, including GPs.	❑	❑	❑
5. Relationships and arrangements with mental health services providing highly specialised services are promoted to ensure age is not a barrier to access and appropriate care.	❑	❑	❑
Notes:			
Staffing mix			
1. Staff have the skills to work with older people with mental illness and a desire to further develop the specialist skills in OPMH.	❑	❑	❑
2. Recruitment and staffing mix of teams are focused upon enabling teams to have the range of skills required to meet the needs of local consumers. Innovative inter-professional practice and utilisation of partnerships are supported as required.	❑	❑	❑
3. Staffing supports the provision of biopsychosocial therapies, either through direct provision or in partnerships, which meet	❑	❑	❑

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
the needs of consumers and carers.			
4. There is a core staffing of dedicated medical and nursing staff with skills in both mental health and care of older people.	❑	❑	❑
5. Skills from other disciplines (including allied health) are accessed to provide a broader range of therapies.	❑	❑	❑
a. Staff from other disciplines have specialist OPMH skills.	❑	❑	❑
b. LHDs with small teams have such staff available/accessible within the MHD, including via telehealth.	❑	❑	❑
6. Interpreters and Aboriginal liaison/health workers, and cultural consultants, are accessed where required.	❑	❑	❑
7. Mechanisms are in place to support and sustain the multidisciplinary team and ensure the provision of interdisciplinary, high quality and appropriate care.	❑	❑	❑
8. Succession planning strategies have been implemented.	❑	❑	❑
9. Staffing structures are in place to facilitate staff and career development within SMHSOP.	❑	❑	❑
10. Operational and clinical leadership and governance processes are in place that support the integration of SMHSOP service elements (inpatient, community and residential) and quality improvement.	❑	❑	❑
Notes:			
Clinical supervision			
1. The local implementation of the *NSW Health Clinical Supervision Framework* is supported.	❑	❑	❑
2. The focus of clinical supervision is on clinical practice in the context of OPMH, with reference to the core skills required as outlined in the *National Mental Health Core Capabilities*, and on the specific skills required for working in OPMH.	❑	❑	❑
3. Cross-discipline supervision is considered and supported to ensure appropriate access to supervisors with skills and experience in OPMH, including supervision from external to the LHD where required.	❑	❑	❑
4. Where clinicians receive clinical supervision from a discipline-specific supervisor without specific OPMH experience/skills, they are encouraged to network with other OPMH clinicians in their discipline as part of 'communities of practice'.	❑	❑	❑
5. Supervisors and supervisees are supported to access training on providing/receiving clinical supervision.	❑	❑	❑
Notes:			

Self-assessment against the 'good practice features' of the SMHSOP community MoC (NB: annotated version) ***Please refer to SMHSOP community MoC guideline for the detailed good practice features of the MoC, and further information.***	**Not commenced**	**Partial compliance**	**Full compliance**
Workforce development			
1. Staff are enabled to access workforce development opportunities.	❑	❑	❑
Notes:			
Peer workers			
1. The SMHSOP community service seeks to increase the involvement of peer workers within the service.	❑	❑	❑
2. The important role played by volunteers is recognised and promoted.	❑	❑	❑
3. Where peer workers are employed, they can function as integral team members and engage in all team activities relevant to their role.	❑	❑	❑
Notes:			
Performance			
1. Relevant routine activity, outcome and performance data and other relevant KPI data are made available to staff.	❑	❑	❑
2. Data is examined and used at the local level.	❑	❑	❑
3. The SMHSOP community service is supported to participate in benchmarking processes and encouraged to use benchmarking findings to guide local service improvement.	❑	❑	❑
4. Performance in the following target areas is monitored and investigated, and quality improvement promoted as required:	❑	❑	❑
a. Recovery-oriented care and practice	❑	❑	❑
b. Access	❑	❑	❑
c. Care coordination with GPs	❑	❑	❑
d. Capabilities	❑	❑	❑
e. Responsiveness.	❑	❑	❑
Notes:			

Action Plan

Key priority actions to address gaps identified in the self-assessment, and to help with implementation and adoption of the SMHSOP Community Services MoC.

Activity	Activity owner	Resources required	Timeframe

LIST OF ACRONYMS

3MS	Modified Mini-Mental State Examination
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Service
ADL	Activities for Daily Living
AIU	Acute Inpatient Unit
BASIS	Behavioural Assessment and Intervention Services
BPSD	Behavioural and Psychological Symptoms of Dementia
CALD	Culturally and Linguistically Diverse
CHIME	Connectedness, Hope and Optimism, Identity, Meaning in Life, and Empowerment
CMO	Community Managed Organisation
COAG	Council of Australian Governments
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcome Measurement Suite
ECT	Electroconvulsive Therapy
EMR	Electronic Medical Record
GP	General Practitioner
HoNOS 65+	Health of the Nation Outcome Scale 65+ years
IADL	Instrumental Activities of Daily Living
IPA	International Psychogeriatric Association
K10+-LM / K10-L3D	2 versions of the Kessler-10 (Kessler Psychological Distress Scale)
KPIs	Key Performance Indicators
LGBTI	Lesbian, Gay, Bisexual, Trans/Transgender and Intersex people
LHD	Local Health District
LSP-16	An abbreviated version of the Life Skills Profile (assessment tool)
MH-AMB	Mental Health Ambulatory (data collection)
MH-OAT	Mental Health Outcomes and Assessment Tools
MoC	Model of Care
MoCA	Montreal Cognitive Assessment
NCAT	NSW Civil and Administrative Tribunal
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
NICE	National Institute for health and Care Excellence, UK
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Service (Standards)
NSW	New South Wales
OPMH	Older People's mental health
PHN	Primary Health Network

RACF	Residential Aged Care Facility
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCT	Randomised Control Trial
RUDAS	Rowland Universal Dementia Assessment Scale
RUG-ADL	Resource Utilisation Groups – Activities of Daily Living
SAT	Self-Audit Tool
SBRT	Severe Behaviour Response Teams
SMHSOP	Specialist Mental Health Services for Older People
SMHTAL	State Mental Health Telephone Access Line
TICP	Trauma Informed Care and Practice
T-BASIS	Transitional Behavioural Assessment and Intervention Service
UK	United Kingdom
WHS	Work Health and Safety
YES	Your Experience of Service

KEY DEFINITIONS

Biopsychosocial	The biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.[173]
Clinical care and coordination	In this MoC, the term 'clinical care and coordination' is broadly taken to include the range of activities involved in providing and/or organising clinical treatment and psychosocial interventions, including helping arrange access to a range of different services across the health and community care sectors, to meet an individual's treatment and recovery goals. This may include: building therapeutic relationships, providing and/or facilitating access to a range of biopsychosocial therapies, fostering community connections and participation, liaison with other professionals/services/agencies including referrals, coordinating various services and providers of care, case conferencing, transition/discharge planning and ensuring continuity of care. The term 'clinical care and coordination' includes what has previously been known as 'case management'.
Carer	The *Mental Health Act 2007*[9] defines two types of carers: • 'Designated carer' is a person nominated by the consumer and may be the guardian of the consumer, the spouse of the consumer, a person who is primarily responsible for providing support or care to the consumer, or a close friend or relative of the consumer as per the definition in the *Mental Health Act*. A consumer can nominate up to two designated carers, except if the consumer is under Guardianship in which case the *Act* sets out who their designated carers are. • 'Principal care provider' is the person who is primarily responsible for providing day to day support and/or care but is not wholly or substantially paid on a commercial basis. Where not nominated by the consumer, a principal care provider can be nominated by the treating clinicians (in addition to the two designated carers). See Section 2.1 for further discussion about exclusion of carers by consumers. The term 'carer' is generally used throughout this document and incorporates both designated carer and principal care provider.
Consent	The starting presumption for all people is that they have capacity to consent to treatment. See the *Guardianship Act 1987 (NSW)*[41] for

	further information on substitute consent provisions when a person loses or lacks the capacity to make decisions about their medical treatment. The *Mental Health Act*[9] allows for non-surgical treatment of involuntary, or detained, patients regardless of the person's consent. However, the *Mental Health Act* and good clinical practice, requires that patients/consumers be involved in their care and recovery and that their views should be considered in the development of treatment plans. The principles of choice and consent support recovery-oriented practice and consumer-led care. During the consultations for this project, it was clear that SMHSOP consumers want to be asked if they agree to the services contacting their family, carer, GP or other relevant service providers to be involved in aspects of their care and treatment, as appropriate. However, many also want their carer to be involved in communication and care processes as much as possible, even at times of incapacity. Carers and consumers expressed frustration that sometimes consent was cited as a reason for lack of necessary communication with carers or other health professionals. Information should be disclosed to carers in accordance with the wishes of the consumer and/or the *Health Records and Information Privacy Act*.
Cultural competence	Cultural competence is a 'set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations'.[174] Cultural competence 'requires that organisations have clearly defined, congruent set of values and principles, and demonstrate behaviours, attitudes, policies, structures and practices that enable them to work effectively cross-culturally'.[175]
Consumer	The term 'consumer' is generally used, rather than 'client' or 'patient', to refer to an individual accessing SMHSOP services.
Initial assessment	The degree and depth of initial assessment undertaken by a SMHSOP clinician following acceptance of a triage referral (usually from the SMHTAL) will be decided on an individual basis by the local service in consultation with a consumer and carer(s). This may range from secondary triage through to comprehensive mental health assessment.
Integrated care	'The provision of seamless, effective and efficient care that reflects the whole of a person's health needs; from prevention through to

	end of life, across both physical and mental health, and in partnership with the individual, their carer(s) and family. It requires greater focus on a person's needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home'.[176]
Model of Care	A 'Model of Care' broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place.[177]. A 'Model of Care' is a multifaceted concept, which broadly defines the way in which health care is delivered including the values and principles; the roles and structures; and the care management and referral processes.[178]
'No wrong door'	The 'no wrong door' approach is a principle of integrated and coordinated service delivery based on the premise that every door in the service system should be a door through which a consumer can access a range of services. What should follow is that all consumers receive care that addresses their range of needs regardless of their initial entry point or what type of service they present to (or are referred) (i.e. there is no wrong door).[179] People who are in need of services and seek them from the wrong source should be provided with the amount of assistance necessary for them to obtain the right support, and that assistance is proportionate to the severity of the health issue being experienced and the capacity of the consumer and/or their carer(s) to access these services themselves.
Secondary triage	Usually undertaken via phone by a SMHSOP clinician, secondary triage is a clinical process conducted to determine a person's eligibility for ongoing SMHSOP service; or how the person should be assisted to be helped by an alternate service. It is guided by the *NSW Mental Health Triage Policy* and *NSW Health Mental Health Clinical Documentation triage module.* This follows the initial triage undertaken in most cases by the NSW centralised mental health intake service (NSW Mental Health Line).
Stepped care	Under the 'stepped care' approach, the level of service provided is matched to each consumer's need. A mental health system built on a stepped care approach will comprise a full continuum of services, from low intensity, early intervention through to high levels of care

	requiring 'wrap around' coordinated care for those with severe and complex mental illness.[14]
Telehealth	Interventions provided over the phone or by video-link. Includes tele-psychiatry.
Techniques and therapies	This term is used rather than 'interventions'. SMHSOP community clinicians utilise a range of techniques and therapies to address the treatment and recovery goals of the consumer and carer(s). Clinicians will utilise a variety of tools in undertaking therapies and to facilitate consumer and /or carer self-management, recovery, resilience and empowerment.
Transition of Care	Transition (or transfer) of care involves a 'set of actions designed to ensure coordination and continuity of care as patients transfer between services'.[180] They occur when a consumer is leaving a health service (i.e. 'discharged' or 'exiting') or being transferred to a different institution or level of care.
Trauma-informed care and practice	An 'approach whereby all aspects of services are organised around the recognition and acknowledgment of trauma and its prevalence, alongside awareness and sensitivity to its dynamics'.[39] A trauma-based approach primarily views the trauma as interpersonal and therefore the individual as being harmed by something or someone.

REFERENCES

[1] National Ageing Research Institute (NARI), 2013, *Supporting older people who are experiencing mental distress or living with a mental illness*. Available from http://www.benevolent.org.au/. Accessed 4 February 2016.

[2] Joint Commissioning Panel for Mental Health, 2013. *Guidance for commissioners of older people's mental health services*. Available from http://www.jcpmh.info/good-services/older-peoples-services/. Accessed 22 September 2015.

[3] Australian Institute of Health and Welfare (AIHW), 2013. *Depression in residential aged care 2008-2012.* Aged care statistics series no. 39 Cat no. AGE 73. Canberra: AIHW. Available from http://www.aihw.gov.au/publication-detail/?id=60129544869. Accessed 22 September 2015.

[4] Australian Bureau of Statistics, 2016. *Causes of Death, Australia, 2014. Catalogue No. 3303.0.*Belconnen, ACT: Commonwealth of Australia. Available at http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2014~Main%20Features~Intentional%20self-harm%20by%20Age~10051. Accessed 15 March 2016.

[5] Commonwealth of Australia, 2013*. A national framework for recovery-oriented mental health services: Policy and theory*. Available at http://www.mhima.org.au/pdfs/Recovery%20Framework%202013_Policy_theory.pdf. Accessed 6 October 2015.

[6] NSW Mental Health Commission. 2014. *Living Well: A Strategic Plan for Mental Health in NSW*. Sydney, NSW Mental Health Commission. Available at http://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20%281%29.pdf. Accessed 6 October 2015.

[7] Commonwealth of Australia, 2009. *Fourth National Mental Health Plan—An agenda for collaborative government action in mental health 2009–2014*. Available at https://www.health.gov.au/internet/main/publishing.nsf/content/9A5A0E8BDFC55D3BCA257BF0001C1B1C/$File/plan09v2.pdf. Accessed 6 October 2015.

[8] Commonwealth of Australia, 2010. *National standards for mental health services 2010: Principles of recovery oriented mental health practice.* Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10. Accessed 23 March 2016

[9] NSW Government, *Mental Health Act 2007 no 8*. Available at http://legislation.nsw.gov.au/maintop/view/inforce/act+8+2007+cd+0+N. Accessed 14 October 2015.

[10] Daley,S., Newton, D., Slade, M., Murray, J., and Banerjee, S., 2013, Development of a framework for recovery in older people with mental disorder. *International Journal of Geriatric Psychiatry* 28: pp. 522-529

[11] Davidson. L, O'Connell. M, Tondora. J, Styron. T, Kangas. K, (2006) The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services* **57**(5) 640-645

[12] Leamy. M, Bird. V, Le Boutillier. C, Williams. J, and Slade. M, (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry* 199, 445–452

[13] NSW Ministry of Health, 2015. *NSW Mental Health Reform 2014-2024*. Available at http://www.health.nsw.gov.au/mentalhealth/reform/Pages/reform-factsheet.aspx. Accessed 17 March 2016

[14] Australian Government Department of Health, 2015, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*. Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response. Accessed 25 February 2016

[15] Australian Government Department of Social Services, webpage, *Aged Care Reform*, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform. Accessed 25 February 2016.

[16] NSW Government, 2011, *NSW 2021: A plan to make NSW number one*. Available at http://www.ipc.nsw.gov.au/sites/default/files/file_manager/NSW2021_WEBVERSION.pdf. Accessed 25 February 2016.

[17] NSW Department of Health, 2008. *NSW community mental health strategy 2007-2012 From prevention and early intervention to recovery*. Available at http://www.health.nsw.gov.au/mhdao/programs/mh/Publications/mental-health-strategy.pdf Accessed 26 October 2015.

[18] NSW Government Department of Family and Community Services, 2014. *NSW Carers Strategy 2014-2019*. Available at http://www.adhc.nsw.gov.au/__data/assets/file/0017/300077/NSW_Carers_Strategy_2014-19.pdf Accessed 25 February 2016.

[19] Commonwealth of Australia, 2010. *National standards for mental health services 2010.* Available at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10. Accessed 23 March 2016

[20] Australian Commission on Safety and Quality in Health Care, 2012, *National Safety and Quality Health Standards*, http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf. Accessed 21 January 2016.

[21] Council of Australian Governments, 2012, *The Roadmap for National Mental Health Reform 2012–2022: An initiative of the Council of Australian Governments*. Available at https://www.coag.gov.au/sites/default/files/The%20Roadmap%20for%20National%20Mental%20Health%20Reform%202012-2022.pdf.pdf. Accessed 21 January 2016.

[22] National Mental Health Commission, 2014, *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services.* Sydney: NMHC. Available at http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx. Accessed 11 May 2016

[23] NSW Ministry of Health, 2012. *Aboriginal Health Plan 2013-2023 PD2012_066*. Available at http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_066.pdf. Accessed 3 February 2016.

[24] NSW Department of Health, 2007, *Aboriginal Mental Health and Well Being Policy 2006-2010.* Available at http://www0.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_059.pdf. Accessed 30 June 2016.

[25] NSW Department of Health, 2006, *Specialist Mental Health Services for Older People (SMHSOP) – NSW Service Plan 2005-2015.*Available at http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_013.pdf. Accessed 14 October 2015.

[26] Draper, B., Brodaty, H., & Low, L. F., 2006, A tiered model of psychogeriatric service delivery: an evidence-based approach. *International journal of geriatric psychiatry*, 21(7), 645-653.

[27] Draper, B. and Low, L., 2005, Evidence-Based Psychogeriatric Service Delivery in B Draper, P Melding and H Brodaty (eds), Psychogeriatric Service Delivery, Oxford, New York. As referenced in: Health Policy Analysis, 2011, *Evaluation of NSW Service Plan for Specialist Mental Health Services for Older People – Final Report Volume 2 (Main report)*, NSW Ministry of Health, Sydney

[28] Frederick, J.T., Steinman, L.E., Prohaska, T., Satariano W.A., Bruce, M., Bryant, L., Ciechanowski, P., DeVellis, B., Leith, K., Leyden, K.M., Sharkey, J., Simon, G.E., Wilson, N., Unutzer, J and Snowden, M., 2007. Community-based treatment of late life depression: An expert panel-informed literature review. *Am J Prev Med 2007*;33(3):222–249

[29] Abendstern, M., Harrington, V., Brand, C., Tucker, S., Wilberforce, M., & Challis, D., 2012. Variations in structures, processes and outcomes of community mental health teams for older people: A systematic review of the literature, *Aging & Mental Health*, 16:7, 861-873, DOI: 10.1080/13607863.2011.651431

[30] NSW Agency for Clinical Innovation, 2014. *Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs.* Available at http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0003/249483/Building_Partnerships_Framework.pdf. Accessed 8 December 2015.

[31] The Kings Fund, 2016, *Bringing together physical and mental health: A new frontier for integrated care*. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Bringing-together-Kings-Fund-March-2016_1.pdf. Accessed 28 April 2016.

[32] NSW Health, 2009. *Physical Health Care of Mental Health Consumers Guidelines GL2009_007*. Available at http://www0.health.nsw.gov.au/policies/gl/2009/pdf/GL2009_007.pdf. Accessed 14 October 2015.

[33] NSW Health, 2009. *Physical Health Care within Mental Health Services Policy Directive*. Available at http://www0.health.nsw.gov.au/policies/pd/2009/PD2009_027.html. Accessed 14 October 2015.

[34] NSW Ministry of Health, 2012. *Specialist Mental Health Services for Older People (SMHSOP) Acute Inpatient Unit Model of Care Project Report*. Available at

http://www.health.nsw.gov.au/mhdao/publications/publications/smhsop_aiu_moc.pdf. Accessed 27 October 2015.

[35] Royal Australian and New Zealand College of Psychiatrists, 2015, *Position Statement 22 Psychiatry Services for Older People*. Available at https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-22-FPOA-Psychiatry-services-for-older-peopl-(1).aspx. Accessed 30 June 2016.

[36] Commonwealth of Australia, 2013*. A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Available at http://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf. Accessed 6 October 2015.

[37] NSW Ministry of Health, 2015. *Specialist Mental Health Services for Older People (SMHSOP) Recovery-Oriented Practice Improvement Project Tool kit* (unpublished)

[38] Graham, H. and White, R., 2011*. Improving services to support recovery from comorbidity in Tasmania*. Salvation Army Bridge Program and University of Tasmania, Hobart. Available at http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=doc_download&gid=63. Accessed 13 July 2016.

[39] Mental Health Coordinating Council (MHCC), webpage, *Trauma-Informed Care and Practice*, http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx. Accessed 5 May 2016.

[40] NSW Ministry of Health, 2015, *Dignity, Respect and Choice: Advance Care Planning for end of life for people with mental illness.* Available at http://www.health.nsw.gov.au/patients/acp/Pages/comprehensive-guide.aspx. Accessed 4 February 2016

[41] NSW Government, *Guardianship Act 1987*. Available at http://www.austlii.edu.au/au/legis/nsw/consol_act/ga1987136/. Accessed 17 March 2016.

[42] Wyder, M., Bland, R. and Crompton, D. (2013) Personal recovery and involuntary mental health admissions: The importance of control, relationships and hope. *Health*, 5, 574-581

[43] NSW Ministry of Health, 2014,*SMHSOP Ambulatory and MH-OAT data analysis results*, NSW, Jan-Jun 2014, unpublished

[44] Australian and New Zealand Society of Geriatric Medicine, 2013. *Position statement 22: Frailty in Older People*. Available at http://www.anzsgm.org/documents/PositionStatementNo22FrailtyinOlderPeople_000.pdf. Accessed 28 July 2016.

[45] AIHW 2014. *Mortality and life expectancy of Indigenous Australians 2008 to 2012*. Cat. no. IHW 140. Canberra: AIHW. Available at http://www.aihw.gov.au/publication-detail/?id=60129548470. Accessed 21 April 2016.

[46] Commonwealth of Australia, 2014. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. 2nd Ed.* Editors: Pat Dudgeon, Helen Milroy and Roz Walker. Available at http://aboriginal.telethonkids.org.au/media/699863/Working-Together-Book.pdf. Accessed 12 May 2016.

[47] NSW Department of Health, 2010. *Aboriginal Older Peoples' Mental Health Project*. Available at http://www.health.nsw.gov.au/mhdao/Documents/aboriginal-mh-report-2010.pdf. Accessed 6 October 2015.

[48] NSW Department of Health, 2004. *Communication positively: A guide to appropriate Aboriginal terminology*. Available at http://www.health.nsw.gov.au/aboriginal/Publications/pub-terminology.pdf. Accessed 4 November 2015.

[49] Rickwood, D., 2006, *Pathways of recovery: 4As framework for preventing further episodes of mental illness*, Commonwealth of Australia, Canberra. Available at https://www.health.gov.au/internet/main/publishing.nsf/content/E8282AA7CC931CD6CA257BF0001D3CF7/$File/frame.pdf. Accessed 20 April 2016.

[50] State of Victoria, Department of Health, 2013. *National practice standards for the mental health workforce 2013.* Available at http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-wkstd13-toc. Accessed 19 October 2015.

[51] Burns, K., Jayasinham R., Tsang, R. and Brodaty, H. for the Dementia Collaborative Research Centre – Assessment and Better Care (DCRC-ABC) at the University of New South Wales, 2012. *Behaviour Management: A Guide to Good Practice: Managing Behavioural and Psychological Symptoms of Dementia.* Available at http://dbmas.org.au/uploads/resources/DBMAS_Guide_21_05_12.for_USB_pdf.pdf. Accessed 3 August 2016.

[52] Dementia Behaviour Management Advisory Service Western Australia, 2012, *Activity guidelines for health professionals working with Indigenous Australians with dementia in rural and remote Australia.* Available at http://dbmas.org.au/uploads/resources/Activity_Guidelines_for_Indigenous_Australians.pdf. Accessed 3 August 2016.

[53]Federation of Ethnic Communities' Councils of Australia, 2015. *Review of Australian Research on Older People from Culturally and Linguistically Diverse Backgrounds March 2015: A project funded by the Australian Government Department of Social Services*. Available at http://fecca.org.au/wp-content/uploads/2015/06/Review-of-Australian-Research-on-Older-People-from-Culturally-and-Linguistically-Diverse-Backgrounds-March-20151.pdf. Accessed 6 October 2015

[54] Uribe Guajardo, M.G., Slewa-Younan, S., Smith, M., Eagar, S. and Stone, G., 2016. Psychological distress is influenced by length of stay in resettled Iraqi refugees in Australia. *International Journal of Mental Health Systems* 10:4.

[55] Mental Health in Multicultural Australia, 2014. *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery.* Available at http://framework.mhima.org.au/framework/. Accessed 25 November 2015.

[56] Transcultural Mental Health Care Centre, 2009. *Transcultural Assessment Checklist*. Available at http://www.dhi.health.nsw.gov.au/Transcultural-Mental-Health-Centre/Programs-and-Campaigns/GPs/Cultural-Resource-Kit/Assessment-Guidelines-and-Tools/default.aspx. Accessed 19 October 2015.

[57] NSW Ministry of Health, 2015. *Older People's Drug and Alcohol Project Project Report*. Available at http://www.health.nsw.gov.au/mhdao/publications/Pages/opdap-fullreport.aspx. Accessed 12 April 2016.

[58] McKay R, Casey J, Stevenson J, McGowan, H, 2015. *Psychiatry services for older people. A report on current issues and evidence to inform the development of services and the revision of RANZP Position Statement 22.* Royal Australian and New Zealand College of Psychiatrists: Melbourne. Available from https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/RPT-FPOA-Psychiatry-services-for-older-people-revi.aspx. Accessed 8 September 2015.

[59] Catholic Community Services, website, *Pathways through the maze,* http://www.hsru.com.au/. Accessed 27 July 2016.

[60] State of Victoria, Department of Health, 2013, Hoarding and Squalor: A practical resource for service providers. Available at https://www2.health.vic.gov.au/ageing-and-aged-care/wellbeing-and-participation/hoarding-and-squalor. Accessed 27 July 2016.

[61] NSW Ministry of Health, 2016, *Clinical care of people who may be suicidal PD2016_007*. Available at http://www0.health.nsw.gov.au/policies/pd/2016/pdf/PD2016_007.pdf. Accessed 13 July 2016.

[62] NSW Ministry of Health, 2016, *Transfer of care from mental health inpatient services PD2016_056.* Available at http://www0.health.nsw.gov.au/policies/pd/2016/PD2016_056.html. Accessed 13 December 2016.

[63] NSW Health, 2011, *Core Competencies and Measurement Criteria for Beginning Clinicians in Specialist Mental Health Services for Older People (SMHSOP).* Available at http://www.health.nsw.gov.au/mhdao/programs/mh/Documents/core-comp-measurcrit-beginclinic.pdf. Accessed 13 January 2016.

[64] Health Workforce Australia, 2014, *National Mental Health Core Capabilities July 2014*. Available at http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/National%20Mental%20Health%20Core%20CapabilitiesJuly%202014.pdf. Accessed 28 July 2016.

[65] Tsasis P, Evans JM, Forrest D et al. Outcome mapping for health system integration. *Journal of Multidisciplinary Healthcare* 2013;6:99-107.

[66] The Royal Australian College of General Practitioners, 2013. *A best practice guide for collaborative care between general practitioners and residential aged care facilities*. Available at http://www.racgp.org.au/download/Documents/PracticeSupport/Best%20practice%20guides/bpg-collaborativecaregpsracfs.pdf. Accessed 8 December 2015.

[67] Crotty, M.M., Henderson, J., Martinez, L., and Fuller, J.D., 2013. Barriers to collaboration in mental health services for older people: external agency views. *Australian Journal of Primary Health.* 20(3): 250-256.

[68] Australian Association of Social Workers, 2014. *AASW Position Paper Improving Service Responses for Older People with a Mental Health Condition*. Available at http://www.aasw.asn.au/document/item/6773. Accessed 8 December 2015.

[69] Pirkis, J., Livingston, J., Herrman, H., Schweitzer, I., Gill, L., Morley, B., Grigg, M., Tanaghow, A., Yung, A., Trauer, T. and Burgess, P., 2004. Improving collaboration between private psychiatrists, the public mental health sector and general practitioners: evaluation of the Partnership Project. *Australian and New Zealand Journal of Psychiatry*, 38: 125-134

[70] Faculty of Psychiatry of Old Age, 2012. *Relationships between geriatric and Aged Care Psychiatry services Position Statement 31*: The Royal Australian & New Zealand College of Psychiatrists. Available at https://www.ranzcp.org/Files/Resources/31-PS-Relationships-between-geriatric-and-Aged-Car.aspx. Accessed 20 October 2015.

[71] NSW Health, website, *Pathways to Community Living Initiative*. Available at http://www.health.nsw.gov.au/mentalhealth/reform/Pages/community-living.aspx. Accessed 20 October 2015.

[72] Futeran, S., & Draper, B., 2012. An examination of the needs of older patients with chronic mental illness in public mental health services. *Aging and Mental Health*, 16(3), 327-334.

[73] NSW Ministry of Health, 2013. *Charter for Mental Health Care in NSW*. Available at http://www.health.nsw.gov.au/mhdao/Pages/charter.aspx. Accessed 26 October 2015.

[74] Australian Government Department of Health, webpage, *National mental health strategy*, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-strat. Accessed 21 January 2016.

[75] Health Partners, 2015. *Review of Consumer Participation* (unpublished report).

[76] NSW Government, 2014, *Carers (Recognition) Act 2010.* Available at http://www.austlii.edu.au/au/legis/nsw/consol_act/ca2010197/. Accessed 13 April 2016.

[77] NSW Ministry of Health, 2015, *NSW Aboriginal Health Partnership Agreement 2015-2025* (unpublished)

[78] NSW Ministry of Health, 2015. *Aboriginal Older People's Mental Health: Resources for LHD SMHSOP Services 2015*. Available at http://www.health.nsw.gov.au/mentalhealth/programs/mh/Documents/aboriginal-opmhresource-forlhds.pdf. Accessed 28 September 2016.

[79] Federation of Ethnic Communities' Councils of Australia, 2015. *Review of Australian Research on Older People from Culturally and Linguistically Diverse Backgrounds March 2015: A project funded by the Australian Government Department of Social Services.* Available at http://fecca.org.au/wp-content/uploads/2015/06/Review-of-Australian-Research-on-Older-People-from-Culturally-and-Linguistically-Diverse-Backgrounds-March-20151.pdf. Accessed 28 September 2016.

[80] Klug, G., Hermann, G., Fuchs-Nieder, B., Panzer, M., Haider-Stupacek, A., Zapotoczky, H.G. and Priebe, S., 2010. Effectiveness of home treatment for elderly people with depression: randomised controlled trial. *The British Journal of Psychiatry* 197: 463-467

[81] Pizzi, L.T., Jutkowitz, E., Frick, K.D., Suh, D-C., Prioli, K.M. and Gitlin, L.N. 2015. Cost-Effectiveness of a Community-Integrated Home-Based Depression Intervention in Older African Americans. *J Am Geriatr Soc* 62: 2288-2295.

[82] Callahan, C., & Hendrie, H. 2010. Mental health services research: Moving from academia to the community. *American Journal of Geriatric Psychiatry, 18*(6), 460-463

[83] NSW Agency of Clinical Information, 2015. *Guidelines for the use of Telehealth for Clinical and Non Clinical Settings in NSW*. Available at http://www.aci.health.nsw.gov.au/resources/telehealth. Accessed 8 December 2015.

[84] Burns, J., Liacos, G., Green, F., with O'Neil, D. and Thapliyal, A., 2014. *Advice on Innovative Technologies in e-Mental Health: Briefing Paper for the National Mental Health Commission*. Available at http://www.mentalhealthcommission.gov.au/media/119671/Innovative%20technologies%20in%20e-mental%20health%20-%20Young%20and%20Well%20CRC.pdf. Accessed 8 December 2015.

[85] Australian Government Department of Health and Ageing, 2012. *E-Mental Health Strategy for Australia*. Available at https://www.health.gov.au/internet/main/publishing.nsf/content/7C7B0BFEB985D0EBCA257BF0001BB0A6/$File/emstrat.pdf. Accessed 8 December 2015.

[86] Wade, V., Whittaker, F., and Hamlyn, H., 2015. An evaluation of the benefits and challenges of video consulting between general practitioners and residential aged care facilities. *J Telemed Telecare* 21:490-493 doi:10.1177/1357633X15611771

[87] Mewton L, Sachdev PS, Andrews G., 2013. A Naturalistic Study of the Acceptability and Effectiveness of Internet-Delivered Cognitive Behavioural Therapy for Psychiatric Disorders in Older Australians. *PLoS ONE*. August 2013;8(8):e71825. doi:10.1371/journal.pone.0071825

[88] Dear BF, Zou J B, Titov N, Lorian C, Johnston L, Spence J, Anderson T, Sachdev P, Brodaty H, Knight RG., 2013. Brief internet-delivered cognitive behavioural therapy for depression: A feasibility open trial for older adults. *Australian and New Zealand Journal of Psychiatry*. 2013;47:169-176.

[89] Zou JB, Dear BF, Titov N, Lorian CN, Johnston L, Spence J, Knight RG, Anderson T, and Sachdev P., 2012, Brief internet-delivered cognitive behavioural therapy for anxiety in older adults: a feasibility trial. *J Anxiety Disord*. 26(6):650-5.

[90] NSW Health, 2015. *SMHSOP Community Team Self-Audit Tool – 2015*. (unpublished)

[91] O'Brien, A., J. Boddy, and D. Hardy, 2007.Culturally specific process measures to improve mental health clinical practice: indigenous focus. *The Australian and New Zealand Journal of Psychiatrists*, 2007. 41: p. 667-674

[92] Department of Developmental Disability Neuropsychiatry, 2014, A*ccessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers*. Department of Developmental Disability Neuropsychiatry ISBN 978-0-7334-3431-0. Available at https://3dn.unsw.edu.au/sites/default/files/ddn/page/Accessible%20Mental%20Health%20Services%20for%20People%20with%20an%20ID%20-%20A%20Guide%20for%20Providers_current.pdf. Accessed 6 July 2016.

[93] NSW Health, 2012. *Mental Health Triage Policy PD2012-053*. Available at http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_053.pdf. Accessed 13 October 2015.

[94] NSW Health, 2014. *Mental Health Clinical Documentation Guidelines GL2014_002*. Available at http://www0.health.nsw.gov.au/policies/gl/2014/pdf/GL2014_002.pdf. Accessed 13 October 2015.

[95] State of Victoria, Department of Health, 2010. *Statewide mental health triage scale guidelines.* Available at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/triage-scale-mental-health-services. Accessed 13 October 2015.

[96] Commonwealth of Australia. 2012. *Mental Health Statement of Rights and Responsibilities*. Available at http://www.health.gov.au/internet/main/publishing.nsf/content/E39137B3C170F93ECA257CBC007CFC8C/$File/rights2.pdf. Accessed 14 October 2015. .

[97] NSW Health, 2009. *Aged Care Assessment and Care Planning Framework* (unpublished)

[98] Victoria Government, 2012. *Best care for older people everywhere: The Toolkit 2012*. Available at https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bEDB0805D-9A73-44B2-9D8F-41C84EE41A79%7d&title=Best%20care%20for%20older%20people%20everywhere%20-%20The%20toolkit%202012. Accessed 14 October 2015.

[99] See http://www.mocatest.org/

[100] Network of Alcohol and Drug Agencies (NADA), 2013. *Complex Needs Capable: A Practice Resource for Drug & Alcohol Services*, Sydney Australia, NADA. Available at http://www.nada.org.au/resources/nadapublications/resourcestoolkits/complexneedscapable/. Accessed 14 October 2015.

[101] Dementia Collaboration Research Centre – Assessment and Better Care, date unknown. *Dementia Outcomes Measurement Suite*. Available at http://www.dementia-assessment.com.au/contact.html. Accessed 9 December 2015.

[102] NSW Institute for Clinical Innovation, 2015. *Care of Confused Hospitalised Older Person Cognitive Screening Tools*. Available at http://www.aci.health.nsw.gov.au/chops/chops-key-principles/undertake-cognitive-screening/cognitive-screening-tools. Accessed 9 December 2015.

[103] NSW Ministry of Health, 2013.*Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) A Handbook for NSW Health Clinicians.* A publication by the NSW Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists. Available at https://www.ranzcp.org/Files/Publications/A-Handbook-for-NSW-Health-Clinicians-BPSD_June13_W.aspx. Accessed 14 October 2015.

[104] NSW Health, 2011. *Prevention of Falls and Harm from Falls among Older People: 2011-2015 PD2011_029*. Available at http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_029.html. Accessed 14 October 2015.

[105] NSW Government, Family and Community Services, 2014. *Preventing and responding to abuse of older people: NSW interagency policy 2014*. Available from

http://elderabusehelpline.com.au/for-professionals/nsw-state-government-policy-tools. Accessed 14 October 2015.

[106] NSW Ministry of Health, 2016, *Trends in alcohol use and health-related harms in NSW: Report of the Chief Health Officer 2016*. Sydney. Available at http://www.health.nsw.gov.au/hsnsw/Pages/chief-health-officers-report-2016.aspx. Accessed 26 July 2016.

[107] Brophy, L., Hodges, C., Halloran K., Grigg M., and Swiftz M., 2014. Impact of care coordination on Australia's mental health service delivery system. *Australian Health Review* 38: 396-400

[108] Cummings, S.M. and Kropf, N.P., 2009. Formal and informal support for older people with severe mental illness. *Ageing & Mental health* 13(4): 619-627

[109] Looi, J.C.L, Byrne, G.J., Macfarlane, S, McKay R., and O'Connor, D.W., 2014. Systemic approach to behavioural and psychological symptoms of dementia in residential aged care facilities. *Australian and New Zealand Journal of Psychiatry* 48(2): 112-115

[110] Clancy, L., Happell, B., and Moxham, L., 2015, Perception of risk for older people living with a mental illness: Balancing uncertainty. *International Journal of Mental Health Nursing* 24, pp. 577-586

[111] Boardman, J. and Roberts, G., 2014, *Risk, Safety and Recovery*. Published by Centre for Mental Health and Mental Health Network, NHS Confederation. Available at https://imroc.org/resources/9-risk-safety-recovery/. Accessed 14 July 2016.

[112] Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., and Barlow, S., 2016. Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy*. Jun 2016, pp.1-13

[113] Davidson, G., Brophy, L., Campbell, J., 2016, Risk, recovery and capacity: Competing or complementary approaches to mental health social work. *Australian Social Work* Vol 69(2), pp. 158-168

[114] Morgan, S., 2011, Positive Risk-Taking. Practical ways of working with risk. A Practice Based Evidence production for Hampshire Partnership NHS Foundation Trust. In Boardman, J. and Roberts, G., 2014, *Risk, Safety and Recovery*. Published by Centre for Mental Health and Mental Health Network, NHS Confederation. Available at http://yavee1czwq2ianky1a2ws010-wpengine.netdna-ssl.com/wp-content/uploads/2016/09/9ImROC-Briefing-Risk-Safety-and-Recovery3-1.pdf. Accessed 20 July 2016.

[115] Warner R., 2009, Recovery from schizophrenia and the Recovery Model. *Current Opinion in Psychiatry*, 2009(22):374–380,

[116] South London and Maudsley NHS Foundation Trust & South West London and St George's Mental Health NHS Trust, 2010, *Recovery is for all. Hope, agency and opportunity in psychiatry: A position statement by consultant psychiatrists*. London, UK. Available at http://www.rcpsych.ac.uk/pdf/recovery%20is%20for%20all.pdf. Accessed 20 July 2016.

[117] NSW Health, 2005, *Consent to Medical Treatment - Patient Information PD2005_406*. Available at http://www0.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_406.pdf. Accessed 13 October 2016.

[118] National Mental Health Information Development Expert Advisory Panel, 2013, *Mental Health National*

*Outcomes and Casemix Collection: NOCC Strategic Directions 2014 – 202*4. Commonwealth of Australia, Canberra. Available at http://www.amhocn.org/sites/default/files/publication_files/nocc_strategic_directions_2014-2024.pdf. Accessed 21 July 2016.

[119] Draper, B and Low, L, *What is the effectiveness of old-age mental health services?*, Synthesis Report for

World Health Organisation Regional Office for Europe's Health Evidence Network, July 2004, p.6., as sited in

NSW Department of Health, 2006. *Specialist Mental Health Services for Older People (SMHSOP) – NSW Service Plan 2005-2015 p.26*

[120] George, K., and Giri, S., 2011. An intensive community team in aged persons mental health. *Australasian Psychiatry* 19(1): 56-58

[121] Health Policy Analysis, 2011, *Evaluation of NSW Service Plan for Specialist Mental Health Services for Older People – Final report Volume 2 (Main report)*, NSW Ministry of Health, Sydney

[122] NSW Ministry of Health, 2014. *NSW State Health Plan Towards 2021*. Available at http://www.health.nsw.gov.au/statehealthplan/Publications/NSW-State-Health-Plan-Towards-2021.pdf. Accessed 18 November 2015.

[123] Zanjani, F., Kruger, T. and Murray, D., 2012. Evaluation of the Mental Healthiness Aging Initiative: Community program to promote awareness about mental health and aging issues. *Community Mental Health Journal* 48:193-201

[124] Reynolds C.F., Cuijpers P., Patel, V., Cohen, A., Dias, A., Chowdhary N., Okereke, O.I., Dew, M.A., Anderson, S.J., Mazumdar, S., Lotrich F. and Albert, S.M., 2012. Early intervention to reduce the global health and economic burden of major depression in older adults. *Annual Reviews* 33: 123-135

[125] Forsman, A.K., Nordmyr, J. and Wahlbeck, K., 2011. Psychosocial interventions for the promotion of mental health and the prevention of depression among older adults. *Health Promotion International* 26(S1): i85-i106

[126] NSW Department of Health, 2010. *NSW Suicide Prevention Strategy 2010-2015: A whole of government strategy promoting a whole of community approach.* Available at http://www.health.nsw.gov.au/mhdao/programs/mh/Publications/suicide-prev-strategy.pdf. Accessed 18 November 2015.

[127] Commonwealth of Australia, 2008. *Living Is For Everyone (LIFE) Framework (2007),* Commonwealth of Australia, Canberra. Available at http://www.livingisforeveryone.com.au/uploads/docs/LIFE_framework-web.pdf. Accessed 18 November 2015.

[128] Australian Government Department of Health and Ageing, 2013. *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013*. Available

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy. Accessed 18 November 2015.

[129] Australian Government Department of Health, 2015, *Fact Sheet: Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Heath Programmes and Services*. Available at http://www.health.gov.au/internet/main/publishing.nsf/content/mental-review-fact. Accessed 11 December 2015

[130] Lifespan, 2016, website, www.lifespan.org.au. Accessed 25 October 2016. .

[131] NHMRC Centre for Research Excellence in Suicide Prevention and Black Dog Institute, 2015. *Proposed Suicide Prevention Framework for NSW*, NSW Mental Health Commission, Sydney. Available at http://nswmentalhealthcommission.com.au/sites/default/files/Subfolder/PROPOSED%20SUICIDE%20PREVENTION%20FRAMEWORK%20FOR%20NSW%202015-2020%204%20Aug%202015.pdf. Accessed 18 November 2015

[132] Slade, M., 2013, *100 ways to support recovery: A guide for mental health professionals: Second edition*. Available at www.rethink.org/100ways. Accessed 7 April 2016.

[133] Substance Abuse and Mental Health Services Administration Center for Mental Health Services, no date, *National consensus statement on mental health recovery*. Available at http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf. Accessed 7 April 2016.

[134] NSW Ministry of Health, 2015. *Health Professional Workforce Plan 2012-2022 Revised 2015.* Available at http://www.health.nsw.gov.au/workforce/hpwp/Publications/health-professionals-workforce-plan.pdf. Accessed 24 November 2015.

[135] NSW Ministry of Health, 2013. *Aboriginal Workforce Strategic Framework 2011-2015 PD2011_048*. Available at http://www0.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_048.pdf. Accessed 25 November 2015

[136] Mitchell G.K., Tieman, J.J., and Shelby-James T.M. (2008), Multidisciplinary care planning and teamwork in primary care, *Medical Journal of Australia*, Vol. 188, No. 8, p.S63.

[137] American Psychological Association, webpage, *Health care reform: Integrated health care*, http://www.apa.org/about/gr/issues/health-care/integrated.aspx. Accessed 10 February 2016.

[138] Interprofessional Education Collaborative Expert Panel, 2011. *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative. Available at http://www.aacn.nche.edu/education-resources/ipecreport.pdf. Accessed 17 March 2016

[139] Curtin University, 2011, *Interprofessional Capability Framework*. Available at http://healthsciences.curtin.edu.au/wp-content/uploads/sites/6/2015/10/interprofessional_A5_broch_1-29072015.pdf. Accessed 17 March 2016

[140] Health Education and Training Institute, 2015, *NSW Health Clinical Supervision Framework May 2015*. Available at http://www.heti.nsw.gov.au/Global/Consultation/DRAFT%20Clinical%20Supervision%20Framework.pdf. Accessed 8 March 2016.

[141] Queensland Government Queensland Health, 2009, *Clinical Supervision Guidelines for Mental Health Services*. Available at https://www.health.qld.gov.au/qcmhl/Supervision/superguide_2009.pdf. Accessed 13 January 2016.

[142] Government of Western Australia Department of Health, 2005, *Clinical Supervision Framework for WA Mental Health Services and Clinicians*. Available at http://www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/HP3095_Clinical_supervision_framework_for_WA_mental_health.pdf. Accessed 13 January 2016.

[143] Australian Association of Social Workers, 2014. *Supervision Standards – 2014*. Available at http://www.aasw.asn.au/document/item/6027. Accessed 25 November 2015.

[144] Australian Psychological Society, 2013. *Ethical Guidelines on supervision*. Melbourne, Vic.

[145] Australian College of Mental Health Nursing, 2011. *Clinical Supervision Position Statement*. Available at http://www.acmhn.org/career-resources/clinical-supervision. Accessed 25 November 2015.

[146] Psychotherapy and Counselling Federation of Australia, 2010. *PACFA Register Requirements and Appeal Process*. Available at http://pacfa.org.au/wp-content/uploads/2012/10/PACFA-Register-Requirements-and-Appeal-Process-2012.pdf. Accessed 25 November 2015.

[147] Department of Developmental Disability Neuropsychiatry, UNSW Australia, and NSW Ministry of Health, 2016, *The Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals*. Department of Developmental Disability Neuropsychiatry ISBN 978-1-76000-321-0. Available at http://3dn.unsw.edu.au/IDMH-CORE-COMPETENCY-FRAMEWORK. Accessed 6 July 2016.

[148] Australian Institute of Health and Welfare, 2015, *Cultural Competency in the delivery of health services for Indigenous people*. Available at http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2015/ctgc-ip13.pdf. Accessed 14 January 2016.

[149] Mental Health in Multicultural Australia, 2014. *The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery.* Available at http://framework.mhima.org.au/framework/. Accessed 25 November 2015.

[150] Multicultural Mental Health Australia, 2010, *National Cultural Competency Tool (NCCT) for Mental Health Services*. Available at www.mhima.org.au/_literature_73821/NCCT. *Accessed 20 January 2016.*

[151] NSW Ministry of Health, 2013. *2013 SMHSOP Workforce Survey NSW Report March 2013* (unpublished)

[152] Chaplin, R.K., Sergeant, J.F., Landry, S., Leedahl, S.N., Rachlin, R., Koenig, T. and Graham, A., 2013. *Reclaiming Joy: Pilot Evaluation of a Mental Health Peer Support Program for Older Adults who receive Medicaid.* The Gerontologist 53: 2, pp. 345-352. Available at http://gerontologist.oxfordjournals.org/content/53/2/345.long. Accessed 12 April 2016.

[153] National Mental Health Consumer & Carer Forum, 2010, *Supporting and Developing the mental health consumer and carer identified workforce – a strategic approach to recovery*, NMH CCF, Canberra. Available at http://nmhccf.org.au/sites/default/files/docs/mhca_carewf_layout_16-9_0.pdf (accessed 12 January 2016)

[154] McLean, J., Biggs, H., Whitehead, I., Pratt, R. and Maxwell, M., 2009, *Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme.* Scottish Government Social Research, Edinburgh. Available at: www.scotland.gov.uk/Resource/Doc/291864/0089933.pdf. Accessed 12 January 2016.

[155] Berry, C., Hayward, M.I., and Chandler, R., 2011, Another rather than other: experiences of peer support specialist workers and their managers working in mental health services, *Journal of Public Mental Health*, Vol. 10 Iss 4 pp. 238 – 249

[156] Grey, F. and O'Hagan, M. 2015. *The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the Mental Health Commission of New South Wales*. Available at http://nswmentalhealthcommission.com.au/publications/the-effectiveness-of-services-led-or-run-by-consumers-in-mental-health-rapid-review-of. Accessed 9 August 2016.

[157] NSW Ministry of Health, 2014. *Building a better system: Investing in workforce*. Available at *http://www.health.nsw.gov.au/mentalhealth/reform/*Publications*/investing-in-workforce.pdf*. Accessed 25 November 2015.

[158] Health Partners Consulting Group Limited, 2015, *Review of Consumer Participation,* (unpublished)

[159] Health Workforce Australia, 2014, *Mental Health Peer Workforce Study*. Available at http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Study_LR.pdf. Accessed 9 August 2016.

[160] NSW Consumer Advisory Group – Mental Health Inc., 2010. *Consumer Workers' Project: Literature Review on the Mental Health Consumer Workforce*. Available at http://being.org.au/wp-content/uploads/2015/06/cwf_literature_review_final.pdf. Accessed 12 January 2016.

[161] Health Workforce Australia, 2014, *Mental Health Peer Workforce Literature Scan*. Available at http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Literature%20scan_LR.pdf . Accessed 9 August 2016.

[162] Available at http://training.gov.au/training/details/CHC42912. Accessed 14 April 2016.

[163] MHPOD, webpage, *Supporting a Mental Health Peer Workforce: Peer Worker Roles: Rationale and Evidence Base,*

http://www.mhpod.gov.au/assets/sample_topics/combined/Supporting_a_Mental_Health_Peer_Workforce/objective1/index.html. Accessed 9 March 2016.

[164] Australian Commission on Safety and Quality in Health Care (2014) *Scoping Study on the Implementation of National Standards in Mental Health Services*, Sydney, ACSQHC. Available at http://www.safetyandquality.gov.au/wp-content/uploads/2014/11/Scoping-Study-on-the-Implementation-of-National-Standards-in-Mental-Health-Services.pdf. Accessed 27 January 2016.

[165] Commonwealth of Australia, webpage, *National Mental Health Performance Framework*. Available at http://meteor.aihw.gov.au/content/index.phtml/itemId/584825. Accessed 20 January 2016.

[166] NSW Ministry of Health, *2016, 201/17 Service Agreement Key Performance Indicators and Service Measures Data Dictionary IB2016_036.* Available at http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_036.pdf. Accessed 3 November 2016.

[167]BEING, webpage, *Your Experience of Service (YES)*. Available at http://being.org.au/resources/yes/. Accessed 21 January 2016.

[168] NSW Ministry of Health, 2015, webpage, *Performance Framework*. Available at http://www.health.nsw.gov.au/Performance/pages/frameworks.aspx. Accessed 20 January 2016.

[169] Australian Mental Health Outcomes and Classification Network, webpage, *NOCC – What is it?.* Available at http://www.amhocn.org/background/nocc-what-it. Accessed 21 January 2016.

[170] Australian Institute of Health and Welfare, webpage, *Health Sector National Minimum Data Sets*. Available at http://meteor.aihw.gov.au/content/index.phtml/itemId/344850. Accessed 21 January 2016.

[171] NSW Ministry of Health, 2016, *Managing for Performance PD2016_040*. Available at http://www0.health.nsw.gov.au/policies/pd/2016/pdf/PD2016_040.pdf Accessed 3 November 2016.

[172] NSW Ministry of Health, 2012, *NSW Health and Medical Research Strategic Review*. Available from http://www.health.nsw.gov.au/ohmr/Publications/strategic-review-report.pdf. Accessed 16 March 2016

[173] University of Rochester Medical Centre, webpage, *The Biopsychosocial Approach*, https://www.urmc.rochester.edu/medialibraries/urmcmedia/education/md/documents/biopsychosocial-model-approach.pdf. Accessed 9 March 2016

[174] Cross, T., Bazron, B., Dennis, K., Issacs, M., 1989, *Towards a culturally competent system of care Volume 1,* Washington DC: Georgetown University Child Development Centre, CASSP Technical Assistance Center. Sited in Ethnic Communities Council of Victoria, 2006, *Cultural Competency Guidelines and Protocols*. Available at http://eccv.org.au/library/doc/CulturalCompetenceGuidelinesandProtocols.pdf. Accessed 22 March 2016.

[175] National Centre for Cultural Competence (NCCC), 2006, *Conceptual Frameworks/Models, Guiding Values and Principles,* Washington DC, Georgetown

University Child Development Centre. Available at http://nccc.georgetown.edu/foundations/frameworks.html. Accessed 22 March 2016.

[176] NSW Ministry of Health, 2015. *Integrated Care*. Available at http://www.health.nsw.gov.au/integratedcare/Pages/default.aspx. Accessed 21 October 2015.

[177] Government of Western Australian Department of Health, webpage, *Aged and Community Care Models of Care*, http://www.agedcare.health.wa.gov.au/home/moc.cfm. Accessed 1 March 2016.

[178] NSW Health, 2015, *NSW Rehabilitation Model of Care: NSW Health Rehabilitation Redesign Project: Final Report – Model of Care: Version 1.5, Issued 06/01/15*. Available at https://www.aci.health.nsw.gov.au/resources/rehabilitation/rehabilitation-model-of-care/rehabilitation-moc. Accessed 1 March 2016

[179] MHCC/NADA, 2009, *No Wrong Door: Mental Health Drug & Alcohol Change Management Project.* Available at http://mhcc.org.au/media/14048/no-wrong-door-project-overview.pdf. Accessed 24 February 2016.

[180] Australian Commission on Safety and Quality in Health Care, 2012. *Safety and Quality Improvement Guide Standard 6: Clinical Handover (October 2012)*. Sydney. ACSQHC, 2012. Available at https://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_Oct_2012_WEB.pdf. Accessed 3 November 2016.