

NSW Older People's Mental Health Services SERVICE PLAN 2017-2027

Summary This plan is intended to guide NSW older people's mental health (OPMH) services over the next ten years. Pressure on these specialist services will grow as the population ages and the number of older people with complex mental health problems increases. The Plan outlines the purpose, scope, target group and key elements of OPMH services, the context in which they operate and current developments in the service environment. It identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of OPMH services.

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NSW OLDER PEOPLE'S MENTAL HEALTH SERVICES SERVICE PLAN 2017- 2027

PURPOSE

The OPMH Service Plan outlines the purpose, scope and key elements of NSW Older People's Mental Health (OPMH) services, the target group for these services, the context in which they operate, and current developments in the service environment. The Plan identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of these services. It will guide OPMH services over the next ten years, seeking to ensure that OPMH services continue to develop and improve, to meet the needs of older people with mental health problems, and to provide consistent, high-quality services across NSW. More broadly, the Plan also promotes key linkages and partnerships to enhance mental health care and support for older people across NSW.

KEY PRINCIPLES

The Plan recognises and supports the impetus in NSW mental health services towards recovery-oriented care and practice. It is underpinned by the principles of improving the accessibility of OPMH services, promoting consistent good practice in OPMH services, and supporting effective and appropriate care for older people with mental illness.

The Plan 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

The intended audience of the Plan is OPMH service managers, clinicians, service planners and policy makers. It focuses on the delivery of care for older people with mental illness by inpatient and community OPMH services in NSW Local Health Districts. An implementation plan is proposed to guide the NSW Ministry of Health and LHD OPMH services in pursuing the strategic directions outlined in the Plan over the next ten years.

The Plan will also be relevant for adult mental health services and other partner services such as GPs and Primary Health Networks, aged health services and aged care services.

REVISION HISTORY

Version	Approved by	Amendment notes
December 2017 (GL2017_022)	Deputy Secretary, Strategy and Resources	Covers the period 2017-2027
August 2006 (GL2006_013)	Director-General	New document.

ATTACHMENTS

1. NSW Older People's Mental Health Services SERVICE PLAN 2017-2027

NSW Older People's Mental Health Services

SERVICE PLAN 2017-2027



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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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December 2017



Foreword

As NSW Minister for Mental Health and Minister for Ageing, I'm pleased to support this ten-year plan for older people's mental health services across NSW. Older people's mental health is a significant priority for the NSW Government.

We hear much about the ageing of Australia's population. By 2030, 20% of the people living in NSW will be aged 65 years or over. It is important to take a positive approach to ageing, and to value the diverse life experiences of older people, their strengths and ongoing potential for growth, their goals and their preferences. Growing old is not a disease, and older people are often very resilient.

However, like people of any age, older people can experience mental illness. Some people develop a mental illness as they age, while others grow older with a mental illness that developed earlier in their lives. Some of these older people will need care from specialist mental health clinical services.

In July 2017, I had the privilege of launching the NSW Mental Health Commission's *Living Well in Later Life* documents. These documents were developed to progress reform in older people's mental health care and support, and to promote the wellbeing of older people living in NSW. This plan for older people's mental health clinical services addresses some of the key priorities identified in the Commission's documents. In particular, it promotes a focus on increasing specialist community clinical services to address population need, expanding partnership service delivery models between mental health services and non-government residential aged care services, and adopting recovery-oriented approaches in older people's mental health care and support.

Ensuring that older people with a mental health issue can live a better life, and participate in their communities is a commitment of the NSW Government under the NSW mental health reforms.

Over the next 12 months, new funding of \$2.374 million will support recruitment of approximately 15 new fulltime specialist community-based clinicians right across NSW and within Justice Health. This builds on previous funding of \$5 million from 2016-17 for older people's mental health community clinical services, which supported recruitment of over 30 new fulltime equivalent clinicians in six local health districts, promoting more equal access to care across NSW.

The NSW Government has provided funding for the expansion of mental health-residential aged care partnership services in a number of local health districts under the first stage of the Pathways to Community Living Initiative – another key mental health reform strategy. Mental health reform funding will also support the rollout of Mental Health First Aid for Older People across NSW, aimed at promoting greater understanding and recognition of mental health issues in older people, and access to help.

Together, these funding enhancements support the implementation of key directions in this plan to expand community clinical services and mental health-residential aged care partnership services. Investment in this area by the Government will mean that older people with mental illness or mental distress and their families will receive improved community mental health care and support, better access to services across NSW and – importantly – more specialist assessment and care, locally.

This plan, and the associated funding, is part of the NSW Government's commitment to a decade-long, whole-of-government reform of mental health care. These reforms put people – not processes – at the centre of the mental health care system.



The Hon Tanya Davies MP
Minister for Mental Health
Minister for Ageing

Acknowledgements

The **NSW Service Plan for Older People's Mental Health (OPMH) Services 2017-2027** is the work of many people. Broad consultation informed the development of the Plan. We acknowledge the consumers and carers who participated in the consultation workshops and the clinicians, organisations and individuals who provided feedback and guidance. The NSW Health Specialist Mental Health Services for Older People (SMHSOP) Advisory Group, OPMH Working Group, and Aboriginal and CALD OPMH Working Groups also contributed significantly to the development of the Plan.

The OPMH Policy Unit of the Mental Health Branch, NSW Ministry of Health led the development of this plan, with advice and input from the Project Team. The NSW Ministry of Health would particularly like to thank the members of the Project Team for their efforts and guidance.

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Executive summary

Mental health improves for many people in later life. However, older people can be vulnerable to mental health problems, including depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, personality disorders, and alcohol and substance misuse disorders. In some circumstances, the presence of mental illness in older people is more common, including in people with chronic illnesses, people living in residential aged care facilities, and people with dementia. As the NSW population ages, the number of older people with mental illness is projected to increase, rising to approximately 260,000 in 2026. The ageing population and growing need for older people's mental health (OPMH) services are significant strategic drivers for this plan.

OPMH services are a clinical stream of public mental health services generally provided to people aged 65 years and over, and 50 years and over for Aboriginal people. OPMH services include: multidisciplinary community services; acute inpatient units/services (AIU) (including units performing some sub-acute functions); non-acute inpatient units/services, including Transitional Behaviour Assessment and Intervention Service (T-BASIS) units, and community OPMH partnership services (including residential services) and programs. Key OPMH service clinical functions include: specialist mental health assessment, care planning and short and longer term clinical management; joint care planning and care coordination with General Practitioners (GPs) and other health care providers, and specialist clinical advice to other key services.

The **NSW Service Plan for Older People's Mental Health (OPMH) Services 2017-2027** outlines the purpose, scope and key elements of NSW OPMH services, the target group for these services, the context in which they operate, and current developments in the service environment. The Plan identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of these services. It will guide OPMH services over the next ten years, seeking to ensure that OPMH services continue to develop and improve, to meet the needs of older people with mental health problems, and to provide consistent, high-quality services across NSW. More broadly, the Plan also promotes key linkages and partnerships to enhance mental health care and support for older people across NSW.

This plan recognises and supports the impetus in NSW mental health services towards recovery-oriented care and practices, and the need for mental health services to actively support individuals to define their own recovery goals and direct their own care. It recognises the current variation in access to OPMH services across NSW, as well as variation in practice and service delivery arrangements. It is underpinned by the principles of improving the accessibility of OPMH services, promoting consistent good practice in OPMH services, and supporting effective and appropriate care for older people with mental illness. Importantly, it seeks to improve care experiences and care outcomes for older people with mental illness, as well as the continuity and integration of care.

An implementation plan is proposed to guide the NSW Ministry of Health and LHD OPMH services in pursuing the strategic directions outlined in the Plan over the next ten years. The implementation plan incorporates two major phases of service development:

- **Phase 1** focusses on expanding and improving community OPMH services, and expanding community partnership models. Policy and service model development work will focus on non-acute inpatient models and services, as well as review of the OPMH acute inpatient unit model of care to ensure it addresses new evidence, practice developments and policy directions. Service development strategies for specific population groups will focus on older people with co-existing mental health and alcohol and other drug issues, older people with co-existing mental health problems and intellectual disability, older people in the criminal justice system and LGBTI communities, supported by recent policy and planning work in these areas. Other strategies for specific population groups will build on developments under the last NSW OPMH Service Plan.

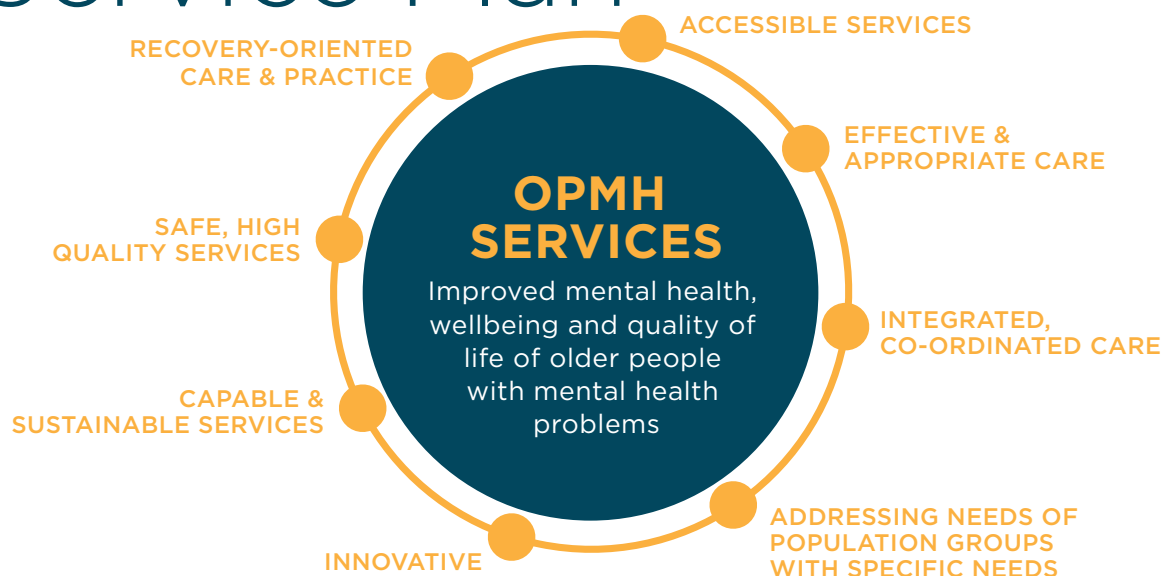
- **Phase 2** focusses on further development of non-acute inpatient services and improvement of acute inpatient services in the context of policy, service model and service model review work in Phase 1 and other developments in the service context. Service development strategies for specific population groups will build on developments in Phase 1.

The implementation plan sets out some indicative performance and process measures as well as data sources for monitoring progress with implementation and evaluating key impacts and outcomes of the Plan. A range of existing NSW mental health reporting processes will enable monitoring of the Plan. Key state-wide mechanisms and national quality and safety assurance processes, including accreditation will be used to monitor implementation of the Plan and the quality, safety and performance of OPMH services.

NSW Health will commission a mid-term evaluation in 2022 to review progress with implementing the Plan and evaluate impacts and outcomes from Phase 1. The evaluation will include a review of the actions outlined for development in Phase 2, based on learnings from Phase 1 and any further developments in the evidence base, policy and planning context, and service environment. This will ensure that the Plan remains relevant and appropriate as the environment changes, and builds on developments in OPMH services progressed in Phase 1.

The figure on the following page provides an overview of the Plan, including its overarching goal and key principles, key strategic directions across the four OPMH service elements, identified population groups with specific needs, and key enablers to support the further development and improvement of OPMH services.

Service Plan at A GLANCE



STRATEGIC DIRECTIONS FOR OPMH SERVICES 2017-2027

COMMUNITY SERVICES	ACUTE INPATIENT UNITS/SERVICES	NON-ACUTE INPATIENT UNITS/SERVICES	COMMUNITY PARTNERSHIP MODELS	
			OPMH-RESIDENTIAL AGED CARE	OPMH - COMMUNITY CARE AND SUPPORT PROGRAMS
Improve appropriateness, outcomes of care & consumer and carer experiences	Improve appropriateness, outcomes of care & consumer and carer experiences	Deliver, develop & reform services (T-BASIS model or other appropriate models)	Expand and further develop MHACPI transition units and Specialist RACFs	Promote recognition of mental health issues and access to community services/programs
Increase accessibility & capacity across NSW	Improve the effectiveness of care (in OPMH and adult MH units)	Progress policy work on state-wide/tertiary intensive care BPSD model	Develop capacity & practice of OPMH community services to support transitions & outreach to RACFs	Promote partnerships, collaboration & integration of care
Promote partnerships, collaboration & integration of care	Promote collaboration & integration of care with OPMH community services	Progress policy work to support clear strategic directions for non-acute inpatient services	Promote partnerships, collaboration & integration of care	
Improve practice, performance & efficiency	Improve practice, performance & efficiency			
Improve equity of access				

POPULATION GROUPS WITH SPECIFIC NEEDS

- Older Aboriginal people
- Older people living in rural & remote areas
- Older people from CALD backgrounds
- Residents of aged care facilities
- Older people with co-existing MH & AoD issues
- Older people with co-existing MH problems & intellectual disability
- Older people in the criminal justice system
- Older people who are homeless
- Older people living in domestic squalor
- Older LGBTI people
- Families & carers

ENABLERS TO SUPPORT THE DEVELOPMENT OF OPMH SERVICES

- Consumer & carer participation
- Planning
- Prevention & early intervention
- Workforce
- Strategic liaison, partnerships & integrated care
- Governance, quality & safety
- Research

Acronyms: AoD: Alcohol and other drugs; BPSD: Behavioural & Psychological Symptoms of Dementia; CALD: Culturally & Linguistically Diverse; LGBTI: Lesbian, gay, bisexual, transgender & intersex; MH: Mental Health; MHACPI: Mental Health Aged Care Partnership Initiative; OPMH: Older People's Mental Health; RACF: Residential Aged Care Facility; T-BASIS: Transitional Behavioural Assessment and Intervention Service

Section 1:

Introduction

The NSW Service Plan for Older People’s Mental Health (OPMH) Services 2017-2027 (the Plan)

outlines the purpose, scope and key elements of NSW OPMH services, the target group for these services, the context in which they operate, and current developments in the service environment. The Plan identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of these services. It will guide OPMH services over the next ten years, and promote key linkages and partnerships to enhance mental health care for older people across NSW. The intended audience of this plan is OPMH service

managers and clinicians, and mental health service planners and policy makers.

The Plan builds on the *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015 NSW*¹ (see [Appendix 1](#)). It aims to ensure that OPMH services continue to develop and improve, to meet the needs of older people with mental health problems, and to provide consistent, high-quality services across NSW. OPMH services play a crucial role within the broader system of mental health care and support by providing specialist clinical care and support to older people with mental health problems, and to their carers and families.

OPMH services

Service elements

Previously known as Specialist Mental Health Services for Older People (or ‘SMHSOP’), OPMH services are a clinical stream of specialist public mental health services generally provided to people aged 65 years and over, and 50 years and over for Aboriginal people (see [Section 1.7](#)). The OPMH service model includes:

- multidisciplinary community services
- acute inpatient units/services (AIU) (including units performing some sub-acute functions)
- non-acute inpatient units/services, including Transitional Behaviour Assessment and Intervention Service (T-BASIS) units
- community OPMH partnership services (including residential services) and programs.

Distribution

Currently, there is variation in the scope and capacity of OPMH services in different Local Health Districts (LHDs) across NSW. However, all LHDs, St Vincent’s Health Network and Justice Health and Forensic Mental Health Network (JH&FMHN) have OPMH community services, the majority of LHDs have or are developing specialist OPMH acute and/or non-acute inpatient units, and residential services are being expanded to most metropolitan and some regional LHDs. Inpatient acute and non-acute OPMH services are a highly specialist resource in a ‘stepped system’ of care,²¹ where people can step up and down to the most appropriate level of care for their needs. General adult mental health services also provide mental health care for older people, including in emergency or crisis situations.

Functions

Key OPMH service clinical functions include:

- specialist mental health assessment, care planning, and short and longer term clinical management involving clinical care, treatment, clinical review and transitions of care
- joint care planning and care coordination with General Practitioners (GPs) and other health care providers
- specialist clinical advice to other key services such as GPs, inpatient services, aged health services, and community and residential aged care services (including assessment and diagnostic opinion, treatment recommendations and advice to support care)
- programs and collaborative activities (such as education, group programs and outreach) to support early intervention and recovery for older people with mental health problems.

Other functions may include specialist consultation and liaison, crisis care, research and evaluation, and specific mental health promotion, illness prevention and early intervention activities.

OPMH services are delivered by a range of health professionals such as specialist old age psychiatrists, nurses and allied health professionals (e.g. psychologists, occupational therapists, diversional therapists and social workers) with skills and expertise in mental health problems affecting older people and people with age-related frailty.

1.1 Mental illness in older people

Contrary to many preconceptions, mental health improves for many people in later life. Mental illness and dementia are not an inevitable part of becoming older, and the proportion of people with diagnosable mental illness reduces with age.² However, like people of any age, older people can be vulnerable to mental health problems. 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.³ Such illnesses include depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, personality disorders and alcohol and substance misuse disorders. In some circumstances, the presence of mental illness in older people is more common, including in people with chronic illnesses,⁴ people living in residential aged care facilities,⁵ people with CALD backgrounds⁶ and people with dementia⁷ (who can experience severe behavioural and psychiatric symptoms).

Ageing brings with it an increased risk of dementia. Dementia affects 10% of people aged over 65 years, and 31% of people over 85 years.⁸ Suicide is a significant issue for older people, particularly older men. Depression is an important risk factor for suicide in later life. Men aged 85 and over persistently have the highest suicide rate in Australia.⁹

As the NSW population ages, the number of older people with a diagnosable mental illness is projected to increase significantly, rising from approximately 190,000 in 2016 to approximately 260,000 in 2026.^{10,i} The ageing population and growing need for OPMH services are significant strategic drivers for this plan.

The presentation of mental illness in older age is often atypical and mental illness often co-occurs with other physical health conditions. Older people frequently have complex care needs, respond differently to medications compared with younger people, and require a longer time for clinical recovery.

Importantly, mental health therapies are as effective in older people as in younger people, and older people with mental illness usually experience improved mental health with the right care and treatment.^{11,12,13}

OPMH services are a key component of the broader system of care and support for older people with or at risk of mental health problems, providing specialist clinical services for older people with mental illness health problems. There are a range of other key partners in this broader system (see [Section 3.9](#)), including GPs, private psychiatrists and psychologists, community care and support services and residential services. Given this, care coordination is paramount, along with an integrated approach to the care of older people with mental health problems across the continuum of care (see [Section 2.4](#) and [Section 3.9](#)).

1.2 A new plan for OPMH services

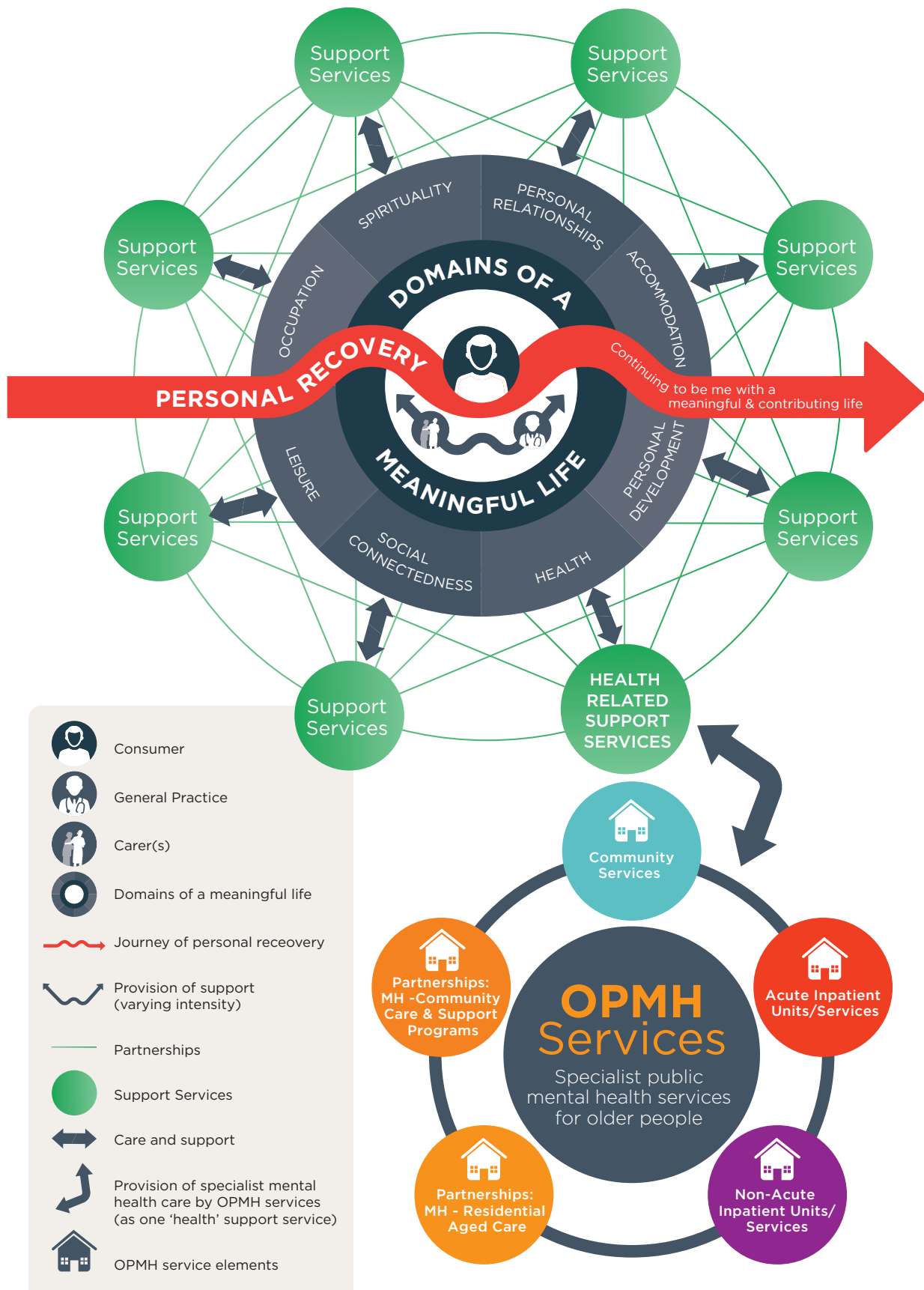
This plan is focussed on the role of OPMH services in providing care for older people with mental illness. However, it also clearly recognises the need for these services to link people with a range of clinical and non-clinical supports to promote recovery and wellbeing. More broadly, it recognises the need for communities, government and non-government agencies and various services to find ways to promote mental health and wellbeing in older people. OPMH services are one part of a complex system that supports an individual's recovery journey, as shown in Figure 1.

The Plan recognises and supports the impetus in NSW mental health services towards recovery-oriented care and practices, and the need for mental health services to actively support individuals to define their own recovery goals and direct their own care. Individual recovery at any age is a unique and personal journey to live a meaningful and contributing life in a community of choice, with or without the presence of mental health issues.¹⁴ Older consumers have described this as 'continuing to be me'.¹⁵ Important elements in personal recovery may include enhancing resilience, maintaining identity, fostering family and community relationships and developing coping strategies.

The Plan recognises that there is currently variation in access to OPMH services across NSW, as well as variation in practice and service delivery arrangements. It is underpinned by the principles of improving the accessibility of OPMH services, promoting consistent good practice in OPMH services, and supporting effective and appropriate care for older people with mental illness. It has a focus on enhancing community-based care and support, whilst supporting the ongoing role of acute and non-acute inpatient services in providing care for those older people with severe mental illness who cannot be treated in community settings. The Plan is expected to guide future resource allocation at the local and state levels.

i Source: NMHSPF, with data drawn from the 2003 Australian Burden of Disease Study, supplemented by other national and international survey data where necessary. This figure indicates the 12 month prevalence of mental illness for people aged 65+ years in NSW across three levels of severity (mild/moderate/severe).

Figure 1: OPMH services are one part of a complex system that supports an older person's recovery



It is recognised that recovery is not always linear, and a person might move back and forth with provision of support at varying levels of intensity.

Domains of a meaningful life adapted from NHS Southern Health¹⁶ and National Framework for Recovery-Oriented Mental Health Services¹⁷

Development of the Plan has been overseen by a Project Group with representation from rural and metropolitan OPMH services in NSW, the OPMH Policy Unit of the NSW Ministry of Health Mental Health Branch and a consumer consultant. Extensive consultation with users of OPMH services and their carers, the NSW SMHSOP Advisory Group, NSW OPMH Working Group, NSW Aboriginal and CALD OPMH Working Groups, NSW Primary Health Networks (PHNs) and other key stakeholders has informed the Plan.

During the timeframe of the Plan, there may be changes in the clinical, policy and service delivery environment. Best practice approaches, models of care and terminology may change over time. A mid-term evaluation of the Plan will be conducted to ensure that the Plan remains relevant and appropriate (see [Section 4.3](#)).

1.3 Scope of the plan

The Plan focuses on the delivery of care for the target group (see [Section 1.7](#)) by inpatient and community OPMH services in NSW LHDs. The Plan will also be relevant for adult mental health services and other partner services such as GPs and PHNs, aged health services and aged care services.

1.4 Outline of the plan

The structure of the Plan is as follows:

- **Section 1** (this section) provides an overview of OPMH services, describes the overall goal and guiding principles underpinning the Plan, outlines the aims and scope of the Plan, and defines the OPMH services target group.
- **Section 2** provides a current overview of OPMH services in NSW, articulates the key messages expressed in consultations with consumers and carers, outlines the planning and policy context for the mental health care of older people, and identifies the key challenges and strategic drivers for the development of OPMH services. This section also describes key priorities and strategies for addressing the mental health needs of 'specific population groups'.
- **Section 3** describes the four key elements of the OPMH service model, summarising the service model and articulating key strategic directions and areas for development. This section also outlines the key enablers of OPMH service development and quality improvement (consumer and carer participation, planning, prevention and

early intervention approaches, workforce, strategic liaison, partnerships and integrated care, governance, quality and safety, and research) and highlights key priorities in each of these areas.

- **Section 4** outlines the implementation plan for the development of OPMH services over the next ten years (with detailed strategies, performance measures and reporting mechanisms included at [Appendix 8](#)). This section also outlines reporting and monitoring processes and Key Performance Indicators (KPIs) for the review and evaluation of the Plan.

1.5 Our goal and guiding principles

Our goal

is to improve the mental health, wellbeing and quality of life of older people with mental health problems.

The Plan is underpinned by the following key principles. Throughout the implementation of the Plan, these principles will continue to provide guidance and support achievement of our goal.

- **Consumers and their families and carers can expect to be provided with care that is consistent with the *Mental Health Statement of Rights and Responsibilities*¹⁸**
 - The value of lived experience of mental illness is acknowledged.
 - Older people are treated with courtesy and dignity.
 - Diversity is respected, valued and embraced.
 - Social inclusion, independence and quality of life of older people with mental health problems is promoted and facilitated.
 - OPMH services advocate for the rights of consumers and carers when required.
- **OPMH services provide recovery-oriented, person-centred care and practice, and clinicians work in partnership with consumers and their families and carers**
 - Care is planned and delivered in full partnership with consumers and their carer(s), and consumers are supported to make informed decisions about their ongoing care and treatment.
 - Consumers are supported to identify their own care and recovery goals and strategies to maintain wellness.

- OPMH services communicate and engage effectively with consumers and carer(s) from initial contact and throughout the consumer’s recovery journey.
- Trauma-informed care and practice is recognised as integral to recovery-oriented practice.
- OPMH services provide opportunities for consumers and carers to become expert partners in improving service quality and care delivery, including through the provision of feedback.
- **OPMH services become more accessible across NSW**
 - There is *improved access* to OPMH services for older people with mental health problems. Services are promoted and service information is provided to primary care providers, other referral partners, consumers and carers.
 - *Easy and timely access* to care is promoted. OPMH services will aim to accept any person referred to OPMH services for secondary triage and/or initial assessment following triage, and to assist them into the care they need.
 - There is more *equitable access* to OPMH services across NSW, with services provided in line with population need, in locations where they are most required and as close to home as possible.
- **Consumers receive effective and appropriate care**
 - All consumers receive *holistic, multidisciplinary, biopsychosocial* care and treatment, in accordance with the evidence base and in line with policy, guidelines, standards and legislative frameworks.
 - Staff have the *specialist skills* to conduct specialist mental health assessment, diagnosis and treatment tailored for older people.
 - The *value and importance of peer workers* particularly in improving the recovery orientation of services and complementing clinical roles is recognised. Access to peer workers is supported in accordance with consumer choice.
 - The important role played by volunteers working with OPMH services is recognised and promoted.
- **Integrated, coordinated care is provided for all consumers**
 - OPMH services work in partnership with GPs, private psychiatrists and psychologists, and other key service and health care providers both within and external to NSW Health, with a focus on recovery and supporting integrated care across different settings.
- **The physical health needs of consumers are identified and addressed.** This will include OPMH services working in partnership with GPs and other key service providers, and supporting consumers to get their physical health needs met.
- **The particular needs of specific population groups and older people with mental illness and co-occurring problems are recognised and addressed.** OPMH services coordinate and work in partnership with other key services to improve responses for these population groups.
- **OPMH services are capable, efficient and sustainable**
 - Staff training, skills development and workforce planning is supported, supportive organisational and team structures are promoted, and there is a focus on research and evaluation.
 - Services work within the Activity Based Funding system to ensure sustainable funding, with a focus on efficiency, and use data at the local and state level to monitor and manage performance and budgets.
- **OPMH services are safe and of high quality**
 - OPMH services identify, measure and act on ways to improve care and OPMH services across NSW.
- **Innovation and new models of care and ways of working are embraced.**

1.6 Our aims

The Plan aims to:

- articulate the target group for OPMH services
- summarise the key elements of OPMH services (OPMH community services, OPMH acute and non-acute inpatient units/services, community partnership models) and associated models of care and service delivery
- describe key directions for OPMH services across NSW over the next 10 years, underpinned by recovery-oriented practice, partnerships and integrated care approaches

- consider good practice and service delivery approaches for specific population groups
- consider the 'enablers' that support the development of OPMH services
- articulate current challenges and new and emerging priorities for OPMH services
- outline an implementation plan for the development of OPMH services across NSW over the next 10 years
- provide direction for LHD OPMH Service Clinical Coordinators/Service Managers for strategic planning and service development work at the local level
- enhance service planning and delivery of OPMH services in metropolitan, regional, rural and remote areas of NSW to improve equity of access for older people with mental health problems, their families and carers
- provide a framework to streamline and standardise reporting, monitoring and review processes for OPMH services, with a focus on clinical service delivery and outcomes.

At a policy and service system level, the Plan aims to:

- facilitate integrated care and partnerships between OPMH services, primary health, aged care, adult mental health, community managed organisations (CMOs), community aged care and mental health services, and residential services
- inform the policy and planning work of other key services, agencies and jurisdictions regarding mental health initiatives and care and support of older people.
- inform the community, consumers and carers on the direction of older people's mental health services in NSW.

By implementing the actions outlined in the Plan, we will:

- increase the accessibility, effectiveness and responsiveness of OPMH services across NSW
- improve the recovery orientation of OPMH services, including trauma-informed care
- contribute to improved health and mental health outcomes and quality of life for older people with mental health problems in NSW.

1.7 OPMH services target group

The broad target group for OPMH services is older people (generally 65 years and over) with mental illness (including people with and without dementia). However, OPMH services should apply

flexibility in seeing people with mental illness who are under 65 years with potential ageing-related problems causing significant functional disability and/or mental health problems in the context of dementia.

Some people with particular clinical symptoms may be 65 years or older (or Aboriginal people 50 years or older) but still be most appropriate for management by adult mental health services, in collaboration with OPMH services. Adult or generalist mental health services maintain a key role in the care of existing consumers beyond the age of 65 where OPMH services are not available, where these consumers are being appropriately managed by adult or generalist services, where this promotes continuity of care and/or if this is the preference of the consumer.

The target group for OPMH services includes older people who:

- develop or are at high risk of developing a mental health disorder or symptoms in later life, including suicidality and self-harm
- have significant difficulties associated with long-term mental illness and/or its treatment, and now experience ageing-related problems causing significant functional disability (i.e. frailty and/or progressive cognitive impairment – see information following), or
- have a recurrence of an earlier mental health problem, have not seen a specialist mental health service for at least two years, and can be optimally managed by the OPMH service, with consideration to individual preference.

Within this plan it is acknowledged that mental health problems in the context of dementia may present differently and include what are sometimes called moderate-severe behavioural and psychological symptoms of dementia (BPSD). People with more severe symptoms and/or complex needs should be prioritised for ongoing care (see sections following).

OPMH services provide support to aged health and aged care services and other key services to ensure care coordination for older people with co-existing mental health problems that may not be the primary focus of care, and/or long-standing mental health problems but no acute symptoms.

The families and carers of consumers are also part of the broader target group for OPMH services.

Aboriginal people and OPMH services

Given the shortened life expectancy of Aboriginal people and the earlier onset of illness and conditions usually associated with ageing in this population, OPMH services provide care to Aboriginal people from age 50 years if they identify as older people and/or with the specific needs of older consumers, and this is their preference. Aboriginal people with a mental health problem who are aged 50-64 years may reasonably choose to be seen by adult mental health or OPMH services.

Younger people who may be suitable for OPMH services

In certain clinical and population groupings, there are people under 65 years who have early ageing issues and may be seen as 'functionally old'. Key factors that should be considered include the presence of frailty, progressive cognitive impairment and/or contact with aged care services. Consumer choice and continuity of care are important considerations in determining whether a consumer should receive care from OPMH or adult mental health services. There are a number of resources available to assist with recognising and managing people with frailty including the British Geriatrics Society [Fit for Frailty](#) resources and the Global Ageing Research Network [White Book on Frailty](#).

Where care is primarily provided by the adult mental health service, the OPMH service should provide specialist support and input as required.

Access and prioritisation

OPMH services aim to accept any person referred for secondary triage and/or initial assessment following triage. However, it is recognised that OPMH services need to prioritise access to ongoing clinical care according to clinical need, risk and a range of other factors. Factors to consider in determining priority include:

- presence of a mental health disorder, including assessment to determine this
- acuity and severity of mental illness
- risk of harm to self or others
- predominance of psychiatric morbidity
- unmet need (i.e. current access to mental health and/or aged care services and effectiveness of treatment; access to family/carer support)
- level of functional impairment (particularly where this presents a risk to the person's safety or ability to remain in their current place of residence)

- complexity of presenting psychiatric and physical symptoms
- consumer preference for treatment by adult or older people's mental health services.

These factors are considered regardless of the care setting, whether a private residence, supported accommodation, hospital or residential aged care facility.

Exclusion criteria

OPMH services are not generally the primary provider of specialist services for:

- older people with a presenting diagnosis of alcohol and/or other drug disorder
- older people with a presenting diagnosis of delirium
- younger people with a static cognitive impairment (i.e. not suffering from a progressive, neurogenerative condition).

However, OPMH services will exercise appropriate flexibility in providing assessment for older people with complex and unclear aetiology.

If an older person with delirium or alcohol and/or other drug disorder is referred to an OPMH service following triage, the OPMH service will, following secondary triage and/or initial assessment, assist the person to obtain assessment and management of these issues from an appropriate service provider.

This referral/assistance should be accompanied by clear information regarding how to re-contact the OPMH service if required.

OPMH services aim to have some capacity to provide assessment and clinical care for older people with co-existing alcohol and other drug (AoD) and mental health issues.¹⁹ This may involve provision of brief interventions and education where appropriate and/or collaborative care with specialist AoD services. OPMH services should also assist AoD services with the assessment of neurocognitive disorders where required. OPMH services also have some capacity to provide advice on managing behavioural symptoms in older people with delirium in collaboration with geriatric medical services.

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

Section 2: Strategic policy and planning context

2.1 Policy context

There are a number of key policies, plans and reports of the NSW and Australian Governments that have informed the Plan and given impetus to its key principles, and will be relevant in its implementation.

The key principles of the Plan reflect the vision and seven priority areas of the *Fifth National Mental Health and Suicide Prevention Plan*,²⁰ including integrated and coordinated care and service delivery, Aboriginal and Torres Strait Islander mental health and suicide prevention, providing appropriate physical health care for people with mental health issues, reducing stigma and discrimination, and safety and quality in mental health care. The Plan also aligns with many of the key directions of [Contributing Lives, Thriving Communities: National Review of Mental Health Programmes and Services](#),²¹ including its emphasis on tailored care through person-centred approaches, community-based care, improving coordination of care and suicide prevention (see [Section 2.4](#) for a discussion of the Commonwealth Government's response to this review). Recovery-oriented care and practice is another key theme of the Plan, guided by the [National Framework for Recovery-Oriented Mental Health Services](#).¹⁴ The Plan also has a focus on addressing the physical health care needs of older people with mental health problems, aligning with the [Equally Well Consensus Statement](#).²²

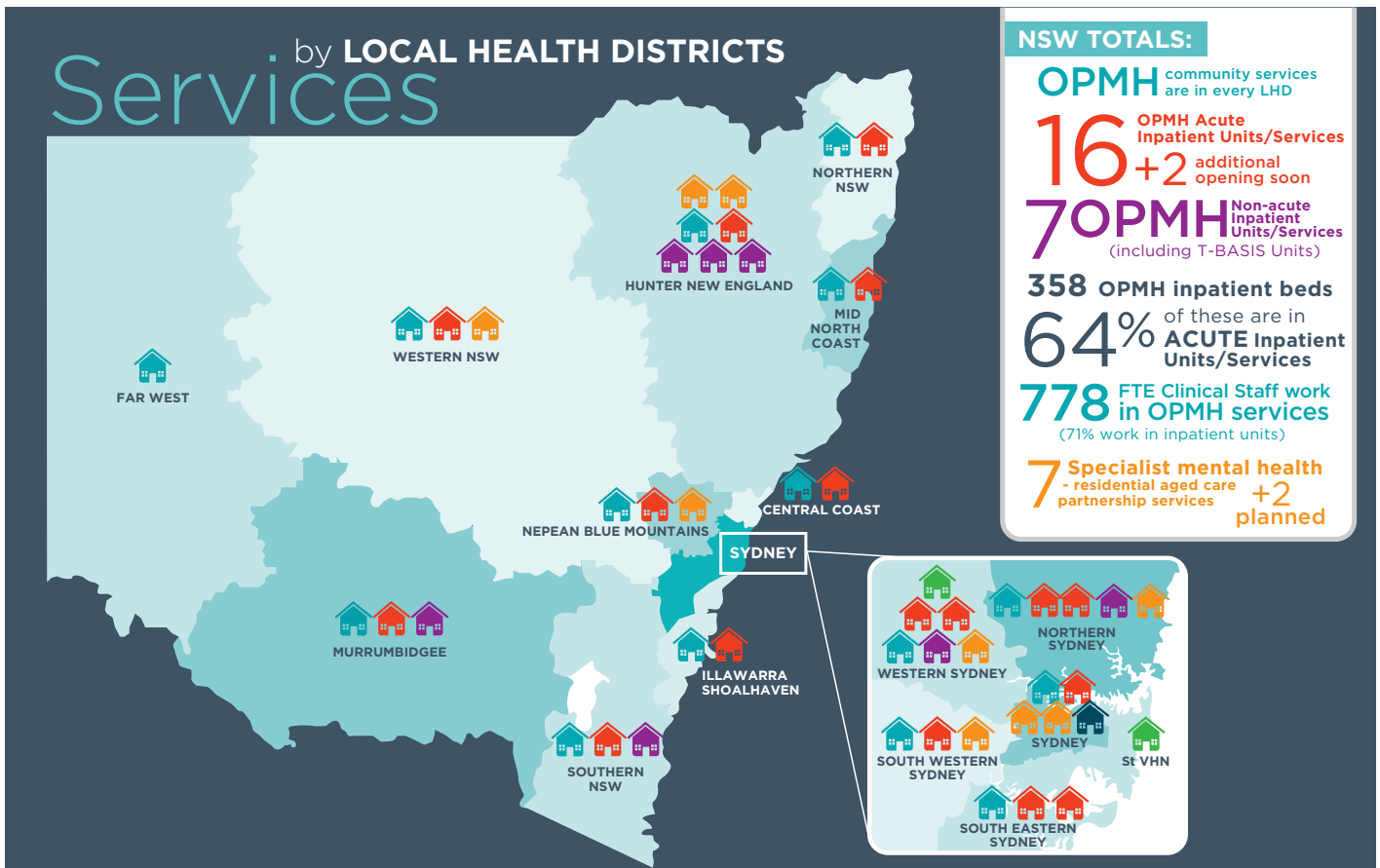
The NSW Mental Health Plan ([Living Well: A Strategic Plan for Mental Health in NSW 2014-2024](#))²³ sets out the directions for reform of the mental health system in NSW over ten years. Informed by the *Living Well* plan, the current NSW mental health reform agenda has five key focus areas: a greater focus on community-based care; strengthening prevention and early intervention; developing a more responsive system; working together to deliver person-centred care; and building a better system.

These key focus areas provide the broad strategic framework for this plan, including its focus on enhancing community-based care and support, and working collaboratively to deliver more responsive, person-centred, recovery-oriented, coordinated mental health care and support for older people with mental illness. The *NSW Strategic Framework for Mental Health* (under development) will also provide guidance and direction to support the development of OPMH services and their linkage to broader NSW mental health services and strategic directions.

The strategic priorities of this plan strongly align with the key principles and priority areas outlined in the two *Living Well in Later Life* resources released by the NSW Mental Health Commission in 2017. The [Case for Change](#)²⁴ presents the evidence to inform ongoing reform to the mental health system in relation to older people's mental health, while the [Statement of Principles](#)²⁵ guides how a range of services, policy makers, planners, consumers and carers and communities can support these changes. This plan particularly progresses the *Living Well in Later Life* agenda regarding: implementing person-centred, trauma-informed, recovery-focused approaches, including peer worker models; expanding specialist services for older people in line with population ageing, and reducing service fragmentation and access barriers for older people with mental illness through partnership models and improved care pathways.

The Plan has been informed by the Premier's Priorities,²⁶ the [NSW State Health Plan: Towards 2021](#)²⁷ and the [NSW Ageing Strategy 2016-2020](#).⁵⁰ There is a range of legislation relevant to OPMH services in NSW, including the [Mental Health Act 2007 \(NSW\)](#),¹⁵⁵ the [Guardianship Act 1987 \(NSW\)](#),²⁸ and the [Carers \(Recognition\) Act 2010 \(NSW\)](#).¹⁵³

2.2 The current picture: overview of OPMH services, staff and consumers



Notes:

St Joseph's AIU is operated by St Vincent's Health Network (St VHN) but is located in Western Sydney. St VHN also provides OPMH community services.

Justice Health & Forensic Mental Health Network provides OPMH community services and clinical input to the Aged Care and Rehab and the Step Down Units of the Long Bay Hospital and to the Forensic Hospital.

3 AIUs largely have sub-acute functions (located in SWSLHD and SESLHD and the unit in Western Sydney operated by St VHN).

As at November 2017, AIUs in MNCLHD and WSLHD are planned but not yet operational. Additional Specialist Mental Health-Residential Aged Care Partnership Services are planned for WSLHD and HNELHD.

Our Consumers in 2016

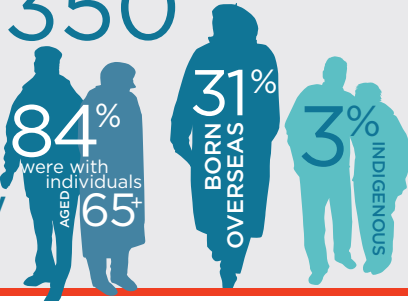
Consumers of OPMH services mostly received care for depression, anxiety and other affective disorders, schizophrenia and organic disorders.

OPMH COMMUNITY SERVICES:

there were **15,879** people were seen by OPMH COMMUNITY SERVICES across **NSW**

there were **194,350**

client-related contacts provided by OPMH Community Services

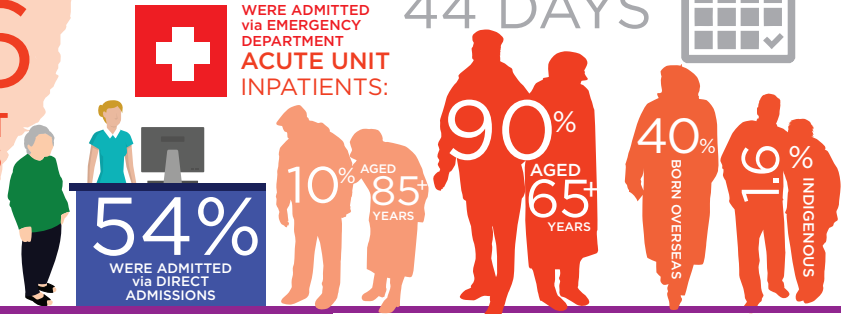


ACUTE INPATIENT UNITS/SERVICES:

there were **2,396** ACUTE INPATIENT episodes across **NSW**

34% WERE ADMITTED via EMERGENCY DEPARTMENT ACUTE UNIT INPATIENTS:

Average length of stay in an OPMH AIU **44 DAYS**

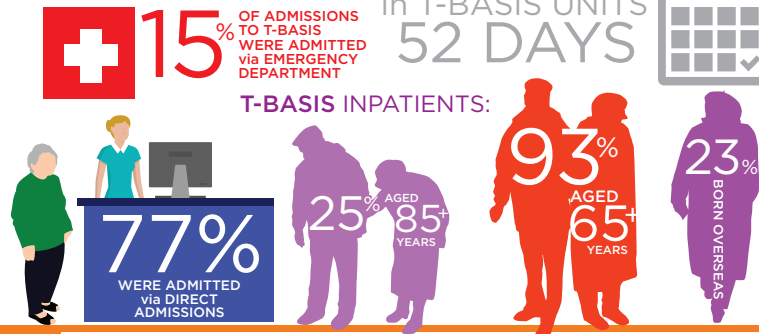


NON-ACUTE & T-BASIS UNITS/SERVICES:

there were **582** NON-ACUTE INPATIENT EPISODES (including T-BASIS units) across **NSW**

15% OF ADMISSIONS TO T-BASIS WERE ADMITTED via EMERGENCY DEPARTMENT

Average length of stay in T-BASIS UNITS **52 DAYS**



PARTNERSHIP MODELS:

there were an estimated... **24** NEW CLIENTS admitted to **3x** Specialist Mental Health - Residential Aged Care Partnership Services



AIU's: Acute Inpatient Units. OPMH: Older People's Mental Health. ED: Emergency Department. RACF: Residential Aged Care Facility. T-BASIS: Transitional Behavioural and Assessment Intervention Service. MHACPI: Mental Health Aged Care Partnership Initiative.

Data sources: CIBRE, 2016 (for inpatient activity reporting and outcome measures); Mental Health Ambulatory data, 2016 (via NSW HIE); Mental Health Establishments NMDS 2015-16 AM2 database (FTEORG table); MHACPI evaluation report²⁹ (for MHACPI units); SRACF data from 2016 annual report to NSW MoH.

Notes: Data on partnership models represents only a sub-set of these services, with more established since 2009. In some LHDs, issues with feeding ambulatory and outcomes measure from the State Based Build of Cerner/CHIME to the HIE in this period have affected data quality and reliability. Inpatient figures (acute & non-acute) are based on overnight separations, except for total number of episodes.

2.3 What our community told us

The Plan has been informed by, and responds to, key themes from consumer, carer, clinician and stakeholder consultations. Consumer, carer and peer worker consultation workshops were held in metropolitan and rural locations (Orange, Central Coast, Western Sydney and Wolloomooloo) during December 2016. Approximately 58 consumers, carers and peer workers shared their experiences, opinions and thoughts, building on previous consultations with 180 consumers, carers and clinicians.³⁰ Consultation was also undertaken with key stakeholders and representatives including peak consumer and carer organisations, PHNs, OPMH service clinicians and managers, mental health service managers and Aboriginal and multicultural services.

In general, people highly value the work of clinicians in NSW OPMH services. They also identified areas for improvement and key inconsistencies in the delivery of care by services. A summary of the key themes from the consultation process is provided below.

- Provide **recovery-oriented, person-centred care** through partnering with consumers and their families and carers in all aspects of care planning and delivery, supporting self-determination, choice and decision-making, and promoting both clinical and personal recovery. Consumers should be supported to contribute to and be involved in their communities.
- **Good communication**, both verbal and written, is important for consumer and family/carer engagement. Communicating well with other clinicians, including GPs and private psychiatrists, and other services will help to ensure consistency and best care for consumers.
- Make OPMH services more **accessible**. Ensure that access is easy and timely and that services are widely available. Improve the level of awareness and knowledge of services by better promoting them. Provide assessment to all people referred to OPMH services, and then determine ongoing care and support needs, facilitating access to other services as needed. Facilitate timely access to OPMH care in the community and in inpatient units when needed.
- Provide treatment and care based on the severity of a person's mental health problems **with or without dementia**. OPMH services should provide care for older people with dementia who have mental health symptoms requiring specialist care (and for those with younger onset dementia where appropriate and required). The focus should be on the mental health symptoms or problems experienced by the individual.
- Be **flexible about the age limit** of OPMH services, and support individual choice and continuity of care as appropriate. Recognise that some younger people would benefit from care from OPMH services, and facilitate this where required.
- OPMH services must **work in partnership** across inpatient and community settings, and with a range of government and non-government agencies, to promote integrated care and help address a consumer's varied needs including physical health and social needs. Services should also ensure appropriate follow-up care and continuity of care.
- Recognise **General Practitioners** as the central coordinators of care and key partners of OPMH services. Actively involve and engage GPs to undertake joint care planning and coordinate with them to provide care. Make GPs aware of the OPMH services target group and how to access these services. OPMH services should work closely with GPs to address a consumer's needs, including physical health needs, and consider how best to support GPs to provide mental health care to their patients, including through shared care and consultation-liaison approaches.
- Provide **care in the community**, including visits to homes, residential aged care facilities where required, and appropriate other locations, as much as possible. OPMH clinicians should provide support to aged care facility staff to enable them to provide better care for those residents with mental health problems.
- Provide an **inpatient care environment** that is conducive to recovery. The inpatient unit should be as calm as possible and help consumers feel 'safe' but should not feel too restrictive. Sufficient activities should be provided for consumers, including social and other activities not associated with therapy and treatment, and OPMH clinicians must engage with consumers in a meaningful way. Flexibility in care delivery is important, and individual choices should be supported as much as possible.
- Provide access to a range of **biopsychosocial therapies and treatments**, and communicate what services are on offer.

- There should be a focus on mental health **promotion, prevention and early intervention**, with OPMH services having some involvement in PPEI activities including linking to other organisations that provide information and support for mental health issues. OPMH clinicians should work at an individual level to assist consumers to maintain their mental health, recognise early warning signs and prevent a relapse of their mental illness.
- **Transitions of care**, from inpatient to community settings and community to inpatient settings, must be well supported, planned and done in partnership with the consumer and their family and carer. There must be a focus on clinical and personal recovery and ensuring adequate, appropriate follow-up and ongoing care and support.
- OPMH services should **identify carers' needs** during assessment processes and provide family and **carer support and education**. Responding to carer needs may involve providing information on and facilitating access to other services that provide carer support. OPMH clinicians should support the carer in their caring role by providing information and advice on how best to support the individual consumer.
- **Peer support** – including **support groups** and support by **peer workers** – is highly valued. The value of peer workers in OPMH services must be recognised and promoted. Services should facilitate access to and/or provide wellness support groups in inpatient and outpatient settings.
- OPMH services should be staffed at required levels, by a **range of staff** who **specialise** in caring for older people with mental health problems.

2.4 Current challenges, strategic drivers and implications for OPMH services

The number of older people in NSW is growing

The NSW population is ageing, with a steady increase in the number and proportion of the population aged 65 years and over. In NSW in 1996, there were 778,603 people aged 65 years and over (73,918 aged 85+), increasing to 1,229,869 in 2016 (168,430 for 85+).³¹ The growth rate of the 65+ age group is projected to accelerate over the next decade, as further cohorts of baby boomers (those born between the years 1946 and 1964) turn 65.³²

In 2026, it is projected that 18.8% of the NSW population – 1,665,500 people – will be aged over 65 years (with 226,700 or 2.6% aged over 85).³³

The uneven distribution of the aged population across NSW is expected to continue. The majority of older people will continue to live in metropolitan areas, although the coastal areas of NSW are also projected to have relatively high numbers of older people.³⁴ A number of regional and rural areas have, and will continue to have in the future, higher proportions of older people than metropolitan areas. In 2026, it is projected that Mid North Coast LHD will have the highest proportion of people aged 65+ (29%), followed by four other rural LHDs: Northern NSW (27%), Far West (26%), Murrumbidgee (25%) and Southern (25%).¹⁰ This will have implications for future service provision in these regions. Over the ten years from 2016, the growth rate within the over 65 population is projected to be highest in metropolitan areas, specifically Western Sydney and South Western Sydney.¹⁰

There is an increasing number of older people with mental health problems

The number of older people with mental health problems is projected to grow by 34% over the next ten years, in line with the total 65+ population growth rate. By 2026, there will be an estimated 260,000 people aged 65 years and over with a mental health problem in NSW, and approximately 56,000 (3.3% of the 65+ population) with a severe mental illness requiring care from specialist mental health services.¹⁰ In particular, the number of older people with severe BPSD is expected to increase significantly,¹⁰ associated with the large growth in the number of people aged 85+, and this will have a substantial impact on OPMH services. The increase in the number of men aged over 85+ (where the suicide risk is currently highest) presents challenges for OPMH services and communities more broadly. Older people with recurrent, life-long or emerging mental illness are already entering OPMH services in increasing numbers via GPs, private psychiatrists, general adult mental health services and other services. The growing number of older people with longstanding or late-onset mental health problems is a significant driver of OPMH service demand.

The number of people with an intellectual disability who have grown old and suffer significant coexisting mental health problems is rising, further adding to the pressures on OPMH services. OPMH services are also increasingly providing care to older people who have previously been in the criminal justice or forensic systems. Their numbers are expected to

further rise in line with an ageing population.

In many cases, the spouse or partner of an older person with mental health problems is also their carer, and older carers may have similar frailty issues to older consumers.

The nature of older age is changing

The ageing of the baby boomer generation, as well as improved population health and health care, has led to changes in what constitutes and is expected in older age. While baby boomers are not a homogenous group in any sense, they are quite different to earlier generations of older people. Generally, they are well educated, socially and politically engaged, used to working in paid employment and are doing this into older age, and have particular expectations and attitudes, including as consumers of healthcare services. They are living longer, with better health until later in their lives,³⁵ although there are some health implications for people who have developed alcohol and substance misuse issues earlier in life and may take these issues into older age.¹⁹ For many, volunteering is an important component of their lives post-retirement, although the expectation to volunteer may be overwhelming for some. A considerable number of older people are informal carers for dependent spouses, older parents and/or dependent children, and many provide child care for grandchildren (almost 20% of children aged 0-11 years attend care with their grandparents).³⁶ These social demographic changes and the roles being undertaken by some older people need to be recognised in working with OPMH service consumers and carers.

The mental health and aged care service landscape is changing

Significant changes are occurring in the mental health and aged care service landscape, under the NSW³⁷ and Commonwealth³⁸ mental health reform agendas and the Commonwealth *Living Longer Living Better* aged care reforms.³⁹ In NSW, there is a renewed focus on community mental health care and support, with both OPMH community services and psychosocial community living supports expanded in the period 2014-15 to 2016-17. People who have experienced long stays in mental health facilities are being assisted to live in the community under the NSW *Pathways to Community Living Initiative (PCLI)*. The introduction of activity based funding into public mental health services is also a key development.

At the national level, a 'stepped care' model of service provision is being introduced, where the level of service provided is matched to each consumer's needs, including 'wrap-around' coordinated care for those with severe and complex mental illness.²¹ Primary Health Networks (PHNs) have a lead role in local mental health planning and integration, and in developing a regional approach to suicide prevention. The PHNs have commenced work in commissioning regionally delivered primary mental health services within the stepped care model. OPMH services will need to ensure that they work in a coordinated way with PHNs to promote appropriate, integrated care and support for older people with mental illness. PHNs have a key role to play in promoting awareness of OPMH services through their local referral pathway resources, supporting continuity of care and potentially supporting primary care access to private psychiatrists with skills in providing mental health care to older people.

Under the aged care reforms, access arrangements, referral pathways and assessment processes for Commonwealth-funded aged care services are changing, and there is a renewed focus on community-based care and support and a move towards consumer-directed care. There is some potential for older people's mental health needs to be better recognised and addressed through Commonwealth aged care assessment and referral processes and through care and support programs.

OPMH services will need to adapt to the changes occurring at the national level in mental health and aged care. They will need to work flexibly and collaboratively with aged care services to promote recognition of mental health problems within aged care assessment processes and appropriate mental health care of older people with mental illness.

Changes are also occurring in the disability space, with the introduction of the National Disability Insurance Scheme (NDIS) and access to non-clinical supports for people with psychosocial disability.⁴⁰ NDIS providers may be key partners as NDIS implementation progresses, particularly in relation to OPMH service consumers who are under 65 and older people with mental illness who are transitioning from NDIS to aged care supports. People who access NDIS supports before age 65 can stay within the NDIS system for as long as practical (instead of moving to residential or community aged care). NDIS participants who are under 65 years of age and living in residential aged care can continue to receive some NDIS assistance. This excludes supports considered to be the responsibility of a RACF or healthcare system to provide.⁴¹

Emerging practice directions in mental health care

Over the last decade, the recovery movement has strongly influenced mental health policy and service delivery. Person-centred and individual-based approaches to care are familiar to both the mental health and aged care sectors, and these are very relevant to the concept of recovery in OPMH. Recovery is much broader than clinical recovery and the interconnectedness between 'clinical' and 'personal' recovery is well recognised.

There is currently a strong service user and government policy agenda to promote practice in mental health services that actively supports the recovery of service users.^{14,42} The *National Framework for Recovery-Oriented Mental Health Services* was released in 2013 and provides a focus and conceptual framework for promoting recovery-oriented mental health services.¹⁴ In addition to the growing focus on recovery-oriented care, research and practice directions 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. There is a close relationship between trauma-informed care and practice (TICP) and recovery-oriented service delivery.¹⁷

While recovery-oriented care and practice is a key practice direction across mental health services, there has been limited work done in Australia (or overseas) focusing on understanding and promoting recovery-oriented practice specifically within an older people's mental health context. The exceptions are the work undertaken in the United Kingdom by Daley et al and the recent NSW OPMH recovery-oriented practice improvement projects.¹⁵ Consumer and carer consultation for this plan confirmed that recovery remains just as important for older people as for younger people, and older consumers expect mental health services to deliver recovery-oriented care.

OPMH 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. OPMH services have been actively exploring how they can refocus their philosophy of care, leading to care that is consumer-led and recovery-focused, but the extent to which this has been embedded into practice is variable across the state.

A broad range of biological, psychological and social interventions should be available to address recovery and treatment goals and support consumer choice. Public specialist OPMH 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 psychosocial services and supports).

Some older people are vulnerable to disadvantage and abuse, and to loneliness

Some older people are at risk of financial disadvantage. Those who rely on the Age Pension, pay rent, live alone, and/or have high costs associated with healthcare or disability (not covered by the public health system) are particularly vulnerable. Older women, particularly those who are single, are more likely to live in permanent income poverty, associated with a complex interplay of factors including the gender wage gap and insufficient superannuation funds, loss of a spouse and sickness/injury.⁴³ Approximately 70% of Australians aged 65 years and over rely, at least in part, on the Age Pension⁴⁴ and 36% of pensioners live below the poverty line.⁴⁵ People aged 65 years and over make up seven percent of the homeless population.⁴⁴ Financial disadvantage and homelessness can be factors in mental health problems for older people, and severe and persistent mental illness, particularly over a long period, can also impact on a person's financial security and living arrangements.⁴⁶

Older people may be at higher risk of persistent social isolation and loneliness. There are multiple reasons that cause older people to become socially isolated including financial disadvantage, poor transport, living in isolated areas, becoming a carer, the loss of a partner, loss of mobility, chronic illness and being from a CALD background and/or having a lack of language fluency. Social loneliness and isolation are harmful to physical and mental health, and are well-established risk factors for depression and anxiety.⁴⁷ People who are socially isolated are less likely to access services when they need them. Addressing social isolation, including in older people, requires a multi-sectorial, multi-pronged, evidence-based approach, at national and local levels, such as that being considered by the *Australian Coalition to End Loneliness*.⁴⁸

It is widely estimated that up to 50,000 older people in NSW have been the victim of some form of abuse.⁴⁹ Addressing 'elder abuse', and domestic violence in older people, requires a recognition of the complex relationship between the victim and

perpetrator and an interagency and cross-sectoral response. Mental health services have a role in preventing, detecting and responding to abuse of older people, guided by relevant policy^{50,51} and with support provided by the NSW Elder Abuse Helpline and Resource Unit as required.

Stigma exists in community attitudes to mental illness and ageing

Stigma and negative attitudes regarding both ageing and mental illness remain common within the community and amongst older people themselves. Such attitudes are also found amongst care providers in health and aged care services to some extent. This is a key issue for older people with mental illness, who can experience double stigma, sometimes combined with outdated views of mental health services (straitjackets, padded cells and relatives who never return). Poor health literacy regarding ageing and/or mental illness and available service options can contribute to stigma. Stigma influences treatment-seeking attitudes and behaviours,⁵² and is a barrier to recognition of mental illness in older people and access to appropriate mental health care.

Stigma erodes confidence that mental disorders in older people are valid, treatable health conditions.⁵³ Different mental disorders in old age are stigmatised in different ways, with some considered to be a natural consequence of ageing, loss and physical illness, and others considered to be more relevant to younger people. There is an ageist belief by some that mental illness in old age cannot be effectively treated or that some therapies (e.g. psychotherapy) are not a viable treatment option.⁵⁴ At a systems level, stigma can result in a lack of available services and funding, hesitation when accepting a referral and inadequate treatment options. Mental health problems may be under-identified by health-care professionals and older people themselves. Programs such as the [Older Person Mental Health First Aid](#)⁵⁵ course help to address stigma and poor mental health literacy.

Ageism in the workplace, combined with stigma and discrimination about mental illness, can make it difficult for an older person to keep working when they want to. This contributes to both financial disadvantage and social isolation and can be a barrier to an individual's recovery.

OPMH services are not well known

Consumers, families, carers and key service partners indicate that there is a lack of awareness of OPMH services. This is particularly evident in

primary care services. Where service partners do know of OPMH services, they are often unaware of their functions, target population, service and prioritisation criteria or access pathways. This lack of knowledge can result in limited and/or delayed referral, impacting on access to OPMH services. To promote awareness and support access to OPMH services, information on OPMH services should be clearly available and shared with key service providers and referral services.

Community mental health care and support for older people within the non-government mental health, aged care and disability sectors is limited

The NSW community managed mental health sector is predominantly made up of not-for-profit organisations providing community-based support and psychosocial services as well as clinical services such as therapeutic/treatment-related and counselling services. Non-clinical psychosocial supports may include accommodation support or support to live at home; support with employment and education, and with engagement in social activities, leisure and recreation; family support and carer programs; self-help and peer support; and information, advocacy and health promotion. For older people with persistent mental illness, relationships and social connectedness are a significant area of unmet need.⁵⁶

Community aged care supports are provided through the *Commonwealth Home Support Program* and *Commonwealth Home Care Packages Program*, predominantly by non-government organisations. These are accessed via *My Aged Care*, which serves as the gateway for all Commonwealth-funded services for older people, with assessment undertaken by either a Regional Assessment Service (RAS) or an Aged Care Assessment Team (ACAT) depending on need and eligibility. Frail older people with a mental illness may require access to a range of supports including Commonwealth subsidised aged care services that require ACAT assessment and approval. As outlined in the *Aged Care Assessment Programme Guidelines* (2015), ACAT assessment and approval for an older person with mental illness is considered appropriate if the person meets eligibility criteria, has a well-controlled mental illness, and community mental health services continue to provide collaborative care.⁵⁷

Home care packages are increasingly delivered on a consumer-directed care basis. Mental health care and support can be accessed as part of a home

care package if it meets a consumer's assessed care needs and is specified in the agreed care package, unless explicitly exempted in the *Quality of Care Principles 2014*.⁵⁸ However, for older people with mental illness, mental health needs may not be identified in assessment processes, specific services may not be communicated or available, mental health services may not feature in the referral pathway and mental health care and support needs may therefore not be addressed in care packages. OPMH services may need to assist older people with mental illness to access Commonwealth aged care services and appropriate mental health support through aged care packages, and partner with community aged care providers to ensure a consumer's mental health care and support needs are identified and met along with their aged care support needs.

Currently, there are few community aged care services or mental health CMOs that are focused on older people with mental health problems and have the capacity (including workforce skills, specific funding and service partnerships) to provide appropriate care and support for this group, without support of mental health services. Generally, there is limited access to these services for older people with mental health problems (e.g. 4.8% of HASI clients were aged over 60 years in 2016⁵⁹), although there are current efforts to improve access to the NSW *Community Living Supports* (CLS) Program and *NSW Housing and Accommodation Support Initiative* (HASI).

A number of Commonwealth-funded mental health support services and programs, such as the *Partners in Recovery Program* (PIR), *Personal Helpers and Mentors* (PHaMs) and *Support for Day to Day Living in the Community* (D2DL), are transitioning to the NDIS and will cease once NDIS rollout is complete in a given area. Historically, older people's access to these programs has been low (e.g. A 2015 report indicates that 4.1% of clients in 15 PIR organisations were aged 65-74 years and 0.7% were aged 75-84 years⁶⁰). However, this access may be further restricted by the transition to the NDIS. Psychosocial supports, similar to those provided through the former PIR, PHaMs and D2DL programs, will continue to be available as a service chosen through an NDIS Support Package. Older people will be able to access these supports if they commenced under the NDIS before age 65 or are eligible for support under the Commonwealth's *Continuity of Support Programme*.

Promoting access to psychosocial and other supports for older people through the aged care system, NDIS, and programs such as HASI and CLS will continue to be a priority for OPMH services at the statewide policy and local service levels. Work will also be required to ensure a smooth transition and interface between NDIS and aged care supports.

See [Appendix 2](#) for an overview of the services provided by CMOs that may be relevant to older people with mental health problems.

Older people have limited access to some psychological services

There is a low rate of access of older people to Medicare-subsidised mental health-related services through the *Better Access* initiative.^{61,62} There may be a range of factors in this, including low referral rates of older people to these services⁵⁴ and a general lack of psychologists and other allied health professionals with specialist skills and interest working with older people living with mental illness. Similarly, older people living with mental illness had limited access to private psychological services and other mental health care services provided through the *Access to Allied Psychological Services* (ATAPS) program.⁶³ ATAPS ceased on 30 June 2016, and instead PHNs have been allocated funding to provide psychological services to underserved groups (people who are unable to access the *Better Access* funding). The extent to which older people's access to private psychological services improves under this new arrangement will largely depend on whether PHNs choose to target older people, and OPMH services will need to promote strategies around this in collaborative work with PHNs.

Access to psychologists and psychological services remains poor in Australian residential aged care facilities. Commonwealth-funded aged care residents are currently not eligible to access *Better Access* services including Medicare-funded GP mental health treatment plans and psychology sessions. The Aged Care Funding Instrument (ACFI) (currently under review⁶⁴) assesses resident's care needs including in relation to depression.⁶⁵ While residents have the right to have access to services and activities available generally in the community, there is currently no legal obligation on the residential care provider to pay for mental health services.⁶⁶ RACFs generally will facilitate access for residents to health practitioners of their choosing. Expanding OPMH service clinical outreach to and partnerships with RACFs, with a focus on older people with severe and/or complex mental health needs, is a key direction of this plan.

There are insufficient community residential care options for older people with complex mental health issues

Older people with complex mental health issues including BPSD often have difficulty accessing residential care and have prolonged stays in acute hospitals and mental health facilities (including long-term mental health inpatient care in some LHDs). Progress has been made in developing residential care options for this group, including OPMH services and residential aged care provider partnership models as discussed in [Section 3.4](#). However, this continues to be an area of need.

Further expansion of mental health aged care partnership services will continue to be a priority in the context of existing spectrum of care for older people with mental illness, PCLI and other factors. See [Section 3.4](#).

Appropriate, efficient and effective specialist mental health care for older people is needed

There is variation in existing service models and clinical practice within OPMH services across NSW, which needs to be addressed. Promoting consistent good practice in all OPMH services, which is evidence-based, recovery-oriented and in line with national and state policy directions, is central to this plan. Improving the appropriateness and outcomes of care for older people with mental illness is also central. Models of care have been developed for OPMH community services (2017)³⁰ and acute inpatient units (2012)⁶⁷ (see [Section 3](#) and [Appendix 3](#) and [Appendix 4](#) for further discussion), and these should continue to drive improvements in these services. The philosophy of care articulated in these models of care – recovery-oriented, person-centred and biopsychosocial – should be adopted in all elements of the OPMH service model. Specific areas of practice such as addressing the physical health care needs of consumers may require a particular focus.²²

Effective collaboration and functional relationships with a range of services are required to meet the needs of older people with mental health problems

From the perspective of the consumer, OPMH services are one partner in a range of services, organisations and people that support their clinical and personal recovery and ensure that their physical, social, behavioural and psychological needs are met. Effective partnerships and coordination between key services, including OPMH services,

and across care settings and jurisdictional, program and professional boundaries are required to support integrated care. See [Section 3.9](#). This is a key emphasis of the NSW Mental Health Commission's *Living Well in Later Life Statement of Principles*.²⁵

Collaboration and integration with services can be complicated by differences in the way 'older age' is defined by services. For instance, many geriatric medical services have a higher age criteria of 70+ years compared to the 65+ years target group for OPMH services. Alcohol and other drug services may consider someone to be an older person from the age of 50.

There is unmet service need for OPMH community and inpatient services

Responding to the increasing need generated by the growing older population, distributed unevenly across NSW, is a challenge for OPMH services. State-wide and local clinical service and workforce planning will need to include a focus on both inpatient (acute and sub-acute/non-acute) and community services to ensure an appropriate number, distribution, balance and mix of services. Services will need to respond to more, increasingly complex, presentations. In rural and remote locations, technology (video-psychiatry, telemedicine and e-health) will continue to play a role, in order to improve access to specialists to advise on and support complex community and inpatient service provision. However, technology is only part of the solution to appropriate rural and remote service provision. There is also a need to upskill the existing health workforce (acute and community) to manage the care and treatment of older people with mental health problems.

Meeting the physical health needs of older people with mental health problems

Many OPMH consumers have complex co-existing conditions, including physical health illnesses and associated disability. Poor physical health, chronic health conditions and disability substantially increase the risk of mental health problems and the complexity of their management. In those who have severe mental illness over a long period, the important link between physical and mental health, and the impact on life expectancy, is well recognised.^{24,22,68,69,70,71,72,73} Frailty syndromes are common in older people with mental health problems. For instance, depression and frailty often co-occur.⁷⁴ Physical health problems in turn impact on the mental health status of older people.

Risk of falling is exacerbated by mental health problems, such as impaired mental status due to dementia, depression, mania, agitation, psychosis and anxiety.^{75,76} In addition, the postictal effects of electroconvulsive therapy, side effects of psychotropic medications including changes in bone mineral density, poor judgement, sleep deprivation, under-nutrition and metabolic syndrome (which is highly prevalent in people with mental illness^{77,78}) will also increase falls risk and increase the severity when falls occur.^{75,76} Multiple falls can be devastating on function and lead to an early placement in residential aged care facility. Younger consumers of OPMH services who have early ageing issues, may also have difficulty accessing falls prevention and rehabilitation activities due to age restrictions of these programs.

There is an expectation that mental health services will provide appropriate physical health assessment and care to people with mental illness, or facilitate or advocate for the provision of such care.^{22,79}

Providing appropriate OPMH care for people with dementia

While dementia is not a natural part of ageing, it is more common after the age of 65.⁸⁰ It is estimated that approximately one-third of people with dementia experience moderate-severe behavioural and psychological symptoms (BPSD),⁷ including symptoms such as significant agitation, depression, aggression and psychosis. The number of people in NSW with dementia is projected to increase to 175,000 by 2025,⁸⁰ with the highest growth occurring in the older age groups. The increase in numbers and ageing of the population with dementia will have implications for the provision of sufficient, appropriate care and services, as is recognised and addressed in the [National Framework for Action on Dementia 2015-2019](#).⁸¹ OPMH services have an important role in specialist assessment and care for people with mental health problems in the context of dementia or moderate-severe BPSD. OPMH services should have the capacity and capability to assess and care for people with BPSD and this may need further development in some areas across NSW.

Dementia is the second leading cause of death of Australians.⁸² The burden of disease for people with dementia, and their families, is significant. The main carers of a person with dementia living in the community are the individual's spouse or partner and other family members. However, the core business of both residential and home-based aged care services increasingly includes providing care to people with dementia. As well as these aged care

services, there are a number of other services providing dementia advice, care and support, including GPs, consumer and carer support organisations (e.g. Dementia Australia), aged health services, mental health services, MHACPI Transition Units and Specialist residential aged care facilities (RACFs) (see [Section 3.4](#)), the national Dementia Behaviour Management Advisory Service and Severe Behaviour Response Teams. New Specialist Dementia Care Units are to be established across Australia's Primary Health Networks over the four years from 2016-17.⁸³ OPMH services will need to work effectively with all of these services, adapting as the service environment changes, to play their part in providing appropriate care for people with dementia.

Workforce issues affect service provision and quality of care

Many OPMH services continue to experience shortages in workforce supply, and there is an uneven distribution of the workforce across NSW. Recruiting and retaining staff with the specialist skills to work in OPMH across the range of disciplines is challenging for many services, particularly in rural and remote areas and some metropolitan areas. This can impact on service accessibility and may limit the types of biopsychosocial therapies available. A multidisciplinary staffing profile and approach is considered best-practice for OPMH services. See [Section 3.8](#) for further discussion on OPMH service workforce planning and development.

There is a general lack of private psychiatrists, psychologists and other mental health professionals specialising in the care of older people. Therefore, access to mental health services and therapies for older people in the private sector is currently limited.

2.5 Population groups with specific needs

Certain population groups have specific needs regarding service appropriateness and accessibility and present particular service delivery and service coordination challenges for mental health services. In some circumstances, responsive and targeted strategies and programs may be required. Some older people can identify with a number of different population groups and/or experience multiple disadvantages, and service responses will need to take account of these complexities.

Some of the key population groups with specific needs are discussed below. It is recognised that there are also other population groups with specific

needs, including older veterans^{84,85} and older people with co-existing chronic disease(s) and mental illness.^{86,87}

Older Aboriginal people

Aboriginal people generally have a holistic view of mental health, incorporating the physical, social, emotional and cultural wellbeing of individuals and their communities. It is important to understand this context and the impact of historical, social, cultural and policy factors on the social and emotional wellbeing of Aboriginal people. Aboriginal people have high levels of psychological distress,⁸⁸ and carry a burden of grief, loss and trauma. Many have been adversely affected by multilayered discrimination, marginalisation and stigma, and transgenerational traumatisation is common. The Stolen Generation have specific needs including those related to the loss of family and community connectedness, resulting in social and cultural isolation.

Aboriginal people have a shorter life expectancy than the general Australian population,⁸⁹ and experience earlier onset of illness and conditions usually associated with ageing including dementia^{90,91} and potentially other age-related mental health problems. Given this, OPMH services and aged care services generally target Aboriginal people from the age of 50 years (see [Section 1.7](#)).

Older Aboriginal people and Elders hold a unique position of respect, leadership and status within their families and communities. The connectedness of older Aboriginal people to family, community and Country are important considerations for service provision. The NSW Health [Aboriginal Older Peoples' Mental Health Project Report](#)⁹² outlines key issues and principles of care for older Aboriginal people in relation to OPMH services.

OPMH services will need to understand the Aboriginal communities and services in their local area, and particularly the important roles of Aboriginal health and mental health workers and Aboriginal community controlled health organisations. Developing and maintaining partnerships and collaboration with these workers and organisations, and with Aboriginal Elders and Elders groups, is fundamental to providing culturally appropriate OPMH services to older Aboriginal people that are responsive to their needs. Supporting OPMH clinicians to work in Aboriginal health services and Aboriginal health/mental health workers to work in OPMH services is one way of building collaboration and service responsiveness. The NSW Health [Aboriginal OPMH: Resources for](#)

[LHDs](#)⁹³ and other key state and national documents^{94,95,96,97,98,99} provide guidance for partnership, workforce and service development and the delivery of culturally-appropriate care.

OPMH services will need to promote an understanding of their services and access arrangements, and monitor referrals and access by older Aboriginal people. OPMH services should provide culturally appropriate, trauma-informed services for Aboriginal older people that consider potential complex family and community relationships and concepts of social and emotional wellbeing. This will require good working relationships with Aboriginal liaison, health and mental health workers, culturally appropriate assessment processes, and culturally appropriate care planning, therapeutic and transfer of care processes.

Older people living in rural and remote communities

In 2014, one-third (33%) of older Australians lived outside of major cities, compared to 28% of the general population.¹⁰⁰ Older people with mental health issues living in rural and remote areas have similar needs to people living in regional or metropolitan areas. However, isolation, mobility and transport issues and lack of GPs and specialist mental health clinicians can be impediments to older people accessing mental health care in rural and remote areas. There are high levels of socio-economic disadvantage in many rural and remote areas, and this can impact on health literacy, resilience and access to mental health care. Non-clinical mental health support services may have a limited presence in some rural and remote areas. However, rural communities often generate innovative solutions to service access and service delivery issues.

In rural and remote areas, OPMH services need to adapt service delivery models to fit local geography, service environments and workforce profiles. Collaborative, innovative local approaches involving a range of partners may be required to provide appropriate mental health care and support. Services will need to build on and/or develop strategies to support the provision of specialist assessment and care to older people within their communities, access to consultation-liaison and advice for local GPs and other health professionals and OPMH workforce development and support. This may include telehealth strategies (such as is offered through the St Vincent's *Psychogeriatric SOS (services-on-screen)* service model) and outreach by urban services.

There is a growing evidence base supporting the role of online technologies and the effectiveness, including cost-effectiveness, of e-mental health solutions.^{101,102,103} 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 may offer particular opportunities to improve access to mental health care and support in rural and remote areas.

Older people from culturally and linguistically diverse (CALD) backgrounds

Older people in Australia are a culturally and linguistically diverse group, reflective of Australia's migration patterns over time. In 2016, 32.2%¹⁰⁴ of people aged 65 years and over living in NSW were born in non-English speaking countries (up from 21.8% in 2011,⁶ and this figure is projected to rise. Some CALD groups contain a higher proportion of older people than the general population, due to historical world events, migration trends and recent changes in migration policy.

A particular vulnerable group among CALD elderly are refugees or older people from refugee-like backgrounds. Some older refugees have grown old in Australia after fleeing persecution in their own country. Some have arrived older as part of Australia's Humanitarian Program, while others have been reunited with their families through the broader migration program. People who are already elderly when they arrive in Australia are a smaller group, but they have high needs for settlement and recovery.¹⁰⁵ In 2016-17, the proportion of newly arrived refugees who were aged over 65 years rose to 6% due to events in the Middle East and migration policy responses. This figure is expected to return to 1-2% from 2017-18 onwards.¹⁰⁶

Older people from CALD backgrounds are at higher risk of having mental health issues than other Australians of similar age who were born in Australia, but are less likely to use mental health services and more likely to present to services at a later stage of their mental illness.⁶ They are likely to have specific needs depending on individual factors and experiences and the extent to which cultural traditions have been maintained. Factors that may impact adversely on their mental health and wellbeing include low English proficiency, cultural and religious issues, lack of social supports and/or family networks, social isolation, former or current refugee status, unrecognised accumulative trauma across the lifespan and low awareness of health services.

For many CALD communities there is a strong stigma attached to having a mental health problem which can lead to denial and delays in a diagnosis and treatment. A key risk factor is also the perceived resilience of more established communities which results in their needs often being overlooked as it is assumed they already have supports in place.¹⁰⁷ Access to culturally sensitive mental health information and services, as well as diagnostic tools, is important in addressing such issues. Older people from refugee backgrounds (including refugee like backgrounds, i.e. post-World War 2 migrants) are particularly vulnerable to mental health issues,¹⁰⁸ and the multiple impacts of severe traumatisation can persist for many years after the traumatic events took place. The experiences of older refugees pose additional challenges associated with the normal ageing process as well as feeling isolated and vulnerable.¹⁰⁵

Community and cultural traditions, beliefs and values play a significant role in and have a significant influence on a person's experience of recovery. It is also important to note that there is great diversity not only across cultures but within all cultures. Cultures vary in their emphasis on individuality, personhood, gender, kinship, family ties and intergenerational status and hierarchy. Deference to community leaders and family members regarding personal decision making is a strong tradition in some communities. Cultural beliefs and practices flow through generations, while, at the same time, individuals and families bring with them (into clinical and related settings) a range of varying and shared perspectives.

The context of community in which refugees and other CALD populations are now operating has changed. Older people from some CALD backgrounds are increasingly connecting with their communities and their countries of origin in different ways, including via the internet. These alternate ways of maintaining bonds with their communities and countries of origin may increase social connectedness and therefore protect their mental health. Simultaneously, this constant access to information from the country of origin may adversely affect mental health particularly when it involves ongoing exposure of their loved ones to terror, violent events and related experiences. Elderly CALD people may have less reliance on physical proximity of community and family, and less involvement with (physically) local support organisations (either because they are no longer as relevant or because services are no longer available in their neighbourhood). Older people within

established communities are more likely to maintain these more traditional ways of connecting with their communities.

OPMH services will need to understand the CALD communities in their local area and how they connect to outside services, family and community, and consider these in their planning, partnerships and service delivery. To promote service access, services will need to engage in locally relevant partnerships, which may include partnerships with transcultural, multicultural and/or refugee services and other agencies working with CALD communities. They will need to promote an understanding of their services and access arrangements, and monitor referrals and access against local CALD community demography to identify any underserved communities. Given the new ways some people from CALD backgrounds remain connected to their communities (e.g. via the internet), OPMH services will need to find new ways to promote service access and work effectively with these communities. However, online information will not reach all CALD groups and multifaceted strategies will continue to be required. OPMH services will need to deliver appropriate services for older people from CALD backgrounds, and this will require the use of translated materials for CALD older people who seek out information and access to mental health services. Equally important are the use of interpreters and other cultural brokers where necessary, culturally appropriate assessment tools and processes, and culturally appropriate care planning (including wellness planning), therapeutic and transfer of care processes.

Residents of aged care facilities

There is a high prevalence of mental health disorders in RACFs, with depression,¹⁰⁹ anxiety¹¹⁰ and moderate-severe BPSD common in residents.^{111,112} This group of older people may not receive diagnosis or treatment of their mental health problems, particularly if their symptoms are not obviously displayed through behavioural disturbance or expressions of distress. Residents are not currently eligible for psychological therapies provided to other Australians under the *Better Access Medicare* program. In some cases, chemical and/or physical restraint may be used inappropriately in RACFs to manage disturbed behaviour.¹¹³

There are currently significant Commonwealth initiatives underway to improve care for people with BPSD in generalist residential aged care facilities and support the development of specialist dementia units (see [discussion above](#)), which may

complement current mental health-residential aged care partnership models in NSW. OPMH services will need to work with RACFs to coordinate effectively with these initiatives and maximise opportunities to improve care and support for the OPMH service target group. More broadly, OPMH service provision to older people with mental illness in RACFs will need to be targeted in a way that is consistent with OPMH community model of care directions, the prioritisation principles in this plan, and local service priorities based on available resources and local service contexts. The expansion of mental health-residential aged care partnership services for older people with severe and complex mental illness and OPMH outreach to generalist RACFs are key directions of this plan, as outlined in [Section 3.4](#).

Older people with co-existing mental health and alcohol & other drug issues

In NSW, people aged over 65 are most likely to drink daily, and to have an alcohol-attributable hospitalisation or death.¹¹⁴ Older people have the highest rates of prescription drug misuse, but lower rates of alcohol misuse, illicit drug use and tobacco consumption than other age groups.^{115,116} However, alcohol and other drug (AoD) issues (including issues co-existing with mental illness) are substantially under-recognised and under-treated in older people. Due to the physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake.¹¹⁷ The number of older people with substance use issues is likely to significantly increase in the near future,¹¹⁸ associated with the increase in the older population and the ageing of the 'baby boomer' generation. In some instances, gambling may be an accompanying issue.

Responding to the needs of older people with co-existing mental health and substance misuse issues will require OPMH services to work in collaboration with specialist AoD services and other organisations. OPMH services should have or develop some capacity to provide assessment and care for older consumers with co-existing substance and mental health issues, and focus on improving the identification of older people with issues and their access to appropriate care and support. The [NSW Health Older People's Drug and Alcohol Report](#)¹⁹ provides some guidance for mental health services, including OPMH services. OPMH services should also assist AoD services with the assessment of neurocognitive disorders where required.

Older people with co-existing mental health problems and intellectual disability

People with an intellectual disability experience high rates of mental health problems, underpinned by a variety of biological, psychological and social factors.¹¹⁹ They may experience age-related health conditions early, often associated with particular genetic disorders, and may have higher support needs at an earlier age than older people generally. At all life stages, people with an intellectual disability are at least two to three times more likely to have a mental illness than the general population.¹¹⁹ In addition, higher rates of dementia are seen in older people with an intellectual disability.¹²⁰ In those with more severe intellectual disability or in people with communication difficulties, presentation of mental disorders is often atypical and can present as problematic behaviours.¹¹⁹

The mental health problems of people with intellectual disabilities are often misdiagnosed, unrecognised and under-treated. They have unique barriers to accessing appropriate mental health care, including service factors such as a lack of coordination between agencies and inadequate training and awareness in mental health clinicians.¹¹⁹

Collaboration and integrated care with a variety of services across sectors including disability, mental health and health is required to address the complex needs of people with an intellectual disability and mental illness. This is particularly important for the 'young old' with intellectual disability and behavioural disturbance, who may also have dementia. There are a range of resources available from the [Department of Developmental Disability Neuropsychiatry \(3DN\), UNSW](#) providing guidance to support OPMH services in providing appropriate care for older people with intellectual disability and mental illness, in collaboration with other key services.

Older people in the criminal justice system

Within the NSW Justice Health system, 'older people' are defined as 55 years and over for non-Aboriginal inmates and over 45 years of age for Aboriginal inmates. This recognises the poorer health status and higher mortality rates of inmates. As of 1 March 2015, there were 1,082 'older' inmates in NSW (9.7% of the total inmate population).¹²¹ The majority of older inmates are male (95%) and 26.9% are Aboriginal.

There has been a steady and significant increase in the number and proportion of older inmates in prison in NSW over the past decade, with a 67.8% increase in older inmates over the decade 2004-2014.^{122 123} This is projected to continue, if not accelerate.¹²⁴

Older inmates often have complex medical and mental health issues and specific needs and vulnerabilities related to their age. The incidence of mental illness is high in prison populations,¹²⁵ with international research indicating that up to 40-50% of older inmates experience mental health issues.¹²⁴ Some inmates may develop a mental illness during the course of their incarceration. The most prevalent mental health conditions among older inmates are depression, psychosis, vascular dementia, alcohol-related dementia, anti-social personality disorder, and Alzheimer's disease.¹²²

The number and proportion of older inmates with mental illness is expected to increase. This raises a range of issues around providing appropriate care, support and accommodation for these inmates. In addition, negotiating and supporting the transition from prison or forensic mental health settings to community settings is often problematic. Accessing appropriate residential aged care placements for frail offenders (many of whom have mental health problems) when eligible for parole can be challenging, particularly for older sex offenders. There are limited options for community placement for ageing forensic patients, and an onus on the accepting LHD OPMH community services responsible for management of the forensic patient once released and implementation of conditions of release. LHD OPMH services may also care for older people with a forensic issue but not in the criminal justice system, and others with a forensic history. This may be relevant in their assessment and treatment.

Justice Health & Forensic Mental Health Network (JH&FMH) OPMH clinicians provide expert clinical advice and consultation and liaison on the management of older people with mental health problems within correctional centres (including the Aged Care and Rehabilitation Unit and the Step Down Unit at Long Bay Hospital and the Forensic Hospital). In addition, they have a key role in discharge planning and ensuring continuing of care upon release.

To respond to the mental health (and other health and aged care needs) of the growing number of older inmates, Justice Health and Corrective Services will need to enhance their capacity to provide appropriate OPMH care, aged care support,

physical environments and accommodation within the Justice Health and Corrective Services systems, as well as pathways to appropriate community care and accommodation. JH&FMHN have identified the need for: targeted standards of practice for health service delivery for older people and aged care programs; partnership approaches with a range of government and non-government agencies, and improved discharge/referral pathways to ensure the journey to services provided by LHDs and other service providers is efficient and effective.¹²⁶

Older people who are homeless or at risk of homelessness

Homelessness can contribute to premature ageing and the early onset of health problems usually associated with old age and early death. Given this, 'older people' in the context of homelessness are usually defined as those aged 55 and over.¹²⁷ One in 7 (14%) of all homeless people in Australia on Census night in 2011 were aged 55 or over – 14,851 people.¹²⁸ Some have been homeless intermittently or continuously for years, but many became homeless for the first time in later life. This includes a growing number of older single women who are experiencing homelessness for the first time later in life.^{129,130}

The number of older Australians at risk of, and experiencing, homelessness, and the number of older people seeking assistance from specialist homeless services, is growing and is expected to increase significantly over the coming decades.^{131,132}

There are many factors that contribute to homelessness, or increase the risk of homelessness, including family breakdown or violence, death of a spouse, physical and/or mental ill-health, problems with alcohol, welfare policy gaps and service delivery deficiencies.^{133,134} While there is an association between mental illness and the risk of homelessness, the estimates of mental illness among people who are homeless, including older people, varies. Some studies have found high rates of mental illness in homeless people,¹³⁵ including in older people.^{139,132} Others have found mental illness to be much less common and not the primary cause of homelessness.¹³⁶ This may be explained by differences in the definition of a mental health disorder and in research design. Research also suggests that a proportion of homeless people develop mental health issues following homelessness.¹³⁶ Poor housing or homelessness increases the chances of developing a mental health problem, or exacerbating an existing condition. Many older people experiencing homelessness have cognitive impairment,^{137,138,139} and a significant number may have or develop mental illness.

Older people experiencing, or at risk of, homelessness are a vulnerable and severely disadvantaged group. A holistic, multi-sectorial approach is required to address the complex social, economic and health factors that may cause homelessness. OPMH services should be guided by relevant frameworks such as the *NSW Housing and Mental Health Agreement* (2011),¹⁴⁰ link with services and programs that cater to people who are homeless or at risk of homelessness, and provide specialist clinical input as needed. Relevant services and programs include: partnership programs, such as the *Housing and Accommodation Support Initiative (HASI)*, that provide housing linked to clinical and psychosocial services, and services provided under the *Commonwealth Home Support Programme*; specialist homelessness services, funded by FACS and delivered by non-government organisations across NSW; supported and crisis accommodation services; social housing services and boarding houses, and residential aged care providers.

Older people living in severe domestic squalor

It is estimated that around 1 in 1,000 people aged over 65 live in moderate to severe domestic squalor.¹⁴¹ Squalor may arise from hoarding or from a passive failure to adequately maintain the environment. This is associated with a variety of conditions including schizophrenia, dementia, depression, head injury, alcohol abuse, intellectual disability and injury to the frontal lobes of the brain. Severe domestic squalor is more commonly seen in older age groups, and the impact of hoarding behaviour becomes more burdensome with age.¹⁴²

Squalor and self-neglect is an issue that cuts across many areas, including mental health, aged and community care, housing, homelessness, fire and rescue, local government, councils, and trustee and guardianship. The availability of specialist hoarding and squalor services across NSW is variable, with services only available in some metropolitan areas of NSW. Interagency cooperation and a collaborative, coordinated approach is crucial to successfully resolving and working with people who are hoarding and/or living in severe domestic squalor, with mental health services working in partnership with other agencies as required. OPMH services will have a role in performing mental health and cognitive assessments, assessing capacity, and treating any underlying psychiatric conditions, and should be guided by relevant local and state frameworks and guidelines.

Older lesbian, gay, bisexual, transgender and intersex (LGBTI) peopleⁱⁱ

According to the 2011 Census, 3% of people in same-sex couples were aged 65 or over, compared with 17% of people in heterosexual relationships.¹⁴³ The number of same-sex couples among people aged 65 and over is expected to increase over the coming decades,¹⁴⁴ which may be associated with an increased willingness to disclose sexual or gender identity due to reduced stigma and improved legal rights.

Many LGBTI people are adversely affected by multilayered discrimination, marginalisation, social exclusion, bullying or rejection, minority stress and stigma.^{145,17} LGBTI people experience a higher prevalence of other risk factors associated with mental ill-health than the rest of the population, such as more harmful and frequent levels of alcohol and other drug misuse, homelessness, poverty and chronic health conditions.¹⁴⁵ Older LGBTI people experience higher rates of depression and anxiety than the general community.^{146,147} A number of other issues which may be relevant when working with older LGBTI people include the impacts of the high LGBTI suicide rate, and the impact of growing up in an environment of legal persecution, pathologisation by the medical profession,¹⁴⁵ and being forced to conform to gender norms.

OPMH services will need to consider the needs and life experiences of older LGBTI people in promoting service accessibility and appropriate, recovery-oriented care. They will be guided in this by the work of LGBTI organisations such as ACON, relevant strategies and projects (such as the National LGBTI Health Alliance's [Silver Rainbow project](#)) and emerging research and evidence base. Partnerships with LGBTI communities and organisations will be important. It must be recognised that older LGBTI people are diverse, and should be treated as individuals with different life experiences.

Families and carers

Most older people with mental health problems will have a carer or family member interested in their welfare and/or providing some level of care and support. While caring for someone can be a positive, rewarding experience, carer responsibilities can reduce education and labour force participation, increase financial disadvantage, relationship breakdown and social isolation, and impact negatively on the carer's health and wellbeing. Carers have the lowest collective wellbeing of any Australian population group and are more likely to experience clinical depression or severe-extreme stress.¹⁴⁸ Carers of people with mental health issues report poorer health and mental health themselves than any other group of carers,¹⁴⁹ and are likely to have greater need for personal supports and coping mechanisms. Caring for an older person who develops mental health problems for the first time in older age presents specific challenges for the carer, including dealing with the shock of diagnosis in later life and adjusting to role changes in the relationship with the older person. Caring for a person with dementia has been found to be more stressful than caring for an adult with other disabilities,¹⁵⁰ with carer burden associated with more intensive supervision of the person with dementia, severity of their neuropsychiatric symptoms and lack of informal carer support.¹⁵¹

Carers of older people with mental health problems require information, resources, skills and support to effectively carry out this role. OPMH services need to consider the specific needs of carers.^{152,153,154, 155, 156} Services should actively engage with carers as partners in the delivery of care, and provide them with key information about a consumer's treatment in line with the *NSW Mental Health Act*. Supporting carers in their caring role is a key consideration, and OPMH services will need to provide information and advice on how best to support the individual consumer, and help the carer understand the symptoms and needs of their loved one. Services should also seek to understand a carer's needs, including any mental health care needs, provide information on appropriate services and supports, and facilitate access. This includes services offered through the *NSW Health Family and Carer Mental Health Program*, LHD family and carer support services, and other carer/peer support organisations, groups or forums.

ii In this document we use the acronym 'LGBTI' to refer to lesbian, gay, bisexual, trans and intersex people and communities. However, we recognise the limitations of 'LGBTI' and that the diversity of human bodies, genders, sexualities, relationships, lived experiences and identities is far broader than any acronym can encompass.

Section 3: OPMH service delivery model and strategic directions

OPMH service elements

The OPMH service model includes four distinct components: community services, acute inpatient units/services, non-acute inpatient units/services and mental health – community partnership services. Key strategic directions for each of these service elements under this plan are outlined below, along with key supporting information (see [Appendix 2](#) for a summary of the OPMH service elements).

Across the OPMH service model, recovery-oriented practice, partnerships and integrated care approaches will continue to drive service delivery and care. Integrated care should include clear mechanisms to support integration between OPMH inpatient and community services (see [Section 3.10](#) for governance structures that support quality care and service).

3.1 OPMH community services

KEY STRATEGIC DIRECTIONS

Key strategic directions for OPMH community services align with and support implementation of recovery-oriented practice, the NSW SMHSOP community services model of care (MoC), NSW mental health reform directions, national mental health planning frameworks, national quality and safety, performance and funding frameworks, and policy directions regarding partnerships and integrated care in a changing service landscape.

- Improve the *appropriateness* of OPMH community services and the *outcomes* of care, as well as *consumer and carer experiences* of services, in line with the SMHSOP community MoC and NSW mental health reform directions.
- Increase the *accessibility and capacity* of OPMH community services across NSW, in line with the SMHSOP community MoC and NSW mental health reform directions, and national mental health planning frameworks.
- Improve *equity of access* by addressing current variation between LHDs in staffing and activity, in line with the principles of this plan, and matching local service provision to population need.
- Improve *practice, performance and efficiency* in OPMH community services, in line with the SMHSOP community MoC and national quality and safety, performance and funding frameworks.
- Promote *partnerships, collaboration and integration* of care in a changing service landscape, in line with recovery-oriented practice and key NSW mental health policy and reform directions.

Overview

OPMH community services are a significant component of OPMH services. Consumers and carers indicated in consultations the high value they place on mental health care and support that is provided in their homes and communities. NSW, national and international mental health policy and reform directions support a focus on community care and support for people with mental illness, provided in the least restrictive care setting, at home or close to home where possible, with minimal disruption to a person's family, community supports, networks and relationships. People with mental illness experience greater quality of life if they are part of, and live in, the community.^{37,23,38,21,157} Hospital care should be reserved only for those whose needs cannot be met in the community.

Mental health planning models indicate that approximately 86% of the target/treatment population for OPMH services can be cared for by OPMH community services only and/or in community settings (including residential aged care, supported accommodation and home settings) along with other care and support. The mid-term evaluation of the *NSW SMHSOP Service Plan* found that most older people accessing public mental health services in NSW (an average of 72% of clients in any one year) were provided care solely in community settings.¹⁵⁸

However, mental health planning models suggest a need for additional OPMH community services – including inreach to RACFs– now and into the future.¹⁰ While many currently receive mental health care in the community, current service levels are insufficient to meet population need. This need will increase in line with the ageing of the NSW population and the projected increase in numbers of older people with mental illness.

There is currently significant variation in the capacity of OPMH community services in different LHDs across NSW, and the need for these services is growing faster in some LHDs than others, due to demographic changes. However, all LHDs have OPMH community services, and these are currently being enhanced under the NSW mental health reforms. This plan aims to improve equity of access to OPMH community services.

The [NSW SMHSOP Community Model of Care \(MoC\) Guideline](#)⁶⁷ and Project Report (2017) aims to improve and re-orient OPMH community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified in consumer, carer, clinician and stakeholder consultations conducted to support the project.

It articulates good practice directions for NSW OPMH community services in seven key areas. Adoption of a recovery-oriented, person-centred, biopsychosocial philosophy of care, reflected in all aspects of practice and service delivery, is the basis of the MoC. Other key priorities of the MoC include improving access and responsiveness of services including through accepting any person for secondary triage and/or initial assessment following triage, effective collaboration and care coordination (particularly with GPs and OPMH AIUs where present), and ensuring service appropriateness and staff capability to care for older people with mental illness. This should improve older people's care experiences and outcomes.

The MoC also supports OPMH community clinicians to work in a range of community settings including RACFs. See [Section 3.4](#) for further discussion of the specialist consultation-liaison and mental health clinical input/support provided by OPMH community services to MHACPI transition units and specialist and generalist RACFs. See [Appendix 3](#) for further information on the *NSW SMHSOP Community Services Model of Care*.

The MoC has a strong emphasis on good practice, performance and efficiency. National and NSW mental health performance frameworks and service standards, quality and safety frameworks and standards, and the development of activity based funding (ABF) are also key drivers of improvements in practice, performance and efficiency in mental health services.

Consumers have indicated that they see community OPMH services as one part of a complex system of care that supports their recovery journey.³⁰ This requires effective collaboration and coordination with key services and across care settings and boundaries (see [Section 2.4](#)). The policy and service environment in which OPMH services operate is dynamic and changing, as discussed in [Section 2.4](#). OPMH community services will need to adapt to this changing service environment, particularly in relation to service responses for people with dementia and BPSD, where significant increases in service demand linked to an ageing population will present both challenges and opportunities.

3.2 OPMH acute inpatient units/services

KEY STRATEGIC DIRECTIONS

Key strategic directions for OPMH acute inpatient units (AIUs) align with and support implementation of recovery-oriented practice, the NSW SMHSOP AIU Model of Care (MoC), national mental health planning frameworks, and national quality and safety, performance and funding frameworks.

- Improve the *appropriateness and outcomes* of inpatient mental health care for older people, as well as *consumer and carer experiences* of services.
- Improve the *effectiveness* of inpatient mental health care for older people in OPMH AIUs and adult mental health units, in line with the SMHSOP AIU MoC. The MoC will require review during the course of this plan to ensure it addresses new evidence, practice developments and policy directions.
- Improve *practice, performance and efficiency* in OPMH AIUs, in line with the SMHSOP AIU MoC and national quality and safety, performance and funding frameworks.
- Promote *collaboration and integration* of care with OPMH community services to support timely access to inpatient care and seamless transitions of care.

Overview

OPMH acute inpatient units are important services for older people with acute, severe clinical symptoms of mental illness. Consumers and carers indicated in consultations the desire for 'safe', calm acute inpatient units, with sufficient facilities (e.g. sufficient number of toilets, especially if there is a gender imbalance in the unit). They also indicated that they want access to a range of therapies and treatments, for staff to engage with them in a meaningful way, sufficient activities to be provided (including those not associated with therapy and treatment), flexibility in care delivery and attention to their recovery goals and follow-up care needs following discharge. NSW, national and international mental health policy and reform directions support the need for specialist acute inpatient services for older people to complement other inpatient services and community mental health care and support. While some older people may be appropriately cared for in general adult mental health units due to their clinical needs, preferences and other factors, OPMH acute inpatient units can provide the specialist staffing, care and physical environments that support older people with acute mental illness most effectively. Mental health planning frameworks indicate that approximately 14% of the target/treatment population for OPMH services will require OPMH acute inpatient care, and that a proportion of these will require acute intensive care services.

According to mental health planning models, the current supply of acute mental health services in NSW for people aged 65+ years is close to benchmarks.¹⁰

This assumes a good balance between inpatient (acute and non-acute) and community services, and includes the two new AIUs under development. However, it is acknowledged that there are current pressures on AIUs and a significant number of older people are being cared for in adult mental health services. The need for OPMH acute inpatient services will be affected by the current local spectrum of care and available community and non-acute inpatient services.

Some OPMH acute units are performing sub-acute functions (associated with longer average lengths of stay), and this may impact on their ability to meet future demand for acute services. There are also some units that were funded as sub-acute but function as acute units, and their future functions will require further consideration within LHD clinical service planning, particularly in the context of ABF. Modelling also suggests that there will be a growing need for older people to have access to acute intensive care services. Future demand for OPMH acute units will depend on the availability of appropriate community care and non-acute inpatient options, but is likely to grow in line with the needs of the growing older population.

Following substantial service development under the previous *NSW SMHSOP Service Plan*¹ and LHD mental health clinical service planning, most LHDS now have or are developing OPMH acute inpatient units. The development of these units has been guided by the [SMHSOP Acute Inpatient Unit \(AIU\) Model of Care Project Report \(2012\)](#)⁶⁷ and [Guideline \(2016\)](#).¹⁵⁹ These documents aim to promote effective inpatient care and consistent

good practice in existing and new OPMH acute inpatient units across NSW. A key direction of the MoC is the adoption of a person-centred, recovery-focused, biopsychosocial philosophy of care, reflected in care environments, processes and practices. The MoC provides recommendations regarding good practice in key areas of OPMH AIU care and operation, as well as service development guidelines to inform service planning and service development. These include recommendations about the key functions and physical design of OPMH AIUs, the delivery of care, the management of comorbid conditions including physical illness and end of life care, effective partnerships and integrated care, appropriate use of seclusion and restraint, and appropriate staffing and governance arrangements. See [Appendix 4](#) for further information on the *NSW SMHSOP Acute Inpatient Unit Model of Care*.

The MoC has a strong emphasis on good practice, performance and efficiency. National and NSW mental health performance frameworks and service standards, quality and safety frameworks and standards, and the development of activity based funding (ABF) are also key drivers of improvements in practice, performance and efficiency in mental health services.

Further policy development work is required regarding AIU staffing profiles and the training and education requirements for staff to enable them to deliver the model of care, facility design, and cost benchmarks (informed by ABF developments). These will be considered as part of the review of the MoC.

3.3 OPMH non-acute inpatient units/services

KEY STRATEGIC DIRECTIONS

Key strategic directions for OPMH non-acute inpatient units align with and support implementation of recovery-oriented practice, NSW mental health reforms (including PCLI), national mental health planning frameworks, and national quality and safety, performance and funding frameworks. It is recognised that non-acute inpatient services in NSW are currently changing and evolving. Further policy and service development work will be required to explore which older people need inpatient models versus community partnership models, to promote appropriate, effective and efficient use of OPMH inpatient services, and to maximise the opportunities for partnerships with community mental health and aged care services.

- Continue to deliver, develop and reform *non-acute inpatient services for older people with severe mental illness (including severe BPSD)*, through the T-BASIS model or other models that are linked to the spectrum of OPMH and aged health care. These services should be informed by the local service environment and local clinical service planning, as well as further state-wide policy development work.
- Progress policy work to determine the need for state-wide/tertiary intensive care *models for ongoing/longer-term care for older people with persistent, very severe/extreme BPSD*.
- Progress further policy work to support clear strategic directions in relation to OPMH non-acute inpatient services.

Overview

OPMH non-acute/sub-acute inpatient services have a primary focus on assessment, specialised clinical treatment and support to reduce functional impairments that limit a person's independence and promote recovery and quality of life. They may provide a step up/step down or rehabilitation function. Non-acute services provide care over an extended period.

It was a limitation of the consultation process for this plan that it did not significantly cover the perspectives of OPMH non-acute inpatient unit consumers. However, consultation with family members as part of the evaluation of the Transitional Behaviour Assessment and Intervention Service (T-BASIS) initiative and model of care have highlighted the importance of individualised, person-centred approaches, specialist staff with experience in ageing and mental health care, and communicating and working in partnership with carers/family members.¹⁶⁰

Consumer, carer and family consultation as part of the PCLI has also highlighted the importance of individualised, recovery-oriented assessment and care planning in non-acute inpatient units, as well as strong carer and family engagement.

Current NSW, national and international mental health policy directions broadly support the need for non-acute and sub-acute inpatient services (general and BPSD-specific) for older people, including residential, hospital-based and mental health-residential aged care partnership services. These complement other inpatient services and community mental health care and support. However, there is limited evidence regarding non-acute inpatient models of care specifically for older people with mental illness. NSW Health has developed the T-BASIS unit model specifically catering for people with severe BPSD.^{160,161} This model is outlined below.

At the state level, mental health planning models suggest a need for some further sub-acute/non-acute inpatient OPMH services to meet current and future demand.¹⁰ However, the estimated need varies between the different service types. The need for sub-acute inpatient services focused on BPSD is currently largely being met. There is a large unmet need for general sub-acute services, increasing over time. However, ALOS data suggests that some OPMH acute units may be performing sub-acute functions (with ALOS 3-6 months), and therefore the need may be somewhat overstated. Modelling suggests that additional non-acute services will be required to meet future needs, and this will be more pronounced with any changes to service models within the existing non-acute services.

Mental health planning frameworks indicate that approximately 5% of the target/treatment population for OPMH services will require some OPMH non-acute or sub-acute inpatient care in a given year, with most of these consumers also receiving acute inpatient care. It should be noted that the modelling aligns inpatient care for people with very severe/extreme BPSD with non-acute, medium secure inpatient care.

Non-acute/sub-acute inpatient care is a significant component of the spectrum of mental health care, particularly in the context of recovery-oriented care. Community mental health and aged care services and residential aged care services are key partners for OPMH non-acute inpatient services. However, the interface between non-acute mental health inpatient care and community mental health and aged care, particularly residential aged care, is constantly evolving in the context of national

mental health and aged care reforms. Which older people need inpatient models versus community partnership models needs to be explored. Associated with this, service development needs to promote appropriate, effective and efficient use of OPMH inpatient services, and maximise the opportunities for partnerships with community mental health and aged care services.

Under the previous *NSW SMHSOP Service Plan*,¹ NSW Health commissioned a review of the Confused and Disturbed Elderly (CADE) units operating in a number of health service areas. This led to service reform of the renamed T-BASIS units to a good practice step-up/step-down model of care for older people with severe BPSD. The T-BASIS model of care involves multidisciplinary assessment, care planning and treatment for older people with severe behavioural disturbance associated with dementia and/or mental illness. Five T-BASIS units now operate in 4 LHDs (with 4 of the units located in rural and regional areas). They are operating substantially in line with the T-BASIS model of care, supported by state-wide benchmarking processes to reflect on practice and performance and support quality improvement. Significant specialist cover from geriatric and psychogeriatric medicine continues to be a key component of the MoC to meet the needs of T-BASIS consumers who generally have significant and multiple medical co-existing conditions. The MoC also recommends that additional medical coverage is available to address routine medical matters, and that access to acute medical care is available in a timely manner when required. T-BASIS units have been found to be clinically effective¹⁶⁰ and cost effective,^{160,162} with high rates of satisfaction from carers, families and residential care facility staff (as key service partners).¹⁶⁰ See [Appendix 5](#) for further information on the *NSW T-BASIS Model of Care*.

T-BASIS units, OPMH AIUs and other non-acute mental health inpatient units currently vary in their capacity and approach around providing inpatient care for the small numbers of people presenting to services across NSW with persistent, very severe/extreme BPSD.

The T-BASIS model continues to evolve. It may be particularly appropriate for regional and rural areas, where the capacity of the residential aged care sector to provide care for older people with severe BPSD, MHACPI units (see [Section 3.4.1](#)) and other specialist mental health-residential aged care facilities is more limited and a step-up/step-down model with shorter length of stays may better maintain a person's family and community connectedness.

Some T-BASIS units have co-located with OPMH acute units, and this appears to be a positive arrangement, allowing some flexibility in managing the inpatient consumer mix and differing consumer needs. A number of other OPMH non-acute inpatient units and general adult units with significant numbers of older people are currently reviewing their future roles and functions in relation to the PCLI, expansion of mental health-residential aged care partnership services and other community partnership models, and local mental health clinical service planning.

3.4 Community partnership models

Community partnership models involving OPMH services and community managed (non-government) mental health and/or aged care services have the potential to provide community-based, individualised, recovery-oriented care, accommodation and support for older people with mental illness. Consumers and carers indicated in consultations the high value they place on mental health care and support that is provided in their homes and communities.

NSW, national and international mental health policy and reform directions support a focus on community care and support for people with mental illness. The policy and service environment is evolving and OPMH services will need to adapt to

and work within these changes. In particular, service responses for people with dementia and BPSD, and the role of OPMH community services in this area, is likely to evolve over time. Service reform and service development in the mental health, aged care and disability sectors all present both challenges and opportunities for improving community mental health care and support for older people with mental illness.

Mental health planning frameworks indicate that approximately 86% of the target/treatment population for OPMH services can be cared for by OPMH community services only and/or in community settings (including residential aged care, supported accommodation and home settings) along with other care and support.

In NSW, there are two kinds of community partnership models that are relevant for older people with mental illness:

1. *Mental health-residential aged care partnership models*
2. *Community care and support programs delivered by other community care providers, in partnership or coordination with mental health/health services.*

These two kinds of partnership models are addressed separately below.

3.4.1 Mental health-residential aged care partnership models

KEY STRATEGIC DIRECTIONS

Key strategic directions for mental health-residential aged care partnership services align with and support implementation of recovery-oriented practice and NSW mental health reforms (including PCLI). It is recognised that further policy and service development work will be required to explore which older people need inpatient models versus community residential partnership models, and to maximise the opportunities for partnerships with residential aged care services.

- Promote *pathways and access to appropriate community (residential) care options*, and the *outcomes of care*, by expanding and further developing MHACPI transition units and Specialist RACFs, in line with NSW mental health reform directions (including PCLI), mental health planning frameworks and PCLI evaluation findings.
- Develop the *capacity and practice* of OPMH community services to support appropriate transitions and outreach to, and partnerships with, RACFs (specialist and generalist), in line with NSW mental health reform directions (including PCLI), the SMHSOP community MoC, mental health planning frameworks and PCLI evaluation findings.
- Promote *partnerships, collaboration and integration* of care in a changing service landscape, in line with recovery-oriented practice and key NSW mental health policy and reform directions.

Overview

In NSW, OPMH service models and strategic directions in relation to mental health-residential aged care partnership models are reasonably well-defined and linked to long-standing OPMH policy directions. Under the previous *SMHSOP Service Plan*,¹ two pilot Mental Health – Aged Care Partnership Initiative (MHACPI) transition units were implemented and evaluated, and OPMH outreach to residential aged care facilities expanded.

Mental health planning models suggest a significant and growing need for additional residential mental health-aged care partnership services for older people with mental illness.¹⁰

OPMH-RACF partnership and outreach models have been further expanded and articulated under the PCLI, with reference to the MHACPI evaluations,^{162,29} *SMHSOP Service Plan* evaluation,¹⁵⁸ existing RACFs targeting people with mental illness, and other relevant literature regarding good practice in promoting pathways to community care for people with complex mental health needs.

There are three key mental health-RACF service components/models developed under the previous *SMHSOP Service Plan*¹ and further articulated and expanded under the PCLI:

1. Specialist MHACPI transition units in RACFs
2. Specialist RACFs
3. Specialist clinical outreach to generalist RACFs (including Multipurpose Services where present) to support placement/transition and continued support of older people with mental illness (including moderate-severe BPSD) in RACFs.

These three models are closely linked to OPMH community services and the community MoC and are described more fully below. They will be further evaluated under the PCLI to support further development and directions in this area.

1. Specialist MHACPI transition units in RACFs

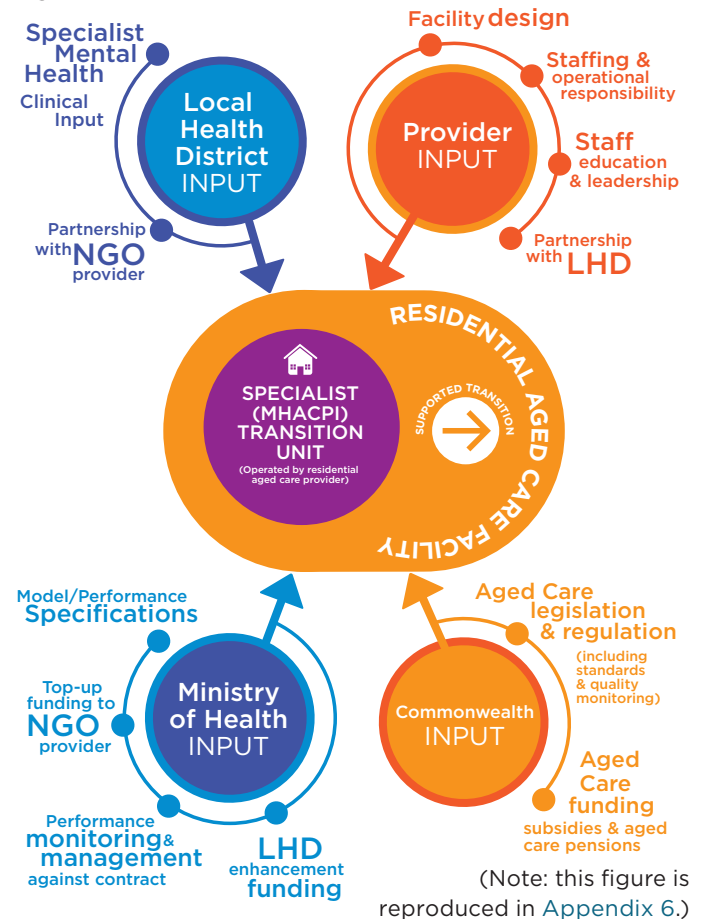
The specialist MHACPI transition unit model aims to address the needs of older people with severe mental illness (including BPSD), as well as aged care needs. It incorporates the following key components (as per Figure 2, below).

- purpose-designed Special Care Units within RACFs, operated by residential aged care providers
- specialist consultation-liaison and mental health clinical input/support from the LHD OPMH service

- supported transition for consumers from the Special Care Unit into other places in the aged care facility, when appropriate.

For more information on the key elements of the MHACPI transition model see [Appendix 6](#).

Figure 2: MHACPI model



Clients of MHACPI services typically have severe challenging behaviours/behaviours of concern, often presenting with psychiatric symptoms in addition to dementia. Clients of MHACPI services may have previously had long stays in mental health, geriatric medical and/or general hospital facilities, frequent hospital admissions from home or RACFs, or unsuccessful residential aged care placements. The initial priority for the new MHACPI services being developed under PCLI will be older people who have had long stays in mental health inpatient units in the priority sites identified under that initiative.

An independent evaluation and economic evaluation of the MHACPI pilot services demonstrated that this model can be an effective and cost-effective service for the target population, delivering better health outcomes than alternative options. In addition, it delivers high family, carer and staff satisfaction and has the potential to relieve pressure on acute hospitals and mental health inpatient services.^{162,29}

2. Specialist residential aged care facility (RACF)

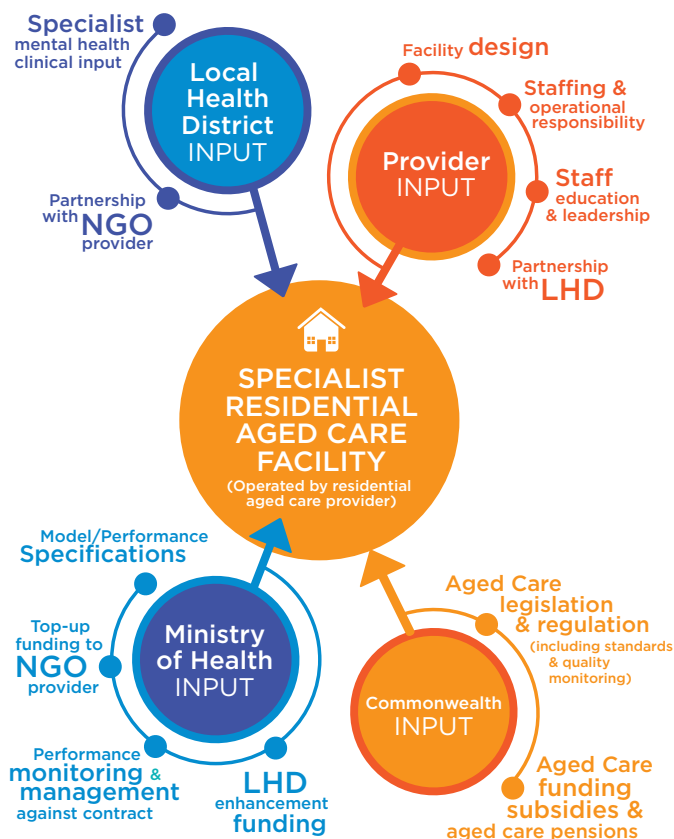
The Specialist RACF is targeted to older people with severe and persistent mental illness and high behavioural needs, as well as aged care needs. These consumers typically have complex needs due to mental illness, ageing, disability and/or co-occurring health conditions. They may experience early ageing issues or frailty associated with severe and persistent mental illness, treatment and/or cognitive impairment, and may experience or be at risk of homelessness or very long stays in hospital.

The Specialist RACF model incorporates the following key components (as per Figure 3, below).

- specifically designed aged care facilities with a contemporary, flexible model of care that includes additional clinical management, appropriate supported daily living and social activities, and strong community linkages
- specialist consultation-liaison and mental health clinical input/support from the LHD OPMH service.

For more information on the key elements of the Specialist RACF model see [Appendix 6](#).

Figure 3: Specialist RACF model



(Note: this figure is reproduced in [Appendix 6](#).)

A key component of both the MHACPI unit and the Specialist RACF model is the partnership between the aged care provider and the LHD mental health service, in particular the OPMH community service.

Joint governance arrangements are supported through LHD-service provider Memorandums of Understanding and joint Clinical Advisory Committees.

3. OPMH community services outreach to generalist RACFs

The model of specialist clinical outreach to generalist RACFs involves additional clinical support, provided by OPMH services, for residents of non-specialist (or generalist) RACFs. This model provides support for people with complex mental health needs (including episodic exacerbation of mental illness and behavioural issues) and aged care needs who prefer a generalist RACF to a MHACPI unit or Specialist RACF and whose care needs can be met in this environment. In rural and remote locations, specialist mental health clinical outreach will also be provided to residents of Multipurpose Services (MPS) as required. Key features of this kind of outreach are: specialist mental health referral and transition support for consumers with ageing issues and complex mental health needs, and ongoing specialist OPMH community consultation-liaison and mental health clinical input/ support as required.

The expansion of OPMH service outreach to RACFs was supported by the development of NSW-funded Behavioural Assessment and Intervention Service (BASIS) functions/positions and Commonwealth-funded Dementia Behaviour Management Advisory Service (DBMAS) functions/positions within OPMH community services from 2007. The loss of DBMAS funding and complex interplay with new Commonwealth-funded dementia programs has reduced the capacity and complicated the role of OPMH community services in this area. However, the *SMHSOP Community Services Model of Care*⁶⁷ highlights the ongoing role of OPMH community services in supporting transitions/transfer of care from inpatient to community settings (including residential aged care), partnerships with residential aged care providers, and integrated care across care settings as key priorities.³⁰

Enhancements to OPMH community services in all LHDs under the NSW mental health reforms is expected to support the re-orientation of OPMH community services to align with the *SMHSOP Community Services Model of Care*, including the provision of clinical outreach to residential aged care services.⁶⁷ In addition, further enhancements and service reform and development under the PCLI is enabling transition of people with complex mental health and aged care needs to MHACPI transition units and specialist and generalist RACFs, and expanded outreach to these facilities.

3.4.2 Community care and support programs and partnership models

KEY STRATEGIC DIRECTIONS

Key strategic directions for mental health-community partnership services align with and support implementation of recovery-oriented practice and the NSW mental health reforms (including PCLI). It is recognised that there are significant national and NSW reforms underway in the mental health, aged care and disability sectors, and OPMH community services will need to adapt to this changing service environment.

- Maximise opportunities for older people with mental illness to be *appropriately supported* in community settings by promoting *recognition* of mental health issues and *access* to community services/programs, and supporting this through collaboration and partnerships.
- Promote *partnerships, collaboration and integration* of care in a changing service landscape, in line with recovery-oriented practice and key NSW mental health policy and reform directions. This will mean maximising opportunities for partnerships between OPMH services and community mental health, aged care and disability services.

Overview

Just like younger people with a mental illness, older people may also experience disability associated with their mental illness which impacts on their day-to-day functioning. An older person with severe mental illness is likely to require a range of clinical and non-clinical supports to promote recovery and wellness. Not all older people with severe mental illness will need or want to be supported in a residential aged care setting. A range of community care and support options, involving a range of service providers and agencies, may be required to meet individual needs and recovery goals (see [Section 2.4](#)).

As discussed in [Section 2.4](#), current access to community-based psychosocial support services and programs for people aged 65 years and over is limited. According to mental health planning models, there is a significant and growing need for community care and support services, including HASI-type services, for older people.¹⁰ Modelling suggests that the number of people aged 65 years and over who require HASI-type care in their homes will increase over time. There is also an unmet need for non-acute community residential services or supported accommodation services (24/7 staffed supported accommodation), and this will increase over time.

Community care and support programs and partnership models for older people are not currently well-defined, and are developing within a dynamic and changing service landscape. However, there are significant opportunities to improve older people's access to community care and support through NSW initiatives and programs such as CLS, HASI, and new service models to be developed under the PCLI, and through the NDIS for some older people. There are also opportunities for older people to access mental health care and support through aged care services and support packages (including consumer-directed care packages) being developed under the national aged care reforms. Promoting recognition of mental health issues in aged care assessment processes and provision of appropriate support will be required at both the policy and service level. Older people with mental health problems may also be able to access mental health supports through services commissioned by PHNs under the national health reforms. The NDIS may provide support for older people transitioning from disability services support and 'functionally old' younger people, in coordination with aged care and mental health support.

[Appendix 2](#) provides an overview of the services provided by CMOs that may be relevant to older people with mental health problems.

3.5 Consumer and carer participation

Effective consumer and carer participation has been promoted in the development of this plan and will be a key enabler of successful implementation. The *Living Well* NSW Mental Health Strategic Plan²³ and *Fifth National Mental Health and Suicide Prevention Plan*²⁰ support engaging consumers and carers in service design and service improvement.

At the clinical level, consumers should be recognised as partners in the management of all aspects of treatment, care and recovery planning and advance care planning.^{163,164,165,21,23,166} The value of carer engagement is underpinned in both legislation and policy, including the *NSW Carers (Recognition) Act 2010*¹⁵³ and the [NSW Carers Strategy 2014-2019](#).¹⁵² At the service and policy level, this will mean further enhancing consumer and carer participation and representation in planning, service delivery, service development and quality improvement processes, and ultimately consumer co-design of services. Work is currently underway to further develop frameworks and processes for effective consumer and carer participation and consumer co-design.¹⁶⁷

3.6 Planning

Effective planning at the state and local levels will help enable the aims of this plan to be realised. State level planning will be guided by *Living Well: NSW Mental Health Strategic Plan 2014-2024*²³ and associated NSW Mental Health Reforms 2014-2024, the *National Mental Health Services Planning Framework*, capital planning processes, the [NSW Health Guide to the Role Delineation of Clinical Services](#),¹⁶⁸ the forthcoming *NSW Strategic Framework for Mental Health*, and other key planning guidelines such as Health Facility Guidelines. Local strategic and clinical service planning will be guided by this state-wide Plan and the state-wide evidence-based service models it promotes. Such planning will require local consultation (including consumer, carer and community consultation), needs assessment, a good understanding of the local service environment, and coordinated planning with other key services including Primary Health Networks. Gap analysis at the local and state level is an ongoing process.

3.7 Prevention and early intervention

Prevention and early intervention approaches, both with individuals and at the broader community level, can promote recognition and understanding of mental health issues, wellness, help-seeking and access to appropriate care. They can also prevent the escalation of mental health problems. Prevention and early intervention in later life is highlighted as a priority in the *Living Well in Later Life A Statement of Principles*.²⁵ OPMH services will need to work with consumers to promote wellness planning and self-care and this should be done in a culturally sensitive way. The NSW Health [Wellbeing in Later Life](#)¹⁶⁹ resource provides guidance for OPMH clinicians about information, programs and resources for older people that may assist in supporting recovery and maintaining wellness.

Some OPMH services may provide recovery-focused group programs and facilitate peer support approaches. Within resource constraints, OPMH services will provide or support education, training and capacity building with families, carers, communities and other key services to promote early recognition of mental health problems in older people, effective mental health support by other services, and appropriate referral to mental health services. The resource [Prevention First: A Prevention and Promotion Framework for Mental Health](#)¹⁷⁰ (Hunter Institute for Mental Health, 2015) provides guidance for mental health services and other services and sectors about prevention approaches. The *Older Person Mental Health First Aid*⁵⁵ course teaches people how to identify risk factors and respond appropriately as early as possible to older people with mental health problems.

Suicide prevention is an important priority, particularly given the high rates of suicide in older men. There are a range of statewide and local suicide prevention initiatives in NSW, and reducing suicide and suicide risk in older people is one of the priorities in the *Living Well in Later Life* document.²⁵ It will be important for OPMH services, policy makers and researchers to be involved in these initiatives to promote an understanding of specific issues for older people and appropriate recognition of suicide risk, and further develop approaches that address these issues effectively. Key current policies and initiatives include:

- NSW Health policy directive [Clinical care of people who may be suicidal](#)¹⁷¹ (2016)
- NSW Suicide Prevention Framework ([Lifespan](#)) and associated Lifespan initiative led by the Black Dog Institute

- the *NSW Suicide Prevention Fund*
- the *NSW Elderly Suicide Prevention Network*
- [Communities Matter](#) suicide prevention tool kit.

3.8 Workforce

As highlighted in the *Living Well* NSW Mental Health Strategic Plan²³ and associated *Living Well in Later Life* documents,^{24,25} a skilled, well-led and well-supported, multidisciplinary workforce with access to appropriate clinical supervision and professional development is fundamental to delivering high quality recovery-oriented OPMH services.

Workforce planning and development will be a key enabler for this plan. The OPMH workforce will need to include a range of clinical disciplines, as well as peer workers. It will need strong leadership – both clinical and strategic. It will need to grow, adapt and develop to meet the need for OPMH services, the expectations and preferences of older people with mental illness, evidence-based good practice and contemporary models of care. The workforce will need to support an appropriate number, distribution, balance and mix of services. The [Health Professionals Workforce Plan 2012-2022](#) (revised 2015)¹⁷² and forthcoming *NSW Mental Health Workforce Plan* are expected to provide further guidance for OPMH workforce development in NSW and to strengthen the process around detailed mental health workforce planning and development.

State-wide and local workforce development strategies will be needed to support the growth and capability of the OPMH workforce. This will include identifying areas for capability development at the individual clinician, service and state level. Promoting access to appropriate eLearning, face-to-face and blended education and training opportunities, leadership development, skills and practice development is also required. This will involve linking to HETI Mental Health portfolio, professional associations and networks such as the Faculty of Psychiatry of Old Age (FPOA), Psychogeriatric Nurses Association (PGNA) and Allied Health professional associations, and other strategies. The *NSW SMHSOP Core Competencies*¹⁷³ and *National Mental Health Core Capabilities*¹⁷⁴ provide guidance regarding core capabilities for OPMH clinicians. Other professional development activities such as teaching, supervising students, undertaking clinical research and participating in conference presentations and professional publication should also be supported and encouraged.

Local leadership of OPMH services – both clinical and strategic – is a key enabler of high quality, innovative services. The mid-term evaluation of the *NSW SMHSOP Service Plan 2005-2015*¹⁷⁵ found that LHD OPMH Service Co-ordinator/Manager (strategic leadership) roles and Clinical Director (clinical leadership) roles have been pivotal in establishing and/or developing OPMH services in LHDs. This includes providing leadership and direction for clinical standards and quality improvement, developing OPMH staff, and managing resources for OPMH services (particularly enhancement funding). The evaluation noted that these roles are crucial to the continuity of the OPMH program.

Development of the peer workforce is a key priority of *Living Well* NSW Mental Health Strategic Plan²³ and a number of key national and state policy directives, reports and standards.^{14,38,156,21,176,177}

Peer workforce development, including integration of the peer workforce, will be further considered in the forthcoming *NSW Mental Health Workforce Plan*. Peer workers are recognised as a key component of recovery-oriented mental health services. 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/carers perspective. The role and importance of volunteers, and the volunteer-peer worker interface, is also recognised.

Research supports the contribution of peer workers generally,^{23,178,179,180} but there are only a few studies^{181,15} that support the effectiveness and role in an OPMH context. This plan supports further development of the OPMH peer workforce, as recommended in the *OPMH Community Services Model of Care Guideline*. In consultations for this plan and the Community Model of Care, older consumers reported they found the opportunity to receive support from others who have a lived experience to be very valuable. It was noted that maturity and life experience were key for OPMH peer workers to be able to connect with older consumers appropriately. Recent NSW OPMH recovery-oriented practice improvement projects have found significant benefits to OPMH consumers, peer workers and clinicians in developing an OPMH peer workforce, particularly in improving the recovery orientation of services and complementing clinical roles. OPMH services should seek to increase the involvement of peer workers within these services to complement clinical roles, building on the evidence that comes from adult services, and seeking to build on the evidence base regarding peer work with older people.

As the need for OPMH care grows, it will become increasingly important to harness, partner with and develop other sectors of the workforce to complement and support specialist public OPMH services. This includes private psychiatrists and psychologists and generalist health nurses/clinicians who already play a key role in providing care of and treatment for older people with mental illness. Generalist health nurses/clinicians in NSW Health facilities can access a range of educational opportunities to improve recognition of and care of older people with mental health problems including HETI education and training modules and the NSW ACI [Care of Confused Older Persons \(CHOPS\)](#) suite of resources.¹⁸² Community and residential aged care staff can also access training to help improve the detection and management of mental health problems experienced by older people, such as *beyondblue's* [Professional Education to Aged Care](#) (PEAC) and the Mental Health Coordinating Council's [Mental Health CONNECT Aged Care](#) courses. Workforce development for aged care assessment services and community aged care providers should be supported where possible, to increase knowledge of mental health referral pathways and treatment and support options.

3.9 Strategic liaison, partnerships and integrated care

Strategic liaison, collaboration and partnerships at the policy, agency, service and professional level are key enablers for realising the goal of this plan. OPMH services play a key role in promoting continuity and coordination between mental health services and services outside of mental health, ensuring the provision of integrated care. There has been further development of key OPMH policy and service partnerships over the last 10 years as these services have expanded and developed across the State under the previous *SMHSOP Service Plan*,¹ supported by an increasing emphasis in health policy and practice on partnerships, collaboration and integrated care.

OPMH services must ensure clinical practices, referral pathways, service structures and service partnerships facilitate integrated and coordinated care that meet the particular needs of the individual older person. They will be guided by relevant NSW policy documents including [Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs](#),¹⁸³ and the *NSW Integrated Care Strategy*.¹⁸⁴ NSW OPMH services will need to maintain and/or develop strong collaborative partnerships with services that

support clinical and personal recovery. Key partners include GPs and PHNs, aged health and geriatric medical services, Commonwealth aged care assessment services, private psychiatrists and residential and community aged care services (see [Appendix 2](#) and [Appendix 7](#) for more information on service partners). Coordination between inpatient and community OPMH services is particularly important. The high rates of physical health conditions experienced by older people with mental illness necessitate collaboration to address both physical and mental health needs.

Developing effective partnerships and collaboration with a range of key partners is an important strategy for promoting access to OPMH services for population groups with specific needs such as Aboriginal communities and CALD communities. Such partnerships will also assist OPMH services in providing appropriate care.

At the strategic and policy level, inter-agency and inter-sectoral collaboration will be required to address barriers for older people with mental illness in accessing appropriate care and support, and pursue opportunities to improve care and support. The *NSW OPMH Working Group* and other state-level advisory committees and collaborative groups will continue to support cross-agency and cross-jurisdictional collaboration on OPMH and partnerships between OPMH services, aged care, primary health, community care, residential services and other relevant health and non-health services. The *NSW OPMH Services Advisory Group* will continue to have a key role in providing advice on OPMH services, facilitating the implementation of this plan and state-wide OPMH service policy directions and promoting collaboration to support service improvement and service development in OPMH services across NSW.

3.10 Governance, quality and safety

NSW Health organisations have governance and accountability requirements in a range of key areas including strategic and service planning, audit and risk management, finance and performance management and clinical governance.¹⁸⁵ Clinical governance arrangements should include well-articulated processes for clinical decision-making, risk management, audit, performance and evaluation, professional development and quality improvement. The [NSW Health Performance Framework](#)¹⁸⁶ includes the performance expected of NSW Health services and organisations to

achieve the required levels of health improvement, service delivery and financial performance.

In terms of clinical and corporate governance, OPMH services are part of LHD mental health services and are therefore operationally responsible to LHD mental health services. This plan promotes service structures that support OPMH as a distinct sub-specialty stream of LHD mental health services. Such service structures can support appropriate, effective care for older consumers, a strong specialist OPMH workforce and service evolution to address changing evidence and consumer and carer expectations. Moreover, a single governance structure across OPMH inpatient and community services supports integrated, continuous care for OPMH consumers.

The OPMH sub-specialty stream was significantly developed under the previous *NSW SMHSOP Service Plan*.¹ As noted in [Section 3.8](#), the mid-term evaluation of that plan found that OPMH clinical and strategic leadership roles were critical to the development of OPMH services, providing leadership and direction for clinical standards and quality improvement in OPMH services¹⁷⁵ and driving innovation and change. This finding was reiterated in the findings of the 2013 workforce survey of LHD OPMH services (approximately 200 respondents).¹⁸⁷ Services with OPMH-specific corporate and clinical governance structures reported that these *help(ed) prevent operational inefficiencies, promoted better access to specialist mental health clinical support and expertise and provided a stronger voice and profile* for OPMH as a distinct specialty area in their LHDs. OPMH managers lacking an OPMH clinical director tended to highlight *limited clinical leadership and support* as a challenge. Managers who reported to an aged health/health service manager reported negotiating *dual governance structures* as a challenge, specifically dual reporting requirements/arrangements and policies across mental health and aged care. OPMH managers who reported to a Director of Nursing identified challenges in managing OPMH service teams effectively, particularly regarding *staffing levels that do not cater for the complex needs associated with older mental health consumers and limited access to medical cover*. OPMH managers reporting within non-OPMH operational management streams reported a primary challenge being a *lack of recognition of OPMH staff specialist skills*, resulting in *staffing and resourcing challenges*. Staffing and governance arrangements that don't recognise the skills/training of OPMH clinicians may have disadvantages for recruitment, retention,

operational efficiency and quality of care.

Improving the quality of OPMH services is a key strategic theme of this plan. Quality and safety are 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. OPMH services are guided by the *NSW Patient Safety and Clinical Quality Program* and the [Australian Safety and Quality Framework for Health Care](#).¹⁸⁸ The [National Standards for Mental Health Services \(2010\) \(NSMHS\)](#)¹⁵⁶ and the [National Safety and Quality Health Service \(NSQHS\) Standards](#)¹⁸⁹ provide health services with a framework for delivering safe care and continuously improving the quality of the services they provide. Implementing *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.¹⁹⁰ The [Mental Health Statement of Rights and Responsibilities](#)¹⁸ is also an important document for OPMH services, particularly in the context of recovery-oriented practice.

OPMH services are required to comply with mandated data collections including the Key Performance Indicators (KPIs) outlined in the [National Mental Health Performance Framework](#)¹⁹¹ and the KPIs included in the Service Performance Agreements¹⁹² between the NSW Ministry of Health and LHDs. These indicators map to key domains of performance such as accessibility, appropriateness, capability, continuity of care, effectiveness, efficiency, responsiveness, safety and sustainability. The key strategic directions of this plan align strongly with these domains.

Current relevant KPIs for mental health inpatient units include average available beds, occupancy, length of stay, acute readmission within 28 days, involuntary patients absconded, and acute seclusion rate, average duration and frequency. Community mental health service KPIs include care hours and treatment days per episode of care. Continuity of care KPIs include acute pre-admission and post-discharge community care (7-day pre-admission and follow-up care). Variation against purchased volume (acute, non-acute, non-admitted), mental health peer workforce FTEs, outcomes readiness (e.g. HoNOS completion rates), consumer outcomes participation (e.g. K10 completion rates) and consumer experience measure (YES) completion rates are performance measures for both inpatient and community services. The YES Measure¹⁹³ is a

nationally developed questionnaire, and is a key measure of consumer experience and feedback mechanism to assist OPMH services in improving service experience, appropriateness and quality – key aims of this plan. In addition, the Mental Health Carer Experience Survey (MH CES)¹⁹⁴ can be used by OPMH services to support quality improvement in relation to the engagement and involvement of carers.

There is currently a significant national and State policy focus on minimising seclusion and restraint in mental health services, including OPMH services. In NSW, this focus is supported by the NSW Policy Directive on managing aggression and minimising seclusion and restraint in NSW mental health services¹⁹⁵ (currently being revised) and Guideline¹⁹⁶ focussed upon older people, reporting and benchmarking processes, and workforce training and practice improvement initiatives.

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](#),¹⁹⁷ and the *Fifth National Mental Health and Suicide Prevention Plan*.²⁰

In NSW, the NSW Health pillar organisations – Clinical Excellence Commission (CEC), the Agency for Clinical Innovation (ACI) and the Bureau of Health Information (BHI) – support clinicians and managers to improve performance and provide safe and effective healthcare. OPMH policy, clinical and service managers and clinicians need to work effectively with relevant ACI Networks such as the Mental Health Network and Aged Health Network, as well as the CEC and BHI. The NSW Ministry of Health also leads a number of quality and safety initiatives.

The NSW OPMH benchmarking model continues to be an effective model for promoting quality, practice improvement and recovery orientation in community and inpatient services across the State. This approach is currently being expanded to include mental health-residential aged care partnership services as these services further develop in line with this plan. Benchmarking allows OPMH 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 OPMH services.

3.11 Research

In relation to research activity, all health services in NSW are guided by the strategies outlined in the [Health and Medical Research Strategic Plan for NSW](#).¹⁹⁸ Fostering translation and innovation from research is a key strategic direction. Key actions in this area include supporting practitioner researchers, building collaboration among policy makers, practitioners/clinicians and researchers, rigorous evaluation of policies and programs, and maximising the use of research in policy, practice and health service delivery. For OPMH services, engagement in research and evaluation is important for promoting translation of evidence into practice, service quality and innovation.

Section 4:

Implementation, reporting, monitoring and evaluation

4.1 A two-phase implementation plan

An implementation plan is proposed to guide the NSW Ministry of Health and LHD OPMH services in pursuing the strategic directions outlined in the Plan over the next ten years (see [Appendix 8](#) and [Appendix 9](#)). The Implementation Plan is expected to guide future resource allocation at the state and local levels. Both the NSW Ministry of Health and LHD OPMH services have key roles in the implementation of key directions and strategies.

The implementation plan incorporates two major phases of service development:

- **Phase 1** focusses on improving and expanding OPMH service elements, service models and service development strategies (e.g. specific population group strategies) where there is a sound evidence base and/or model of care, strong support from consumers, carers and other stakeholders in OPMH services, and clear alignment with current NSW and national mental health policy directions. This phase is particularly aimed at *expanding and improving community OPMH services, and expanding community partnership models. Policy and service model development work will focus on non-acute inpatient models and services, as well as review of the OPMH acute inpatient unit model of care to ensure it addresses new evidence, practice developments and policy directions. Service development strategies for specific population groups will focus on older people with co-existing mental health and alcohol and other drug issues, older people with co-existing mental health problems and intellectual disability, older people in the criminal justice system and LGBTI communities, supported by recent policy and planning work in these areas. Other strategies for specific population groups will build on developments under the last NSW SMHSOP Service Plan.*¹
- **Phase 2** focusses on *further development of non-acute inpatient services and improvement of acute inpatient services* in the context of policy, service model and service model review work in Phase 1 and other developments in the service context. Service development strategies for specific population groups will build on developments in Phase 1, and population groups where further policy directions or evidence-based strategies have emerged. Importantly, Phase 2 implementation will be *guided by a mid-term evaluation of the Plan* to ensure that strategies remain relevant and appropriate as the clinical, policy and service delivery environment changes and build on Phase 1 developments.

The implementation plan sets out some key performance indicators and reporting mechanisms for monitoring progress with implementation and evaluating key impacts and outcomes of the Plan. The detailed **Implementation Plan Phase 1: 2017-2022** is at [Appendix 8](#).

Implementation Plan Phase 2: 2023-2027 is at [Appendix 9](#).

4.2 Reporting and monitoring

A range of existing NSW mental health reporting processes will enable monitoring of the Plan. These include:

- consumer 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.
- consumer experience reporting through the YES survey (and carer experience through the carer experience survey)
- activity reporting through the Admitted Patient (AP) and Mental Health Ambulatory (MH-AMB) data collections

- service and staffing data through the Mental Health Service Entity Register (MHSER) and Mental Health Establishments
- NSW mental health performance reporting and national health performance reporting
- financial reporting and monitoring, and ABF reporting
- mental health reform reporting, program reporting and qualitative reporting on specific strategies and initiatives.

The NSW Health data collection and reporting systems link to relevant national collections such as the Mental Health National Outcomes and Casemix Collection¹⁹⁹ and the mental health National Minimum Data Sets.²⁰⁰

Implementation of the Plan and the quality, safety and performance of OPMH services will be monitored through relevant state-wide mechanisms such as state-wide governance committees, Health Service Performance Agreements, NSW OPMH benchmarking activities, the NSW Official Visitors Program, NSW mental health reform reporting, NSW Mental Health Commission reporting and national quality and safety assurance processes, including accreditation.

4.3 Evaluation

A mid-term evaluation will be conducted in 2022 to:

- review progress with implementing the Plan
- evaluate impacts and outcomes from Phase 1, with consideration of cost effectiveness and efficiency
- review the actions outlined for development in Phase 2, based on learning from Phase 1 and any further developments in the evidence base, policy and planning context, and service environment for the Plan.

This will ensure that the Plan remains relevant and appropriate as the clinical, policy and service delivery environment changes, and builds on developments in OPMH services progressed in Phase 1.

Phase 1 implementation focusses *on expanding and improving community OPMH services and expanding community partnership models, on promoting the appropriateness, accessibility, and efficiency of these services, and on improving the recovery orientation of care, care experiences and care outcomes* for older people with mental illness, as well as the *continuity and integration* of care.

The mid-term evaluation will focus on these areas, and will also review the progress and outcomes of service development strategies for specific population groups, and of strategies addressing the key enablers of OPMH service development and improvement. It will build on the findings of the PCLI evaluation regarding mental health-residential aged care partnership services. Consumer and carer input to the evaluation will be important, in line with the principles of the Plan.

The evaluation will use national mental health planning frameworks, the National Key Performance Indicators for Australian Public Mental Health Services, key national and NSW mental health quality and safety, performance and funding frameworks, and any further relevant and valid performance indicators that are developed for the purpose of the assessing progress, impacts and outcomes from Phase 1 implementation.

Appendix 1: Overview of OPMH program and service developments, 2000-present

Developments under the last Plan

The previous services plan (titled *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015*¹) covered the period 2005-2015. Significant program and service development has occurred in OPMH services across NSW over this period, guided by this Plan and underpinned by funding enhancements, predominantly in the period 2005/06 to 2009/10. This has included:

- development of mental health-residential aged care partnership models, including implementation and evaluation of two pilot Mental Health Aged Care Partnership Initiative (MHACPI) services, and the expansion of OPMH service outreach to residential aged care facilities
- expansion of OPMH community services to address service gaps and population need and promotion of quality improvement and consistent good practice through OPMH service benchmarking, as well as the development and progressive implementation of a good practice *SMHSOP Community Services Model of Care*³⁰
- development of a good practice *SMHSOP Acute Inpatient Unit (AIU) Model of Care (MoC)*⁶⁷ and progressive implementation of the MoC in existing OPMH AIUs across NSW supported by OPMH service benchmarking, as well as in new/redeveloped units
- development of the *Transitional Behaviour Assessment and Intervention Service (T-BASIS) (non-acute) Unit Model of Care* and clinical service redesign with former Confused and Disturbed Elderly (CADE) units to this model
- development of OPMH service capacity and role in the care of older people with severe Behavioural and Psychological Symptoms of Dementia (BPSD), in line with key policy directions in this plan
- significant partnership work and partnership/capacity development with key stakeholders and service partners in older people's mental health (OPMH), including work around mental health promotion, prevention and early intervention (PP&EI)
- improving the accessibility and responsiveness of OPMH services to the needs of rural communities, CALD communities and consumers, Aboriginal communities and consumers, and people with alcohol and other drug issues, in particular.

Appendix 2: Services that provide care and support for older people with mental illness

Overview of NSW public specialist older people’s mental health (OPMH) services

Older People’s Mental Health Services

What:

Previously known as Specialist Mental Health Services for Older People (or ‘SMHSOP’), OPMH services are a clinical stream of public mental health services generally provided to people aged 65 years and over and 50 years and over for Aboriginal people. There are four components to the OPMH service model.

1. OPMH Community Services

What:

Functions of all OPMH 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.

Where:

Each LHD

St Vincent’s Health Network

Justice Health & Forensic Mental Health Network (Malabar)

2. OPMH Acute Inpatient Units

What:

OPMH AIUs provide specialist psychiatric care for people who present with acute, severe symptoms of mental illness. AIUs may be discrete facilities or sub-units within acute mental health facilities or acute hospitals. The units provide multidisciplinary assessment of a person’s mental and behavioural status, including with physical health and psycho-social issues, and short term clinical treatment (voluntary or involuntary) for the acute phase of an illness which cannot be managed in the community.

Where:

16 units in NSW + 2 additional to open soon.
Various locations across NSW: Central Coast, Hunter/New England, Illawarra/Shoalhaven, Mid North Coast (under development), Murrumbidgee, Nepean/Blue Mountains, Northern NSW, Northern Sydney, Southern NSW, South Eastern Sydney, South Western Sydney, Sydney, Western NSW and Western Sydney (one under development) LHDs, and St Vincent’s Health Network.

Note: AIUs with largely sub-acute functions included in this list are Braeside Hospital, Fairfield (South Western Sydney LHD), St Joseph’s Hospital, Auburn (St Vincent’s Health Network) and St George Hospital (South Eastern Sydney LHD).

JH&FMHN OPMH clinicians provide clinical input to the Aged Care and Rehab Unit and the Step Down Unit of the Long Bay Hospital and Forensic Hospital

3. OPMH Non-Acute Inpatient Units (including Transitional Behavioural Assessment and Intervention Service – TBASIS – units)

What:

Non-acute mental health inpatient services have a primary focus on intervention to reduce functional impairments that limit the independence of the person and promote recovery. Non-acute mental health inpatient services provide specialist clinical assessment, treatment and rehabilitation where patients are not able to be managed in the community, with an expectation that consumers will improve sufficiently for discharge to a mainstream service or community setting with additional support from OPMH and other services. Strong links with residential and community services are important in these models.

Transitional Behavioural Assessment and Intervention Service (TBASIS) Units

What:

Specialist interim care inpatient facilities providing multidisciplinary assessment, care planning and intensive treatment for older people with severe behavioural and psychological symptoms of dementia (BPSD).

Where:

Non-acute OPMH inpatient units: Northern Sydney and Hunter/New England.

Where:

Hunter/New England, Murrumbidgee, Southern NSW and Western Sydney LHDs

4a. Mental Health Residential Aged Care Partnership Services

What:

Community residential care or mental health-residential aged care partnership services provide long term care for people with severe and persistent psychiatric symptoms associated with dementia and/or mental illness through partnerships between OPMH services, aged care services/ACATs and residential aged care providers. This includes specialist Mental Health Aged Care Partnership Initiative (MHACPI) transition units in RACFs and Specialist RACFs. These models are currently being expanded under the *Pathways to Community Living Initiative* (NSW Mental Health Reforms). Services with NSW Health mental health funding and partnership arrangements are listed, noting that there are range of aged care providers and RACFs with some focus on people with mental illness and/or BPSD.

Where:

Specialist RACF: Mission Australia (Western NSW LHD) and St Vincent de Paul (Sydney LHD)

Specialist MHACPI transition units: HammondCare (South Western Sydney LHD), Catholic Health Care (Sydney LHD), Catholic Health Care (Hunter New England LHD), RSL Lifecare (Northern Sydney LHD) and RSL Lifecare (Nepean Blue Mountains/Western Sydney LHDs).

One further MHACPI transition unit and one further Specialist RACF are planned for 2017/18.

4b. Partnerships with mental health and/or aged care community care and support programs

What:

By partnering with community care and support programs, OPMH services aim to improve older people's access to mental health and/or aged care community care and supports. See following table.

Where:

See following table

Information in this table is current as at November 2017

Other NSW public specialist clinical and CMO mental health services and Commonwealth mental health services/programs relevant to older people with mental illness

Public specialist clinical mental health services (adult/general)	
<p>What: Services most commonly provided by non age-specific mental health services include:</p> <ul style="list-style-type: none"> • Intake • After-hours crisis teams • Psychiatric Emergency Care Centres – the PECC model provides 24 hour consultation to Emergency Department, and also a small 4-6 bed mental health inpatient unit located within the EDs • Inpatient mental health intensive care units <p>In locations without OPMH inpatient units, older people requiring a period of inpatient care will be admitted into adult acute (or sub-acute or non-acute) inpatient services.</p>	<p>Where: Each LHD has an intake service and provides after-hours crisis support.</p> <p>Each LHD provides adult inpatient services. However, availability of the range of services (PECCs, acute, subacute, non-acute and intensive care) varies. Acute inpatient units are found in all LHDs, whilst PECCs and MH intensive care units are generally available in larger metropolitan hospitals and a few larger regional hospitals. The location of subacute and non-acute units varies.</p>
Community and ambulatory mental health services and support	
<p>What: There are a range of services delivered by community managed (non-government) organisations complementing clinical mental health services, including:</p> <ul style="list-style-type: none"> • Housing and Accommodation Support Initiative (HASI): HASI is a partnership between NSW Health, Housing NSW and various CMOs to assist people to live independently in the community. Clinical care is provided by LHD mental health services, psychosocial supports by mental health CMOs and housing provided by social housing providers when required. Agreed hours of psychosocial supports are provided on an individualised and flexible basis. • Community Living Support Program: Funded under the NSW Mental Health Reforms, CLS is a partnership between NSW Health and various CMOs to assist people to live independently in the community. As per HASI, psychosocial services are delivered by CMOs, in partnership with community specialist mental health services. There are no age limits to HASI or CLS. Older people are eligible if they have a willingness / ability to actively engage in CLS/HASI (this can include people receiving care or support within the MH or Guardianship Acts). Older people receiving aged and community support services are also able to access CLS/HASI. • Mental health support and rehabilitation services: CMOs deliver a range of other psychiatric disability rehabilitation and support services, such as supported accommodation, psychosocial rehabilitation day programs, mutual support and self-help, and the Family and Carer Mental Health Program. 	<p>Where:</p> <p>HASI services are provided in all LHDs.</p> <p>CLS is available through NSW, with 7 CMOs covering all NSW regions</p> <p>Other support and rehabilitation services are delivered by CMOs in most LHDs. LHDS should be contacted if more detail is sought on the availability of CMO services in the region.</p>

Commonwealth mental health initiatives, services, programs and supports

<p>What: There are a range of services that are available to complement public specialist clinical mental health services, including:</p> <ul style="list-style-type: none"> • Better Access initiative: This supports better access to community mental health services through Medicare. Medicare rebates are available to patients for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists. Up to 10 individual and 10 group allied mental health services are available per year. • Psychological services to underserved groups (via PHNs): Psychological therapy services commissioned by PHNs for people in underserved groups, where there are barriers to accessing MBS based mental health services. The focus of these services differs between PHNs and depends on local determination of 'underserved' groups. It is not yet known whether PHNs will choose to target older people. • Mental health support services and programs (via NDIS): Commonwealth-funded programs such as <i>the Partners in Recovery Program, Personal Helpers and Mentors Program</i> and <i>Support for Day to Day Living in the Community Program</i> are transitioning to the NDIS. Older people will only be able to access these services if they commenced under the NDIS before age 65 years. Some older people may be eligible for support under the Commonwealth's <i>Continuity of Support Program</i>. 	<p>Where:</p> <p>Limited by the availability of GPs and private mental health clinicians</p> <p>Available in each PHN region, but there is variability in the type and focus of the services provided.</p> <p>While these programs are available across NSW, there is limited access for older people.</p>
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Commonwealth aged care support programs

<p>What: Aged care supports are provided through the:</p> <ul style="list-style-type: none"> • Commonwealth Home Support Program – an entry level home help program for older people who needs some help with daily tasks to live independently at home. This may include home support such as personal care and domestic assistance, social support and transport, food services and allied health support services. • Commonwealth Home Care Packages Program – provides a range of ongoing personal services, support services and clinical care to older Australians with complex care needs. There are four levels of support, ranging from basic care needs to high care needs. Services are delivered on a consumer-directed care basis. Unless mental health services are explicitly exempted in the <i>Quality of Care Principles 2014</i>,⁵⁸ mental health services can be arranged if it meets the consumer's assessed care needs and is specified and agreed to in the home care agreement entered into. 	<p>Where:</p> <p>Home Care Packages are available across NSW. Potentially mental health services/supports can be provided as part of a Home Care Package. However, this will depend on assessment practices, provider capability and effective partnerships mechanisms.</p>
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Information in this table is current as at November 2017

Appendix 3:

OPMH Community Services Model of Care

The [SMHSOP Community Services Model of Care](#)³⁰ was released as a NSW Health Guideline in January 2017. The model of care contains key supporting information and presents 'good practice features' to support the further development of OPMH community services in seven key areas. Some priorities of the model of care are summarised following:

Philosophy of care, target population and functions: Under the *SMHSOP community MoC*, OPMH 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 OPMH community services may embed this philosophy of care into organisational processes.

Promoting timely access to care and support is another key theme of the MoC. To support this, each OPMH 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 OPMH services for secondary triage and/or initial assessment following triage. Other key directions in relation to the target population for OPMH community services are reflected in this Plan.

Partnerships: Effective collaboration and functional relationships with a range of health and community services and providers are critical to the implementation of the *SMHSOP community MoC*, as they are to OPMH services more broadly. Each OPMH 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 partnerships with GPs and OPMH AIUs

where present, and should aim to improve relationships with them to promote integrated and continuous care. Many OPMH community services may need to improve their 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, OPMH community services should ensure processes and procedures support clinicians to work in a range of settings including a person's normal place of residence (which may be a residential aged care facility) and to utilise a variety of modalities (including face-to-face, telehealth and/or e-health). In particular, OPMH community services should consider logistical arrangements such as access to transport and telehealth facilities and appropriate staff resourcing.

Key processes: Each OPMH community service will need to review their current processes against the good practice features outlined in the MoC, and prioritise strategies to address any gaps. This will be assisted through state-wide OPMH services benchmarking processes. 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 OPMH community services. It is also anticipated that meeting the requirements of the [Physical Health Care of Mental Health Consumers Guidelines](#)²⁰¹ and the [Physical Health Care within Mental Health Services Policy Directive](#)²⁰² will require concerted effort in some services. Other key processes that may require significant service reorientation in some services include intake and admission, care planning, and assessment and review (particularly the focus on recovery goals).

Techniques and therapies: The range of biopsychosocial therapies provided directly by each OPMH community service is likely to be quite variable, associated with clinical preferences and skills, team staffing mix and size of team.

However, the MoC emphasises that to support evidence-based good practice and equity of access to a range of therapies for OPMH service consumers, each OPMH 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 OPMH community service will need to negotiate access to these services as appropriate.

Staffing: The implementation of the MoC will need to be supported by strong service culture, orientation, clinical supervision and workforce development processes, and multidisciplinary staffing and approaches. Ongoing support of clinical leaders will be required along with programs that support change management and quality improvement.

It is recognised that not all OPMH 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 OPMH peer workers will increase over time. Where there are OPMH peer workers, they will need to be treated as members of OPMH community teams and engaged in all team activities relevant to their roles.

Performance: 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. OPMH community services will need to review their current procedures against the highlighted performance measures.

Appendix 4:

OPMH Acute Inpatient Unit Model of Care

The *SMHSOP Acute Inpatient Unit Model of Care* was developed in 2012 (Project Report⁶⁷, with the accompanying guideline released in 2016¹⁵⁹). It aims to promote effective inpatient care and consistent good practice in OPMH AIUs across NSW. Recommendations regarding good practice are presented in nine key areas, as well as service development guidelines to inform service planning and service development. Some priorities of the model of care are summarised following.

Philosophy of care, functions and target

population: It is recommended that AIUs should adopt a person-centred, recovery-focused, biopsychosocial philosophy of care, and ensure that care environments, processes and practices reflect this philosophy.

The AIU will be part of the continuum of care that also includes mental health promotion, prevention and early intervention, ambulatory/community services, sub-acute and non-acute inpatient care and community residential care. The primary functions of the AIU include: assessment; clinical review and care planning; management of acute risk; treatment focused on clinical symptom reduction with a reasonable expectation of improvement in the short term; and transfer of care from the unit as soon as feasible.

The primary target population for OPMH AIUs comprises older people with acute, severe clinical symptoms of mental illness that have the potential for prolonged dysfunction or risk to self or others. These units must be able to manage both voluntary and involuntary patients under the [Mental Health Act](#).

It is preferable that OPMH AIUs are designed and staffed for the acute management of all mental health disorders, including severe BPSD. Their role should be seen as complementary to the role of specialist aged health services for older consumers with the broader range of BPSD. Indeed, aged health inpatient services are key partners for OPMH AIUs in acute care for people with severe BPSD.

In general, OPMH AIUs will focus on older consumers with severe BPSD associated with predominant mood or psychotic symptoms, and specialist aged health inpatient units on delirium and BPSD associated with likely acute medical needs. However, appropriate flexibility is required and consumer need should drive decisions regarding location of care within local service systems. Where older consumers with severe BPSD display very high risk to themselves or others and cannot be managed in OPMH AIUs, provision must be made for their appropriate management in other inpatient facilities. All units must develop some capacity to appropriately manage severe BPSD.

Comorbid disorders and problems and end of life care:

Physical illness often precipitates psychiatric admission and complicates treatment. It is important that consumers in OPMH AIUs receive appropriate physical health care including procedures to identify and manage common causes of delirium that arise in the unit. It is recommended that there be regular geriatrician ward rounds and/or consultations and access to other medical and surgical care as required. AIUs must have processes in place to prevent the development of secondary comorbidity, such as falls prevention strategies. AIUs should encourage advanced care planning early in the care of older consumers with terminal illness, including dementia. End of life care may be appropriately provided in some circumstances.

Functional relationships, location and other operational arrangements:

In order to provide optimal care, OPMH AIUs need to have effective partnerships with a range of other services, particularly OPMH community services, aged care services and adult mental health services. Functional relationships with OPMH community services are fundamental and the MoC must support integrated service provision across inpatient, community and residential settings. However, there is no expert consensus as to whether the OPMH AIU and community service should necessarily be co-located.

New AIUs should be co-located with Electroconvulsive Therapy (ECT) facilities and geriatric inpatient units. Co-location on the site of a general hospital, with adult mental health inpatient facilities, emergency department (ED), imaging and pathology services is strongly desirable.

Visiting hours ought to be flexible and any restrictions determined by therapeutic need and consumer and carer preference, rather than staff routines. There should be good access to parking and public transport.

Key processes: There are multiple possible entry points to the AIU. Entry procedures must ensure that consumers are admitted to the most appropriate setting at the outset, without inappropriately delaying admission. Direct admission is preferable to admission via the ED, unless there are specific reasons for admission via the ED. Assessment and care planning must cover multiple domains and be appropriately inclusive of the consumer and key carers. A face-to-face medical officer review of each older consumer will occur at least once every working day, with consultant psychiatrist in-person review at least weekly. A multidisciplinary case review of the mental and physical health care of, and the care plan for, all consumers will occur at least weekly. Discharge to less intensive care will occur as soon as this can be safely and appropriately conducted. There must be systems in place to ensure continuity of care and communication with key providers on discharge.

Clinical interventions: The physical and care environment should promote recovery from illness, maintenance of function and a person-centred philosophy of care. Older consumers should have tailored individual treatment plans which are developed in collaboration with the consumer and carer. Consumers should not be excluded from particular treatments on the basis of age or dependency. Available treatments should include psychotherapy, behavioural interventions, psychoeducation, pharmacotherapy, ECT, family and carer education and therapy as well as other non-pharmacological interventions appropriate for the range of common conditions managed within the units. OPMH AIUs should have local access to ECT. This must be conducted in a manner consistent with the [NSW Health Electroconvulsive Therapy: ECT Minimum Standards of Practice in NSW](#)²⁰³ (currently under review).

Seclusion and restraint: Units should aim to minimise the use of all forms of seclusion and restraint in older people. A seclusion room should not be required. If restraint cannot be avoided then it must only be used after clinical review, for the briefest period required to allow the consumer to regain control or their behaviour and maintain their safety, and in the form that is considered to have the least risk to the individual consumer. It is important to note that older consumers from an Aboriginal background may be at particular risk of self-harm whilst in seclusion, and should be monitored closely. More detailed guidance is available in the NSW Health policy directive [Aggression, seclusion and restraint: preventing, minimising and managing disturbed behaviour in mental health facilities in NSW](#)²⁰⁴ (currently under review) and accompanying guideline relating to OPMH settings (currently under review).

Facility design: Facility design will follow the *Australasian Health Facility Guidelines* for OPMH AIUs with particular attention to good visual access, adequate indoor and outdoor space, acoustics, and features to optimise mobility and reduce falls. Design will significantly influence the ability of the AIU to optimally deliver the recommended MoC. Older consumers with severe agitation and/or BPSD require particular design features. For new units this will mean design will allow for segregation of older consumers with different clinical needs. For existing units this may require modification to allow the functional separation of depressed, anxious and/or frail older consumers from those with severe agitation and/or BPSD. Consideration will also need to be given to the requirement that design features reduce the risk of suicide as well as provide for the needs of vulnerable or frail older consumers. For example, the risk of suicide by hanging needs to be balanced with the need for appropriately designed handrails and tapware. It is acknowledged that the *Australasian Health Facility Guideline* was revised in 2016,²⁰⁵ and any new directions on facility design will be considered as part of the review of the MoC.

Staffing: OPMH AIUs will require a multidisciplinary team approach. Staff require extensive knowledge and skills, as well as the capacity to work in collaboration with a number of key stakeholders. They require specialist training to manage older consumers with mental illness and the problems associated with cognitive impairment, restricted mobility, physical illness and sensory impairment. The multidisciplinary staffing profile and approach must enable the older consumer's goals of care to be achieved. Staff in the unit should be able to

manage intravenous and subcutaneous fluids, intravenous medications, ongoing oxygen therapy and incontinence. The AIU's staffing must support the delivery of appropriate diversional and non-pharmacological interventions. Staffing numbers required will vary significantly depending on the acuity, dependency and presenting problems of the older consumers admitted. In particular, older consumers admitted with severe agitation and/or BPSD will require higher ratios of staff as well as specific training aimed at reducing or eliminating restraint use.

Performance: Local mental health services should have clear structures, governance arrangements and reporting frameworks in place to ensure monitoring and improvement of OPMH AIUs. The performance framework should be consistent with existing national and state performance frameworks and relevant mental health or other relevant clinical standards. The units should be involved in benchmarking activities with similar units. Key performance indicators reported in the current *NSW CIBRE tool* include: 7-day follow-up; 28-day readmission rate; occupancy; average length of stay, and admission-discharge Health of the National Outcome Scale (HoNOS) 65+ change.

Appendix 5:

T-BASIS Unit Model of Care

As a result of the 2006 Review of Confused and Disturbed Elderly (CADE) Units in NSW, the Transitional Behaviour Assessment and Intervention Service (T-BASIS) model of care was developed and implemented. The T-BASIS MoC is outlined in more detail below:

Functions and target population: The T-BASIS units will provide multi-disciplinary assessment, care planning, and case-specific bio-psychosocial treatment for older people with severe behavioural disturbance associated with dementia and/or mental illness which cannot be managed at their current place of residence. The units will provide both a 'step-up' function by taking admissions direct from the community (either home or residential care), and a 'step-down' function by taking admissions from acute medical or psychiatric inpatient services (where appropriate). The model of care includes outreach services to RACFs and community care providers to enhance the capacity of these providers in the care of older people with severe BPSD, and thereby to reduce admissions to and facilitate the discharge of consumers from T-BASIS units.¹⁶⁰

Governance and security/operational arrangements: Key governance-related recommendations relate to clear lines of reporting and accountability within the LHD and formal mechanisms for regular consultation between mental health, aged health and LHD managers on planning and service issues affecting T-BASIS units. These issues address previous issues relating to T-BASIS unit accountability and reporting and the importance of these units to both the OPMH and aged health spectrum of services. The T-BASIS MoC emphasizes the need for appropriate security arrangements, risk management strategies, environment and fittings to support the safe and effective operation of these units.

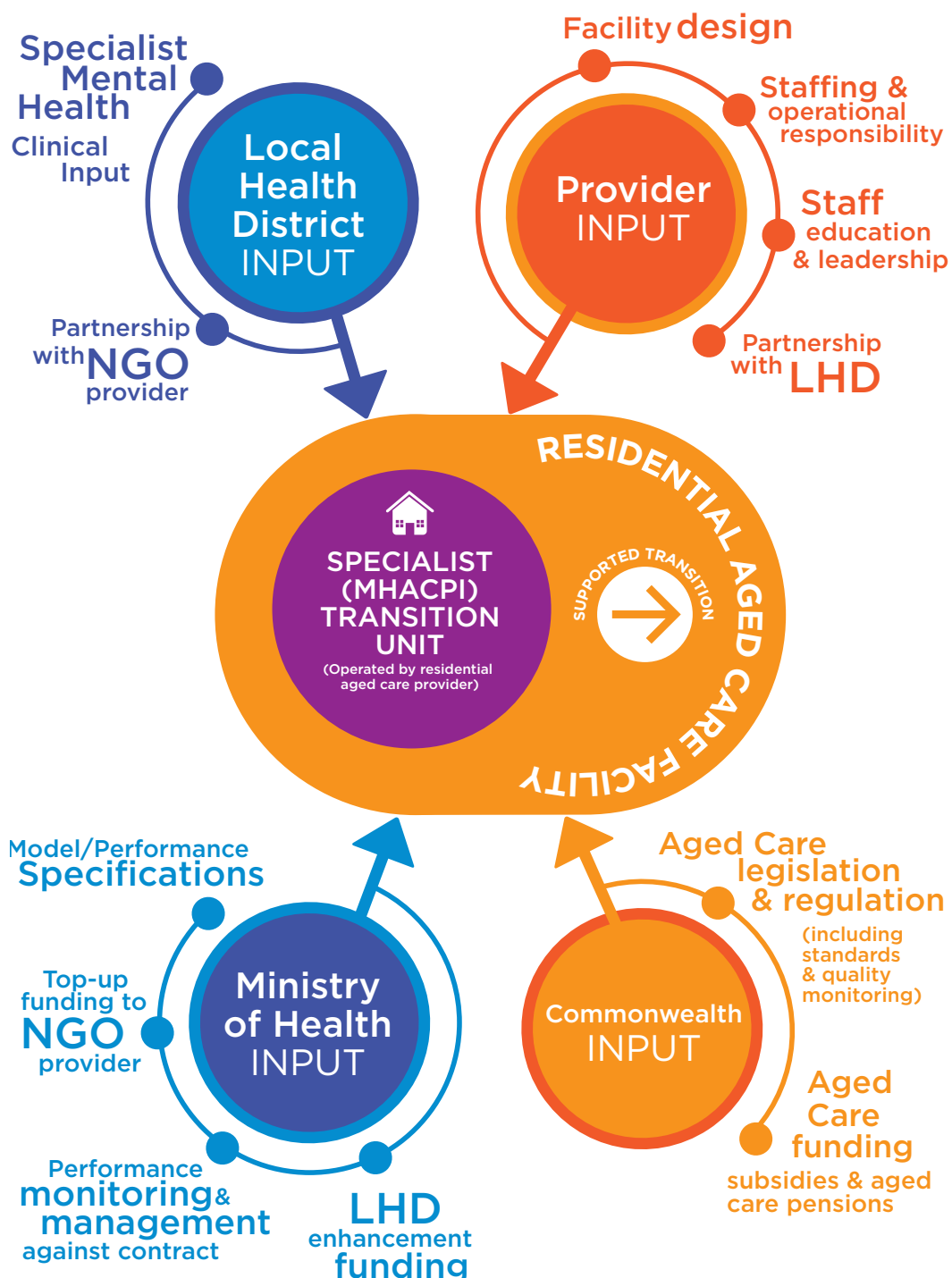
Staffing: Key staffing recommendations in the MoC include the need for a Medical Director for each T-BASIS unit, and regular access to clinical input from both a geriatrician and old age psychiatrist (with minimum levels of medical staff coverage and access specified). Nursing and allied health staffing recommendations include the need for an experienced Nurse Unit Manager, senior clinician (to train, mentor and supervise staff and students on placement, run staff mentoring and behaviour support meetings, and raise the profile of psychosocial interventions in case reviews), nursing staff, diversional therapist, and access to sessional allied health such as psychologists, physiotherapists and speech therapists. 'Outreach clinicians' to promote linkages with all community aged services across the LHD including the RACF sector, facilitate admissions and discharges, and increase capacity for people to be managed in situ, are a key staffing element. The T-BASIS MoC emphasizes the need for appropriate staff education and training, supervision and support to support the safe and effective operation of these units.

Clinical process and practice: Specific clinical process recommendations relate to: nursing and care staff being active participants in devising, monitoring, adapting and sharing bio-psychosocial treatment strategies, with structures put in place to ensure this occurs; weekly staff mentoring and behaviour support meetings, and weekly multi-disciplinary clinical review meetings including medical staff, NUM, senior clinicians, social worker/discharge planner, a representative of the outreach service and, where appropriate, other service providers such as ACATs.

Performance: Measures of good clinical practice relate to timely, multidisciplinary and comprehensive care planning (including psychosocial interventions), regular clinical review, and family and carer involvement in care planning, medication review, and transfer of care plans.

Appendix 6: Mental health – residential aged care partnership models

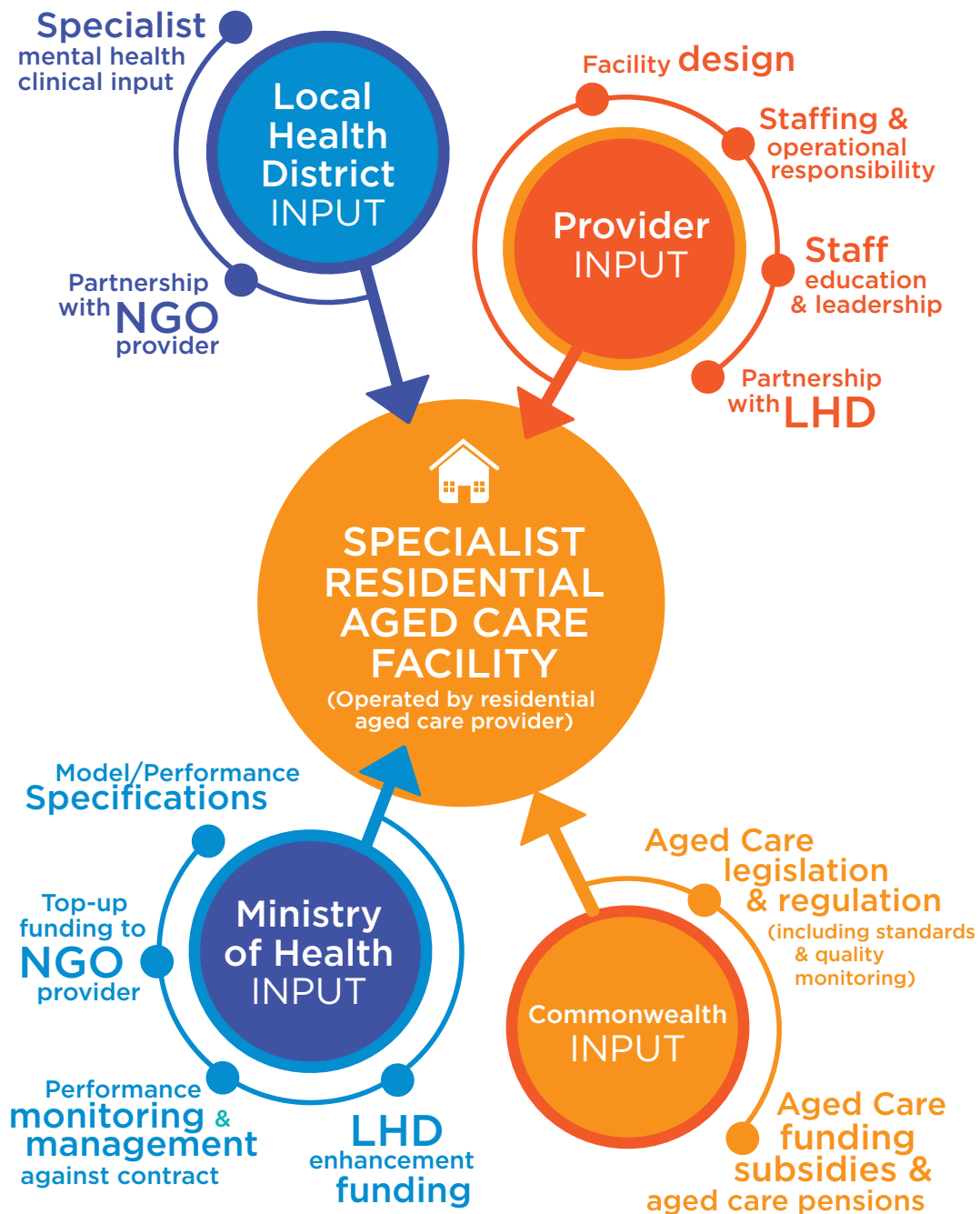
Mental Health Aged Care Partnership Initiatives (MHACPI) Transition Model



Key elements of the MHACPI transition model include:

- strong clinical governance mechanisms and partnership with the LHD in which the facility is located, specifically the mental health service and OPMH community service
- strong partnerships and arrangements with mental health services (including the acute or non-acute mental health facility in the case of transition from an inpatient setting)
- person-centred, recovery-focused approach and philosophy of care, with use of psychosocial approaches to behaviour management
- a commitment to continuous improvement in line with current evidence-based best practice
- effective communication between staff, families and carers
- an appropriate staff to resident ratio which ensures all elements of care can be provided to the resident population
- highly-skilled, multidisciplinary and experienced staff with commitment to, and confidence in, working with older people with behavioural and psychological symptoms associated with mental illness and/or dementia
- strong education and training program for staff
- well-designed facility with a home-like environment, which takes account of the need for unobtrusive safety features; appropriate size; controlled stimulation; good visual access; links to the community; familiarity; a variety of spaces and opportunities for engagement stimulated by internal and external features, and meets relevant guidelines and standards
- effective leadership
- partnerships with GPs and other health and social services, including acute hospitals, and aged health services; community aged care services; community managed organisations; other residential and community residential aged care providers; and Primary Health Networks/individual GPs.

Specialist Residential Aged Care Facility Model



Key elements of the Specialist RACF model include:

- facility design, which takes account of the need for unobtrusive safety features, appropriate size, controlled stimulation, good visual access, links to the community, familiarity, a variety of spaces and opportunities for engagement stimulated by internal and external features and meets relevant guidelines and standards
- specialist staffing and strong leadership of team
- well-developed program of daily living and social activities
- flexible and contemporary care model, taking into account the range of backgrounds, clinical history and needs of client group
- partnerships with the LHD and specialist clinical input from the LHD mental health service
- partnerships with GPs and other health and social services.

Appendix 7:

Clinical and community service partners

Clinical service partners

To support *clinical* recovery, OPMH services need strong partnerships with key services, particularly GPs, aged health and geriatric medical services, as well as coordination between inpatient and community mental health services. The high rates of physical health conditions experienced by older people with mental illness necessitate collaboration to address both physical and mental health needs. Various mental health therapies may be provided by OPMH services or by partnering with, or linking to, other service providers.

Other key OPMH service partners for supporting clinical recovery include: adult mental health services; private mental health professionals; aged care assessment services including ACAT; dementia services including Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRT); community and residential aged care services; alcohol and other drug services; other health services; other hospital services and emergency departments; pharmacy services; Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal health and mental health workers; multicultural/transcultural health and mental health services; LGBTI service providers; CMOs, NGOs, and legal partners including the Mental Health Review Tribunal and Public Guardian.

Community service partners

Whilst joint involvement between OPMH services and social/community services isn't always required, it should be available when it is. OPMH services should follow an integrated care approach across services to promote consumer independence and maximise care coordination, including at times of discharge/transition of care. Key partners for OPMH services 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. National Disability Insurance Scheme (NDIS) providers may be key partners as NDIS implementation progresses, particularly in relation to OPMH consumers who are under 65 and older people with mental illness who are transitioning from NDIS to aged care supports.

Appendix 8: Implementation plan: Phase 1 2017-2022

Key

ABF: Activity Based Funding

AP: Admitted Patient

CLS: Community Living Supports

HASI: Housing and Accommodation Support Initiative

MH-AMB: Mental Health Ambulatory data collection

MHE: Mental Health Establishment

MHSER: Mental Health Service Entity Register

MH-OAT: Standard (client clinical) outcome measures. Required tools for older people currently include the HoNOS 65+, RUG-ADL, LSP-16 and K10+-LM/K10-L3D.

NMHS: National Mental Health Survey

PCLI: Pathways to Community Living Initiative

YES: Your Experience of Service

Both the NSW Ministry of Health and LHD OPMH services have key roles in the implementation of key directions and strategies in this plan. The data sources outlined below are some of the proposed ways to measure progress with implementation. Further work will be undertaken to confirm indicators and data sources.

Strategies	Indicative performance or process measures	Indicative data sources
OPMH service elements		
1.1 Promote recovery-oriented, person-centred care in all aspects of practice and service delivery	Recovery-oriented practices in place	Self-Audit Tool (benchmarking); MH-OAT; YES data;
OPMH community services		
2.1 Implement the NSW SMHSOP community MoC across NSW, and progress findings of the external MoC evaluation of initial impacts and outcomes.	MoC implemented External evaluation completed and recommendations implemented	Self-Audit Tool (benchmarking); MH-AMB; MH-OAT; YES data
2.2 Build capacity and capability to provide accessible, equitable, effective and efficient OPMH community services through planning, funding, service redesign and workforce strategies.	Community service activity Consumer access (including new clients), experience and outcomes Resource allocation, staffing and service utilisation	MH-AMB MH-OAT; YES data Financial reporting; MHSER; MHE data; ABF markers including HoNOS completion rates and complexity

Strategies	Indicative performance or process measures	Indicative data sources
OPMH acute inpatient units/services		
3.1 Continue implementation and monitoring of the <i>SMHSOP AIU MoC</i> across NSW, including in any new units.	MoC implemented AIU activity Consumer experience and outcomes	Self-Audit Tool (benchmarking); AP collection; MH-OAT; YES data
3.2 Implement and/or formalise intra-LHD access arrangements in LHDs with limited OPMH AIU beds.	Arrangements and protocols in place	Qualitative reporting
3.3 Strengthen clinical input to adult mental health inpatient units and EDs.	In-reach and C/L activity	AP collection Qualitative reporting
3.4 Review the <i>SMHSOP AIU MoC</i> , and revised as required	Revised <i>SMHSOP AIU MoC</i>	Qualitative reporting
OPMH non-acute inpatient units/services		
4.1 Further develop OPMH non-acute inpatient services through the T-BASIS model or other appropriate models.	Activity and performance of T-BASIS/non-acute units (including alignment with T-BASIS MoC and AIU MoC as relevant) Consumer access, experience and outcomes Quality monitoring and service development processes in place	Self-Audit Tool (benchmarking); MH performance reporting AP collection; MH-OAT; YES data LHD clinical service plans
4.2 Undertake policy work to confirm future requirements, target group, role and function of OPMH non-acute inpatient services, and develop and/or reform service model(s) and arrangements accordingly.	Policy work completed and implementation commenced	Qualitative reporting and analysis
4.3 Scope need and model for state-wide/tertiary intensive care for ongoing/longer-term care for older people with persistent, very severe/extreme BPSD.	Policy work completed	Qualitative reporting and analysis
Mental health – residential aged care partnership services		
5.1 Expand and further develop MHACPI transition units and Specialist RACFs.	Service models and arrangements in place Activity and performance of MH-RAC services and LHD OPMH service partners against performance requirements OPMH consumer access, experience and outcomes	Qualitative reporting; PCLI evaluation MH-RAC services data collection; MH-AMB MH-RAC services data collection; PCLI evaluation; MH-OAT
5.2 Develop capacity and practice of OPMH community services to support transitions and outreach to specialist and generalist RACFs.	Activity in non-acute inpatient setting Activity in RAC settings (specialist and generalist) Consumer outcomes (post transition)	PCLI evaluation; AP collection MH-AMB; MH-RAC services data collection PCLI evaluation; MH-OAT; qualitative reporting

Strategies	Indicative performance or process measures	Indicative data sources
Mental health – community partnership services		
6.1 Strengthen inter-agency and inter-sectoral collaborative arrangements to improve older people’s access to mental health (MH) community care and support services/programs.	Access to MH services/ programs for OPMH consumers	CLS, HASI and other MH support program data collections; qualitative reporting;
Targeted responses for specific population groups		
7.1 Develop and implement strategies to improve access to and responses by OPMH services for older people with co-existing mental health and alcohol and other drug (AoD) problems, including: <ul style="list-style-type: none"> • collaborative care arrangements with specialist AoD services and other services • increasing OPMH services capacity to recognise, assess and facilitate appropriate care for older people with co-existing mental health and substance misuse problems. 	Strategies implemented. Collaborative care arrangements in place Access to OPMH services by people with MH and D&A problems Clinical activity with people with MH and D&A problems Education and training activity	Qualitative reporting and evaluation AP collection; MH-AMB AP collection; MH-AMB Qualitative reporting
7.2 Develop and implement strategies to improve access to and responses by OPMH services for older people with an intellectual disability and a mental illness, including: <ul style="list-style-type: none"> • collaborative care arrangements with specialist assessment and disability support services • increasing OPMH service capacity to assist in assessment and facilitate appropriate care for older people with an intellectual disability and mental illness 	Strategies implemented. Collaborative care arrangements in place Access to OPMH services by people with MH problems and ID Clinical activity with people with MH problems and ID Education and training activity	Qualitative reporting and evaluation AP collection; MH-AMB AP collection; MH-AMB Qualitative reporting
7.3 Develop and implement strategies to address the needs of older people with complex mental health problems in the criminal justice system, including: <ul style="list-style-type: none"> • increasing Justice Health & Forensic Mental Health Network (JH&FMHN) capacity to provide appropriate OPMH care, aged care support and physical environments for older people in line with Network planning • strengthening collaborative processes between LHD OPMH services and JH&FMHN • improving discharge and referral processes to better address community care and accommodation requirements for older people post-release. 	JH&FMHN strategies and activity Collaborative care arrangements/ processes in place Care planning, referral and discharge activity and outcomes Consumer outcomes & experience	Qualitative reporting; MH-AMB Qualitative reporting Qualitative reporting; MH-AMB MH-OAT; qualitative reporting; YES data
7.4 Continue to address carer needs by facilitating access to appropriate carer support services/ programs, and providing information and advice to support carers in their caring role.	Carer access to information, advice and carer support OPMH service partnership activity with carer support services/programs	Qualitative reporting; carer support program data and carer experience collections MH-AMB; AP collection

Strategies	Indicative performance or process measures	Indicative data sources
<p>7.5 Strengthen and develop knowledge and understanding of the specific needs of the different population groups and adapt and/or inform practice as per emerging research and contemporary evidence base (e.g. regarding LGBTI older people)</p>	<p>Access to OPMH services by people from specific population groups</p> <p>Appropriate clinical processes</p> <p>Consumer experience and outcomes</p>	<p>MH-AMB; AP collection</p> <p>Benchmarking Self-Audit Tool</p> <p>YES; MH-OAT</p>
<p>7.6 Build on initiatives in the last OPMH (SMHSOP) Service Plan and continue to improve access to and responses by OPMH services to:</p> <ul style="list-style-type: none"> • older Aboriginal people with mental health problems, • older people with CALD backgrounds with mental health problems • older people in rural and remote areas. 	<p>Access to OPMH services by Aboriginal, CALD and rural/remote older people</p> <p>Appropriate clinical processes</p> <p>Consumer experience and outcomes</p>	<p>MH-AMB; AP collection</p> <p>Benchmarking Self-Audit Tool</p> <p>YES; MH-OAT</p>

Enablers

Consumer and carer participation

<p>8.1 Implement strategies to increase the participation and representation of consumers and carers in OPMH service design, development and delivery, and evaluation and quality improvement (QI) processes.</p>	<p>Evidence of carer and consumer representation/ engagement</p> <p>Consumer and carer representatives on relevant committees</p> <p>Consumer and carer perspectives evident in service design and development, QI and evaluation processes</p>	<p>Qualitative reporting</p> <p>Qualitative reporting</p> <p>Qualitative reporting</p> <p>Use of YES data for quality improvement</p>
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Planning

<p>9.1 Promote a focus on older people's mental health needs and services in state-wide and local clinical services planning.</p>	<p>OPMH needs and service responses evident in state-wide and local clinical services plans</p>	<p>State-wide and local clinical services plans; NSW Health Financial Allocation Monitoring</p>
<p>9.2 Inform state and local capital planning processes to promote development of OPMH acute and non-acute inpatient services and appropriate environments in existing and new inpatient facilities catering to older people with mental health problems.</p>	<p>New OPMH acute and non-acute inpatient services on NSW Health capital plans</p> <p>Environmental modifications (including capital works) to existing facilities</p> <p>Use of and compliance with relevant NSW Health guidelines</p>	<p>NSW Health capital plans; NSW Health Financial Allocation Monitoring</p> <p>Qualitative reporting</p> <p>Qualitative reporting and compliance monitoring</p>
<p>9.3 Participate in coordinated planning with aged care services, Primary Health Networks and other relevant services to develop joint initiatives and coordinated responses to the needs of older people with mental health problems.</p>	<p>MH partnership activity</p>	<p>MH-AMB; qualitative reporting</p>

Strategies	Indicative performance or process measures	Indicative data sources
Prevention and early intervention		
10.1 Promote individualised prevention and promotion strategies and other activities complementary to clinical care that support consumer self-care, wellness planning and recovery.	Client (including group) activity Use of wellness plans Referrals and/or arrangements with other agencies/programs	Qualitative reporting MH-AMB; AP collection; qualitative reporting
10.2 Collaborate to deliver and/or facilitate access to mental health literacy training, education, mental health promotion initiatives and social support programs for older people.	Education and skills training activity PPEI/social support activities conducted	MH-AMB; qualitative reporting MH-AMB; qualitative reporting
10.3 Influence and support state-wide and local suicide prevention initiatives to better address the specific issues of older people.	MH partnership activity OPMH strategies included as part of these initiatives	MH-AMB Qualitative reporting and evaluation
10.4 Work with the aged care assessment services, community and residential aged care sectors, PHNs and other key services to support early identification of mental health problems in older people and appropriate referral to OPMH services.	MH partnership activity Referrals from these service partners	MH-AMB MH-AMB; AP collection; evaluation
Workforce		
11.1 Promote a focus on older people's mental health needs, services and workforce requirements in state-wide and local workforce planning.	State-wide and local workforce plans and strategies	Qualitative reporting and evaluation
11.2 Promote effective state-wide and local clinical and strategic leadership of OPMH services.	Clinical and strategic leadership arrangements in place and effective	Qualitative reporting and evaluation
11.3 Identify and address areas for workforce and capability development (including change management capability) across the OPMH services workforce.	NSW mental health workforce needs analysis and development strategies State-wide OPMH workforce survey undertaken and findings used, along with OPMH benchmarking processes, to develop strategies	NSW Health Financial Allocation Monitoring; MHE; qualitative reporting Qualitative reporting
11.4 Promote access to appropriate education, training, leadership development, and skills and practice development initiatives, in partnership with HETI and other education and training organisations and peak professional bodies.	Participation in training activities Partnership activities	LHD extracts of myhealth learning reports; Qualitative reporting Qualitative reporting
11.5 Implement and monitor NSW Aboriginal health and mental health/wellbeing workforce strategies in OPMH services	As per measures in NSW Health Aboriginal Health and Mental Health Wellbeing policies	As per policies
11.6 Implement recruitment strategies to increase the supply of appropriately qualified medical, nursing and allied health staff for OPMH services	Number and type of OPMH staff	Qualitative reporting and evaluation

Strategies	Indicative performance or process measures	Indicative data sources
11.7 Promote and further develop the OPMH peer workforce.	Number of OPMH peer workers Feedback provided by consumers and carers	Available reporting Qualitative reporting

Strategic liaison, partnerships and integrated care

12.1 Promote arrangements to improve service coordination, integration and continuity of care between different care settings and service providers, particularly between OPMH community and inpatient services, OPMH and adult MH services, and OPMH and aged health services and aged care assessment services.	Arrangements in place Care planning and referral activity	Qualitative reporting AP collection; MH-AMB; Qualitative reporting and evaluation; File/specific audits
12.2 Implement strategies and practices that facilitate access to the full spectrum of services and supports required for holistic care and recovery.	Care planning and referral activity	AP collection; MH-AMB; Qualitative reporting and evaluation; File/specific audits
12.3 Promote consistent good practice in the care of older people across adult and older people's services.	Strategies developed and implemented Consumer experience and outcomes	Qualitative reporting MH-OAT; YES evaluation
12.4 Work with GPs and other primary care providers to promote coordinated care for older people with mental health problems	Care planning and referral activity	MH-AMB; AP collection
12.5 Strengthen collaborative arrangements with new and/or evolving partners, including with PHNs, NDIS service providers and dementia services, to promote better response to the needs of older people.	Arrangements in place Access to services by OPMH service consumers	Qualitative reporting NDIS services data; PHN data; dementia services data
12.6 Further develop relevant collaboration and partnerships that improve service access and address the needs of older people from specific population groups.	Arrangements in place Access to OPMH services by older people from specific population groups, as well as consumer outcomes and experiences of care	Qualitative reporting AP collection; MH-AMB; MH-OAT; YES
12.7 Strengthen inter-agency and inter-sectoral links and collaboration at the strategic and policy level to address barriers in accessing care and support and improve care outcomes.	Arrangements and consultative processes in place	Qualitative reporting

Governance, quality and safety

13.1 Implement strategies to support operational and clinical governance that: <ul style="list-style-type: none"> reflect the specialised nature of OPMH services promote quality and safety in clinical care support integration across OPMH service elements recognise and support local arrangements with aged health services. 	Operational and clinical governance arrangements in place Reportable incidents	Qualitative reporting Incident Management System
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Strategies	Indicative performance or process measures	Indicative data sources
13.2 Continue to facilitate and support state-wide OPMH committees to provide strategic guidance to OPMH services and OPMH more broadly.	Meetings held Policy work completed	Qualitative reporting
13.3 Continue benchmarking processes at state and local levels and use benchmarking strategies and findings to: <ul style="list-style-type: none"> • guide local service improvement • increase activity, outcome measure and performance reporting by clinicians • facilitate reporting quality and consistency • provide feedback on data reports to staff • develop quality improvement strategies based on data findings, to improve clinical practice and consumer and carer experience and outcomes. 	Benchmarking conducted OPMH service participation in state benchmarking Reporting against targets Feedback provided to staff OPMH quality improvement strategies	Qualitative reporting; regular evaluation and benchmarking self-audit tool; Qualitative reporting MH-OAT; MH-AMB; AP collection; qualitative reporting
13.4 Promote measurement of and feedback on consumer and carer experiences, and use to guide quality improvement.	Consumer and carer experience	YES and carer surveys; Qualitative reporting
13.5 Strengthen collaboration with key state quality agencies including the ACI and CEC, and OPMH involvement in quality initiatives.	Arrangements in place Joint activities	Qualitative reporting
Research		
14.1 Promote translation of research findings and evidence into practice through: <ul style="list-style-type: none"> • supporting practitioner researchers • building collaborative partnerships among policy makers, practitioners/clinicians and researchers • rigorous evaluation of policies and programs • maximising the use of research in policy, practice and health service delivery. 	Adoption of evidence based practice and new research into OPMH services	Qualitative reporting and evaluation

Appendix 9: Implementation plan: Phase 2 2022–2027

Strategies	
OPMH service elements	
OPMH community services	
1.1	Continue to develop and maintain OPMH community service capacity, accessibility, appropriateness and outcomes of care, based on service development in Phase 1 and advances in best-practice community care and service provision.
OPMH acute inpatient units	
2.1	Develop and implement any new/revised MoC directions across NSW.
2.2	Continue to develop and maintain OPMH inpatient service capacity, accessibility, appropriateness and outcomes of care, based on service development in Phase 1.
OPMH non-acute inpatient services	
3.1	Continue to develop and/or reform OPMH non-acute inpatient service model(s), based on policy and service development work undertaken in Phase 1.
3.2	Pending findings of scoping work undertaken in Phase 1, implement agreed model of state-wide/tertiary intensive care for ongoing/longer-term care for older people with persistent, very severe/extreme BPSD.
Mental health – residential aged care partnership services	
4.1	Continue to develop and maintain mental health – residential aged care partnership services and models, based on service developments in Phase 1 and planning requirements.
Mental health – community partnership services	
5.1	Continue to develop and maintain mental health – community partnership arrangements and focus, based on service developments in Phase 1 and emerging requirements.
Targeted response for specific population groups	
6.1	Build on service development strategies for specific population groups in Phase 1 and implement further strategies, informed by the mid-term evaluation, for: <ul style="list-style-type: none"> • older Aboriginal people • older people living in rural and remote areas • older people from CALD backgrounds • residents of aged care facilities • older people with co-existing MH and AoD issues • older people with co-existing MH problems and intellectual disability • older people in the criminal justice system • older people who are homeless • older people living in domestic squalor • older LGBTI people • families and carers
Enablers	
7.1	Continue to develop strategies to enable the development of OPMH services by strengthening: <ul style="list-style-type: none"> • consumer and carer participation • prevention and early intervention • strategic liaison, partnership and integrated care • research • planning • workforce • governance, quality and safety

Key terms and acronyms

ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
ACCHS	Aboriginal Community Controlled Health Service
ACFI	Aged Care Funding Instrument
ACI	NSW Agency for Clinical Innovation
AIU	Acute Inpatient Unit
AoD	Alcohol and Other Drugs
AP	Admitted Patient (data collection)
ATAPS	Access to Allied Psychological Services program (now ceased)
BHI	NSW Bureau of Health Information
BPSD	Behavioural & Psychological Symptoms of Dementia
CALD	Culturally and Linguistically Diverse
CEC	NSW Clinical Excellence Commission
C/L	Consultation liaison
CLS	NSW Community Living Supports Program
CMO	Community Managed Organisation
D2DL	Support for Day to Day Living in the Community program (transitioning to NDIS)
DBMAS	Dementia Behaviour Management Advisory Service
ECT	Electroconvulsive Therapy
ED	Emergency Department
FTE	Full Time Equivalent
FPOA	Faculty of Psychiatry of Old Age
GP	General Practitioner
HASI	NSW Housing and Accommodation Support Initiative
HETI	NSW Health Education and Training Institute
HoNOS 65+	Health of the Nation Outcome Scale 65+ years
JH&FMHN	Justice Health and Forensic Mental Health Network
K10+-LM / K10-L3D	2 versions of the Kessler-10 (Kessler Psychological Distress Scale)
KPI	Key Performance Indicator
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	Mental Health
MH-AMB	Mental Health Ambulatory (data collection)
MH-OAT	Mental Health Outcomes and Assessment Tool
MH-RAC	Mental health - residential aged care
MHACPI	Mental Health Aged Care Partnership Initiative

MBS	Medicare Benefits Scheme
MHE	Mental Health Establishment
MHSER	Mental Health Service Entity Register
MoC	Model of Care
MPS	Multipurpose Service
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHS	National Mental Health Survey
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Services (Standards)
OPMH	Older People's Mental Health
PCLI	Pathways to Community Living Initiative
PECC	Psychiatric Emergency Care Centre
PIR	Partners in Recovery program (transitioning to NDIS)
PHaMS	Personal Helpers and Mentors (transitioning to NDIS)
PGNA	Psychogeriatric Nurses Association
PHN	Primary Health Network
PPEI	Prevention, Promotion and Early Intervention
RAC	Residential Aged Care
RACF	Residential Aged Care Facility
RUG-ADL	Resource Utilisation Group - Activities of Daily Living
RAS	Regional Assessment Service
SBRT	Severe Behaviour Response Teams
SMHSOP	Specialist Mental Health Services for Older People (previous name of OPMH Services)
SRACF	Specialist Residential Aged Care Facility
T-BASIS	Transitional Behaviour Assessment and Intervention Service
TICP	Trauma Informed Care and Practice
YES	Your Experience of Service
Consumer	The term 'consumer' is generally used throughout this plan, rather than 'client', 'patient' or 'service user', to refer to an individual accessing OPMH services.
Mental health problems/ mental illness	Both of these terms are used in this plan, depending on the context. A person may present with a mental health problem but not necessarily be diagnosed with a mental illness.

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