NSW Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care Guideline

Summary This Guideline promotes evidence-based good practice in older people's mental health (OPMH) acute inpatient units across NSW, supporting consistent, high quality and safe care. It is intended to support ongoing quality improvement in existing OPMH acute inpatient units and planning of new units.

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OLDER PEOPLE'S MENTAL HEALTH (OPMH) ACUTE INPATIENT UNIT MODEL OF CARE

GUIDELINE SUMMARY

This Guideline promotes evidence-based good practice in older people's mental health (OPMH) acute inpatient units across NSW, supporting consistent, high quality and safe care. It includes guidance around relationships and processes, clinical interventions, facility design, staffing and performance.

KEY PRINCIPLES

This Guideline reflects current best practice for older people's mental health acute inpatients units and findings from consumer and carer consultation, including a strong preference for direct admission pathways.

It provides recommendations with supporting evidence to guide implementation of a good practice model of care in older people's mental health acute inpatient units. It includes service development guidance to support implementation of core elements of good practice in all units, while informing the development of advanced practice where appropriate.

Emphasises recovery-focused, person-centred, biopsychosocial and trauma-informed care. It promotes timely triage, intake and admission, comprehensive assessment, collaborative care planning with the older person and their carers, and clinical review and transfer of care that maximises consumer engagement, choice and control.

It promotes access to a range of clinical interventions to achieve the older person's treatment goals and support their recover.

It highlights the importance of appropriate care for specific population groups, integrated care (including mental health and physical health care), multidisciplinary staffing and care, minimising seclusion and restraint, and appropriate physical environments.

It promotes alignment of older people's mental health acute inpatient unit practice with national and state practice and performance standards.

This Guideline aligns with NSW Health Guideline *NSW Older People's Mental Health Services Service Plan 2017-2027* (GL2017_022*)* and reflects findings from the NSW OPMH Recovery-Oriented Practice Improvement Project (2017).

USE OF THE GUIDELINE

This Guideline is intended to support ongoing quality improvement and service development in existing older people's mental health acute inpatient units and to inform planning of new units.

REVISION HISTORY

Version	Approved by	Amendment notes
March-2022 (GL2022_003)	Deputy Secretary, Health System Strategy and Planning	Major revisions to existing guidance with new recommendations and background content to align with current priorities. New sections added including guidance around polypharmacy.
May-2016 (GL2016_016)	Deputy Secretary, Strategy and Resources	New Guideline

ATTACHMENTS

1. Older people's mental health (OPMH) acute inpatient unit model of care: Guideline

NSW Health

NSW Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care Guideline

March 2022

NSW GOVERNMENT

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Definitions

The term 'older consumer/s', as distinct from the term 'patient/s', is generally used throughout the guideline to refer to an older person with a lived experience of mental illness. The term 'inpatient' is used as an adjective where the use of the term 'consumer' would be unclear (e.g. 'inpatient unit') or when referring to consumers in general hospital or similar settings. The term 'patient', because of its special meaning, is also used in reference to consumers admitted under the Mental Health Act as 'involuntary patients'.

Acronyms

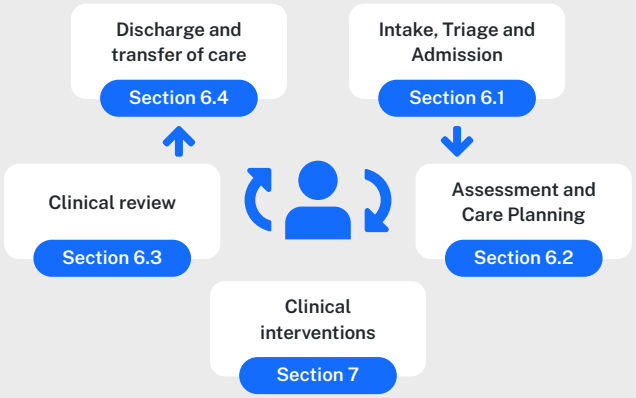
AIU	Acute inpatient Unit
BPSD	Behavioural and Psychological Symptoms of Dementia (all levels including extreme)
CALD	Culturally and Linguistically Diverse
ECT	Electroconvulsive Therapy
ED	Emergency Department
HoNOS 65+	Health of the Nation Outcome Scale 65+
ICU	Intensive Care Unit
LHD	Local Health District
OPMH	Older People's Mental Health
T-BASIS	Transitional Behavioural Assessment and Intervention Service

NSW Older People's Mental Health Acute Inpatient Unit Model of Care Summary

Section 2.1	**Our philosophy**	Recovery-oriented, person-centred, biopsychosocial, trauma-informed care with the consumer at the centre
Section 2.2	**Our target population**	We care for older people who are experiencing acute and/or severe mental health disorders or symptoms. This may include severe behavioural and psychological symptoms of dementia.
Section 2.3	**Our functions**	We provide appropriate reception, multidisciplinary assessment, admission, diagnosis and treatment of older people with known or suspected psychiatric conditions and behavioural disorders, along with the assessment of other complex comorbidities including physical health issues and psychosocial problems.

Key Processes

- Intake, triage and admission processes that are timely, direct where possible, and based on clinical prioritisation.
- Comprehensive assessment that considers the whole life situation of an older person, including psychological, functional, physical and social dimensions, and facilitates physical assessment and care.
- Collaborative care planning that engages the older person as an active participant, considers dignity of risk, addresses personal goals, and builds on the person's strengths, abilities and resources.
- Clinical review processes that maximise consumer choice and control and include discharge planning supported by wellness planning.
- All key processes should actively involve the consumer, carer and family, promote recovery, and support continuity of care, including care from GPs and community OPMH services.



Section 7

Clinical Interventions

Clinical interventions in the OPMH AIU aim to address the treatment goals of the consumer and their carer and to prevent secondary morbidity. Initial treatment goals will be established either prior to admission or through goal setting during an early assessment phase of the admission. Goals are not limited to mental health issues but may cover comorbid physical and social problems, improving functional status and addressing the older consumer's health and social needs.

OPMH AIUs should provide a range of clinical interventions including psychotherapy, behavioural therapy and other psychosocial interventions, pharmacotherapy, ECT, family and carer education and therapy, and social and legal interventions. Other interventions may include podiatry, speech therapy, nutritional interventions, exercise and diversional therapy, falls prevention training, and assistance with vision and hearing. The use of seclusion and restraint should be minimised and monitored.

Functional relationships and Partnerships

OPMH AIUs optimise relationships with EDs, geriatric medical units, community MH services, adult MH units, ECT, imaging and pathology services, pharmacy and other units specialising in the care of older people in particular. For continuity of care, relationships with GPs, OPMH community teams and other community-based services are important.

Section 5

Facility Design

A safe, positive and therapeutic physical environment enhances care. The physical environment should align to the unit's model of care, with flexibility to adapt to changes in practice and treatment. Design should consider the specific preferences of older consumers and relatively longer stays.

Section 9

Staffing

The assessment and management of complex physical, psychiatric and social needs of OPMH consumers requires a multidisciplinary team approach and staff with specialist skills in the care of older people with mental illness. Considering staff with specialist knowledge and skills in BPSD management is important, where relevant.

Section 10

Performance

OPMH AIUs align with key national and state standards for safety, quality and performance, and relevant policies and guidelines.

We improve the quality and safety of our services through clinical benchmarking, quality improvement programs and managing for performance.

Section 11

1 Introduction

The population is ageing and the mental health of older people in NSW is a priority in health policy and service delivery. Mental health problems in older people are complex and specialist services are necessary to meet the mental health needs of this group. The NSW Older People's Mental Health Services Service Plan 2017–2027[1] responds to these issues with clear service models, structures, and priorities to guide older people's mental health (OPMH) services across NSW.

Background

This guideline promotes good practice in OPMH acute inpatient units (AIUs) across NSW, supporting consistent, high quality and safe care in these units. The guideline draws on the 2012 *Specialist Mental Health Services for Older People Acute Inpatient Unit (AIU) Model of Care Project Report*[2] and guideline released in 2015. This document replaces the 2015 guideline, reflecting current evidence, policy and good practice as per PD2016_049 NSW Health Policy Directives and Other Policy Documents.[3]

An OPMH AIU services guide for consumers and carers on is available on the NSW Health website, Information for consumers, family and carers.

This revised guideline has been informed by an Expert Reference Group (ERG) including OPMH service managers, medical, nursing and allied health clinicians, and people representing the perspectives of OPMH consumers, carers, peer workers, Aboriginal older people and older people from culturally and linguistically diverse backgrounds.

Targeted consumer and carer consultation was undertaken to inform this guideline to reflect what is important to OPMH consumers and carers. The consultation included consumers and carers with experiences of OPMH inpatient care within the previous 12 months. A majority of the participants (total 89) were OPMH inpatient unit consumers. Approximately 13% participants were carers. The sample, from three local health districts, broadly reflected the overall profile of OPMH AIU consumers in terms of age, gender mix, and representation of CALD and Aboriginal consumers. Approximately 45% of participants reported they had experienced an involuntary mental health admission.

The key findings from consumer and carer consultation have informed recommendations in each of the sections of this document: Consumers and carers identified that they valued:

- Direct admission to OPMH AIUs as preferable to admission via an emergency department
- GP involvement throughout their admission
- Contact with their treating clinician/psychiatrist
- Access to information about legal rights including access to treating medical staff for their legal representative
- Meaningful activities during their admission including ongoing support of hobbies and personal interests
- Privacy, both personal and with visitors
- Access to outdoor spaces.

The OPMH AIU Model of Care is underpinned by relevant national and NSW policy and planning frameworks including:

- NSW Older People's Mental Health Services Service Plan 2017–2027[1]
- Fifth National Mental Health Plan (2017–2022)[4]
- National Mental Health Service Planning Framework v.2.2[5]
- Australian Health Facility Guideline HPU135 Older Persons Acute Mental Health Unit[6]
- Australian Charter of Healthcare Rights 2nd ed7 and NSW Health Your Health Rights and Responsibilities[8]
- National Partnership Agreement On Hospital And Health Workforce Reform (2012)[9]
- National Framework for Recovery-Oriented Mental Health Services (2013)[10]
- National Safety and Quality Health Service Standards 2nd ed (2017)[11]
- Seclusion and Restraint in NSW Health Settings (2020)[12]
- Physical health care for people living with mental health issues (2021)[13]

Purpose and scope of this guideline

This guideline is intended to inform service improvement and development in existing OPMH acute units and planning for new units. It aims to promote effective consumer care and good practice in OPMH acute inpatient units (AIUs) across NSW. It supports greater consistency and quality of care in OPMH AIUs, addressing strategic priorities identified in the *NSW OPMH Service Plan 2017–2027*.

The OPMH AIU Model of Care Guideline covers the following key components:

- Philosophy of care and functions
- Target population, including special population groups
- Comorbid disorders and problems and end of life care
- Functional relationships, location and other operational arrangements
- Key processes
- Clinical interventions
- Seclusion and restraint
- Facility design
- Staffing
- Performance

The service development guidance at the end of this document is intended to support implementation of core elements of good practice in all units, while informing further development and advanced practice where appropriate.

2 Philosophy of Care and Functions

Recommendations: Philosophy of Care and Functions

Philosophy of care recommendations

2.1 Older people's mental health acute inpatient units (OPMH AIUs) will:

- adopt a person-centred, trauma informed, biopsychosocial philosophy of care
- ensure that care environments, processes and practices reflect this philosophy.

2.2 Service delivery will focus on the principles of recovery. OPMH AIUs will work with consumers to:

- tailor care based on the consumer's goals
- provide seamless services
- address the factors that affect the consumer's mental health.

2.3 Consumer needs should drive decisions about the location of care in local service systems. People, not service convenience, should be the focus.

2.4 OPMH AIUs must:

- take a multidisciplinary approach to assessment and care planning
- offer relevant staff education, training or research activities
- regularly monitor unit practice and performance
- manage and comply with relevant legislation
- develop consultation-liaison services other inpatient services in the LHD that manage consumers in the same population
- work with Aboriginal, multicultural and transcultural mental health services to enable culturally competent assessments.

Recommendations about functions

2.5 OPMH AIUs assess, plan care for and treat people in the target population who cannot receive the help they need outside an acute inpatient setting. Units must:

- intervene in ways unique to this setting
- offer treatment that reduces acute mental health symptoms and related behaviors
- assess and manage acute risk
- assess any physical health or drug and alcohol comorbidities, including delirium, substance dependence or withdrawal, at admission or during a consumer's stay
- manage any such comorbidities without unduly prolonging admission or compromising care
- plan care for, manage and try to prevent physical health comorbidities that may arise due to psychiatric treatments, such as metabolic syndrome or falls
- try to prevent secondary morbidity
- do clinical reviews
- promote recovery and plan for an eventual transfer to less intense yet continuous care.

2.6 OPMH AIUs will arrange for a consumer to transfer to other care as soon as possible, often into community or residential care. But a consumer may also transfer to other inpatient care — whether acute, sub-acute or non-acute — or a drug and alcohol facility if:

- their acute symptoms improve but their function is still impaired
- after 35 days they still have symptoms or behaviours that require further care before they can return to the community.

2.7 OPMH AIUs will assess consumers' supports, then plan and provide care along with their carers, family or significant others, if the consumer wishes. The unit should contact carers as soon as possible after admission, and no more than seven days later. They should also help consumers reconcile important relationships.

2.8 OPMH AIUs must be able to manage voluntary and involuntary patients under the *Mental Health Act 2007* (NSW), and be able to support appropriate hearings and inquiries.

Philosophy of care

Recovery-focused, person-centred, biopsychosocial, trauma informed care underpins care provided to the person in collaboration with their family/carer.[1] This promotes shared decision making.[14] Older people have a right to confidentiality which they may exercise by refusing the treating teams permission to contact their family.[15] For some people, there may be periods during their admission where they lack the capacity to provide informed consent and treatment may can be given in accordance with the NSW Mental Health Act or NSW Guardianship Act. Consumers and their families must be provided with clear information about their legal status at all times. The value consumers place on being treated as an individual and having control over their own care, were strong and consistent messages throughout the consumer consultations for this project and the *NSW OPMH Service Plan 2017–2027*.[1]

The National Standards in Mental Health Services (2010), the National Safety and Quality Health Service (NSQHS) Standards 2nd ed (2017) and the National Framework for Recovery-Oriented Mental Health Services (2013) all recommend that mental health services should incorporate recovery principles into service delivery, culture and practice. Personal recovery is defined within the National Recovery Framework as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.[23,24] This should include providing consumers with access and referral to various programs to support sustainable recovery. There is good evidence older people want an active role in decision making.[17]

From the perspective of the individual, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.[20] Recovery in older people is a concept that is closely aligned to person-centred care.[19] Older consumers have conceptualised recovery as 'continuing to be me' or 'getting back to being me'.[21,22]

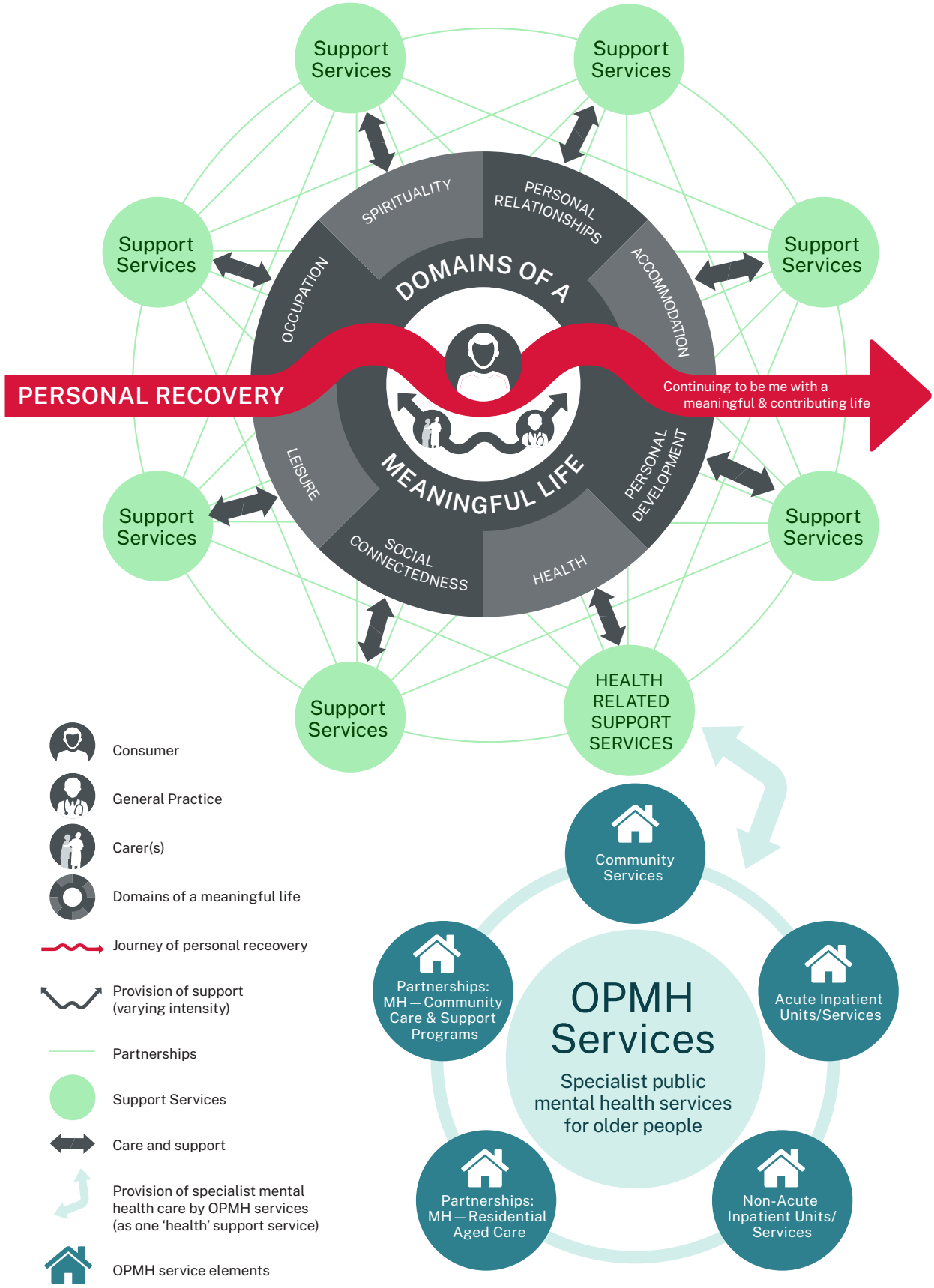
The NSW OPMH Recovery-Oriented Practice Improvement Project identified recovery-oriented practice is achievable for consumers and OPMH services and included a tool kit of supportive resources .[22] The project identified specific characteristics that differ from those in adults . For older people with mental illness, recovery can be seen as continuing/regaining an enduring sense of identity, drawing on a lifetime's experience, coping strategies and resilience.[22] This contrasts with younger people, who are often still establishing their identity, coping strategies and resilience as part of their recovery journey. This should inform how we approach recovery for older consumers of mental health services.

The NSW OPMH Recovery Project showed that having peer workers employed within OPMHS has promoted recovery-oriented practice in OPMH services. It identified that peer workers needed to be mature and relate well to older consumers. They also have different training requirements to younger peer workers. Involving older consumers in exploring ideas of recovery, promoting recovery-oriented practice and implementing practice change at the service level is highly beneficial, and can positively transform experiences and outcomes for consumers, staff and services.[22]

Working with the consumer in collaboration with their clinicians and families/carers is important to identify their personal goals. The OPMH AIU should support clear collaborative goal setting with the older consumer (and their family/carers, as appropriate), and measure attainment of these goals. Various methods have been described for goal focused monitoring.[17,25]

The figure below shows how recovery-oriented practice and care should be provided in NSW OPMH AIUs.

Figure 1.


Support Services
Support Services
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Support Services
Support Services
SPIRITUALITY
PERSONAL RELATIONSHIPS
ACCOMMODATION
PERSONAL DEVELOPMENT
HEALTH
SOCIAL CONNECTEDNESS
LEISURE
OCCUPATION
DOMAINS OF A MEANINGFUL LIFE
PERSONAL RECOVERY
Continuing to be me with a meaningful & contributing life
HEALTH RELATED SUPPORT SERVICES
Consumer
General Practice
Carer(s)
Domains of a meaningful life
Journey of personal receovery
Provision of support (varying intensity)
Partnerships
Support Services
Care and support
Provision of specialist mental health care by OPMH services (as one 'health' support service)
OPMH service elements
Community Services
Partnerships: MH — Community Care & Support Programs
Acute Inpatient Units/Services
OPMH Services
Specialist public mental health services for older people
Partnerships: MH — Residential Aged Care
Non-Acute Inpatient Units/ Services

In addition to recovery-oriented care, research and best practice supports trauma informed care and practice, positive ageing and enablement and consumer-directed care. It also supports the involvement of people with lived experience of mental illness in guiding service design, development, evaluation and improvement. Trauma informed care is a strengths-based framework that is responsive to the impact of lived trauma, emphasising physical, psychological and emotional safety, in addition to creating opportunities for survivors to rebuild a sense of control and empowerment'.[18]

NSW Health recognises the relationship between trauma and the development of mental health conditions, co-existing difficulties and complex psychosocial problems, and the importance of responding appropriately.[26] Trauma informed care is an approach to service delivery that is based on knowledge and understanding of how trauma affects people's lives, and their service needs .[27] Trauma is a complex concept that includes a broad range of harmful, abusive or neglectful experiences. Addressing trauma involves better individual care for the person and their family. It also addresses the needs of staff and how health systems need to be 'trauma aware' so that services and treatment do not unintentionally cause harm re-traumatising[27] those undergoing care and treatment in NSW mental health units.

Applying trauma informed practice in older people's mental health as distinct from general adult mental health has not been well explored. A 2018 US paper[28] exploring trauma informed practices in hospice and palliative care has relevance to the mental health care of older people. It identifies emerging evidence for additional opportunities for exposure to psychological trauma at or near the end of life.[28] There is recognition that intensive medical interventions may be traumatic and opportunities for trauma exposure may combine towards the end of life, particularly in the presence of pain, anxiety, delirium, dementia, or ordinary old age. This, in turn, can negatively affect consumer mental health, well-being, behavior, and reported experience of pain.[28]

The NSW Agency for Clinical Innovation is undertaking a Trauma Informed Care and Practice Project that will guide trauma informed care in OPMH AIUs. This project will support the development of best practice guidelines and practical resources for trauma informed care and practice.[27]

There is evidence that older people with mental illness experience disadvantage in accessing physical health assessment and care. They experience poorer physical health and earlier mortality than the general population. This is particularly so for people who grow older with a continuing experience of severe and persistent mental illness, compared with older people who have developed mental illness in later life who generally have a history of better health care management. Providing appropriate physical health care for people with mental health issues is one of the key principles in the *Fifth National Mental Health and Suicide Prevention Plan*.[4] A focus on addressing the physical health care needs of older people with mental health problems also responds to the national *Equally Well Consensus Statement*.[29] NSW OPMH services should provide and aid access to appropriate physical health assessment and care for OPMH consumers as standard practice.

Functions

OPMH AIUs provide, multidisciplinary assessment, admission, diagnosis and treatment for older people with psychiatric conditions and behavioural disorders Including assessment of comorbid physical health and psychosocial problems.[1] All such units in NSW are declared mental health facilities within the NSW Mental Health Act (2007),[30,31] allowing admission of people on a voluntary or involuntary basis.

The OPMH AIU is part of the continuum of care for the OPMH target population including: community clinical services; sub-acute and non-acute inpatient services, and community residential aged care services. OPMH AIUs also have links and integration with other key services.

OPMH units include consultation-liaison services for older people admitted to other hospital settings. OPMH inpatient consultation-liaison roles assist in the management of older consumers known to the service. This includes supporting the staff of adult mental health and geriatric medical wards (or their equivalents in rural areas) in managing older people with mental health disorders. The *OPMH Service Plan*[1] does not specify how consultation and liaison are delivered or by whom as this is a local operational issue.

OPMH units have some capacity to provide assessment and clinical care for older people where co-existing alcohol and other drug are not the primary focus of care and should exercise flexibility in providing assessment for older people with unclear presentations. This may involve provision of brief interventions and education where appropriate and/or collaborative care with specialist Alcohol or Other Drug services.

Inpatient care of older people with a primary diagnosis of drug and alcohol disorder or delirium is generally the responsibility for drug and alcohol services and geriatric medical services.

OPMH services may be provided through a consultation-liaison model, for example, to an Alcohol or Other Drug setting.[39] It is important that the OPMH AIU has strong links and partnerships with local drug and alcohol services for referral and joint management of consumers with comorbid substance misuse and to assist in the assessment of neurocognitive disorders where required. The drug and alcohol consultation-liaison service is a key point of referral for older people with substance use issues in the AIU.

Consumers whose needs may be best met elsewhere

Delirium is a common presenting problem in frail older people, is often unrecognised, has high morbidity and mortality, and is considered a medical emergency.[38] This condition is often mistaken for dementia, depression, mania, or a primary psychotic disorder in older people. Delirium is an acute medical condition, and it should primarily be treated in a GP ambulatory care, or specialist physician-hospital track, rather than in OPMH units.

It is recommended that there be agreed local pathways to care for individuals with delirium, dementia and behavioral difficulties through ED, acute and sub-acute care for all hospitals. Effective collaboration between OPMH and aged care services is essential to address the needs of people experiencing BPSD, but may be excluded from admission to the OPMH AIU because of their comorbidities.

OPMH services should be flexible in providing assessment for older people presenting with complex and unclear histories. If an older person with delirium, alcohol and/or other drug disorder is referred to an OPMH service, the service should, following secondary triage or initial assessment, provide a brief intervention and assist the person to obtain assessment and referral to an appropriate service setting with mental health consultation and liaison as required.

OPMH AIUs are not generally the primary provider of specialist services for:[1]

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

3 Target Population and Specific Population Groups

Target population recommendations

1 The target population for OPMH services, including OPMH AIUs, is older people (generally aged 65 and older) with or without dementia, who:

- develop or are at high risk of developing a mental disorder or symptoms in later life, including suicidality and self-harm, depression, acute psychosis, anxiety, late-onset schizophrenia or a severe adjustment disorder
- have significant trouble related to long-term mental illness or treatment combined with age-related functional disability such as frailty or progressive cognitive impairment
- have an earlier mental health problem that has returned, but 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
- show severe behavioural or psychiatric symptoms related to dementia or other long-standing organic brain disorder and would be optimally managed with input from OPMH. This may include people who are deemed at risk of harm to themselves or others. Symptoms may include depression, severe physical and/or verbal aggression, severe agitation or psychosis
- are Aboriginal people aged 50 or older who develop, or are at risk of developing, a mental health disorder and identify with older consumers or their needs.

2 If the OPMH AIU is not designed or staffed for high dependency consumers, people with very high risk of serious harm will not be in that unit's target population. Instead, they may need care in an adult mental health high dependency unit or a mental health intensive care unit.

3 The target population's families and carers are part of the broader target group.

4 OPMH AIUs should prioritise local consumers for admission, but they should also consider:

- the LHD's other available service options
- that some people may prefer to be in an adult mental health AIU, or that such units can better manage their needs.

5 OPMH AIUs will generally not serve people whose main diagnosis is a drug and alcohol disorder. Alcohol and other drug services have the expertise to manage this. But the units:

- aim to have some capacity to assess and provide clinical care for people with co-existing alcohol and drug problems where this is not the primary focus
- should be appropriately flexible in their assessment of people with complex and unclear symptoms, which may include briefly intervening and providing education where relevant
- should have strong ties to local drug and alcohol services for referrals, such as the local drug and alcohol consultation liaison service
- should collaborate with these local services to manage and care for consumers with comorbid substance use and mental health problems
- should help these services assess neurocognitive disorders as needed.

6 OPMH AIUs will generally not admit people whose main diagnosis is delirium, unless they have resolving delirium and meet other admission criteria. The unit should carefully assess the risks and benefits before admitting such consumers.

7 The following care providers should manage people with delirium, as they have the expertise to manage this acute condition:

- geriatric medical services
- GP–ambulatory care
- specialist physician–hospital track.

8 OPMH AIUs will not admit people:

- with unstable medical conditions
- who need respite but do not have severe clinical symptoms
- whose physical health care or nursing needs are the main focus
- if the unit cannot safely meet their physical health care needs, such as people with acute delirium.

9 If they admit consumers from outside the target population, OPMH AIUs must consider how this will affect their staff and the unit's ability to meet all consumers' needs.

Recommendations about consumers with BPSD

10 All OPMH AIUs have a role in the support and management of people experiencing behavioural and psychological symptoms of dementia (BPSD). AIUs should map their role, which should complement the role of other aged care services. Generally, OPMH AIUs will focus on consumers with BPSD related to predominant mood or psychotic symptoms and other aged care inpatient units will focus on consumers with delirium and BPSD that is related to acute medical needs. However, appropriate flexibility is required and consumer need should drive decisions regarding location of care within local service systems.

11 OPMH AIUs should be designed to enable the management of BPSD and minimise its effects. Physical environments should accommodate the needs of people with dementia or BPSD while ensuring safe and effective care for other consumers in the unit.

12 If an OPMH AIU cannot appropriately manage consumers with severe to extreme BPSD, it should arrange for and support other inpatient facilities to do this, such as:

- Transitional Behavioural Assessment and Intervention Service (T-BASIS) units
- adult mental health units
- acute geriatric behavioural units.

13 There should be clear local service responsibilities and pathways in place for the care, treatment and management of people with BPSD in inpatient services. Such pathways should put people, not service convenience, as their focus.

14 There should be opportunity for joint clinical input from both geriatric/aged health and OPMH clinicians in the care of people with BPSD.

15 OPMH AIUs should agree local pathways for people with BPSD coming to and from the unit.

16 OPMH AIUs should have enough staff with a range of skills to provide quality care for people with BPSD while maintaining their own wellbeing.

Recommendations: Specific population groups

17 Older people's mental health acute inpatient units (OPMH AIUs) treat diverse populations and should:

- consider the diverse needs of those who access the unit
- respond to each person's specific needs during their stay
- have processes for using trauma informed care and practice.

Recommendations about Aboriginal consumers

18 OPMH AIUs should arrange for staff to have cultural awareness training and information about local services for Aboriginal people.

19 Assessment and care processes for Aboriginal consumers should:

- be trauma informed, culturally safe and appropriate
- include an Aboriginal health or mental health worker if the consumer chooses
- consider the potential for complex family and community relationships and large numbers of visitors.

20 The following groups should take part in OPMH AIU referral, intake, assessment and care, and transfer of care processes where possible and relevant:

- Aboriginal health and mental health workers
- other Aboriginal service providers and cultural brokers.

21 Each OPMH AIU will support culturally safe, appropriate and integrated care for Aboriginal consumers by:

- engaging with older Aboriginal consumers and carers
- forming LHD partnerships with health and aged care services, such as Aboriginal Medical Services, Aboriginal Community Controlled Health Services, and other Aboriginal-specific services.

Recommendations about culturally and linguistically diverse consumers

22 Bilingual counsellors and other cultural brokers should take part in OPMH AIU referral, intake and assessment processes where possible and relevant.

23 Assessment, care and transfer of care processes for culturally and linguistically diverse consumers will:

- be culturally appropriate
- use the Multicultural Mental Health Outcomes and Assessment Tools as relevant
- consider each customer's cultural customs and values, religious beliefs, and other relevant beliefs and practices.

24 OPMH AIUs should arrange for staff to have training in:

- cultural awareness and competence
- interpreter services, including when and how to access and use them appropriately.[58]

25 Each OPMH AIU should form strong relationships with multicultural service providers, building on LHD service partnerships.

Target Population

The *NSW OPMH Service Plan*[1] defines the OPMH target population as older people (generally 65 years and over), including people with and without dementia, who:

- Develop or are at high risk of developing a mental health disorder or symptoms in later life. This includes suicidality and self-harm, depression, acute psychosis, anxiety, late onset schizophrenia or a severe adjustment disorder;
- Have significant difficulties with long-term mental illness and/or its treatment, and now experience ageing-related problems causing functional disability (i.e. frailty and/or progressive cognitive impairment), 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 best managed by the OPMH service, with consideration to individual preference.

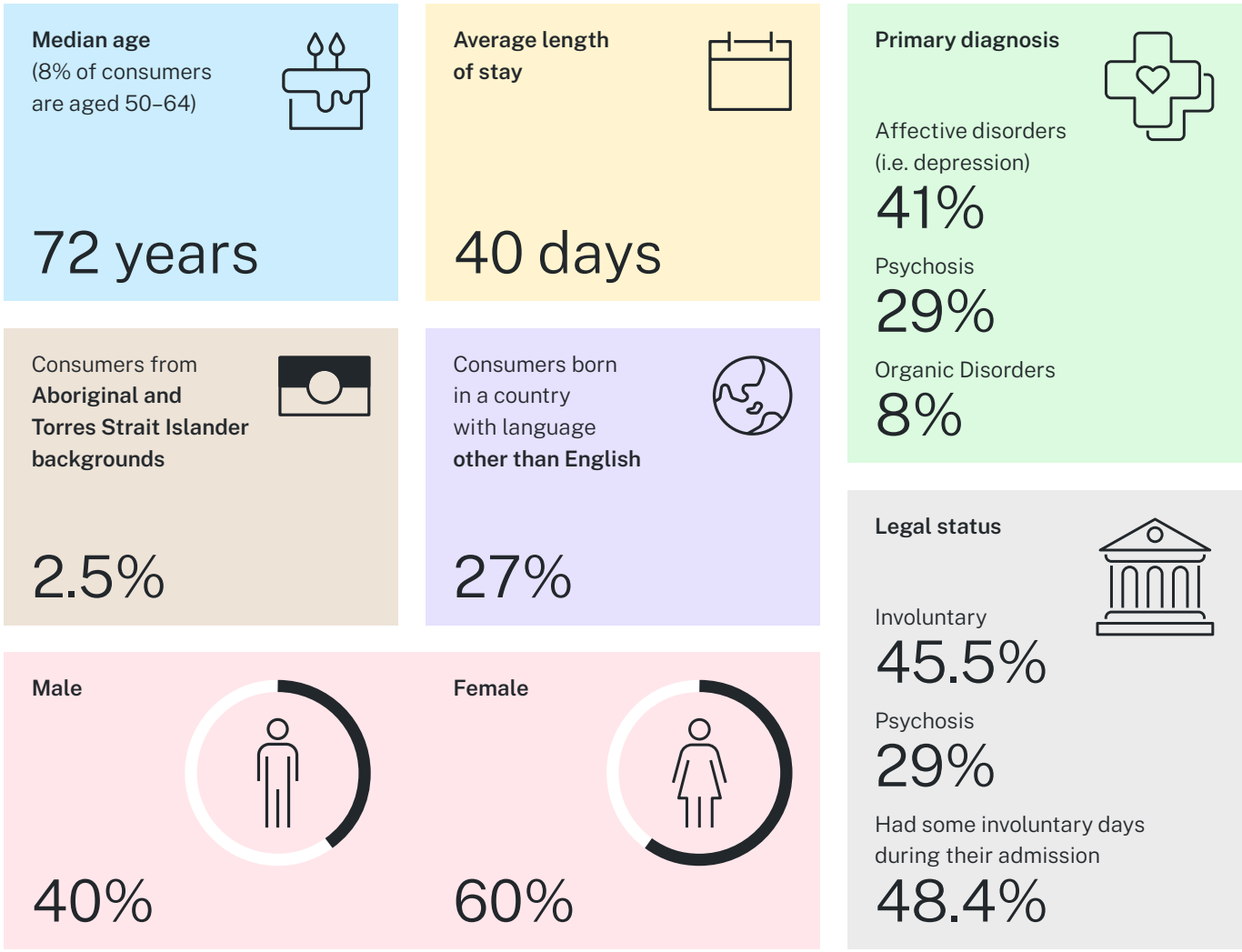
OPMH services provide care to Aboriginal people aged from 50 years where they identify as older people and/or with the specific needs of older consumers, and express a preference for receiving care from OPMH rather than adult services.

Older consumers with severe behavioural or psychological symptoms of dementia (BPSD) needing care in an OPMH AIU may have depression, anxiety, aggression, agitation, psychosis, hoarding, vocally disruptive behaviour, be sexually disinhibited, or have a tendency to abscond. Younger people who develop functional disorders normally associated with ageing, primarily those with younger onset dementia, may also be appropriately admitted to the OPMH AIU.[33] People with more severe symptoms or complex needs should be prioritised.

Families and carers of older people are also included as part of the broader target group for OPMH AIUs. Families and carers require skills, resources and support to care for older people with mental health problems and in navigating a complex health system. There is limited evidence to indicate if or when older people with lifelong (or recurring mental illness but without age-related problems causing significant functional disability) should be admitted to an OPMH AIU in preference to a general adult mental health AIU. Consumer preference should be considered in admission processes.

Figure two below provides a snapshot (from 2020) of the demographics seen in OPMH AIUs across NSW, whilst noting that the average length of stay was 40 days and that just under half of the consumers were admitted as involuntary consumers or had some invo9lintary days during their admission.

Figure 2. Consumers in Older People's Mental Health Acute Inpatient Units



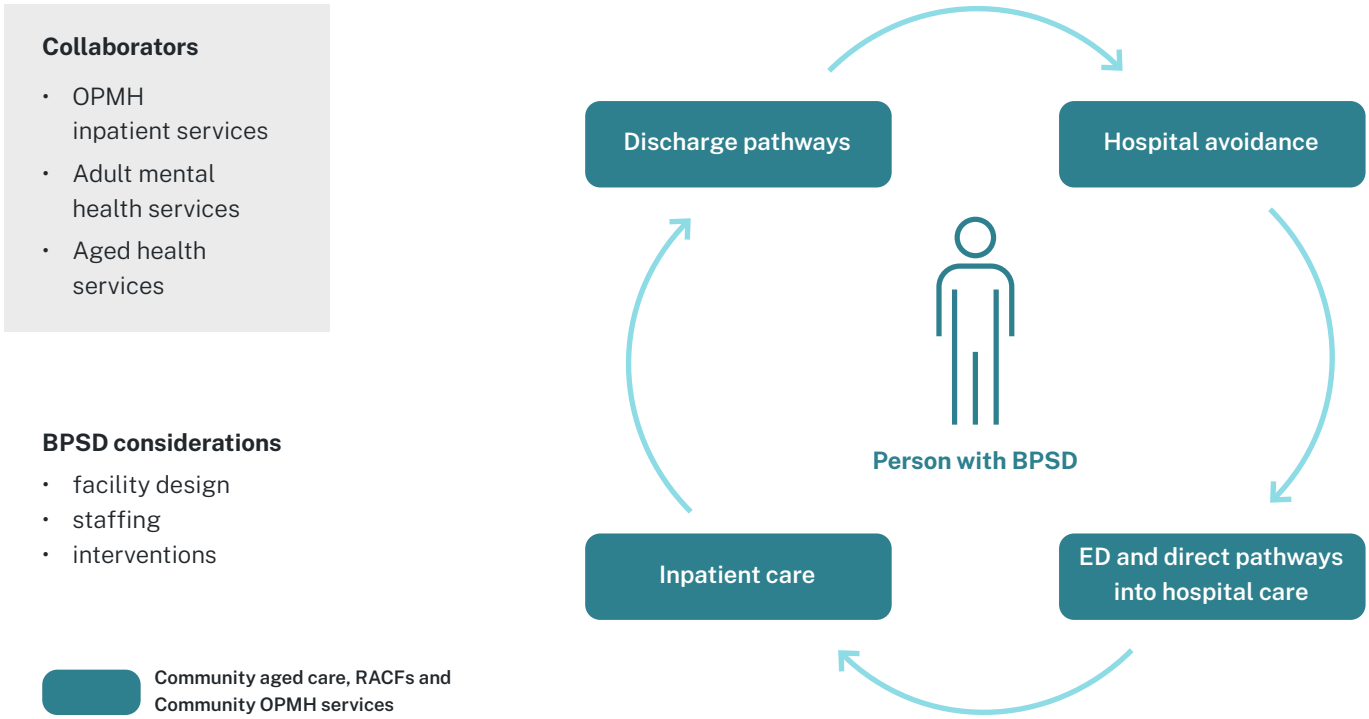
Management of people experiencing behavioral and psychological symptoms of dementia (BPSD)

All OPMH AIUs have a role in the support and management of people experiencing behavioral and psychological symptoms of dementia (BPSD). People experiencing BPSD can be managed within an OPMH AIU with older people with a functional mental illness if the environment is suitable to manage two different groups of people. Care of people experiencing BPSD requires effective leadership and staff with specialist knowledge and skills in BPSD. In referring to BPSD in this document, we refer to all levels of BPSD including extreme BPSD.[34]

Figure 3 below depicts consumer care pathways and considerations, key partnerships and collaborators for people experiencing very severe or extreme BPSD.

Data sourced from 2020 OPMH Benchmarking report

Figure 3.



The physical environments for people experiencing BPSD must meet the needs of the person and allow for the safe and effective care of other consumers in the unit. For example, specific facility design features may allow separation of a very aggressive person from other consumers. Alternatively, reducing the number of people within a unit may allow for safe management of a very aggressive person. See health facility guidelines[6] and the dementia design guide[35] for specific advice regarding dementia friendly environments.[34]

It is equally important that the multidisciplinary team have specialist skills in dementia care and in the prevention of violence. Care should reflect best practice for BPSD including physical health care, behaviour management strategies, psychological engagement, medication and care for the carer.[34] Therapeutic and meaningful activities that support individual choice should be available as outlined in the NSW Heath Extreme BPSD Project Report.[36]

Responsive staffing approaches, including regular staff rotations promoting quality of care and workforce wellbeing are key considerations when caring for someone experiencing extreme BPSD. Staffing should be based on current consumer needs to ensure appropriate staff numbers and skill mix. Services providing care for people experiencing severe and extreme BPSD require a high ratio of staff to consumers.[36,37]

Specific population groups

The *OPMH AIU Model of Care Project Report* and OPMH policy work highlight considerations in care for two vulnerable populations — Aboriginal older people and culturally and linguistically diverse (CALD) older people. These considerations are highlighted below.

There are a number of other specific population groups where the evidence and guidance around mental health supports are still developing. These groups include older people with co-existing mental health and alcohol and other drug issues,[39] older people at risk of homelessness or living in severe domestic squalor,[40] older people with an intellectual disability or brain injury,[41] older people in the criminal justice system[42] and older LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms communities.[43] OPMH AIUs should be sensitive to the cultural safety needs of all diverse groups who are accessing the unit and consider their specific needs as part of admission and discharge, and throughout their stay on the unit. A trauma informed approach should be considered when working with diverse populations.[44]

Aboriginal older people

While there have been some improvements in mortality rates for Aboriginal and Torres Strait Islander people over recent decades, a notable gap between the Aboriginal and non-Aboriginal population remains.[45] The life expectancy of Aboriginal people is estimated to be 8.6 years lower than that of the non-Aboriginal population for males and 7.8 years for females.[45] Aboriginal people are affected by the early onset of diseases and conditions usually associated with old age, including dementia. In this context, planning and service delivery for OPMH (consistent with aged care planning and service delivery) targets Aboriginal people 50 years and over.[1]

Philosophy of care

There is an opportunity to draw on learnings and wisdom from Aboriginal people to inform service delivery. Aboriginal people often view 'mental health' holistically. The concept of 'social and emotional wellbeing' applies to individuals, extended families and entire communities and is not separate from physical health and spirituality. Health and mental health are seen as intimately connected through the inter-related nature of mind, body and spirit.[46] The term 'mental health' can be inappropriate from an Aboriginal person's perspective.

Person-centred, recovery-oriented care approaches should address the special connectedness, role and relationships to family, multiple communities and country, and the significant sense of loss, grief and trauma many Aboriginal people experience. The NSW Health Aboriginal Older People's Mental Health Project Report[47] and the guideline Communicating Positively[48] provide resources to understand key principles of service delivery and respectful communication with older Aboriginal people. The Gayaa Dhuwi (Proud Spirit) Declaration is the touchstone of Australia's work to reform Aboriginal social and emotional wellbeing, mental health and suicide prevention and secure a fit-for-purpose mental health system for Aboriginal and Torres Strait islander peoples.[49]

End of life care

Death and dying for Aboriginal people can sometimes be understood with reference to: historical and/or current contexts; the importance of Country and sometimes the preference to die on Country; sensitivity surrounding the topic of death for the person dying and their community; spirituality and/or religious beliefs; and the diversity of rituals before, during and after the dying process.[50] Working with the person, their family/community and relevant Aboriginal-specific service providers and/or clinicians is essential in the provision of end of life care for Aboriginal people.

Key processes

There are a number of factors to consider when assessing Aboriginal people[51] within clinical settings. These include cultural views and taboos, the cultural and political context of the assessment and setting, cultural safety and access to Aboriginal mental health workers in the AIU, and consideration of the appropriateness of standardised tests in a particular cultural setting. A list of culturally validated assessment tools is available in: Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice 2nd ed.[51] Consideration should be given to any inherited factors from the culture in which the assessment tool was developed, such as the understanding of language, terminology and other factors that may not be appropriate when considered from an Aboriginal cultural perspective. Without culturally appropriate assessments, the process relies heavily on the abilities and skills of the clinician which may lead to poor diagnosis.[52]

Care should be delivered in partnership with Aboriginal consumers, carers and clinicians.[53] The role of extended family and wider community should be taken into account when working with Aboriginal and Torres Strait Islander communities. Culture influences Aboriginal and Torres Strait Islander people's decisions about when, where and why they seek services, if they accept or reject treatment and how likely they are to continue treatment and follow-up. It can also affect the success of health promotion and prevention strategies, the persons' view of the care, and the health service and its staff. Aboriginal health workers and cultural 'guides' are vital in establishing meaningful contact with Aboriginal families from rural and remote communities.[54]

Carers should be included as soon as possible in the planning of care with clear and open communication. The mental health service should regularly seek information from carers that contributes to care. The mental health service should try to identify if this did not happen when the consumer was admitted with the carer.[54]

Clinical interventions

The *Aboriginal Older Peoples' Mental Health Project Report*[47] highlights that family and community connections are very important to older Aboriginal people, particularly with the passing of cultural knowledge onto younger people. Consideration should be given to the older

person's cultural obligations and responsibility within the family and community unit and potential status as a community elder. Understanding culture and an older Aboriginal person's contribution to culture and family are important factors that may impact family/carer education and therapy. Taking a holistic view of mental health, social and emotional wellbeing is also important. Older Aboriginal people may experience mental health not only at an individual level but also at the community level. Considering the impact of transgenerational trauma for both the older Aboriginal person and their family/communities is also important. Aboriginal service providers and clinicians can facilitate and enhance the effectiveness of family/carer education and therapy for Aboriginal people.

Non-government organisations (NGOs) including Aboriginal Medical Services and other Aboriginal Community Controlled Health Services (ACCHS), are often sensitive to new issues and changing needs in the Aboriginal community. They can be well placed to develop innovative forms of service delivery. In many instances they may act as advocates for their people and frequently provide services for those who have difficulty accessing mainstream health services. LHDs should seek to develop appropriate consultation-liaison services to other inpatient services in the LHD that manage older consumers who are within the *NSW OPMH Service Plan* target population. This includes engaging Aboriginal specific services to facilitate culturally competent assessments, treatment and care planning. A resource package for LHDs[55] has been developed to help with practical ideas and strategies regarding Aboriginal partnerships and workforce development.

Culturally and Linguistically Diverse (CALD) older people

Research and policy supports the importance of delivering culturally safe and competent mental health services. Cultural competence is a set of behaviours, attitudes and policies that enable the system, agency or individuals to work in cross cultural situations. A culturally competent system is aware of its cultural world view, assumptions and biases. It has a positive attitude towards cultural differences and demonstrates cross-cultural communication skills. It is also conscious of the dynamics that occur when culture interacts, and adapts service delivery to reflect an understanding of the diversity between and within cultures. Mental Health in Multicultural Australia has released a Framework for Mental Health in Multicultural Australia[56] outlining frameworks for services to evaluate their cultural responsiveness and enhance the delivery of services for CALD communities.

Philosophy of care

Person-centred, recovery-oriented care approaches for CALD consumers emphasise the role of family and cultural belonging. Alternative approaches may be required for older people from CALD communities who are experiencing isolation and loneliness. These people may not have extended family networks for support, are ageing in an unfamiliar cultural environment, or could be experiencing grief, loss, shame and stigma associated with migration or displacement.

End of life care

There are many different CALD communities with different ethno-cultural backgrounds, customs, values, religious beliefs, and other beliefs and practices around death and dying. It is essential that services work with the person, their family, community, and relevant multicultural and transcultural mental health services to provide culturally appropriate end of life care.

Key processes

OPMH staff should consider the impact of their own ethno-cultural background (i.e. language, specific knowledge of the consumer's culture, any links between their own and consumer's culture of origin) when working with a consumer from a CALD background. Concepts of confidentiality are understood differently between cultural communities. Staff may need to explain confidentiality in several ways depending on the persons' understanding. Some CALD consumers prefer direct questions while others may prefer indirect questioning. Never assume people from the same cultural heritage are similar to each other as there is diversity within all cultures. Importantly, there is also variation in an individual's adherence to their culture depending on how long they have lived in Australia. Mental health symptoms may be expressed in somatic, spiritual or behavioural ways with CALD consumers.[57]

The suite of *Multicultural Mental Health Outcomes and Assessment Tools* was developed by the Transcultural Mental Health Centre and NSW Ministry of Health to assist health care professionals to provide culturally appropriate care to people from CALD communities.

4 Comorbid Disorders and Problems, and End of Life Care

The Physical health care for people living with mental health issues and the Physical Health Care within Mental Health Services Policy outline the responsibilities of LHD mental health services in relation to providing physical health care for consumers with a mental illness. Information sheets (in multiple languages) have been developed to inform mental health staff, consumers, families, carers and GPs about the physical health care provided by local mental health services.[59]

Mental health consumers have a right to receive physical health care that is in line with the general population.[60] Family and/or carers also play a vital role and should be encouraged to participate through the provision of a detailed health history as well as providing support to the person.

Staff in some AIUs might not have the skills and expertise to manage end of life care, and specialist advice should be sought where appropriate.

Recommendations: Comorbid Disorders and Problems, and End of Life Care

Medical and surgical management recommendations

4.1 Older people's mental health acute inpatient units (OPMH AIUs) should:

- have strategies to prevent falls
- arrange consultations with geriatricians and medical specialists as needed
- help consumers access medical and surgical care through Aboriginal Community Controlled Health Services and other relevant medical services as needed.

4.2 OPMH AIUs may admit consumers who are bedbound because of a comorbid disorder or severe mental health condition if the unit can manage their mental health conditions appropriately.

4.3 OPMH AIUs should be able to manage:

- intravenous and subcutaneous fluids
- intravenous medications
- incontinence.

4.4 OPMH AIUs will offer appropriate physical and mobility support to consumers if needed.

4.5 Each OPMH AIU must have access to clinical emergency response systems and medical services in line with the Recognition and management of patients who are deteriorating policy directive (PD2020_018).

End of life care recommendations

4.6 OPMH AIUs can provide end of life care in some cases. They should use NSW Health's tools and resources to encourage early advance care planning when caring for consumers with terminal illness.[61]

4.7 OPMH AIUs should seek advice from palliative care services where relevant. If a consumer transfers to palliative care, the AIU should ensure ongoing mental health support.

5 Functional Relationships, Location and Other Operational Arrangements

Acute inpatient care for older people should be considered as part of the range of care for people with psychiatric disorders. Ideally, adult mental health inpatient units, aged care services and OPMH community services have been designed to meet the complex interrelated physical and social, behavioural or psychological needs of older people.[62] OPMH services, including AIUs, need to develop effective partnerships with GPs, geriatric medical services, aged care services including Aged Care Assessment Teams (ACATs) and dementia support services, forensic mental health services, EDs, non-government organisations (NGOs), home support and community aged care services, residential aged care facilities (RACF), Aboriginal service providers such as Aboriginal Medical Services and multicultural services.[1]

Aged health and aged care services in NSW have a role in the assessment and management of older people experiencing BPSD in collaboration with OPMH services. Joint case conferences, education and cross-referral should be considered to integrate care (e.g. regular BPSD Grand Rounds).[63]

Relationships which are considered the most critical for OPMH AIUs include adult acute mental health, acute geriatric inpatient units, and other units such as medical imaging and pathology.[64] Co-location with these services and proximity to a larger facility, and access to ECT, should be considered when establishing new OPMH AIU units.

Ease of access for hospital visitors is recommended in government guidelines.[65] Flexible visiting hours improve consumers' experiences[66,67] and have been known to reduce agitation and aggression among some consumers. OPMH AIUs should consider the availability and any potentially high costs associated with parking for families and carers, and access to public transport. OPMH AIUs should consider virtual or telehealth arrangements to support carer and family connections where face-to-face visiting is not possible, and virtual or telehealth arrangements to support key functional relationships e.g. GP liaison.

Recommendations: Functional Relationships, Location and Other Operational Arrangements

Functional relationship recommendations

5.1 Each OPMH AIU will form strong relationships with these inpatient services and facilities:

- geriatric medical units or other medical units in rural areas
- acute adult mental health inpatient units
- emergency departments, including access to ward and security staff
- electroconvulsive therapy (ECT) facilities
- imaging facilities and pathology services
- pharmacy services
- other relevant units specialising in the care of older people, such as acute medical behavioural units, T-BASIS units and mental health–residential aged care partnership services.

5.2 Each OPMH AIU will also form strong relationships with these community services:

- general practitioners
- private psychiatrists and other community mental health providers
- OPMH community teams
- acute (crisis teams) and other adult mental health community teams
- emergency services, such as police and ambulance
- aged care assessment teams, aged health community teams and community aged care services
- residential aged care facilities, including specialist facilities where available
- Primary Health Network partners
- home support and housing and squalor services
- domestic violence services and elder abuse partnership services

- statewide services including the Mental Health Review Tribunal (MHRT), NSW Civil and Administrative Tribunal (NCAT) Guardianship Division, Office of the NSW Public Trustee, Legal Aid NSW and NSW Health Care Interpreters Services.

5.3 OPMH AIUs must develop and support these relationships. This could be through:

- clear expectations around timing and modes of communication
- formal agreements outlining services roles and responsibilities
- cross-referrals
- joint assessments, case conferences and service planning
- reciprocal consultation–liaison.

Unit location and access recommendations

5.4 Following their Clinical Services Plan, LHDs should decide the capacity and location of new units to provide optimal access to safe and effective services.

5.5 Each OPMH AIU will provide prioritised access for referrals from key service partners. This will have particular impact on the unit's function and staffing requirements.

5.6 For close functional relationships, it is important that OPMH AIUs are close to, or co-located with, the following services:

- ECT facilities
- geriatric inpatient units.

5.7 OPMH AIU co-location with the following units/ services is also strongly desirable:

- a general hospital with a range of acute services
- an adult mental health inpatient unit
- an emergency department
- an imaging and pathology service.

5.8 Consumers and visitors will be able to access the OPMH AIU by both public and private transport.

5.9 Visitor parking should be affordable and close to the OPMH AIU. Where general hospital parking is not suitable, the OPMH AIU should advocate for other visitor arrangements.

5.10 Units should allow visitors to access parts of the unit that allow an appropriate level of privacy.

5.11 Visiting hours should be as flexible as possible to accommodate consumers' needs, give families and carers better access, and encourage families to get involved in care.

5.12 Therapeutic need, risk, and consumer, carer and family preference will determine any restrictions to visiting hours. Staff routines will not affect visiting hours.

5.13 Training in person-centred care should consider ways to address the disconnect between families who think of themselves as 'intruding or interfering' in care and staff who believe they are 'effectively involving families in care'.

5.14 Person-centred care may mean having a family member stay with the consumer. This is particularly important to Aboriginal consumers, culturally and linguistically diverse consumers and some other communities. OPMH AIUs should give family clear information to support this.

5.15 OPMH AIUs should:

- ensure that anyone who may visit is given relevant information
- have refreshments for visitors, especially those travelling long distances
- advocate for affordable local accommodation options for carers, especially those travelling from rural or remote areas, when appropriate
- use telehealth to enhance access where appropriate.

5.16 Consumers should have access to mobile phones and other communication devices, except where there are clinical reasons for limiting this.

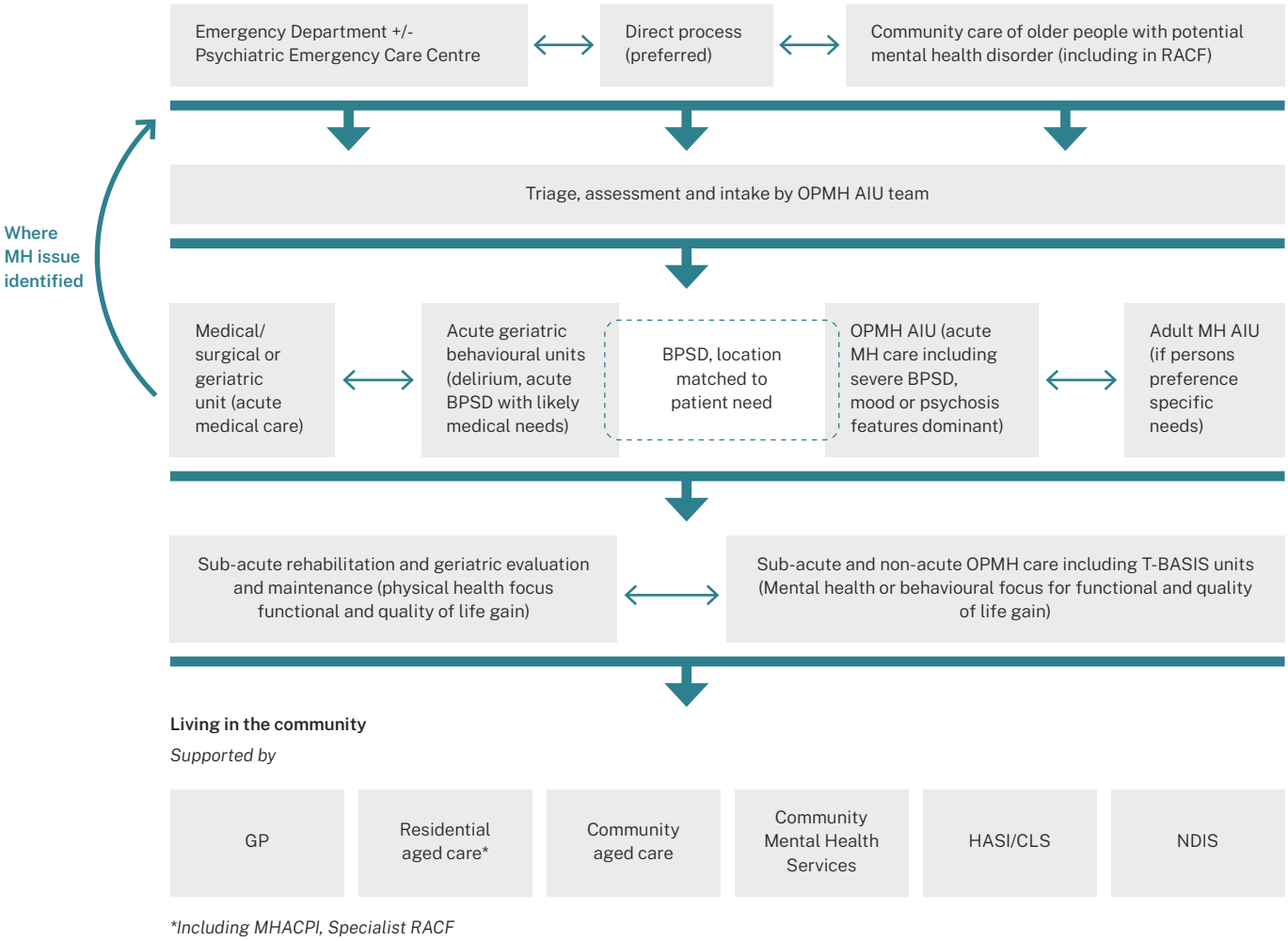
5.17 OPMH AIUs should limit the risk of cross-infection from visitors by:

- hand washing
- using bactericidal hand wash and personal protective equipment (PPE) as needed.

6 Key Processes

Clinical pathways for OPMH consumers should be integrated with other service components. The relationships between the most relevant services are shown in Figure 1.

Figure 4. Clinical pathway for older people with potential mental health disorder



Including MHACPI, Specialist RACF

Recommendations: Key Processes

Process recommendations

6.1 Older people's mental health (OPMH) services should work with Mental Health Line and bed management staff to ensure their procedures align with the following standards:

- Intake and bed management systems prioritise consumers who meet the local intake criteria for specific OPMH beds.
- Intake criteria prioritise the NSW Older People's Mental Health Services Service Plan 2017–2027 target group (including people with dementia).
- Referral and intake systems actively involve GPs from the start wherever possible.

- OPMH acute inpatient units (AIUs) accept direct referral and intake outside of admission through an emergency department.
- OPMH AIUs have procedures for notifying referring agencies when a referral is not accepted, including the reasons why and advice or actions for accessing appropriate ongoing care.

6.2 All OPMH services should have processes to help clinicians, consumers and carers:

- use a 'positive risk taking' approach to risk assessment and planning
- comply with relevant NSW Health policies, such as Clinical Care of People Who May Be Suicidal[74] and Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services.[75]

Preadmission and admission recommendations

6.3 OPMH AIUs should have a clear preadmission process with tools to screen consumers and assess likely delirium or acute medical deterioration without unnecessary delay.

6.4 The OPMH AIU's admission process should:

- be documented
- cover OPMH-specific issues
- enable direct admission (outside of an emergency department) where an OPMH consultant deems it appropriate and safe after assessing the consumer and considering the risk of acute medical illness
- be welcoming and comfortable for consumers and their families and carers, and tell them about the unit and the types of disorders managed there.

6.5 Both the preadmission and admission processes should involve the following groups wherever possible and relevant:

- Aboriginal health and mental health workers
- bilingual counsellors and other cultural brokers
- community mental health teams
- GPs
- private psychiatrists.

6.6 Units should try to admit consumers on the day they are referred. This means maximising their ability to accept admissions 24 hours a day and having OPMH senior clinicians available to make decisions about admissions and care after hours.

6.7 The unit must notify designated carers and primary care providers about nine specific events, as specified in the *Mental Health Act 2007* (NSW). Examples include when the consumer is:

- detained in a mental health facility
- reclassified or admitted as a voluntary patient
- to be discharged.

6.8 If the unit cannot accommodate certain consumers, it should have clearly documented pathways to other care providers.

Assessment and care planning recommendations

6.9 To inform a person-centred approach, OPMH AIU assessments must consider the consumer's:

- strengths
- care goals, as well as their families' and carers' care goals and needs
- sensory impairment
- medical and family medical histories, including risk of delirium or acute medical conditions
- mental health history and current state, including cognitive assessment
- past and current social, housing and work situation, which is relevant for discharge planning
- cognitive abilities
- activities of daily living and instrumental activities of daily living, including their ability to manage finances and drive, and if they need enduring power of attorney or guardianship.

6.10 Assessments must further consider key risk issues, such as the consumer's:

- risk of absconding, falling or harming themselves or others
- risk of abuse
- allergies, pressure areas or polypharmacy.

6.11 OPMH AIUs must use relevant standardised instruments in their assessments.

6.12 OPMH AIUs should try to minimise any cultural biases in their assessments. They should:

- consider a consumer's language, culture and spiritual affiliation
- use an interpreter to assess any consumer who has a preferred language other than English and again during all planned clinical interactions throughout their stay.

6.13 OPMH AIUs should have processes to adapt assessment and care planning for culturally and linguistically diverse consumers. This may include using the Multicultural Mental Health Outcomes and Assessment Tools or making them available if they are not already in local electronic medical record (eMR) systems.

6.14 Assessments must include each consumer's key carers, GP and private psychiatrist where relevant and the consumer consents. If consumers cannot give informed consent, OPMH AIUs must assess them and plan their care in line with the *Guardianship Act 1987 (NSW)* and the *Mental Health Act 2007 (NSW)*.

6.15 OPMH AIUs' assessments must be multidisciplinary, timely, comprehensive and consistent with professional and policy standards. These currently include:

- Clinical Care of People Who May Be Suicidal policy (PD2016_007)
- Mental Health Clinical Documentation Guidelines and related training materials
- OPMH Benchmarking Self-Audit Tool standards
- Physical Health Care for People Living with Mental Health Issues guideline (GL2021_006).

6.16 Assessments must also be consistent with these other Australian standards including:

- the Australian Commission on Safety and Quality in Health Care's best practice guidelines for Preventing Falls and Harm From Falls in Older People
- the Centre for Health Service Development's Dementia Outcome Measurement Suite Project final report.

6.17 All consumers should have a full physical exam when admitted, which includes taking their vital signs and doing a neurological exam. If they are too distressed or aggressive, the OPMH AIU should document this and complete the exam at their first chance.

6.18 The OPMH AIU's care plans must:

- include tools for collaborating with consumers, carers and other disciplines
- include factors relevant to transfer of care, such as post-discharge accommodation and support services for follow-up
- be reviewed at defined periods.

6.19 OPMH AIUs must have clear guidelines about how to access specialty medical consultations.

Clinical review recommendations

6.20 If the community team knows the consumer, the care coordinator should attend at the first clinical review meeting and share:

relevant background information

details of the person's level of functioning when well.

6.21 OPMH AIUs must have policies to ensure appropriate:

- multidisciplinary clinical review meetings
- shift handover, including when multidisciplinary participation is required
- reviews after clinical incidents
- frequency of reviews from designated professional groups
- consumer participation.

6.22 OPMH AIUs will have clear expectations about multidisciplinary reviews. These expectations should align with the following NSW Health standards, as well as the NSW Clinical Excellence Commission's 'Between the Flags' program:

- Clinical Handover Policy (PD2019_20)
- Incident Management Policy (PD2020_20)
- OPMH Benchmarking Self-Audit Tool standards
- Mental Health Clinical Documentation Guidelines and related training materials.

Discharge or transfer of care recommendations

6.23 OPMH AIUs should:

- start discharge plans during the admission assessment
- regularly review discharge plans with the consumer and key carers
- consult the consumer's GP about their discharge or transfer of care
- agree the discharge and wellness plan with the consumer and key carers
- give them a copy of the discharge summary.

6.24 A consumer should only be discharged to a residential aged care service once:

- the OPMH AIU gives the consumer and provider a clinical handover, discharge summaries and a medications list
- the provider acknowledges it has received these.[79]

6.25 The unit must notify designated carers and primary care providers on discharge.

6.26 OPMH AIUs will have clear expectations about planning to discharge consumers or transfer their care. These expectations should align with NSW Health standards, currently including:

- Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services policy directive (PD2019_045)
- OPMH Benchmarking Self-Audit Tool standards.

6.27 Relevant staff must be familiar with these standards, and how to access appropriate support from mental health and aged care focused resources.

Intake and Admission

Internal NSW Health information indicates that approximately 1 in 3 presentations to Emergency Departments (EDs) by older people with a mental health problem include the presence of suicidal ideation or self-harm. All of these people will require admission to an AIU or timely specialist follow-up by mental health clinicians with expertise in working with older people. Where initial medical admission is required, care planning must include access to a specialist mental health assessment prior to discharge.

Often an admission to the OPMH AIU occurs when the OPMH community team or private psychiatrist have identified a need for further management and interventions that are not available within the community or outside the unit. While often requiring urgent care, these people generally do not present as an 'emergency' or benefit from further assessment in an ED. A 'direct admission' to the AIU through negotiation with the AIU medical and nursing staff is ideal in this situation. Consumer consultation has highlighted consumers' preference for direct admission to OPMH AIUs over admission via an emergency department. Screening evaluations should take place at the relevant entry point, prior to admission to the OPMH AIU.

Medical assessment does not necessarily need to occur in the ED and is best avoided where possible. It is important that screening processes to exclude delirium and other acute medical illness do not delay admission. The decision for direct admission should be considered by a senior medical officer or clinician with knowledge and experience in the assessment of people with delirium (e.g. old age psychiatrist or consultation-liaison psychiatrist). Where there is unclear or complex medical history or the person has an acute medical problem, additional assessments from one or more relevant service partners may be required prior to admission.

It is recommended that OPMH services liaise with relevant Mental Health Line and/or bed management staff to ensure their procedures are consistent with:

1. Intake and/or bed management systems that prioritise access to specific OPMH beds for consumers who meet local OPMH intake criteria.
2. Intake and referral systems should actively seek the involvement of GPs wherever possible as part of the intake process.
3. The service can facilitate direct referral and admission pathways other than via EDs.
4. The intake system notifies referring agencies if a referral is not accepted. This should include reasons for non-acceptance, and advice or actions to facilitate access to appropriate ongoing care.
5. Intake criteria is based on local prioritisation of the *NSW OPMH Service Plan* target group criteria (including people with dementia).

When an older person is admitted as an involuntary consumer, a nominated principal care provider must be notified of the admission and discharge, and notified of events affecting the consumer.[31]

Assessment and Care Planning

Comprehensive assessment of the older person considers the whole life situation of an older person[68] that enables a holistic care plan to be developed. It should be done through a multidisciplinary process that addresses immediate as well as long term mental health, physical health and ongoing support needs.[69]

The assessment process in the OPMH AIU will cover a range of psychological, functional, physical and social aspects of the person and consider these in the context of the person's environment. It will also consider the risks and vulnerabilities associated with the environment for the

person's family and/or carers. The goal of this assessment is to address and/or minimise any identified risks in relation to the care plan.[69]

The following principles of care are useful in the assessment and care planning of older consumers:

- Comprehensive assessment is a continuous, interdisciplinary, multidimensional process that identifies and evaluates all factors affecting an older person's health and wellbeing and links diagnostic conclusions to targeted intervention strategies.
- The assessment of personal goals are fundamental to the concept of personal recovery and form the basis of assessment and care planning.
- Personal goals may encompass physical, psychological, cultural, social and/or spiritual dimensions and considers the goals of the persons nominated or designated carer/advocate, where appropriate.
- Comprehensive assessment identifies the older person's restorative potential and builds on their strengths, abilities and resources.
- Comprehensive assessment with older person is conducted by competent and skilled assessors using valid and reliable tools. This is done in partnership with the consumer and their carer.
- Comprehensive assessment focuses on the met and unmet therapy, support service needs and preferences of the older person and their carer. This should be considered independently of the interests of health and service providers.
- Comprehensive assessment is coordinated and does not overburden the older person, their carers, family or health staff with unnecessary processes.
- Comprehensive assessment accesses and considers all assessment information gathered on the older person's journey.
- The older person, their carer and family are active participants in comprehensive assessment and care planning processes. They are informed of assessment outcomes and participate in the development of negotiated plans of care.

An older person participating in a comprehensive assessment process has the right to privacy and confidentiality, to be informed, to have carer or advocate involvement, and to complain or request corrections to their information.

GL2021_006. Physical Health Care for People Living with Mental Health Issues provides guidance for assessment, interventions and reviews to support sustained health outcomes for people receiving mental health services. These guidelines should be implemented in all OPMH AIUs.

Physical health assessment will include assessment of vital signs in the context of obtaining a medical and drug and alcohol history. NSW Health has developed a program called 'Between the Flags' to standardise the way clinicians respond to these signs.[70] A history of health-related behaviours such as smoking, diet or exercise should also be obtained. The OPMH AIU should have access to a well-lit private examination area with a bed or couch and equipment for the physical examination.

People admitted into a OPMH AIU are involved in a comprehensive assessment utilising the *NSW Health Guideline Mental Health Clinical Documentation* suite.[71] Base modules include the *Triage, Assessment, Care Planning* and *Review, Transfer and Discharge*.

Based on the information gathered during the assessment, clinicians should complete the HoNOS65+ and K10 as well as other relevant outcome measures and record the results in the *Assessment* module under 'Measures'. The *Care Plan* module provides a framework for summarising the goals and clinical issues for the episode of care with the intent of aiding the monitoring of clinical status.[71]

Other important assessments include falls risk (e.g. FRAMP), assessment of skin integrity (e.g. Waterlow Scale), hydration and nutrition, dentition, nail care and continence.

Dignity of Risk

Recovery-oriented care supports the development of hope, self-determination, choice, and opportunities. Risk management in health services is traditionally a clinician-led activity, focused on avoiding danger and reducing harm to the consumer and others. It typically includes implementing restrictions of some form to manage these.[72] A clinician needs to consider how best to support the consumer in their choice, which may involve implementing risk mitigation strategies, or engaging in positive risk taking.[23] Positive risk taking is a way of working that enables clinicians to support people in taking risks as a route to positive outcomes and personal recovery. It may be defined as:

'Weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves

using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes'.[73]

This recovery-oriented practice approach links the risk assessment with planning for safety, learning and personal growth. A consumer's confidence, capacity and resilience may be improved through carefully considered and appropriately supported engagement with risk.

Where it is deemed necessary to detain a person as a mentally ill person within the meaning of the NSW Mental Health Act, the person's goals may conflict with the goals of the referring or treating clinicians. This conflict should be explicitly acknowledged and minimised as much as possible within the bounds of safe and appropriate clinical care. Services should consult with the person's family and consider factors around capacity when enabling the consumer to undertake dignity of risk.

Clinical Review

Regular structured handover and clinical review meetings are an opportunity to improve the quality, safety and effectiveness of care. The care goals and views of the older person and their carers must be clearly understood and considered by the multidisciplinary team in clinical review. The person's management plan should aim to promote those goals through collaborative goal setting and informed consent. The community OPMH service should, where possible, visit consumers at least once prior to discharge[76].

An estimated date of discharge should be set at the earliest opportunity, consistent with good care. AIU clinicians and peer workers should participate in a handover meeting at each change of each shift and participate in a 'huddle' at the beginning of the day with the full multidisciplinary team. The consumer and their family have a right to seek a second opinion if there are concerns regarding treatment or procedures after they have been discussed with the consultant and/or treating team.[8]

Discharge/Transfer of Care

Effective discharge planning is essential to the safe and successful transition of mental health consumers from hospital to the community[75]. Effective care and the *NSW Mental Health Act 2007*[31] requires that when planning for discharge from a mental health facility, the service must:

- Consult with the consumer and their designated carer;
- Provide clinically appropriate information to the consumer and carer including types of medications and dosages administered and details of follow-up care, and
- Consult with agencies involved in providing relevant services post-discharge.

'Discharge' of older consumers is a misleading term in relation to consumers transferring from an OPMH AIU to community care in their home or a residential aged care facility, as in this context they are returning home. Most older consumers will require ongoing support by OPMH or adult community mental health services. 'Transfer' is the preferred term to reflect the transition to continuing care from community mental health or private psychiatry services. Clinicians must be sensitive in responding to the needs and abilities of carers when planning the older person's transition to returning home and their community.

The Peer Supported Transfer of Care initiative (Peer-STOC) is an emerging peer workforce program for mental health inpatient consumers being discharged into the community. Peer-STOC provides up to 6 weeks of support by experienced, qualified peer workers for people who are discharged from acute mental health care. These workers are based in community mental health teams and provide in-reach support to people prior to discharge.

A copy of the current *Care Plan, the Physical Examination* module, the *Consumer Wellness Plan and Safety Plan* (if applicable) and the consumer's recovery goals should also be attached to the *Transfer/Discharge Summary* when the consumer is discharged.[71]

7 Clinical Interventions

Clinical interventions in the OPMH AIU address the treatment goals and personal recovery of the consumer and carer. Treatment goals will be established in partnership with the consumer and carer/s prior to admission or through goal setting during the early assessment phase of admission. These are also revised during the admission. Goals are not limited to mental health issues. They may address other physical health comorbidities and social issues to improve the person's functioning and social support in collaboration with their carer. All clinical interventions should consider the role culture and previous exposure to trauma may play in the therapeutic relationship and the person's openness to interventions.

Recommendations: Clinical interventions

Clinical intervention recommendations

7.1 Consumers in older people's mental health acute inpatient units (OPMH AIU) will:

- receive tailored treatment plans
- not be excluded from certain treatments based on age or dependency.

7.2 The physical and care environment should:

- help consumers recover from illness and maintain function
- reflect a person-centred, trauma informed and culturally responsive philosophy of care
- separate consumers who are likely to be negatively affected by frequent interactions — such as depressed, anxious or very frail people — from people with behavioural and psychological symptoms of dementia (BPSD) or similar behavioural disturbance or disorganisation.

Psychotherapy and education recommendations

7.3 BPSD management techniques should emphasise person-centred care, non-pharmacological intervention and less reliance on psychopharmacology.

7.4 All consumers should:

- have access to psychotherapy that is tailored to their needs, such as relationship or couples therapy
- receive appropriate psycho-education or skills training, along with their carers.

7.5 Staff who offer psychotherapy should:

- recognise that it is an interdisciplinary practice
- consider the therapeutic value of their interactions with consumers and carers
- receive relevant training.

7.6 The general environment should complement any such therapy and related behavioural interventions.

7.7 All families and carers should have access to need-based education and interventions in inpatient units. This may include anxiety management, support and grief counselling.

7.8 Staff should:

- ensure carers and families understand the available interventions, and inform them about the different treatments
- help reduce the stress and stigma of some of the options
- encourage families to seek other family and carer support, such as from Carers NSW, Mental Health Carers NSW and Dementia Australia.

Pharmacotherapy recommendations

7.9 Pharmacotherapy must follow relevant guidelines but also be adapted to suit a consumer's age, frailty and medical comorbidities.

7.10 An OPMH AIU should only offer medication to a consumer after:

- carefully reviewing the risks and benefits
- discussing it with the consumer and/or carer.

7.11 Any consumer admitted voluntarily must consent before starting medication. The OPMH AIU should also seek consent from their substitute decision makers if relevant.

7.12 OPMH AIUs must develop a process for identifying polypharmacy and addressing concerns about it.

7.13 Before discharge, the OPMH AIU must discuss with the consumer, and/or their carer and GP, the consumer's medications and how they will access them after discharge.

7.14 OPMH AIUs must develop non-pharmacological interventions for the range of common conditions they manage. The strategies:

- must be based on a person-centred assessment and care plan
- may involve both group and individual activities.

Electroconvulsive therapy (ECT) recommendations

7.15 All OPMH AIUs should have local access to electroconvulsive therapy (ECT), ideally in a dedicated facility in a theatre complex with its own staff. Standalone suites can provide excellent and clinically effective ECT.

7.16 ECT must be done in line with the NSW Health ECT Guidelines.

Ward social environment

The ward social environment is thought to influence consumer outcomes and behaviour,[80] as well as staff morale.[81] The concept of an optimal healing environment focuses on recovery-oriented person-centred care. It supports healing relationships, safety and co-operation among clinicians within a holistic practice atmosphere.[82] The ward environment should support the person's eventual return home or good transition to residential aged care.

Special consideration should be given to the appropriate ward social environment for Aboriginal or Torres Strait Islander people, people from CALD backgrounds and people who have experienced trauma.

Psychotherapy

Individual psychotherapy such as cognitive behavioural therapy (CBT), supportive therapy or grief therapy is appropriate in OPMH AIUs. Although some people may not be suitable candidates for psychotherapy prior to discharge, the treating team should have sufficient understanding and familiarity with psychodynamic therapeutic interventions to provide empathic listening, gentle confrontation (e.g. pointing out obvious avoidance) and clarification to help older people recognise feeling states they may be unaware of. Interpretation of unconscious process is a rare intervention on most short-term treatment units.[83] Many people are suitable for Cognitive Behaviour Therapy and psycho-education for their presenting symptoms and could benefit from engagement in these therapies. Behavioural activation is an important process for recovery from depression that may be helpful for some OPMH AIU consumers during their stay. There are some psychological approaches devised specifically for older people, such as reminiscence and life review.[84]

Behavioral therapy and other psychosocial interventions

Behavioural therapy and modification can be useful for selected people. All behavioural interventions must be based on individual need with rigorous and individualised assessment.

The most common forms of behaviour therapy include relaxation training, desensitisation for anxiety-related disorders and biofeedback, which may be helpful in the management of chronic pain. Other interventions include behavioural activation, in vivo exposure and imaginal exposure.[85] Behaviour modification techniques which can be applied by staff in the overall approach to individuals include positive reinforcement of adaptive behaviour, counter conditioning and reciprocal inhibition.[85]

Potential behavioural strategies for agitated older people experiencing BPSD include distraction, diversion, music, exercise, socialisation and avoidance of identified triggers.[34] Environmental factors include appropriate levels of light and sound and orienting cues. The presence of culturally appropriate or familiar objects, people, food, family support, reduction of stimuli and presence of adequate numbers of consistently rostered staff who are trained in managing older consumers with BPSD may augment specific behavioural strategies. See the BPSD Handbook for further details.

Peer consumer workers are an important member of the team and have skills in engaging with consumers and involvement in providing meaningful activities and psychosocial interventions. Physical activity including walking, Tai Chi, balance and strength training should be encouraged where possible.

Pharmacotherapy

Pharmacotherapy should be considered as only one part of a multifaceted treatment program, and should only be initiated after careful consideration of its benefits and risks. Specific target symptoms should be chosen for monitoring, and assessment of efficacy and adverse effects should occur regularly. Consideration should be given to the presence of age-related changes in drug absorption, pharmacokinetics and pharmacodynamics. Monitoring should include observations, physical examination and investigations such as metabolic monitoring, serum drug levels and ECG. Because older people are extremely sensitive to the side-effects of psychotropic medications, staff should be particularly vigilant for adverse drug reactions due to psychotropics.[86,87]

Psychotropic medications are invariably required in the management of moderate to severe depressive disorder, bipolar disorder and psychotic disorders. Psychotropics also have an important but limited role in the management of BPSD and the results of trials suggest modest benefits and the potential for clinically significant adverse effects — see BPSD Handbook. Clinicians should remain particularly vigilant in monitoring the potential adverse effects of individual drugs and drug interactions in BPSD. It is not desirable to treat fearfulness, dysphoria, irritability and other "negative" affects solely with psychotropic medications, all of which work variably.

It is essential that consent is obtained. If there are doubts about the person's capacity to provide informed consent, or the person does not have capacity to consent to treatment under the NSW Mental Health Act[31] may be required. See the *Mental Health Act Guidebook* for details.[30] In some limited situations where informed consent cannot be obtained, treatment may be given in accordance with the NSW Guardianship Act.[62] Consent should be re-obtained as soon as capacity has been regained, ideally with the support of the person's guardian or person responsible.

Older people are likely to be treated with multiple medications for illnesses affecting many organ systems[87] and polypharmacy (defined by the World Health Organisation as the use of at least four medicines concurrently) may be unavoidable. Nevertheless, it is important to note that polypharmacy is associated with increased risk of falls, frailty, confusion, readmission and mortality. Hospitalisation should be seen as an ideal opportunity for reviewing the medications of all consumers, in conjunction with specialists from geriatric medicine and other appropriate specialties.

It is especially important to avoid psychotropic polypharmacy. Whilst there is no adequate evidence from studies of older people that combination treatment — the concurrent use of more than one antipsychotic medication or the concurrent use of more than one antidepressant — is beneficial, it is recognised some clinicians follow this practice.

A Cochrane review of adult consumers found very low-quality evidence that combination antipsychotics may improve clinical response in schizophrenia.[88] Most of this evidence was derived from short-term trials, limiting any conclusions about long-term efficacy and safety. Similarly, another Cochrane review of studies of clozapine combined with other antipsychotics found these studies to be of such low quality that no conclusions could be drawn about efficacy.[89] Similarly, there is limited evidence of benefit of combination antidepressants. One meta-analysis found some evidence for combining a reuptake inhibitor with an antagonist of presynaptic α2-autoreceptors.[90] While combination antidepressants may be a reasonable consideration in older people with very treatment resistant depression, they should still be used with caution given the potential for increased adverse effects. There is evidence that combination antidepressant treatment and psychotherapy increase efficacy in depression.[91]

Electroconvulsive Therapy (ECT)

The most common indication for ECT in Australia is a major depressive episode.[32] It is considered to be the most effective treatment in severe major depression. It may be particularly effective in older people with psychotic symptoms and psychomotor retardation.[92,93] ECT is usually reserved for consumers who have not responded to several trials of medications but is recommended as first line treatment in extremely severe melancholic depression, particularly when the person is not eating or drinking and/or is a very high suicide risk.[94] It is also used in other conditions including mania, mixed episodes, schizophrenia, schizoaffective disorder, catatonia and neuroleptic malignant syndrome.[32]

Consumer preference and past response to ECT should also be considered as factors in the use of ECT.[95] Fitness for ECT should be established carefully after physical work-up and anaesthetic review.[95] Consumers and their

carers should be given access to appropriate information about ECT. Forms of ECT that minimise cognitive adverse effects such as ultra-brief right unilateral ECT and bifrontal (instead of bitemporal) ECT should be offered. Consumers in facilities that do not offer an ECT service should either be transported to one that does or consideration should be given to formal transfer of care. Where teams are not co-located with a facility capable of providing ECT, arrangements should be in place to transport consumers so that they may receive this treatment.

Family and carer education and therapy

Acute presentations to the unit may correspond to a range of disruptions in family relationships. Family and carer education and therapy has been shown to benefit older consumers and carers. This should be available in all OPMH AIUs.[96,97] Family work can complement other treatments for dementia, psychosis and depression in old age. While there are a diverse range of approaches in family and systems therapy (e.g. psychoeducational, behavioural/problem-solving, systemic, strategic, psychodynamic), there are many similarities across the various models that can be applied usefully to family work. The choice of approach will depend on the skills, training and resources of staff and the older consumer's needs.

Social and legal interventions

Social and legal interventions are often a key component of care in the OPMH AIU. These often involve interventions related to administration of the NSW Mental Health and Guardianship Acts, and liaison with related agencies. Interventions may also involve linking older consumers with appropriate community services or residential care, which can require extensive knowledge of a complex array of available resources. The provision of such services is often fundamental to older consumers returning to the community. The importance of access to legal information, advice and support has been emphasised in consumer and carer consultations. Some older consumers will need support to find alternative accommodation, protection from financial exploitation or medico-legal assistance. This may include protecting the older person from making material decisions during periods when they lack capacity to do so.

Consumer peer role

Consumer peer workers draw on their own lived experience of mental illness and recovery to provide authentic engagement and support for people accessing mental health care. Peer workers are in a unique position to build connections and rapport with people in care. They can inspire hope and role model recovery. The support peer workers can provide includes individual and group peer support, recovery planning, goal setting, help with navigating the system, and individual and systemic advocacy.[98]

Other interventions

Other interventions can include functional and skills retraining, strength and balance training for falls prevention, wound care, podiatry, speech therapy, nutritional interventions, dental care and welfare support. Older consumers in OPMH AIUs may benefit from exercise, diversional therapy, tailored activity programs, carer support, provision of equipment, hairdressing, home care assessments and assistance with vision and hearing. In consumer and carer consultations for this model of care, consumers identified a need for more meaningful activities during their inpatient stay, including the ability to engage with their hobbies and personal interests in a more recovery-oriented way.

8 Seclusion and Restraint

Recommendations: Seclusion and Restraint

Seclusion and restraint general recommendations

8.1 Older people's mental health acute inpatient units (OPMH AIUs) must only use seclusion or restraint to reduce behaviours that have an immediate risk of harm. If they do:

- the safety and wellbeing of the consumer and unit staff are vital
- units must monitor the consumer regularly, note any decline in their physical condition, and manage this quickly and appropriately.

Seclusion recommendations

8.2 OPMH AIUs should minimise and try to avoid seclusion where possible. This means units should:

- not have a seclusion room
- have clear policies about when a courtyard or other larger area may be considered seclusion
- use seclusion for the shortest time needed when they cannot avoid it
- have clear guidance about transferring a consumer to another unit if they need seclusion, to ensure the move is appropriate and safe.

Restraint recommendations

8.3 OPMH AIUs should minimise and try to avoid restraint where possible, but if they cannot, they must only restrain consumers:

- after a clinical review
- in the least restrictive way to ensure their safety
- in a way that causes them the least risk
- for the shortest time needed to allow them to regain control of their behaviour.

The release of NSW Health Policy Directive PD2020_004, Seclusion and Restraint in NSW Health Settings[12] followed the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*.[99] NSW Health has committed to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint in NSW Health settings.[12] It is recommended that seclusion rooms are not provided in NSW OPMH AIUs.[12] 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.

There are key principles that apply in relation to restraint in both NSW Health and aged care settings, and significant alignment between NSW Health guidance and Commonwealth guidance in this area, noting that there is currently further work underway regarding restrictive practice in aged care following the Royal Commission into Aged Care Quality and Safety.

NSW Health staff must only use seclusion and restraint:[12]

- Where there is a legal basis to do so
- As a last resort to prevent serious harm, usually associated with Acute Severe Behavioural Disturbance
- To allow administration of lawful medical treatment
- After less restrictive alternatives, including prevention strategies, have been trialled or considered, where safe to do so
- Proportionate to the risk of harm
- For the minimum duration necessary.

Restrictive practices include locked exit doors in facilities and fenced areas with locked gates, which are considered the least restrictive forms of restraint.[101] Other forms of restraint include:[101]

- Chairs with deep seats
- Rockers and recliners
- Large pillows/ bean bags on floors
- Comfort or supportive chairs which prevent a person slumping or support posture
- Any skeletal support that restricts mobility
- Lap rugs with ties
- Lap sashes (waist restraints)
- Hand mitts

- Geri/protective chairs with tables
- Wheelchair safety bars
- Seat belts on chairs
- Concave mattresses
- Rolled blankets or swimming noodles under sheets (as the person may believe they cannot get past them).

Manacles or hard shackles, leg or ankle restraints, soft wrist or hand restraints, Posey criss-cross vest and seclusion are considered as extreme restraints and are not to be used in OPMH AIUs. The use of bed rails as a safety mechanism to reduce the risk of a person accidentally falling out of bed is not considered mechanical restraint, except in circumstances associated with physical restraint as outlined in the Quality of Care Amendment (Minimising the Use of restraints) Principles 2019. The use of medications (chemical restraint) through the overuse of sedation is not an acceptable form of restraint and is not used in NSW.[102] Proactive approaches that help address the person's needs (eg communication strategies, sensory preferences, positive behaviour support plans) are encouraged and staff must collaborate with the person, their carers and families (as applicable) to understand potential triggers which may cause the person to become distressed and unsafe.[101]

Sensory modulation has been shown to be effective in the management of agitation and anxiety, thereby reducing restraint.[103] NSW Health staff must document all episodes of seclusion and restraint and debriefing sessions in the Health Care Record in proportionate detail to enable a review of practice as per policy.[12] Consideration should also be given to PD PD2017_025 Engagement and Observation in Mental Health Inpatient Units in this context and staff should ensure that meaningful and engaged observation is taking place.[104]

9 Facility Design

Recommendations: Facility design

Location, size and capacity recommendations

9.1 Facility design should follow the Australasian Health Facility Guidelines. Older people's mental health acute inpatient units (OPMH AIU) should:

- be on the ground floor
- include an outdoor garden as a priority
- have enough space for people with dementia to wander
- have features that maximise mobility and reduce falls
- have calming visuals and acoustics
- offer a stimulating environment with regular therapeutic activities or other occupations that help consumers recover.

9.2 Any newly built OPMH AIU should be designed to enable the functional separation of different consumer cohorts who might be negatively affected by co-management, such as people with severe agitation or aggression and frail or vulnerable older people. Planning for new OPMH AIUs should strongly consider inclusion of a high dependency area to separate consumers with high behavioural needs, including behavioural and psychological symptoms of dementia, from other consumers.

9.3 OPMH AIUs should have:

- fewer than 15 beds per cluster
- 6–8 beds for a BPSD cluster.

Security recommendations

9.4 The following security measures should be consistent with those in other acute mental health units:

- duress alarms
- security services and staff
- behavioural emergency response teams.

9.5 Behavioural response teams must be trained to respond appropriately to behavioural emergencies involving consumers with dementia.

9.6 The OPMH AIU should have a flexible door policy, with secure and non-secure areas.

9.7 Consumers at high risk of harming themselves or others should have access to a secure high dependency ward.[36]

Physical environment plays a significant role in the care of people with mental health problems. There are special environmental issues for people with dementia[105] but these designs do not necessarily meet the needs of older people with mental health needs. It is critical that physical environments are flexible and can adapt over time in response to changes in consumer needs and service delivery models. This flexibility should be provided in ways that will maintain a positive and therapeutic physical environment. It requires consultation with key stakeholders to ensure physical environments in OPMH AIUs are safe and enhance the delivery of consumer care. Therefore, it is essential that service managers, older consumers, carers and clinicians are consulted on the operational policies and models of care in each facility.[5] Due to the long length of stay of older consumers in acute inpatient care, access to outdoor spaces is especially important to overall wellbeing.

Consumer and carer consultation for this guideline highlighted that consumers and carers place importance on privacy during their stay, both personal privacy and privacy during visitation, including access to outdoor spaces.

The unit must provide a high level of security and have the capacity to contain an aggressive and agitated older consumer who may present a risk to themselves or others.[6] Separation of older consumers with severe agitation or aggression from frail and vulnerable older people is critical to the safe and effective functioning of the unit.[106]

Unit size and capacity

The total unit size and capacity are determined by local service needs. *The Australasian Health Facility Guidelines for older people's mental health inpatient units*[6] provide advice about optimal unit size and configuration. Bed numbers are recommended to be fewer than 15 beds per cluster or 'pod' depending on local factors. Groups of eight beds have been found to be the right size for the care of mobile, confused and disturbed older people. An 18-24 bed unit, consisting of multiple clusters, is considered to be efficient from a staffing and budget perspective.[64]

Security

Protecting People and Property: NSW Health Policy and Standards for Security Risk Management is an information bulletin that outlines the security policy manuals relevant to NSW Health AIUs.[107,108]

Locking doors

Most OPMH AIUs in NSW are locked to minimise absconding. Within the AIU, consumers' desires to lock their bedroom doors may conflict with the needs of staff to have access in case of mishap.[105,109] Some lock systems can be over-ridden by nursing staff and should be considered to balance privacy and safety.

10 Staffing

The assessment and management of the complex physical, psychiatric and social needs of OPMH consumers requires a multidisciplinary team approach.[109,110] Staff need specialist training to manage issues associated with cognitive impairment, restricted mobility, physical illness and sensory impairment. Specialist staff bring extensive knowledge and skills to their practice as well as the capacity to work in collaboration with a number of key stakeholders.[110]

Patience, social competence and calmness are important traits for staff to show when caring for older consumers. Staff require a good understanding of mental health and age related conditions. Ongoing professional development is required to develop and maintain these skills.[63]

Staffing numbers required will vary significantly depending on the acuity and presenting problems of the older consumers admitted in a unit. In particular, older consumers admitted with BPSD will need higher ratios of nursing staff. Gonski *et al*[111] report 24 hour staffing for a behavioural unit in an acute hospital of at least two nurses / six consumers (or more depending on severity of behaviour). Shortage of staff, especially of adequately trained staff, increases incidence of violence.[112]

Recommendations: Staffing

Recruitment, education and training recommendations

10.1 Older people's mental health acute inpatient units (OPMH AIUs) should recruit, educate and train staff in line with the philosophy of care they have adopted.

10.2 Each OPMH AIU:

- will have and consistently meet an agreed minimum staffing level across all shifts
- will have a policy and procedure for recruiting and using volunteers
- should have a clear model of clinical supervision.

10.3 All staff should receive unit-specific orientation and induction, in line with relevant policies.[136,137] This will include:

- access to a mentor or preceptor
- mandatory training in line with hospital policy
- basic training in how to assess capacity and understand the *NSW Guardianship Act* and *NSW Mental Health Act*.

10.4 OPMH AIUs should arrange for staff to have training in:

- cultural awareness and competence
- interpreter services, including when and how to use them appropriately
- managing severe behavioural and psychological symptoms of dementia (BPSD), so they can do so with little or no restraint.

10.5 Medical and nursing staff should receive training in and be able to manage:

- intravenous and subcutaneous fluids
- intravenous medications
- incontinence
- ongoing oxygen therapy.

10.6 Staff who assess consumers and plan care should receive relevant training in line with the NSW Public Service Commission Performance Development Framework. This may include topics such as:

- assessing carers' needs
- assessing and managing risks
- assessing and supporting people with vision or hearing impairments
- dementia awareness
- suicide awareness and prevention
- discharge planning
- referring people to other agencies.

10.7 OPMH AIU recruitment, professional development and performance reviews should:

- refer to relevant core competencies and capabilities for staff
- ensure staff have the appropriate skills, knowledge and attitudes to provide safe and effective care.

Unit and support staff recommendations

10.8 All OPMH AIU staff should:

- promote mental health among consumers, families and carers
- support prevention and early intervention for consumers, families and carers
- have the appropriate skills, knowledge and attitudes to provide safe and effective care
- have planned and quarantined time to ensure they provide key activities and interventions regularly.

10.9 Staffing will reflect consumer needs on the unit at the time. It should be flexible enough to:

- provide safe and appropriate care, including for consumers with high levels of dependency
- accommodate one-on-one care or supervision.

10.10 OPMH AIU staff should span a range of disciplines and approaches. This means an appropriate mix of:

- staff, including registered nurses, enrolled nurses, clinical nurse specialists and assistants in nursing
- allied health staff, including dedicated social workers, clinical and neuropsychologists, occupational and diversional therapists, exercise physiologists and physiotherapists.

10.11 Each OPMH AIU should have a dedicated nurse unit manager (NUM) with OPMH expertise. The NUM should:

- provide clinical leadership in the supervision of consumers
- enforce safety and quality standards in patient care
- have support from other staff so they can focus on clinical duties rather than administration, management and transactions.

10.12 At all times, the OPMH AIU will have:

- at least one registered nurse with relevant mental health experience present
- a doctor that can to respond to a staff alert within 30 minutes.

10.13 OPMH AIUs should offer access to the following supports:

- a clinical nurse educator with OPMH expertise
- a clinical nurse consultant
- a nurse educator
- Aboriginal mental health workers
- consumer and carer consultants
- data managers, quality and safety staff and security staff
- speech therapists, podiatrists, nutritionists and dentists
- specialist psychological therapists to see consumers one session a week for up to four hours.

10.14 OPMH AIUs should have enough:

- registrar cover to ensure consumers are seen at least once each weekday
- consultant psychiatrist cover to supervise and teach registrars, review consumers twice a week, fulfil a consultation-liaison role and follow up with consumers after discharge.

10.15 Administrative staff will support the OPMH AIU, allowing clinical staff to maximise care.

Leadership and governance recommendations

10.16 Each OPMH AIU will have:

- clear clinical leadership arrangements, with related training for senior staff
- a local clinical governance group that should have oversight of relevant key local and service-wide clinical governance processes and structures.

10.17 Consultants and other senior staff will be active leaders. They will commit to improving the acute care pathway and other work processes.

10.18 All staff will:

- know their level of authority and what decisions they can and cannot make
- have access to senior colleagues for advice as needed.

Review recommendations

10.19 Each OPMH AIU should have systems to review staffing levels daily and assess any factors that affect the staff numbers and skill mix needed, such as:

- levels of observation, supervision and training
- therapeutic engagement
- physical health needs
- sickness and other absence
- risk of falls and violence
- escorts.

10.20 OPMH AIUs should monitor nursing staff reports, including details about the use of agency staff, in the Department of Health Reporting System.[25]

10.21 Staff should receive an annual performance review, as well as professional development and clinical supervision plans.[138]

10.22 OPMH AIUs should give managers feedback from staff exit interviews.

Medical

Consultant psychiatrists provide clinical expertise and leadership with support from registrars and career medical officers (CMOs). Resident medical officers (RMOs) are essential staff members for a consumer population that has a high medical needs as they help provide medical assessments, investigations and accessing consults and other departments within a hospital. Access to other medical staff is required, including geriatricians, rehabilitation specialists, general and specialist physicians, surgeons, anaesthetists, ophthalmologists, ENT, palliative care and radiologists. Of these, geriatricians are the most critical and arrangements should be made for them to consult in the OPMH AIU.

Nursing

In OPMH AIUs nurses undertake biopsychosocial assessments and participate in developing care plans in partnership with consumer, their carers' and family. Nursing staff monitor consumers' mental state, complete comprehensive risk assessments (such as harm to self and others, and falls), monitor and maintain skin integrity, mobility and assist with continence needs.[13] They also assist with activities of daily living and provide treatments as required. These structural and contextual dimensions of consumer care are commonly represented through a variety of nursing care models.[113] Nursing staff also commonly engage in psychotherapeutic interventions, delivering psychoeducation, facilitating consumer groups, and participating in family and carer meetings.

OPMH AIU Nurse Unit Managers should be enabled to undertake clinical leadership in the supervision of nursing staff and the enforcement of appropriate standards of safety and quality in treatment and care of consumers in the unit or ward for which they are responsible.[114]

Allied Health

Occupational Therapy

Occupational Therapists (OTs) have an important role to improve the independence and occupational performance of older consumers with mental illness. They assist consumers to become more actively engaged in their life activities.[115,116]

OTs also have a major role in discharge planning to ensure consumers are safe and optimally supported in the community. This can include education to carers about consumers' best ability to function, timing and type of assistance required (such as training carers in how to assist and cue behaviours and actions), safety precautions and use of compensatory strategies, including adaptive equipment.[117]

Diversional Therapy

What therapies are appropriate in the OPMH AIU depends on the older consumers' diagnoses. Strategies for those with BPSD includes massage, individually tailored music, aromatherapy, reminiscence, light exercise, visual and tactile stimulation, and horticulture therapy. Pharmacological interventions should only be considered if the older consumer is severely distressed or if there is an immediate risk of harm to themselves or others.[118]

For older consumers without cognitive impairment a different style and level of stimulation and challenge is required. The diversional therapist can work with individuals in a therapeutic way that meets their emotional, social and creative needs. Engaging with the consumer in this way helps those with cognitive impairment to be stimulated through praise and positive reinforcement.[119]

Psychology

Services offered by psychologists working clinically in AIUs cover a broad range of activities, including assessing people for suspected dementia, offering education and counselling for families, assisting staff in managing BPSD, offering suggestions to improve daily functioning and quality of life for a person with dementia, and providing evidence-based treatment for psychological disorders as required.[120,121]

Psychological services for older adults may also be provided for a wide variety of comorbid physical disorders and problems, including incontinence and chronic pain.[122,123] Provision of diagnostic and prognostic information is one of the main roles for psychologists in

OPMH AIUs. Psychologists are best placed to conduct comprehensive assessment, and are in a good position to assist in evaluating a person's capacity for making decisions on medical treatments, financial decisions, and other important matters. Determination of decision-making capacity requires clinical skills, knowledge of the relevant legislation, and particular skills in questioning consumers to evaluate their reasoning about decisions.[124] Research has also shown that psychosocial approaches can be more cost-effective than pharmacotherapy for BPSD.[127]

Social Work

Social workers are important to the management of older consumers with mental illnesses, including providing direct support to people and as part of a multidisciplinary clinical review processes to achieve the best possible levels of personal and social wellbeing for consumers of OPMH services.[128]

Social work assistance is particularly valuable for consumers who have complex psychosocial problems or vulnerabilities. Social, financial and consumer advocacy are a large part of the social worker's role. Reporting to legal bodies within the mental health jurisdiction, such as the Mental Health Review Tribunal, and taking the major co-ordination role with applications to the New South Wales Civil and Administrative Tribunal, are significant processes where social workers assist consumers and the multidisciplinary team, working towards an optimal outcome for consumers.

Other key roles of social workers include discharge planning, maintaining continuity of care and consumers when they are ready to return back into the community.[129]. Returning back into the community can be more complex for OPMH consumers because of overlapping medical and psychiatric needs.[129] Families are often faced with complex issues and interventions may be necessary to assist carers to support consumers post-discharge. Education and liaison with community-based services, other government services and non-government services is essential.

Consumer peer worker

Older people's mental health peer support workers are a new and growing workforce that draws on their own personal lived experience of mental illness and recovery to provide authentic engagement and support for people accessing mental health care. A model of an older peer workforce has been published[130] following the older persons peer worker project developed in Central Coast Local Health District. Following this model, peer workers play a key role in co-facilitated group work, individual peer work with consumers and carers, and education, advocacy and mental health promotion activities.

Physiotherapy and Exercise Physiology

Physiotherapy and Exercise Physiology play an important role in NSW acute mental health units, in the assessment, diagnosis, planning and management of consumer care.

Physiotherapists develop programs of care to assess and address risk factors arising from other health issues and physical limitations in people with chronic or progressive neurological conditions. Physiotherapists provide detailed individual assessment and treatment of consumers with acute, chronic or complex pain conditions, accommodating for mental illness and managing the effects chronic pain has in the mentally unwell person. They also assist in preventing deconditioning and providing physical rehabilitation (e.g. after a fracture or other injury). Physiotherapists are trained to diagnose, plan and manage the care of consumers across a broad range of musculoskeletal, neurological and cardiothoracic problems, and prescribe and supervise exercises for consumers.[131] They also provide health promotion education, occupational health assessments and injury prevention activities, including falls prevention and management, improving balance and mobility in older people with mental illness.[132]

Exercise physiologists offer a range of services that may include health education, exercise counselling and physical rehabilitation. Exercise physiology interventions aim to prevent or manage acute, sub-acute or chronic physical health issues or injury, and assist in restoring optimal physical function. These interventions are exercise-based and include health and physical activity education, advice and support and lifestyle modification.[133]

Dietetics

Experts in food and nutrition, dieticians provide guidance about how to appropriately manage diets and nutrition for people who may be affected by those with other health issues including diabetes, obesity, heart disease, etc. as well as assisting in managing food allergies. Nutritional vulnerability increases in later and is often related to the physiological impact of ageing as well as social and economic challenges. Specific nutrients and overall diet quality may impact on mood.[134] Effective nutrition and dietetic interventions with older people may help manage and prevent other physical health issues.[135]

11 Performance

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

The *National Standards for Mental Health Services (2010) (NSMHS)* and the *National Safety and Quality Health Service (NSQHS) Standards 2nd ed (2017)* provide health services with a framework for safe care and continuously improving care. Implementation of both sets of standards is seen as important in meeting the safety and quality requirements for people with lived experience of mental health issues accessing the mental health sector, with neither set of standards able to stand alone.

NSW Health recognises there is a responsibility to assess, achieve and maintain competence at an organisational, team and individual level to ensure the safe and effective health care. *PD2016_040 Managing for Performance*[138] outlines responsibilities at the corporate and individual level. It is linked to the *Performance Development Framework for the NSW Public Sector*[127] which identifies the important role performance management plays in other processes.

Indicators of performance and benchmarking

NSW OPMH AIUs are required to comply with mandated data collections including the Key Performance Indicators (KPIs) outlined in the *National Mental Health Performance Framework* and the KPIs included in the Service Performance Agreements between the NSW Ministry of Health and LHDs.

The NSW OPMH benchmarking strategy continues to be an effective model for promoting quality and practice improvement in OPMH services across NSW. Benchmarking allows NSW OPMH AIUs to learn from each other, determine best practice and improve care. Benchmarking in NSW has led to significant and sustained improvements in OPMH consumer services.

Recommendations: Performance

Performance management recommendations

11.1 Older people's mental health acute inpatient units (OPMH AIUs) should:

- assign a consultant psychiatrist and nurse unit manager responsibility for monitoring and improving the unit's performance
- involve consumers and carers in monitoring and improving the unit's performance.

11.2 Each OPMH AIU should:

- work with similar units on benchmarking activities
- have tools to coordinate and conduct OPMH-specific quality improvement activities for staff across all relevant disciplines
- receive regular performance reports
- assess service performance and consumer outcomes at regular all-staff forums, using data from these reports.

11.3 LHD mental health management and performance structures should clearly assign mental health executive responsibility for monitoring and improving OPMH AIUs. These duties should consider all of the Australian Health Performance Framework (AHPF) 2020 domains.[142]

11.4 The OPMH AIU will monitor if the care, interventions and service it provides:

- are based on established standards
- are relevant to consumers' needs
- are person-centred, respectful and support dignity[24]
- encourage consumers to participate in choices, such as choice of provider, and access social support networks[24]
- are confidential and prompt, and provide quality amenities[24]
- achieve desired results in the most cost-effective way.

11.5 Financial reporting will be a part of each unit's performance reporting. Cost efficiency will be considered in the context of national pricing and activity-based funding frameworks.

11.6 The OPMH AIU will further monitor if:

- people in its catchment can obtain health care at the right place and time regardless of their income, physical location and cultural background
- the service avoids or lessens actual or potential harm from the health care management or environment.

11.7 The OPMH AIU will monitor its ability to provide:

- service based on appropriate skills and knowledge
- service that is innovative and responds to emerging needs
- uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time
- ongoing infrastructure, such as staff, facilities and equipment.

Length of stay

Studies of psychiatric consumer length of stay among mixed age populations generally find that other health issues, prior hospitalisation and the use of ECT are associated with increased length of stay.[140] Older people with severe mental illness differ from the general adult population in several ways that would be expected to lengthen their stay in hospital. Greater levels of functional disability, cognitive impairment, medical problems, polypharmacy and higher rates of residential care make their overall care more complex.

Current NSW OPMH benchmarking data indicates that the average length of stay for a consumer in an NSW OPMH acute unit is approximately 40 days.[141] Nationally, the average length of stay for an older person with an acute stay is approximately 35 days.[142] It is preferable that people have short stays in hospital as needed, but longer stays may be necessary. This may be due to complex physical health issues, slow response to treatment or limited availability of essential support services and residential services. The range of community and sub or non-acute care options available will also impact upon length of stay.

Readmission rates

NSW Health is committed to minimising consumer readmissions within 28 days of discharge. As part of NSW Health performance frameworks, Key Performance Indicators (KPIs) are identified for LHD Service Performance Agreements.[143] Post-discharge community care discussions with consumers should take place prior to discharge. Follow-up with the consumer by the receiving OPMH community team should occur within 7 days.

Outcome and experience of care measurement

Compliance with OPMH outcome measurement protocols is mandatory for services classified as a mental health unit.[144] These measures enable the comparison of clinician and consumer ratings of outcomes for individuals, and comparison of outcome and experience reports for monitoring and improving performance.

Units use the HoNOS 65+ and the K10 tools on admission and discharge. Outcome measures should be reviewed as part of routine clinical review and discharge planning processes. Consumers and carers should be given access to the Your Experience of Service (YES) and Carer Experience of Service (CES) surveys, and supported to complete these if required.

Service development guidelines

The following section outlines guidance to inform service planning and development. Service development may occur over an extended period of time and implementation of the model of care will require consideration of local service factors. This guidance provides succinct practical detail to support state and local service planners, policy managers, and service managers in the development of new OPMH AIUs and the review and improvement of existing OPMH AIUs.

Philosophy of care

Basic specific features

Staff orientation includes an orientation to the philosophy of care of the unit. This will reflect cultural and social information relevant to the service catchment area's demographic.

Philosophy of care is evident in relevant policies, procedures and training.

Advanced specific features

Philosophy of care is used to inform recruitment practices.

Access to specific training relevant to the philosophy is facilitated.

Audit processes include assessment of the extent to which the unit is meeting this philosophy.

Units are able to operate 24/7

Innovative specific features

Development and evaluation of specific strategies to improve incorporation of the philosophy of care into practice.

Functions of the OPMH AIU

Basic specific features

The OPMH AIU is part of a continuum of care that includes promotion, prevention and early intervention, community care, non-acute inpatient care and residential/long-term care.

LHD Clinical Services Plans (or equivalent) reflect population needs and the principle of equitable access to prioritise development of OPMH AIU facilities and functions.

OPMH AIUs are declared as Mental Health Facilities under the NSW Mental Health Act and staff are proficient in meeting the requirements of this Act.

OPMH AIU staff are proficient in meeting the requirements of the NSW Guardianship Act and liaising with the NSW Trustee and Public Guardian.

OPMH clinical staff provide advice within working hours to support Aged Care Services Emergency Teams (ASET) and mental health staff within Emergency Departments (ED) or Psychiatric Emergency Care Centres (PECCs) in the care of older people with acute mental health symptoms.

OPMH AIU consultation services are provided on request to other public hospital inpatient services in the LHD who manage older consumers who are within the *NSW OPMH Service Plan* target population. These will be prioritised as follows:

- Older people with mental illness in adult mental health wards or geriatric wards.
- Older people with mental illness in other general hospital units, following either mental health consultation and liaison (CL) or geriatric involvement.

Advanced specific features

OPMH staff provide, on request, in-person support to Aged Care Services Emergency Teams and mental health staff within EDs or Psychiatric Emergency Care Centres, in the care of older people with acute mental health symptoms.

Phone advice is available after hours from on-call OPMH clinical staff to support Aged Care Services Emergency Teams and Mental Health staff within EDs or Psychiatric Emergency Care Centres.

Regular consultation-liaison services are provided to other inpatient services in the LHD that manage older consumers who are within the NSW *OPMH Service Plan 2017–2027* target population. This includes older people with mental illness in adult mental health wards, geriatric wards and other hospital settings.

Teaching is provided to both undergraduates and postgraduate medical, nursing and allied health staff.

Older people have free access to their mobile phone unless an individual risk assessment indicates the person should have restricted or supervised access

Specific population groups

Basic specific features

There is access to interpreter services and staff are trained in how to access and use these services appropriately.

There is linkage to appropriate consultation-liaison services to other inpatient services in the LHD that assist in identifying and understanding specific cultural norms for CALD consumers.

The OPMH AIU optimises its functional relationships with older consumers and carers, and its integration with the local health care community. This should include relationships with local Aboriginal Medical Services.

Advanced specific features

There is access to Aboriginal mental health workers for consultation in the AIU.

Innovative specific features

The development of appropriate consultation-liaison services to other inpatient services in the LHD that manage older consumers who are within the *NSW OPMH Service Plan* target population. This includes engaging Aboriginal and multicultural specific services to facilitate culturally competent assessments, treatment and care planning.

Medical/surgical management

Basic specific features

Older consumers' falls risk is assessed and managed from the time of admission.

Older consumers have mobility aids prescribed when appropriate.

Once mobility aids are prescribed appropriate training should be provided to reduce the risk of injury and falls from misuse

Ability to identify and manage common causes of delirium that arise, with the support of geriatric or medical expertise.

Advanced specific features

Ability to manage more complex medical comorbidities in conjunction with geriatric or medical expertise.

Regular geriatrician wards rounds e.g. weekly.

OPMH AIUs are able to manage consumers with IV and SC fluids, IV medications and incontinence.

Innovative specific features

Joint ward rounds with geriatrician for consumers with complex comorbidities.

Advanced geriatrics trainees are seconded to the OPMH AIU on a regular basis.

End of Life Care

Basic specific features

The unit is able to manage end of life care when necessary. It is expected that this will only be in exceptional circumstances.

Staff are aware of any existing advanced care directives at the point of admission.

Advanced specific features

Availability of specialised palliative care services in the OPMH AIU.

Functional relationships

Basic specific features

The OPMH AIU participates in mental health promotion activities in the local community.

The unit is well integrated into the wider hospital community and there are smooth consumer flows between the AIU and the geriatric unit, other mental health units and the ED.

Consumers have timely access to imaging and pathology services.

Advanced specific features

The local community has a high level of awareness of the role of the OPMH AIU and it is perceived positively in the local community.

There are formal service level agreements and joint planning of services with aged care services to ensure there are clear agreed pathways for the care of older people.

OPMH clinicians participate in Medical Grand Rounds and aged care case conferences.

Geriatricians participate in Mental Health Grand Rounds.

Innovative specific features

OPMH and aged care services are involved in joint research and quality improvement activities.

Location

Basic specific features

The AIU should ideally be on an acute hospital site but other options may be feasible if limitations to role or function are addressed in other ways in the LHD.

Advanced specific features

ECT facilities are on site.

The OPMH AIU is co-located with geriatric and other medical services where possible.

The OPMH AIU is co-located with other mental health inpatient facilities, ED, imaging, pathology and other medical specialist services.

Innovative specific features

Remote areas have local facilities and services which provide a comparable model of care to that provided in an OPMH AIU.

Visiting hours and access

Basic specific features

Visiting hours is as flexible as possible to accommodate the varying needs of older consumers and enable better access to families and carers.

Parking for older visitors is affordable and located close to AIUs.

Advanced specific features

Public transport is available from all parts of the OPMH AIU catchment area.

The hospital provides frequent regular shuttle buses from railway stations.

Innovative specific features

Public transport timetables match visiting hours.

Access to communication devices such as email, communication apps or internet access could be developed where it is clinically appropriate and safe to do so.

Free or affordable accommodation options for carers

Admission or entry

Basic specific features

Staff are aware of entry and admission policies relevant to the OPMH AIU.

Preadmission processes include screening for likely delirium or acute medical deterioration in a manner that does not unnecessarily delay admission.

Intake and/or bed management systems operated or used by OPMH are able to coordinate requests for OPMH admission from different sources e.g. ED, other units and community teams.

Intake processes involve carers and families.

In preadmission processes, staff actively contact and seek involvement of GPs wherever possible.

Wherever possible, community mental health assessment occurs prior to admission to determine if admission can be appropriately avoided.

If there are older consumers awaiting admission to the unit, there is a clear process to document key aspects of their condition and location, and a process for daily prioritisation of potential admissions.

Where local prioritisation results in OPMH not catering to a subset of older consumers, there are clearly documented pathways to alternative care providers.

A consultant psychiatrist with experience appropriate to the management of OPMH consumers can be contacted every working day.

Advanced specific features

Community resources can be focused upon urgent assessments for designated periods at times of maximal demand for OPMH AIU beds.

Urgent assessments in the community do not rely on physical assessment in the ED and clinicians can facilitate direct admission.

Admissions can occur on a '24 hours a day, 7 days a week' basis.

The service has mechanisms in place to facilitate direct referral and admission pathways other than via emergency departments

A consultant psychiatrist with experience appropriate to the management of OPMH consumers can be contacted at all times.

Innovative specific features

Through the coordinated management of all inpatient and community OPMH and aged care resources, older consumers can be reliably admitted on the day of referral, including out of regular hours.

Where admission is not urgent, a pre-admission meeting opportunity is provided involving the consumer, their family, the admitting psychiatrist and nursing staff to address questions and concerns that the consumer and carers may have. This might occur, for example, 7-10 days before a proposed admission.

Assessment and care planning

Basic specific features

The OPMH AIU has clear guidelines regarding the expected timing of relevant assessments detailed above, and the responsibilities of staff who are conducting these.

Assessment is coordinated by an appointed care coordinator who is a member of the multidisciplinary team.

Staff with appropriate specialist skills conduct in depth assessments to clarify the extent or nature of any deficits where this may impact upon care or prognosis.

All older consumers have a full physical assessment on admission, including a neurological examination. If an older consumer is too distressed or aggressive to co-operate with a physical examination, this is documented and a physical examination completed at first opportunity. Vital signs should always be taken on arrival.

The OPMH AIU regularly audits compliance with *Physical Healthcare Guidelines*, and has a system for improving any deficiencies.

The OPMH AIU has at least twice weekly access to a consultant physician with skills relevant to the physical health needs of older people.

Unless there are no involved carers, or the consumer opts out, there is an early (7–10 days) post admission meeting between family (in person or via teleconference) and staff to discuss assessment and care plans.

Advanced specific features

The consumer and carers are informed of the assessments which will be undertaken while in the unit.

The OPMH AIU regularly audits the quality and timing of relevant assessments, and has a system for improving any deficiencies.

The OPMH AIU has daily access to geriatric medical and/or other consultant physician consultation or review.

Assessment includes a pharmacist review for potential adverse drug interactions.

Assessment includes a nutritionist assessment.

Assessment includes a formal mobility assessment.

Care planning includes maintenance and review of 'at risk' functions, particularly mobility and cognition.

Community clinical staff regularly attends the clinical review meeting during the consumer's admission

Innovative specific features

There are agreed criteria for joint management between psychiatrist and consultant physician for older consumers with primary mental health problems who have acute physical health needs which are best managed in the OPMH AIU.

The unit regularly reviews relevant data from assessments and care plans to evaluate the service and guide future developments.

Clinical Review

Basic specific features

Daily nursing mental state review occurs.

Physical observations are consistent with relevant guidelines.

Medical Officer in-person review of all older consumers occurs at least every working day.

Consultant psychiatrist review of all older consumers occurs in-person at least weekly, with at least one additional review each week in person, or by a registrar or Career Medical Officer, under supervision.

Multidisciplinary case review of the condition of, and care plan for, all older consumers occurs at least weekly with:

- Attendance including medical, nursing and allied health staff
- Relevant community team representation in-person or via telephone/video link
- Tasks for follow up are allocated
- Review of the completion of tasks set during previous reviews

Review of key admission goal achievement against milestones, or using a documented instrument (this can include the Mental Health Care Plan progress scale or any other appropriate instrument).

Nursing handover occurs in a manner consistent with NSW Health policy.

Support and training is provided for appropriate monitoring of common mental health-related factors (e.g. aggression, agitation, anxiety, and depression).

Risk assessments (e.g. suicide, falls, delirium, violence) are reviewed and appropriate interventions implemented.

Processes are in place to support the consumer and their family in seeking a second opinion when requested.

Advanced specific features

Multidisciplinary handover of the condition and care plan for all older consumers occurs every weekday.

All goal achievement is reviewed against milestones, or using a documented instrument.

Protocols available for case conference clearly delineate staff roles, the expected preparation prior to case review, and the linkage of review to assessment or outcome instruments.

A pharmacist is included as part of the review team.

Review includes direct involvement of older consumers, carers and/or consumer consultants.

Dietician is included as part of the clinical review team

Innovative specific features

Multidisciplinary case review explicitly includes the perspectives of the consumer and/or carer.

The unit regularly reviews relevant data from clinical reviews to evaluate the service effectiveness and guide future developments.

The service has additional specific measures to promote integration of care across inpatient and community settings

Second opinion occurs as determined by length of stay set by the LHD.

Discharge/transfer of care

Basic specific features

A system is in place to set and regularly review estimated dates of transfer/discharge.

Discharge/transfer to less intensive care occurs as soon as this can be safely and appropriately conducted.

Criteria exist for consumer transfer to more acute mental health or medical care, and procedures are in place to facilitate this.

Discharge planning and making arrangements for discharge/transfer of care are the role of various members of the multidisciplinary team.

Staff responsible for transfer/discharge planning have appropriate orientation, education and/or training about both mental health and aged care policies and resources relevant to discharge planning.

Prior to discharge, appropriate written information is provided to the consumer and/or carer about their condition, follow up, and re-entry options.

A system is in place to ensure that contact with the GP, private psychiatrist where relevant, and any other follow-up providers has occurred, and been documented, prior to discharge.

A NSW mental health *Discharge Summary* is completed for all older consumers on the day of discharge. Discharge communication includes relevant information regarding the older consumers' mental health, medical, functional and behavioural support needs, current mental state and medications.

A system is in place to ensure that the above discharge summary is dispatched to the consumer's GP and private psychiatrist where relevant, on the day of discharge.

A system is in place to ensure that verbal communication occurs with, and the discharge summary is dispatched to, the primary follow-up provider on the day of discharge.

A specific staff member (but not necessarily the one person) is responsible for coordinating each discharge. This person ensures the discharge plan is fulfilled but does not necessarily make all the arrangements themselves.

Discharge will only take place when essential services are in place and it is considered safe for the consumer to leave the hospital.

A system is in place to ensure appropriate follow up care is provided when a consumer is discharged while on leave.

There is a process to ensure older consumers transferred/discharged from inpatient care are contacted by inpatient or community OPMH clinicians, by phone or in person, within seven days of discharge, including for older consumers discharged to destinations outside the unit's catchment area.

Advanced specific features

Community follow up intensity can be increased for designated periods to facilitate early transfer/discharge from inpatient care at times of maximal demand for OPMH AIU beds.

Behavioural management plans are adapted for the post discharge environment prior to transfer/discharge, and discussed with follow up care providers prior to discharge.

Discharge planning includes relapse prevention planning.

The AIU has a transfer and discharge checklists that is specifically tailored towards the needs of OPMH older consumers.

A regular review occurs after transfer/discharge to ensure that key actions have occurred.

Innovative specific features

Intensive community mental health and functional support and follow up is available for older consumers for whom this can appropriately facilitate earlier transfer/discharge from hospital.

The service has additional specific measures to promote integration of care across inpatient and community settings.

Ward social environment

Basic specific features

The environment is perceived as familiar, welcoming and non-threatening for older consumers and their families.

There is an ability to include 'personal' features to help orientate older consumers and/or make them less anxious about admission.

There exists a facility for older consumers to be able to retreat to private areas within the unit as required.

There is use of admission information to facilitate person-centred care.

Advanced specific features

Functional separation of older consumers with disruptive, intrusive or aggressive behaviours from other vulnerable consumers.

Innovative specific features

There is regular independent assessment of the overall ward social environment with input from older consumers and carers.

Psychotherapy and education

Basic specific features

Staff receive training regarding person-centred care techniques, aggression minimisation in older people, and reflective listening.

Staff are resourced and trained to provide psychoeducation and information regarding:

- Sleep hygiene
- Simple relaxation techniques
- Common mental health conditions in older people
- Medication compliance
- ECT
- Common psychiatric medications used in older people
- Community and residential supports for older people.

There is access to time-limited clinical psychologist input for selected cases.

Advanced specific features

There is the availability of regular access to clinical psychologist input and psychology interventions.

There is the availability of aromatherapy, bed baths, person-centred bathing and preferred music for older consumers with BPSD.

Staff are resourced and trained to provide psychoeducation regarding:

- Consent issues in older people
- Structured problem solving.

Innovative specific features

There is availability and/or provision of psychotherapy in an integrated manner across inpatient and community settings.

Pharmacotherapy

Basic specific features

OPMH AIUs have:

- A review of medication charts by a pharmacist at least weekly
- Availability of prescribing guidelines for psychotropic medications
- A process for review of all medication-related incidents
- A process for direct consultant psychiatrist involvement in the commencement, regular review and/or cessation of all medications

Advanced specific features

OPMH AIUs have:

- A pharmacist present at team case reviews
- Availability of prescribing guidelines for psychotropic medications with specific guidance for use in the OPMH target population
- A process for review of trended information regarding OPMH AIU medication related incidents.

Innovative specific features

A process for review of trended information regarding OPMH AIU medication related incidents and prescribing patterns.

ECT

Basic specific features

The indication for the use of ECT is clearly documented in the consumer's file including both the diagnosis and the reason for the choice of ECT.

A second opinion from a psychiatrist experienced in the practice of ECT is sought:

- when there is any uncertainty about the recommendation of ECT
- when ECT is being considered for indications other than those listed in the Guidelines: ECT Minimum Standards of Practice in NSW.[32]

All older consumers undergo assessment of cognitive function prior to ECT, during the ECT course, and at the completion of the course. Unusual levels of confusion or memory problems prompt a review of ECT.

A pre-ECT work-up is performed and documented, including a thorough history, physical (including neurological) examination, clinically relevant investigations and specialist consultations. A CT brain scan is performed if raised intracranial pressure is suspected. A pre-ECT anaesthetic consultation occurs. Other consultations are available as required.

A medication review occurs prior to ECT in order to minimise psychotropic medications.

Specific requirements of the NSW Mental Health Act govern the information that must be provided for informed consent for ECT. It is particularly important that the older consumer is aware of and understands the risks of the treatment as might apply to the older consumer's own circumstances.

ECT is administered to an involuntary older consumer in accordance with an ECT determination made by the Mental Health Review Tribunal at an ECT Administration Inquiry.

ECT services are designed in a consumer-focused manner that respects the need for autonomy and privacy. Minimum standards for ECT facility and recovery design, equipment and staffing are adhered to.

A medical officer who has clinical privileging for providing ECT is present at each treatment.

If ECT is not available onsite then the consumer is able to be transferred to an appropriate facility for the course of ECT, with the appropriate communication to ensure continuity of care.

Achievement and maintenance of ECT minimum standards of clinical practice is overseen by a Standing Committee.

Advanced specific features

Cognitive assessments occur during the treatment course to assist in early detection of cognitive deficits and facilitate alterations in treatment technique to minimise adverse cognitive effects.

ECT is administered within an appropriate day-only procedure area or theatre. It is strongly recommended that it is not administered in the recovery area or other areas that lack privacy.

There is dedicated staffing provided for ECT.

While there are many factors that influence electrode placement, electrode placement should be unilateral, with appropriate supra-threshold dosage, for many older consumers.

Following the end of a treatment course and discharge from hospital it is recommended that the consumer be monitored regularly by a psychiatrist or community team in conjunction with the GP for a minimum of six months.

Continuation, maintenance and outpatient ECT is available locally and given in accordance with the Guidelines: ECT Minimum Standards of Practice in NSW.[32]

All consumers have access to ECT locally. This is ideally in a dedicated ECT facility within a theatre complex.

Innovative specific features

Both consultant psychiatrists and anaesthetists attend every ECT.

There is a regular forum for peer review of older consumers with challenging problems e.g. area wide ECT Grand Rounds.

Other interventions

Basic specific features

There are a range of appropriate diversional therapy activities.

There is access to appropriate exercise activities.

There are appropriate activities to promote socialisation and maintenance of role (e.g. 'morning tea' with older consumers possibly including carers assisting with preparation).

There is the availability of person-centred behavioural assessment and management techniques, with appropriate staff training and availability of resources.

There are appropriate procedures, and staff training for the management of severe aggression.

There is an emphasis on behavioural management of BPSD and less reliance on psychopharmacology.

Advanced specific features

There is the availability of individualised diversional therapy based on appropriate assessment.

There is a 'quiet' or 'modified stimulation' room with appropriate procedures and staff training.

Innovative specific features

There is implementation and evaluation of other forms of non-pharmacological management.

There is availability of relaxation training, desensitisation, habit retraining, biofeedback, and behaviour modification techniques.

Seclusion and restraint

Basic specific features

Relevant NSW policies and guidelines are adhered to.

Regular review of all episodes of seclusion or restraint use in accordance with NSW Health policy.

Falls prevention strategies are in place to reduce the need for restraint aimed at preventing falls.

Behavioural management of BPSD

Advanced specific features

Programs to enhance mobility are a core activity within the unit.

Quality initiatives occur that focus upon preventing occurrence of incidents potentially requiring seclusion or restraint.

Innovative specific features

Seclusion and restraint is eliminated through preventative strategies.

The AIU has a sensory modulation room/equipment.

Facility design

Basic specific features

Good visual access to all parts of the unit and avoidance of areas where older consumers may fall and not be observed.

Reduction of unnecessary stimuli and highlighting of useful stimuli.

Provision of space for planned wandering.

Provision of opportunities for both privacy and community.

Environment is as domestic as possible to encourage older consumers to use their abilities.

Involve Consumers and carers in any facility design processes

Advanced specific features

Ground floor location with access to outdoor garden areas.

Excellent natural lighting and views of nature.

Innovative specific features

Segregation of older consumers with BPSD.

Unit size and capacity

Basic specific features

The unit has large enough common spaces and corridors to minimise aggression due to crowding.

Pods should not be larger than 15 beds. Consumers requiring intensive support and supervision (such as BPSD) should be cared for in a separated zone of no more than 6 to 8 beds.

Advanced specific features

Capacity of the unit is such that occupancy does not exceed 85%.

Innovative specific features

Capacity for growth to occur within the expected lifespan of the unit.

Security

Basic specific features

All staff carries duress alarms.

Advanced specific features

Separate secure and non-secure areas.

Security should be unobtrusive such that the unit does not feel confined and institutional.

Innovative specific features

Flexible door policy.

Locking doors

Basic specific features

Ability to lock exit doors when required.

Advanced specific features

Older consumers at high risk of harming themselves or others should have access to a secure high dependency ward area.

Unit doors may not then need to be locked.

Staffing (general)

Basic specific features

Units should adopt the person-centred, biopsychosocial, goal focused care philosophy and recruit, educate and train staff accordingly.

Clinical supervision is provided for all staff.

Advanced specific features

Core competencies are utilised in recruitment, professional development and performance review.

Innovative specific features

Regular monitoring of staff satisfaction and quality improvement activities to address dissatisfaction.

Staffing (mix)

Medical

Basic specific features

Sufficient registrar availability to ensure older consumers are seen each week day.

Sufficient consultant cover to supervise registrars, review older consumers at least weekly and to participate in weekly clinical review

Sufficient consultant cover to review older consumers twice weekly, provide C/L role, teaching and follow up older consumers on discharge.

Advanced specific features

Consultant involvement in continuous quality improvement activities in the unit

Innovative specific features

OPMH AIU considers a vertical integration model.

Nursing

Basic specific features

The nursing model and staffing profile must enable the older consumers goals of care to be achieved.

Dedicated NUM, CNC, CNE with expertise in OPMH.

Advanced specific features

Staff trained to be able to manage IV fluids, SC fluids, IV medication, ongoing oxygen therapy, and incontinence.

Staff trained to be able to manage severe BPSD especially aimed at reducing or eliminating restraint use.

Allied health

Basic specific features

Dedicated allied health staff with expertise in OPMH will include some but not necessarily all of the following disciplines: social workers, occupational therapists, diversional therapists, clinical and neuropsychologists, exercise physiologists and physiotherapists.

Advanced specific features

Dedicated allied health staff with expertise in OPMH will include all of the following disciplines: social workers, occupational therapists, diversional therapists, clinical psychologist and neuropsychologists.

Innovative specific features

There is a dedicated physiotherapist or exercise physiologist with expertise in OPMH.

Staffing (supporting staff)

Basic specific features

There is agreed access to speech therapists, physiotherapy, podiatrists, nutritionists and dentists as required.

There is availability of consumer and carer consultants.

There is access to data managers and quality and safety personnel as required.

There is access to Aboriginal mental health workers for consultation in the AIU.

There is access to interpreters, bilingual staff and multicultural workers.

There is appropriate level of access to security staff.

Advanced specific features

Physiotherapy is involved in assessments so that consumers are safely discharged.

Managing performance

Basic specific features

There is a clear responsibility within the LHD Executive for the monitoring and improvement of the OPMH AIU.

LHD performance and reporting frameworks include explicit data regarding the performance of the OPMH AIU.

The OPMH AIU shall have a consultant psychiatrist and nursing unit manager with specific responsibilities related to monitoring and improving the performance of the OPMH AIU. These staff receive relevant aspects of the above reports.

OPMH incidents and adverse outcomes are explicitly included in Mental Health review processes.

At some level of the LHD, there is consumer and carer involvement in mechanisms to monitor and improve the performance of the OPMH AIU.

The OPMH AIU has a regular forum at which service performance and consumer outcomes are examined, informed by the above, and other relevant data.

The OPMH AIU is involved in benchmarking activities with similar units to monitor performance.

The unit conducts regular file audits to monitor key aspects of access (including access by CALD and Aboriginal consumers), and care to inform service improvement

The OPMH AIU shall conduct OPMH-specific quality improvement activities linked to the above actions.

Advanced specific features

LHD Mental Health management and performance structures shall ensure that there is clear Mental Health Executive responsibility for the monitoring and improvement of the OPMH AIU. These duties shall consider all of the Mental Health Performance Framework domains.

The OPMH AIU shall have a consultant psychiatrist as director of the unit and a specific nursing unit manager, with specific responsibilities related to monitoring and improving the performance of the OPMH AIU.

There is specific OPMH consumer and carer involvement in mechanisms to monitor and improve the performance of the OPMH AIU.

The OPMH AIU shall receive regular reports targeting any specific OPMH needs to support the monitoring of performance.

The OPMH AIU is involved in benchmarking activities with similar units to monitor performance and practice, and inform the prioritisation of improvement projects.

The OPMH AIU shall have mechanisms to coordinate and conduct OPMH-specific quality improvement activities involving staff of all relevant disciplines.

Innovative specific features

There is an individual with specific responsibility for the monitoring and improvement of the OPMH AIU within the LHD Mental Health management and performance structures These duties shall cover aspects of all of the Mental Health Performance Framework domains.

The OPMH AIU shall have access to a OPMH clinical nurse consultant and senior allied health staff with OPMH experience, who have specific responsibilities related to monitoring and improving the performance of the OPMH AIU.

There are OPMH specific multidisciplinary mechanisms to specifically review incidents and adverse outcomes.

The OPMH AIU shall have mechanisms to coordinate and conduct OPMH-specific quality improvement activities involving older consumers, carers and staff of all relevant disciplines.

Effectiveness

Basic specific features

28 day readmission rate is monitored by the OPMH AIU, and reasons investigated for rates of greater than 10%, marked variation from historical performance, or the performance of benchmarked units.

HoNOS 65+ change indicator is monitored by the OPMH AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Advanced specific features

Analysis of 28 day readmission rate, and any related quality activities, conducted in conjunction with relevant community services.

Innovative specific features

HoNOS 65+ change indicator is used by the OPMH AIU, to identify consumer with deterioration or lack of improvement during admission; for multidisciplinary review processes.

K10 or other consumer completed measurement data are monitored by the OPMH AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Carer perception measurement data are monitored by the OPMH AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers who return to their original place of residence is monitored, and reasons investigated for marked variation from historical performance.

Appropriateness

Basic specific features

OPMH AIU participates in accreditation processes utilising the National Mental Health Standards.

The OPMH AIU has policies or procedures defining acceptable interventions within the unit that draw on or are consistent with this model of care.

Advanced specific features

File audits are conducted regularly that monitor the occurrence and/or quality of key assessments or interventions.

Services include clinicians from geriatric services in monitoring and reviewing the appropriateness of care interventions.

Innovative specific features

File audits are conducted regularly that monitor the performance of key elements of care reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Efficiency

Basic specific features

Average length of stay is monitored by the OPMH AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units (typically 35-50 days).

Regular file audits identify the proportion of admissions with Estimated Date of Discharge set at admission.

OPMH AIU participates in mental health monitoring of costs and budget.

All clinicians attend training in the use of measures, and are familiar with the protocols for their use.

Measures of complaints or concerns are acted upon in accordance with policy timeframes.

Advanced specific features

Analysis of length of stay, and any related quality activities, is conducted in conjunction with relevant community services.

Innovative specific features

The service identifies consumer groups at increased risk of prolonged length of stay and considers the need for service redesign processes, e.g. intensive case management and active coordination of aftercare for selected older consumers.

Older consumers with LOS greater than 150% of the AIU's Average Length of Stay will be referred for a review by another psychiatrist who is expected to provide at least one new recommendation.

There is measurement of:

- Empowerment of older consumers to engage in decision making
- Whether carers are informed and supported
- Carer assessment
- Whether cultural spiritual or communication needs are met.

The service participates in cost benchmarking against similar units and there is investigation of marked variation from historical performance, or the performance of benchmarked units.

Measurement of:

- Appropriate and timely admissions
- Multidisciplinary assessment
- Symptom resolution or optimisation
- Degree of Optimum functioning
- Delays in discharge
- Communication with GPs
- Positive feedback from older consumers and carers of their experience in hospital
- Staff satisfaction.

Responsive

Basic specific features

The proportion of older consumers completing a K10 at admission and discharge from the service is monitored and there is investigation of any marked variation from historical performance.

Regular file audits identify the proportion of admissions in which a conference occurs within 10 days of admission involving the consumer, carer, psychiatrist and another mental health professional.

Each consumer who identifies as having a preferred language other than English is assessed with an interpreter during all planned clinical interactions throughout their admission.

Advanced specific features

OPMH AIU conducts regular assessments of consumer and carer perceptions of care, and utilises these to inform need for service improvement.

Innovative specific features

OPMH AIU conducts regular assessments of consumer and carer perceptions of care, and reasons investigated for any marked variation from historical performance, or the performance of benchmarked units.

Safety

Basic specific features

The OPMH AIU has a system compliant with NSW Health guidelines for the management, review, and analysis, of incidents.

The service monitors performance data regarding:

- Seclusion
- Restraint
- Falls
- Aggressive incidents resulting in harm to self or others.

Advanced specific features

The above data is monitored, and reasons investigated for marked variation from historical performance or the performance of benchmarked comparable units.

Innovative specific features

Consumers and carers are specifically surveyed to seek their views on improving safety In the unit and the unit acts to implement their suggestions where possible .

Continuous

Basic specific features

Seven day follow up rate is monitored by the OPMH AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers with an identified GP is monitored and reasons investigated for marked variation from historical performance.

Advanced specific features

Analysis of seven day follow up rate, and any related quality activities, conducted in conjunction with relevant community services.

The proportions of admissions in which the discharge summary is completed on the day of discharge is monitored and reasons investigated for marked variation from historical performance.

Innovative specific features

The proportions of admissions in which the discharge summary is completed on the day of discharge, and

Given to the consumer and/or carer; is monitored and reasons investigated for marked variation from historical performance

Sent to GPs; is monitored and reasons investigated for marked variation from historical performance

Able to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

Capable

Basic specific features

The service has access to a regular in-service program regarding OPMH related issues.

The proportion of admissions with paired admission and discharge HoNOS 65+ data is monitored and reasons for marked variation from historical performance, or the performance of benchmark partners is investigated.

Advanced specific features

The proportion of staff with postgraduate training in mental health or aged care is monitored and used to inform internal training and quality improvement projects.

Regular quality improvement in-service program has its outcomes evaluated.

Innovative specific features

The OPMH AIU monitors its capacity to provide a mental health service based on appropriate skills and knowledge.

Sustainable

Basic specific features

Staff turnover, sick leave and overtime are monitored and consistent with the performance of benchmarked units.

Advanced specific features

Staffing mix and levels are benchmarked against benchmarking partners in a cost benchmarking framework; and marked variations considered in mental health executive planning.

Innovative specific features

There is networking of senior clinician positions with those in community OPMH services and other OPMH AIUs to support leave coverage and continuity of care in times of staff vacancies.

The OPMH AIU shall monitor the system or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).

Accessible

Basic specific features

The 'source of admission' of older consumers is monitored, and reasons investigated for significant variation from historical performance, or the performance of benchmarked units.

Advanced specific features

The total number of 'waiting days' (cumulative) on a waiting list for admission is monitored, and reasons investigated for variation from historical performance or the performance of benchmarked units

The proportion of older consumers aged 65 or over who require their mental health admission to an adult general mental health unit is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of consumers aged under 65 who require mental health admission to the OPMH AIU is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Diagnostic and HoNOS 65+ item profiles of admitted older consumers' is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers who are born outside Australia is monitored. and reasons investigated for marked variation from catchment demographics, historical performance, or the performance of benchmarked units.

Innovative specific features

Monitor the proportion of older consumers admitted directly from and reasons investigated for marked variation from historical performance on these proportions, or the performance of benchmarked units.

An indicator of proportion of older consumers admitted out of area for OPMH AIU care is implemented and utilised.

Formal feedback is sought from key stakeholders regarding accessibility to the unit, and any groups for whom this is problematic.

The OPMH AIU monitors the ability of people to receive health care at the right place and right time irrespective of income, physical location and cultural background.

References

A number of key grey literature documents are referenced throughout this guideline that are of particular importance to OPMH acute inpatient units. While these appear in the reference list below, they are worth highlighting separately.

National references	State references	State Mental Health references	International references
Commonwealth of Australia (2017) Fifth National Mental Health Plan 2017–2022.	NSW Ministry of Health (2020) PD2020_004 Seclusion and Restraint in NSW Health Settings	NSW Ministry of Health, Mental Health Branch (2017) GL2017_022 NSW Older People's Mental Health Services Service Plan 2017-2027	Ottawa Charter for Health Promotion
Australian Commission on Safety and Quality in Healthcare (2019) Australian Charter of Healthcare Rights 2nd ed.	NSW Public Health Act 2010	Mental Health Act 2007 No 8 and guide book	
Australian Department of Health (2013) A national framework for recovery-oriented mental health services: guide for practitioners and providers.	NSW Guardianship Act 1987	Health Education and Training Institute (2015) NSW Mental Health Act (2007) No. 8 Guide Book 6th edition incorporating the 2015 Mental Health Act amendments.	
Australian National Mental Health Commission (2016) Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia.	NSW Privacy and Personal Information Protection Act 1998	NSW Health (2013) Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD)	
Commonwealth of Australia (2010) National standards for mental health services	NSW Health Incident Management policy (PD2020_047)	NSW Health PD2017_025 Engagement and Observation in Mental Health Inpatient Units	
Commonwealth of Australia (2013) National practice standards for the mental health workforce		NSW Ministry of Health (2021) GL2021_006 The Physical Health for People Living with Mental Health Issues: A Guideline	
The National Safety and Quality Health Service (NSQHS) Standards		NSW Ministry of Health (forthcoming), Extreme BPSD Project Report	
Australian Health Facility Guidelines		Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW (PD2011_003)	
The Gayaa Dhuwi (Proud Spirit) Declaration			

References

1. NSW Ministry of Health. NSW Older People's Mental Health Services — Service Plan 2017–2027 [Internet]. 2017. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_022.pdf
2. NSW Ministry of Health. NSW Specialist Mental Health Services for Older People (SMHSOP) Acute Inpatient Unit Model of Care Project Report [Internet]. Sydney: NSW Health; 2012. Available from: https://www.health.nsw.gov.au/mentalhealth/resources/Publications/smhsop-aiu-moc.pdf
3. NSW Ministry of Health. NSW Health Policy Directives and Other Policy Documents (PD2016_049) [Internet]. 2016. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_049.pdf
4. Australian Government Department of Health. The Fifth National Mental Health and Suicide Prevention Plan [Internet]. Council of Australian Governments Health Council; 2017. Available from: https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention
5. Australian Institute of Health and Welfare (2021) National Mental Health service planning framework 2.2. Available from: https://www.aihw.gov.au/nmhspf/overview/introduction
6. Alliance AHI. Australian Health facility guideline [B-0135. Older Pers Acute Ment Health Unit. 2019;V(3).
7. Australian commission on safety and quality in healthcare. Australian Charter of Healthcare Rights (2nd ed) [Internet]. 2019. Available from: https://www.safetyandquality.gov.au/sites/default/files/2019-06/Charter%20of%20Healthcare%20Rights%20A4%20poster%20ACCESSIBLE%20pdf.pdf
8. Clinical Excellence Commission. Your Health Rights and Responsibilities: A guide for NSW Health staff (PD 2011_022) [Internet]. 2020. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_022.pdf#page=4
9. Council of Australian Governments. National Partnership Agreement On Hospital And Health Workforce Reform [Internet]. 2012. Available from: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/Hosp_Health_Workforce_Reform-NP.pdf
10. Australia C. National framework for recovery-oriented mental health services. 2013.
11. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney: Australian Commission on Safety and Quality in Health Care; 2017.
12. NSW Ministry of Health. Seclusion and Restraint in NSW Health Settings (PD2020_004) [Internet]. 2020. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_004.pdf
13. NSW Ministry of Health. Physical Health Care of Mental Health Consumers (GL2017_019) [Internet]. 2017. Available from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_019
14. Stewart M. Toward a global definition of patient centred care: The patient should be the judge of patient centred care. BMJ. 2001;322:444.
15. NSW Ministry of Health. Privacy manual for health information [Internet]. 2015. Available from: https://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-health-information.pdf
16. Brooker, Latham. Person-Centred Dementia Care, Second Edition. 2nd edition. London ; Philadelphia: Jessica Kingsley Publishers; 2015. 224 p.
17. O'Neal EL, Adams JR, McHugo GJ, Van Citters AD, Drake RE, Bartels SJ. Preferences of older and younger adults with serious mental illness for involvement in decision-making in medical and psychiatric settings. Am J Geriatr Psychiatry Off J Am Assoc Geriatr Psychiatry. 2008 Oct;16(10):826–33.
18. Agency for Clinical Innovation. Trauma-Informed Care and Practice in Mental Health Services [Internet]. Agency for Clinical Innovation. Agency for Clinical Innovation (ACI); 2020 [cited 2020 Nov 26]. Available from: https://aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services
19. McKay R, McDonald R, Lie D, McGowan H. Reclaiming the best of the biopsychosocial model of mental health care and 'recovery' for older people through a 'person-centred' approach. Australas Psychiatry [Internet]. 2012 Dec [cited 2020 May 28];20(6):492–5. Available from: http://journals.sagepub.com/doi/10.1177/1039856212460286
20. Daley S, Newton D, Slade M. Development of a framework for recovery in older people with mental disorder. Int J Geriatr Psychiatry. 2013;28:522–9.
21. Daley S, Slade M, Dewey M, Banerjee S. A feasibility study of the effects of implementing a staff-level recovery-oriented training intervention in older people's mental health services. Aging Ment Health. 2019;
22. Health NSWM. NSW Older People's Mental Health Recovery-oriented Practice Improvement Project; Statewide project report [Internet]. 2018. Available from: https://www.health.nsw.gov.au/mentalhealth/resources/Publications/opmh-recovery-project-report.pdf
23. Australian Helath Ministers Advisory Council. A national framework for recovery-oriented mental health services: guide for practitioners and providers. Canberra: Commonwealth of Australia; 2013.
24. Australian Health Ministers Advisory Council. A national framework for recovery-oriented mental health services: policy and theory [Internet]. Commonwealth of Australia; 2013 [cited 2020 Nov 27]. Available from: https://www.health.gov.au/resources/publications/a-national-framework-for-recovery-oriented-mental-health-services-policy-and-theory
25. McDonald R, McMinn B. Mental Health and Illness in Old Age. In: Brown P, editor. Health Care of the Older Adult: An Australian and New Zealand nursing Perspective. Australia: Woodslane Press Pty Ltd; 2010.

26. Mental Health Coordinating Council, Bateman J, Henderson C, Kezelman C. Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction [Internet]. 2013. 116 p. Available from: https://www.mhcc.org.au/wp-content/uploads/2018/05/ticp_awg_position_paper__v_44_final___07_11_13-1.pdf
27. Agency for Clinical Innovation. Trauma-informed care and mental health in NSW [Internet]. NSW Government; 2019. 28 p. Available from: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/561977/ACI-Mental-Health-Trauma-informed-care-mental-health-NSW.pdf
28. Ganzel B. Trauma-Informed Hospice and Palliative Care. Gerontologist. 2018;58(3):409–19.
29. Australian national mental health commission. Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia [Internet]. 2016 [cited 2020 Nov 26]. Available from: https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf
30. Health Education and Training Institute. NSW Mental Health Act (2007) no. 8 guide book [Internet]. 2019 [cited 2020 May 29]. Available from: https://nla.gov.au/nla.obj-2203537982
31. NSW Government. Mental Health Act 2007 No 8 — NSW Legislation [Internet]. [cited 2020 Nov 26]. Available from: https://www.legislation.nsw.gov.au/view/html/inforce/current/act-2007-008
32. NSW Ministry of Health. Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW (PD2011_003) [Internet]. 2011. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_003.pdf
33. Laver A. Older People's Mental Health (OPMH) Service (Harrogate and Rural District) Inpatient bed capacity evaluation and proposal for future service provision 2007. Yorkshire: North Yorkshire and York NHS Primary Care Trust; 2007.
34. NSW Ministry of Health. Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD). A Handbook for NSW Health Clinicians [Internet]. NSW Health; 2013. Available from: https://www.health.nsw.gov.au/mentalhealth/resources/Publications/assessment-mgmt-people-bpsd.pdf
35. Agency for Clinical Innovation. Key Principles for Improving Healthcare Environments for People with Dementia [Internet]. 2014 [cited 2020 Dec 16]. Available from: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/280270/ACI_Key_Principles_for_Improving_Healthcare_Environments_for_People_with_Dementia.PDF
36. NSW Ministry of Health. NSW Health Extreme BPSD Project report [Internet]. 2021. Available from: URL TBA
37. The Australian Centre for Social Innovation The Australian Centre for Social Innovation. Engaging People with Lived Experience in the design of the Repat Health Precinct Neurobehavioural Unit [Internet]. SA Health.; 2019 [cited 2020 Dec 16]. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/b4a22f25-f99d-4e70-a835-647623718327/A1598845+Attachment+1+Final+Report+Engaging+people+with+lived+experience+in+the+design+of+the+Repat+health+precinct+NBU.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-b4a22f25-f99d-4e70-a835-647623718327-mSf4ZdN
38. Caplan GA, Coconis J, Board N, Sayers A, Woods J. Does home treatment affect delirium? A randomised controlled trial of rehabilitation of elderly and care at home or usual treatment (The REACH-OUT trial). Age Ageing. 2006 Jan;35(1):53–60.
39. NSW Ministry of Health. Older People's Drug and Alcohol Project — Full Report [Internet]. Sydney: NSW Health; 2015. 138 p. Available from: https://www.health.nsw.gov.au/aod/professionals/Publications/opdap-fullreport.pdf
40. Blue Mountains Domestic Squalor/Hoarding Working Party. Domestic squalor and Hoarding Information kit for Residents [Internet]. 2019 [cited 2021 Mar 10]. Available from: https://www.bmcc.nsw.gov.au/sites/default/files/docs/Domestic_Squalor_and_Hoarding_Information_Kit_for_Residents_JAN2019.pdf
41. Home | Department of Developmental Disability Neuropsychiatry (3DN) [Internet]. [cited 2021 Mar 10]. Available from: https://www.3dn.unsw.edu.au/
42. Baidawi S, Turner S, Trotter C, Browning C, Collier P, O'Connor D, et al. Older prisoners: A challenge for Australian corrections. Trends Issues Crime Crim Justice Canberra Aust Inst Criminol [Internet]. 2011 Aug 23 [cited 2021 Mar 10];426. Available from: https://www.aic.gov.au/publications/tandi/tandi426
43. The Royal Australian and New Zealand College of Psychiatrists. Recognising and addressing the mental health needs of the LGBTIQ+ population: Position statement 83 [Internet]. RANZCP; 2019. Available from: https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-needs-lgbtiq
44. Bateman J, Henderson C, Ke. Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group [Internet]. [cited 2021 Mar 10]. Available from: https://www.mhcc.org.au/wp-content/uploads/2018/05/ticp_awg_position_paper__v_44_final___07_11_13-1.pdf
45. Australian Institute of Health and Welfare. Deaths in Australia [Internet]. Canberra; 2020 [cited 2021 Feb 24]. Available from: https://www.aihw.gov.au/getmedia/743dd325-7e96-4674-bb87-9f77420a7ef5/Deaths-in-Australia.pdf.aspx?inline=true
46. Zubrick S, Silburn SR, Lawrence D, Mitrou FG, Dalby RB, Blair E, et al. The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people [Internet]. Curtin University of Technology and the Telethon Institute for ChildHealth Research; 2005 [cited 2020 Nov 30]. Available from: https://research-repository.uwa.edu.au/en/publications/the-western-australian-aboriginal-child-health-survey-the-social-
47. NSW Department of Health. Aboriginal Older Peoples' Mental Health Project Report [Internet]. 2010. Available from: https://www.health.nsw.gov.au/mentalhealth/Documents/aboriginal-mh-report-2010.pdf
48. NSW Ministry of Health. Communicating positively A guide to appropriate Aboriginal terminology (GL2019_008) [Internet]. 2019. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2019_008.pdf

49. Commonwealth of Australia. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 [Internet]. Commonwealth of Australia; 52 p. Available from: https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf
50. World Health Organisation. Integrating palliative care and symptom relief into primary health care: a WHO guide for planners, implementers and managers [Internet]. Switzerland: World Health Organisation; 2018. Available from: https://apps.who.int/iris/rest/bitstreams/1151571/retrieve
51. Dudgeon P, Milroy H, Walker R, editors. Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice [Internet]. 2nd ed. Commonwealth of Australia; 2014. Available from: https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf
52. Dingwall K, Cairney S. Psychological and Cognitive Assessment of Indigenous Australians. Aust N Z J Psychiatry. 2010 Jan 1;44:20–30.
53. Commonwealth of Australia. National standards for mental health services [Internet]. 2010. Available from: https://www.health.gov.au/resources/publications/national-standards-for-mental-health-services-2010-and-implementation-guidelines
54. Commonwealth of Australia. Implementation guidelines for Public Mental Health Services and Private Hospitals: National standards for mental health services [Internet]. 2010. Available from: https://www.health.gov.au/resources/publications/national-standards-for-mental-health-services-2010-and-implementation-guidelines
55. NSW Ministry of Health. Aboriginal Older People's Mental Health: Resources for Local Health District SMHSOP Services [Internet]. 2015. Available from: https://www.health.nsw.gov.au/mentalhealth/resources/Documents/aboriginal-opmh.pdf
56. MHiMA, Embrace Multicultural Mental Health. The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery [Internet]. 2014 [cited 2020 Nov 30]. Available from: https://embracementalhealth.org.au/service-providers/framework-landing
57. NSW Health, Transcultural Mental Health Centre. Transcultural Assessment Checklist (TAC) A practical guide for cultural assessment [Internet]. NSW Health; Available from: https://www.dhi.health.nsw.gov.au/ArticleDocuments/209/Transcultural%20Assessment%20Checklist.pdf.aspx
58. NSW Ministry of Health. Interpreters – Standard Procedures for Working with Health Care Interpreters (PD2017_044) [Internet]. 2017. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_044.pdf
59. NSW Health. Linking physical and mental health care…it makes sense for people who use mental health services [Internet]. 2020 [cited 2020 Nov 26]. Available from: https://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/PresentDetail?Open&s=Linking_physical_and_mental_health_care…it_makes_sense_for_people_who_use_mental_health_services
60. Australian national mental health commission. Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia [Internet]. 2016 [cited 2020 Nov 26]. Available from: https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf
61. NSW Health. Advance care planning online portal and resources [Internet]. 2020 [cited 2021 Feb 24]. Available from: https://www.health.nsw.gov.au/patients/acp/Pages/default.aspx
62. NSW Government. Guardianship Act 1987 No 257 — NSW Legislation [Internet]. 2020 [cited 2020 Nov 26]. Available from: https://legislation.nsw.gov.au/view/whole/html/inforce/2003-02-01/act-1987-257
63. Cambridgeshire and Peterborough NHS FoundationTrust. Older People's Mental Health Service Care Pathways – Inpatient Care [Internet]. 2009. Available from: https://www.cambridgeshireandpeterboroughccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=20788
64. NSW Ministry of Health. Australasian Health Facility Guidelines — Use in NSW (GL2018_024) [Internet]. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2018_024.pdf
65. Lu JH, Chan DKY, Ong B, Shen Q, Reuten S, Ko A. Management and outcomes of delirium in a secured, co-located geriatric and psychogeriatric unit. J Am Geriatr Soc. 2009 Sep;57(9):1725–7.
66. Department of Health and Social Security and Welsh Office. The organisation of the in-patients day. In: Report of the Committee of the Central Health Services Council. London HSMO; 1976.
67. Hurst H, Griffiths J, Hunt C, Martinez E. A realist evaluation of the implementation of open visiting in an acute care setting for older people. BMC Health Serv Res. 2019 Nov 21;19(1):867.
68. Freyne A, Wrigley M. Acute inpatient admissions in a community oriented old age psychiatry service. Ir J Psychol Med. 1997;14:4–7.
69. NSW Health. Aged Care Assessment and Care Planning Framework. 2009.
70. Clinical Excellence Commission. Between the Flags [Internet]. [cited 2021 Feb 24]. Available from: https://www.cec.health.nsw.gov.au/keep-patients-safe/deteriorating-patient-program/between-the-flags
71. NSW Ministry of Health. Mental Health Clinical Documentation Guidelines (GL2014_002) [Internet]. NSW Health; 2014. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2014_002.pdf
72. NSW Ministry of Health. Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care Guideline (GL2017_003) [Internet]. 2017. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_003.pdf
73. Morgan S. Positive Risk-Taking. Practical ways of working with risk. A Practice Based Evidence production. UK: Hampshire Partnership NHS Foundation Trust.; 2011.
74. NSW Ministry of Health. Clinical Care of People Who May Be Suicidal (PD2016_007) [Internet]. 2016. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_007.pdf

75. NSW Ministry of Health. Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services (PD2019_045) [Internet]. 2019. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_045.pdf
76. Central Coast Area Health Service. Clinical Review/Handovers MHDA Interim Procedure PR2009_290 (unpublished). 2009.
77. NSW Ministry of Health. Clinical handover (PD2019_020) [Internet]. 2019. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_020.pdf
78. NSW Ministry of Health. Incident Management Policy (PD 2020_047) [Internet]. NSW Ministry of Health; 2020. Available from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_047
79. Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect [Internet]. Commonwealth of Australia; 2021 [cited 2021 Mar 10]. Available from: https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1.pdf
80. Davis C, Glick ID, Rosow I. The architectural design of a psychotherapeutic milieu. Hosp Community Psychiatry. 1979 Jul;30(7):453–60.
81. Minde R, Haynes E, Rodenburg M. The ward milieu and its effect on the behaviour of psychogeriatric patients. Can J Psychiatry Rev Can Psychiatr. 1990 Mar;35(2):133–8.
82. Mahoney JS, Palyo N, Napier G, Giordano J. The therapeutic milieu reconceptualized for the 21st century. Arch Psychiatr Nurs. 2009 Dec;23(6):423–9.
83. Rogoff J. Individual Psychotherapy. Ch in Inpatient Psychiatry: Diagnosis and Treatment. 2nd edition. M. D. Sederer LI, editor. Baltimore: Williams & Wilkins; 1986. 399 p.
84. Woods B, Charlesworth G. Psychological assessment and treatment, Ch. in Psychiatry in the Elderly. In: Jacoby R, Oppenheimer C, editors. Psychiatry in the Elderly. Oxford: Oxford University Press; 2002.
85. Yates AJ. Theory and Practice in Behavior Therapy. Wiley; 1975. 278 p.
86. Charles Schatzberg A and N. The American Psychiatric Association Publishing Textbook of Psychopharmacology 5ed. 5th edition. Schatzberg A, Nemeroff C, editors. Arlington, Virginia: American Psychiatric Association Publishing; 2017. 1823 p.
87. Hategan A, Bourgeois JA, Hirsch C, Giroux C, editors. Geriatric Psychiatry: A Case-Based Textbook [Internet]. Springer International Publishing; 2018 [cited 2021 Feb 24]. Available from: https://www.springer.com/gp/book/9783319675541
88. Ortiz-Orendain J, Obeso SC, Colunga-Lozano LE, Hu Y, Maayan N, Adams CE. Antipsychotic combinations for schizophrenia. Cochrane Database Syst Rev [Internet]. 2017 [cited 2021 Mar 10];(6). Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009005.pub2/full
89. Barber S, Olotu U, Corsi M, Cipriani A. Clozapine combined with different antipsychotic drugs for treatment-resistant schizophrenia. Cochrane Database Syst Rev [Internet]. 2017 [cited 2021 Mar 10];(3). Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006324.pub3/full
90. Henssler J, Bschor T, Baethge C. Combining Antidepressants in Acute Treatment of Depression: A Meta-Analysis of 38 Studies Including 4511 Patients. Can J Psychiatry Rev Can Psychiatr. 2016 Jan;61(1):29–43.
91. Davey CG, Chanen AM. The unfulfilled promise of the antidepressant medications. Med J Aust. 2016 May 16;204(9):348–50.
92. van Diermen L, van den Ameele S, Kamperman AM, Sabbe BCG, Vermeulen T, Schrijvers D, et al. Prediction of electroconvulsive therapy response and remission in major depression: meta-analysis. Br J Psychiatry J Ment Sci. 2018 Feb;212(2):71–80.
93. Heijnen WTCJ, Kamperman AM, Tjokrodipo LD, Hoogendijk WJG, van den Broek WW, Birkenhager TK. Influence of age on ECT efficacy in depression and the mediating role of psychomotor retardation and psychotic features. J Psychiatr Res. 2019 Feb;109:41–7.
94. Malhi GS, Bassett D, Boyce P, Bryant R, Fitzgerald PB, Fritz K, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Aust N Z J Psychiatry. 2015 Dec;49(12):1087–206.
95. Abrams R. Electroconvulsive Therapy. 4th edition. Oxford ; New York: Oxford University Press; 2002. 344 p.
96. Tisher M, Dean S. Family Therapy with the Elderly. Aust N Z J Fam Ther. 2000 Jun 1;21.
97. Peisah C. Practical application of family and systems theory in old age psychiatry: Three case reports. Int Psychogeriatr IPA. 2006 Jul 1;18:345–53.
98. NSW Health. Mental Health Peer workers [Internet]. 2020 [cited 2020 Nov 26]. Available from: https://www.health.nsw.gov.au/mentalhealth/professionals/pages/peer-workers.aspx
99. NSW Ministry of Health. Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities [Internet]. 2017. Available from: https://www.health.nsw.gov.au/mentalhealth/reviews/seclusionprevention/Documents/report-seclusion-restraint-observation.pdf
100. Australian Government Department of Health. Minimising restraints in aged care [Internet]. Australian Government Department of Health. Australian Government Department of Health; 2019 [cited 2020 Nov 26]. Available from: https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/working-in-aged-care/minimising-restraints-in-aged-care
101. Australia, Department of Health and Ageing. Decision-making tool: supporting a restraint free environment in residential aged care [Internet]. Canberra: Department of Health and Ageing; 2012 [cited 2020 Nov 26]. Available from: https://www.agedcarequality.gov.au/media/87628
102. NSW Ministry of Health. Aggression, Seclusion & Restraint in Mental Health Facilities — Guideline Focused Upon Older People (GL2012_005) [Internet]. 2012. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2012_005.pdf
103. OT Innovations. Sensory Rooms in Mental Health [Internet]. OT-Innovations. 2012 [cited 2020 Nov 26]. Available from: https://www.ot-innovations.com/clinical-practice/sensory-modulation/sensory-rooms-in-mental-health-3/

104. NSW Ministry of Health. Engagement and Observation in Mental Health Inpatient Units (PD2017_025) [Internet]. 2017. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_025.pdf
105. Fleming R, Forbes I. Adapting the Ward for People with Dementia. Hammond Care Group; 2003. 122 p.
106. Dobrohotoff JT, Llewellyn-Jones RH. Psychogeriatric inpatient unit design: a literature review. Int Psychogeriatr. 2011 Mar;23(2):174–89.
107. NSW Health. Protecting People and Property: NSW Health Policy and Standards for Security Risk Management (revised). 2018.
108. Peter Anderson. Improvements to security in hospitals. Final Report 2020 [Internet]. NSW Health; 2020 [cited 2021 Mar 10]. Available from: https://www.health.nsw.gov.au/Hospitals/securityreview/Documents/pa-final-report.pdf
109. van der Merwe M, Bowers L, Jones J, Simpson A, Haglund K. Locked doors in acute inpatient psychiatry: a literature review. J Psychiatr Ment Health Nurs. 2009 Apr;16(3):293–9.
110. Age Concern. Improving services and support for older people with mental health problems. The second report from the UK Inquiry into Mental Health and Well-Being in Later Life [Internet]. England: Age Concern; 2007. Available from: http://www.mentalhealthpromotion.net/resources/improving-services-and-support-for-older-people-with-mental-health-problems.pdf
111. Gonski P, Chan D, Creasey H, Cullen J. Behavioural Units in Acute Hospital Settings. 2008.
112. Fineberg NA, James DV, Shah AK. Agency nurses and violence in a psychiatric ward. Lancet Lond Engl. 1988 Feb 27;1(8583):474.
113. Fowler J, Hardy J, Howarth T. Trialing collaborative nursing Models of Care: the impact of change. Aust J Adv Nurs Q Publ R Aust Nurs Fed. 2006 Aug;23(4):40–6.
114. Garling P. Final report of the Special Commission of Inquiry, Acute Care Services in NSW Public Hospitals [Internet]. Sydney, N.S.W.: NSW Dept. of Premier and Cabinet; 2008. 72 p. Available from: https://www.psnetwork.org/wp-content/uploads/2018/06/Overview-Special-Commission-of-Inquiry-into-Acute-Care-Services-in-NSW.pdf
115. Atler K, Michel GS. Maximizing abilities: occupational therapy's role in geriatric psychiatry. Psychiatr Serv Wash DC. 1996 Sep;47(9):933–5.
116. Law MC, Baum CM, Dunn W. Measuring Occupational Performance: Supporting Best Practice in Occupational Therapy. 3rd ed. SLACK Incorporated; 2016. 480 p.
117. Allen CK, Earhart CA, Blue T. Occupational Therapy Treatment Goals for the Physically and Cognitively Disabled. American Occupational Therapy Association; 1992. 380 p.
118. Rockwood K, Howlett S, Stadnyk K, Carver D, Powell C, Stolee P. Responsiveness of goal attainment scaling in a randomized controlled trial of comprehensive geriatric assessment. J Clin Epidemiol. 2003 Aug;56(8):736–43.
119. MS BB. Counseling the Elderly in a Therapeutic Recreation Setting. Act Adapt Aging. 1993 Mar 18;17(2):57–63.
120. Hepple J, Pearce J, Wilkinson P, editors. Psychological Therapies with Older People: Developing Treatments for Effective Practice. Hove England : New York: Psychology Press; 2002. 208 p.
121. Baldwin RC, Chiu E, Graham N, Katona C. Guidelines on Depression in Older People: Practising the Evidence. Taylor & Francis; 2002. 120 p.
122. Burgio KL, Locher JL, Goode PS, Hardin JM, McDowell BJ, Dombrowski M, et al. Behavioral vs Drug Treatment for Urge Urinary Incontinence in Older Women: A Randomized Controlled Trial. JAMA. 1998 Dec 16;280(23):1995.
123. Cook AJ. Cognitive-Behavioral Pain Management for Elderly Nursing Home Residents. J Gerontol Ser B. 1998 Jan 1;53B(1):P51–9.
124. Lo B. Assessing Decision-Making Capacity. Law Med Health Care. 1990 Sep 1;18(3):193–201.
125. Bird M. Challenging Behaviour in Dementia: A Critical Role for Psychology. Aust Psychol. 1999;34(2):144–8.
126. Bird M, Llewellyn-Jones R, Smithers H, Korten A. Psychosocial approaches to challenging behaviour in dementia: A controlled trial [Internet]. Canberra, ACT: Commonwealth Department of Health and Ageing: Office for Older Australians; 2002. Available from: https://trove.nla.gov.au/work/11366835
127. Bird M, Llewellyn-Jones RH, Korten A. An evaluation of the effectiveness of a case-specific approach to challenging behaviour associated with dementia. Aging Ment Health. 2009 Jan;13(1):73–83.
128. Australian Association of Social Workers. Australian Association of Social Workers Code of Ethics 2020 [Internet]. 2020 [cited 2020 Nov 26]. 32 p. Available from: https://www.aasw.asn.au/document/item/1201
129. Inventor BRE, Henricks J, Rodman L, Imel J, Holemon L, Hernandez F. The impact of medical issues in inpatient geriatric psychiatry. Issues Ment Health Nurs. 2005 Jan;26(1):23–46.
130. Coates D, Livermore P, Green R. The development and implementation of a peer support model for a specialist mental health service for older people: lessons learned. Ment Health Rev J. 2018;23(2):73–85.
131. Allied health professionals Australia. Physiotherapy [Internet]. 2020 [cited 2020 Nov 20]. Available from: https://ahpa.com.au/allied-health-professions/physiotherapy/
132. Robinson L, Newton JL, Jones D, Dawson P. Self-management and adherence with exercise-based falls prevention programmes: a qualitative study to explore the views and experiences of older people and physiotherapists. Disabil Rehabil. 2014;36(5):379–86.
133. Allied health professionals Australia. Exercise physiology [Internet]. 2020 [cited 2020 Nov 20]. Available from: https://ahpa.com.au/allied-health-professions/exercise-physiology/
134. Harbottle L. The effect of nutrition on older people's mental health. Br J Community Nurs. 2019 Jul 1;24(Sup7):S12–6.
135. Bernstein M, Munoz N, Academy of Nutrition and Dietetics. Position of the Academy of Nutrition and Dietetics: food and nutrition for older adults: promoting health and wellness. J Acad Nutr Diet. 2012 Aug;112(8):1255–77.

136. Australian Government, Department of Health. National practice standards for the mental health workforce [Internet]. 2013 [cited 2020 Nov 26]. Available from: https://www.health.gov.au/resources/publications/national-practice-standards-for-the-mental-health-workforce-2013

137. New South Wales, Ministry of Health. Health Professionals Workforce Plan 2012-2022. 2015.

138. NSW Ministry of Health. Managing for Performance (PD2016_040) [Internet]. 2016. Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_040.pdf

139. NSW Public service commission. Performance Development Framework v2: NSW Public Sector [Internet]. NSW Public Sector; 2018. Available from: https://www.psc.nsw.gov.au/workforce-management/performance-development/performance-development-framework

140. Blank K, Hixon L, Gruman C, Robison J, Hickey G, Schwartz HI. Determinants of geropsychiatric inpatient length of stay. Psychiatr Q. 2005;76(2):195–212.

141. NSW Health OPMHPU. 2019 OPMH Benchmarking annual report [Unpublished]. NSW Health; 2019.

142. National Mental Health Performance Framework 2020 [Internet]. [cited 2021 Feb 24]. Available from: https://meteor.aihw.gov.au/content/index.phtml/itemId/721188

143. NSW Health. NSW Health Service Agreement 2019/2020 template [Internet]. 2019 [cited 2020 Jun 20]. Available from: https://www.health.nsw.gov.au/Performance/Documents/service-agreement-generic.pdf

144. NSW Ministry of Health. Mental Health Outcomes & Assessment Tools (MH-OAT) Data Collection Reporting Requirement (PD2006_041) [Internet]. Data Collection Reporting; 2006. Available from: https://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=PD2006_041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