

# NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015

NSW: A new direction for Mental Health

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# Foreword

Specialist Mental Health Services for Older People (SMHSOP) are on the edge of change in NSW.

The Australian population is ageing, and approximately one third of Australia's older people live in NSW. Many people will live a healthy and independent life to old age. However, increasing levels of physical illness, neurodegenerative diseases and disability are associated with increasing longevity. Anxiety and depression are particular risk issues for older people and can accompany physical illness, dementia, disability or bereavement. People with life-long mental illnesses and related disabilities will experience age-related frailty and diseases.

Population ageing will result in increased demand on health and aged care services across Australia and will impact heavily on families and carers. A coordinated approach to service planning and service delivery is required to address these multiple demands and to ensure the health care and support needs of older people and their families are met.

SMHSOP are essential to the health and aged care service system. Mental health problems in older people are complex in their presentation and management, and SMHSOP have the specialist clinical knowledge and skills to manage these issues across a range of service settings. However, in many Area Health Services, SMHSOP are at an early stage of development. Pressure on these specialist services will grow as the population ages and the number of older people with complex mental health problems increases.

The NSW Government has recognised these issues and demonstrated its commitment to addressing the needs of the growing number of older people with mental health problems in NSW through significant funding enhancements for SMHSOP. From 2006/07, the NSW Government has committed \$63.8 million new funding over five years to support the implementation of

this plan. This funding builds on \$3.95 million new funding provided for older people's mental health services in the community mental health funding package announced in the 2005 NSW Budget. Funding enhancements for older people's mental health under this package will total \$25.5 million over the next five years. These enhancements are targeted to SMHSOP community teams and other community-based SMHSOP services and partnership initiatives, consistent with the priorities outlined in this plan.

A number of significant, innovative service development initiatives are underway in this area, including:

- The establishment of integrated Behavioural Assessment and Intervention Services (BASIS) to provide SMHSOP input to assessment and management of older people with severe, complex behavioural disturbance, in partnership with aged care services.
- The establishment of a number of pilot Special Care Units within residential aged care facilities for older people with complex behavioural and psychological symptoms, to be operated by residential aged care providers in partnership with NSW Area Health Services.

NSW is fortunate to have some leading clinicians in older people's mental health, and many committed medical, nursing and allied health professionals and other staff. This plan provides a strong framework for further developing specialist mental health services for older people across NSW, building on this expertise and commitment, to meet the challenges ahead.



John Hatzistergos  
Minister for Health

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# Executive summary

A clearly articulated state-wide service delivery framework based on a population health approach is required for Specialist Mental Health Services for Older People (SMHSOP) across NSW.

The Australian population is ageing. By 2041, it is projected that 5.7 million or one quarter of Australia's population will be aged over 65 years.<sup>1</sup> Many people are living longer and there are increasing numbers of people aged 80 years and over. It is estimated that over one third of Australia's older people live in NSW.

Many people will live a healthy and independent life to old age. However, increasing levels of physical illness, neurodegenerative diseases and disability are associated with increasing longevity. Anxiety and depression are particular risk issues for older people and can accompany physical illness, dementia, disability or bereavement. People with life-long mental illnesses and related disabilities will experience age-related frailty and diseases.

Ageing brings with it an increased risk of dementia. Dementia affects around 5 per cent of people aged over 65 years, and approximately 20 per cent over 80 years of age.<sup>2</sup> It is estimated that one third of this group will experience moderate-severe behavioural and psychiatric symptoms and would benefit from input from SMHSOP at some level.<sup>3</sup>

Population ageing will result in increased demand on health and aged care services across Australia and will impact heavily on families and carers. A coordinated approach to service planning and service delivery is required to address these multiple demands and to ensure the health care and support needs of older people and their families are met.

The demographic and mental health issues that provide the context and impetus for this plan are outlined in Section 2, along with the policy and planning context for the Plan. Mental health issues for special needs groups such as older Aboriginal people and older people from culturally and linguistically diverse (CALD) backgrounds are also addressed.

SMHSOP are essential to the health and aged care service system. Mental health problems in older people are complex in their presentation and management, and SMHSOP have the specialist clinical knowledge and skills to manage these issues across a range of service settings. These specialist services include old age psychiatrists, specialist psycho-geriatric nurses and allied health professionals such as psychologists, occupational therapists and social workers with expertise in mental health problems affecting older people. SMHSOP clinical functions include specialist clinical assessment and treatment, consultation/liaison and capacity building with other key services, and joint care planning and case management with general practitioners (GPs) and other health care providers. These clinical functions are described in Section 1, along with an outline of the target group for SMHSOP.

These specialist services need to be provided to older people and their families in an integrated way, in combination with primary health and aged care services, community support services, hospital services and the housing and residential aged care sectors. The service system for older people with mental health problems and the role of SMHSOP within that system are described in Section 3, along with the broad strategic challenges facing NSW Health and other key stakeholders in responding to older people's mental health issues as the population ages.

Currently, SMHSOP are at an early stage of development in many Area Health Services (AHSs) and access to SMHSOP is varied across NSW. The NSW Health policy *Caring for Older People's Mental Health* (1998) provided the policy framework for promoting a population health approach to the mental health care of older people. A detailed service planning framework is now required to guide service development in SMHSOP and address the projected needs of older people in NSW for these services.

The Service Plan for SMHSOP sets out clear service models and structures, planning benchmarks, service partners, priorities and an implementation plan to guide a staged development of SMHSOP across NSW, appropriate to population needs and AHS demographics, workforce and geographical profiles and service infrastructures.

The Plan outlines a SMHSOP service delivery model (in Section 4) comprising five clinical service components:

- SMHSOP community teams
- SMHSOP acute inpatient services
- SMHSOP non-acute inpatient services
- SMHSOP community residential services
- Severely and persistently challenging behaviours model.

The 'severely and persistently challenging behaviours' model comprises a specialist assessment function for older people with severe and complex behavioural disturbance associated with dementia and/or mental illness, and a number of other service model elements for this group. These service model elements link to and will integrate with other SMHSOP clinical service components. The model of care, which draws on a recent report commissioned by NSW Health, is outlined in Section 4.

The SMHSOP implementation plan in Section 5 outlines the process for building this service delivery model across NSW in two phases of service development. Phase 1 of implementation focuses on the development of community SMHSOP teams and community-based SMHSOP initiatives, in partnership with other key services. It also proposes that SMHSOP will negotiate protocols to cover bed access arrangements for the care of older people with acute mental illness or sub-acute care needs in adult mental health inpatient facilities, acute geriatric units and acute hospitals.

This phase of service development will ensure that, at a minimum, the SMHSOP target group has access to mental health assessment and some case management, as well as appropriate acute services, across NSW. GPs and aged care services (including Aged Care Assessment Teams, geriatric medical staff, Home and Community Care services and residential aged care facilities) will have access to mental health consultation and liaison services. The establishment of Area SMHSOP Clinical Coordinator positions across NSW is the first step in progressing these partnerships and service developments.

Phase 2 of implementation focuses on service developments in acute and non-acute inpatient care and specialist rehabilitation and recovery programs, as well as consolidating service developments in community-based SMHSOP services and initiatives in Phase 1. Depending on the outcomes of scoping and planning work in Phase 1, tertiary services with an inter-AHS network or statewide role, such as an intensive care neurobehavioural unit, may also be developed in Phase 2.

The reporting, monitoring and evaluation processes for the *Plan* (outlined in Section 5) are based on existing reporting systems, performance monitoring processes, and accountability frameworks. The implementation of the Plan will be guided by a set of key principles relating to accessibility, effectiveness and appropriateness, integration, responsiveness, efficiency, capability, sustainability, quality and safety. These principles align with agreed national Key Performance Indicators for public mental health services.

A mid-term evaluation will be conducted in 2010 to review progress and outcomes of Phase 1 and ensure that the Plan builds on this work and remains relevant and appropriate as the clinical, policy and service delivery environment changes.





# Introduction

This plan has been developed by the Centre for Mental Health together with the NSW Health Area SMHSOP Clinical Coordinators Network, Older People's Mental Health (OPMH) Working Group and OPMH Planning Group (Appendix 1) and in consultation with Area Health Services and other key stakeholders.

### 1.1 Purpose, scope and structure of the *Service Plan*

The purpose of the Plan is to guide the development of SMHSOP across NSW over the next ten years. In many Area Health Services (AHS), SMHSOP are at an early stage of development. Indeed, the medical specialty of old age psychiatry is relatively new, with the Faculty of the Psychiatry of Old Age gaining formal 'faculty' status from the Royal Australian and New Zealand College of Psychiatrists in January 1999.

The Plan is primarily directed at Area Mental Health Services (AMHSs) in NSW. However, it is recognized that it will inform the policy and planning work of other key services, agencies and jurisdictions regarding mental health initiatives and care and support for older people, and it is intended to assist key stakeholders in this regard.

The Plan focuses on the development of SMHSOP within AMHSs and the fostering of key partnerships and linkages to enhance mental health care for older people across NSW. The scope and structure of the Plan is as follows:

- **Section 1** (this section) outlines the aims of the SMHSOP Service Plan, defines the SMHSOP target group, describes SMHSOP and outlines the values and principles underpinning the care provided by SMHSOP.
- **Section 2** outlines the policy and planning context for the mental health care of older people and the demographic and population mental health context for the development of SMHSOP.
- **Section 3** describes the broader health and aged care service system, articulates the role of SMHSOP in this service system and identifies the key strategic challenges in older people's mental health.
- **Section 4** proposes and describes a SMHSOP planning and service delivery model, comprising five clinical service components, for development across NSW. This section also describes key priorities and strategies for addressing the mental health needs of 'special needs groups' such as older Aboriginal and Torres Strait Islander peoples, older people from CALD backgrounds and older people in the criminal justice system.
- **Section 5** outlines a two-phase implementation plan for the development of the SMHSOP service model over the next ten years, underpinned by explicit implementation and service delivery principles, as well as reporting and monitoring processes and Key Performance Indicators (KPIs) for the review and evaluation of the Plan.

### 1.2 Aims of the *Service Plan*

In a population health context, the aims of the Plan are to:

- Promote improved access to SMHSOP for older people with mental health problems, including severe behavioural and psychiatric symptoms associated with dementia, and for older people at risk of developing mental health problems across NSW.
- Contribute to improved health and mental health outcomes for older people in NSW.

It is recognised that a range of other agencies and partners have a role in improving responses to the mental health needs of older people.

In providing a framework for planning and service development within AMHSs, the Plan aims to:

- Define the target group for SMHSOP.
- Describe the key clinical service components of SMHSOP, service delivery options and models, and a SMHSOP service delivery model for development across NSW to meet the needs of this target group.
- Outline an implementation plan for the development of SMHSOP across NSW.

- Support strategies to ensure increased recruitment and retention of a skilled specialist workforce for SMHSOP.
- Identify how SMHSOP will augment the ability of generalist mental health workers, aged care services and primary health and community care services, and residential aged care services to manage older people with complex mental health problems.
- Provide direction to Area SMHSOP Clinical Coordinators for strategic planning and service development work at the local level, including the development of collaborative partnerships, service models and referral pathways between SMHSOP, adult mental health teams and aged care services.
- Enhance service planning and delivery of SMHSOP in metropolitan, regional, rural and remote areas of NSW to improve equity of access for older people with mental health problems, their families and carers.
- Provide a framework to streamline and standardise reporting, monitoring and review processes for SMHSOP, with a focus on clinical service delivery and outcomes.

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

- Improve collaboration and partnerships between SMHSOP, aged care, adult mental health, primary health and community care and residential services in a manner that is consistent with NSW Health's *Framework for integrated support and management of older people in the NSW health care system 2004–2006*.
- Promote improved access for older people with mental illness to aged care services and other key services, where appropriate.
- Promote greater capacity in the general health system and the human services sector to assess, care for and support older people experiencing complex mental health problems.
- Promote improved continuity of care for older people with complex mental health problems.

### 1.3 The SMHSOP target group

In the broadest sense, the target group for SMHSOP is people 65 years and over who have a diagnosable mental health disorder or problem. In certain clinical and population groupings, it is noted that there are younger people who are 'functionally old' and may have complex morbidity issues, including dementia, acquired cognitive impairment and poor health status. Where possible and

appropriate, SMHSOP will provide some services for these clients, in collaboration with aged care services. In other clinical groupings, patients may be 65 years or older but still be most appropriate for management by adult mental health services, in collaboration with SMHSOP.

Current epidemiological data, drawn from NSW Health's Mental Health Clinical Care and Prevention (MH-CCP) planning model, indicates that the prevalence of mental illness in the SMHSOP target group of people over 65 years in NSW is 12.9 per cent or 114,366 people.<sup>4</sup> Under the MH-CCP model, the target group for SMHSOP is people aged 65 years and older who have a diagnosable mental health disorder or problem. MH-CCP Version 1.11 (under review) does not fully address the needs of older people with severe Behavioural and Psychological Symptoms of Dementia (BPSD) or 'functionally old' younger people and therefore represents an underestimate of the population need for access to SMHSOP.

SMHSOP are currently at an early stage of development in many Areas. Therefore, AMHSs will need to:

- Identify priority sub-groups within this broader group to target within the first phase of this plan, through local consultation and Area SMHSOP Strategic Plans, underpinned by local linkages and referral protocols with aged care services.
- Prioritise access to SMHSOP, based on clinical need and risk assessments.

Factors to consider in determining priority would include:

- Presence of a mental health disorder, including assessment to determine this.
- Acuity and severity of mental illness.
- Risk of harm to self or others.
- Predominance of psychiatric morbidity, including severe BPSD.
- Unmet need (ie current access to mental health and/or aged care services and effectiveness of treatment; access to family/carer support).
- Level of functional impairment (particularly whether this presents a risk to the person's safety or ability to remain in the current place of residence).
- Complexity of presenting psychiatric and physical symptoms.

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

As SMHSOP develop across NSW, the target group for these services will comprise older people who:

- Develop or are at high risk of developing a mental health disorder at the age of 65 years and over, such as depression, psychosis, anxiety or a severe adjustment disorder.
- Have had a life long or recurring mental illness, and now experience age-related problems causing significant functional disability (ie become 'functionally old').
- Have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by SMHSOP.
- Present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:
  - major depression
  - severe physical and/or verbal aggression
  - severe agitation
  - screaming
  - psychosis.<sup>5</sup>

The families and carers of these older people are also part of the broader target group for SMHSOP.

SMHSOP will not generally provide services for older people with a primary diagnosis of drug and alcohol disorder or delirium, as drug and alcohol services and geriatric medical services respectively have the primary expertise and responsibility for managing these clients. However, SMHSOP will exercise appropriate flexibility in providing assessment for older people with complex and unclear aetiology.

Adult or generalist mental health teams will maintain a key role in the care of existing clients beyond the age of 65, where SMHSOP are not available, where these clients are being appropriately managed by adult or generalist teams, and/or where this promotes continuity of care. SMHSOP will provide support to adult mental health teams and aged care services to ensure care coordination for older people with co-morbid mental health problems that may not be the primary focus of care, and/or long-standing mental health problems but no acute symptoms.

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

## 1.4 Description of SMHSOP

Specialist Mental Health Services for Older People, as described in this plan, include old age psychiatrists, specialist psycho-geriatric nurses and allied health professionals such as psychologists, occupational therapists and social workers with expertise in mental health problems affecting older people. Whilst it is clearly indicated that SMHSOP in different AHS will have different levels of capacity, clinical service components of the SMHSOP service model include multidisciplinary community or ambulatory teams, designated acute and non-acute inpatient facilities and long-stay community residential facilities. These clinical service components are described in more detail in Section 4.

SMHSOP clinical functions include:

- Capacity building (outreach services and education and training to other key services and health care providers).
- Specialist clinical assessment and treatment services.
- Specialist mental health assessment through consultation/liaison with other key services and health care providers.
- Joint care planning and case management with GPs and other key services and health care providers.
- Mental health promotion, prevention and early intervention programs.
- Rehabilitation and recovery programs.
- Research and evaluation.

In terms of governance, SMHSOP are a clinical service of AMHSs and are therefore operationally responsible to AMHSs. Clinical governance arrangements should include well-articulated processes for clinical risk management, audit, performance and evaluation, professional development and quality improvement. However, strong collaboration and functional integration between SMHSOP and NSW Health aged care services is a clear priority under this plan. Co-location of SMHSOP community teams and Aged Care Assessment Teams (ACATs) is encouraged. Where co-location is not feasible, strong partnerships and referral protocols between SMHSOP and ACATs will be necessary, particularly with respect to the management of older people with BPSD.

It is proposed that the role of SMHSOP in providing assessment and case management for older people with severe BPSD is further developed in the implementation of this plan, in line with the integrated behavioural assessment and intervention service function and other service model elements of the 'severely and persistently challenging behaviours model' outlined in Section 4.1.5.

## 1.5 Principles of care

The following principles and values underpin this plan and will guide the development of SMHSOP across NSW:

- **Promote independence, dignity and quality of life for older people with mental health problems, their families and carers.** Older age is an opportunity for people to enjoy new challenges and the treatment of older people with courtesy and dignity is a core value of SMHSOP. These services aim to assist older people to remain as healthy and independent as possible for as long as possible, and to participate in community life. Care will be delivered 'in situ' or as close to home as possible.
- **Embrace diversity in older people.** Ageing is a normal process, influenced by personality, culture, language, religion, personal circumstances and coping style. This means that there is wide diversity among older people and SMHSOP will respect, value and respond to this diversity.
- **Respect the rights of individual older people, their families and carers, and their goals in accessing care.** Care should be delivered in accordance with relevant legislative frameworks, including the *NSW Guardianship Act (1997)*, *Mental Health Act (1990)* and *Aged Care Act (1997)*. Consumers should be empowered to articulate their individual care goals and participate in the development of their care plans.
- **Respond to the special needs of priority population groups.** Targeted responses and specific strategies may be required to address the mental health needs of particular priority population groups, including Aboriginal communities, people from CALD backgrounds, rural and remote communities and older people in the criminal justice system.
- **Promote a holistic and multidisciplinary approach to care.** Older people with mental health problems may have complex care needs, including physical health needs. A holistic and multidisciplinary approach will be required to maximise their recovery, independence and quality of life.
- **Take a flexible approach.** In responding to the particular needs and care goals of older people with mental health problems, SMHSOP may need to take a flexible approach, as much as possible, in collaboration with families, carers and other service providers.
- **Support continuity of care for older people with mental health problems.** Older people with complex mental health needs may access a range of services and move between different service settings. It will be important for SMHSOP to take a coordinated approach with other key services to ensure continuity of care for their clients.

# Policy and planning context

## A population health approach to the mental health care of older people

This section outlines the policy, planning and demographic context for the *Service Plan for SMHSOP* and the population health issues that provide the imperative for the development of SMHSOP to promote improved mental health outcomes for older people in NSW.

### 2.1 National and state policy planning frameworks

This *Service Plan* is part of a wider policy and planning focus on ageing, aged care, service access and care coordination for older people across a range of services and service interfaces, in the context of the ageing of the Australian population. These documents are summarised in *Appendix 2*.

#### Mental health policy and planning frameworks

The provision of mental health services in NSW is the responsibility of NSW Health. However, both national and state policy and planning frameworks guide the NSW Mental Health Program, which is delivered through AMHSs. The program is based on a population health model that recognizes that health and illness result from the interaction of biological, psychological, social, environmental and economic factors at the individual, family and community levels, acknowledges the relationship between mental health and physical health, and addresses complex mental health disorders across the life span that affect the health of the community.

Current policy and planning frameworks for mental health are as follows:

- *National Mental Health Policy*<sup>6</sup>
- *Mental Health Statement of Rights and Responsibilities*<sup>7</sup>
- *National Mental Health Plan 2003–2008*<sup>8</sup>
- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*<sup>9</sup>

- *NSW Government Interagency Plan for Better Mental Health (2005)*<sup>10</sup>
- *NSW Health Caring for Mental Health Policy*<sup>11</sup>
- *NSW Health NSW Mental Health Planning Framework 2005–2010 (2006)*
- *NSW Health NSW Community Mental Health Strategy (2006)*
- *NSW Health Mental Health Clinical Care and Prevention Model (MH-CCP)*<sup>12</sup>
- *NSW Health Caring for Older People's Mental Health policy (1998)*<sup>13</sup>

The NSW Health policy *Caring for Older People's Mental Health* was an important first step in developing a focus on the mental health needs of older people and articulating a number of key strategic directions for NSW Health regarding the development of SMHSOP and key partnerships in older people's mental health care. It is aligned with the NSW mental health policy document, *Caring for Mental Health* and the *National Mental Health Policy*. *Caring for Older People's Mental Health* outlines policy directions relating to partnerships and better mental health care for older people, mental health promotion, prevention and early intervention for older people, and quality and effectiveness in services that provide for the mental health care of older people. As a policy framework, it remains relevant to the development of SMHSOP in NSW.

The mental health of older people is a focus area under the population health framework adopted in the *National Mental Health Plan 2003–2008*. Under this plan, older people's mental health is highlighted in relation to the priority themes of improving service responsiveness to people with diverse and complex needs and promoting continuity of care. These broad imperatives underpin this service plan.

Older people are a priority population group under the *NSW Mental Health Planning Framework 2005–2010* currently being finalised. This plan sets out a strategic service development and reform agenda for mental health service delivery in NSW over the next five years.



It is linked to the *NSW Interagency Plan for Better Mental Health* and focuses on three major strategic priority areas:

- Prevention and early intervention programs.
- Care of people with or at risk of recurring and chronic illnesses.
- Emergency and acute care.

These priority areas provide the broad strategic framework for the *Service Plan for SMHSOP*.

The *NSW Community Mental Health Strategy* sets the agenda for service development and service reform in community mental health in NSW and describes the model for community mental health services to be developed and delivered by 2011. This model covers the spectrum of mental health care and provides a framework for improving responses to the needs of people with mental illness or disorder, their families and carers across NSW, across the age range, and across diverse communities. SMHSOP are a key component of the community mental health model and the *Service Plan for SMHSOP* provides a detailed implementation plan to support community mental health service development, partnership programs and service reform within specialist mental health services for older people.

The MH-CCP model is an epidemiological population-based service model developed by the NSW Department of Health (Centre for Mental Health) to guide mental health planning and service provision. It incorporates an evidence-based approach, building on a set of explicit and quantified statements of 'who needs what services from whom', based on the projections of the prevalence of mental illnesses in a standard NSW population and an assumed standard of care over a 12 month period. Under MH-CCP, the scope of services to be delivered includes care required during 12 months by specialist public sector mental health services and the provision of mental health expertise to non-specialist mental health services. The model therefore covers the scope of service outlined in this plan.

According to current MH-CCP estimates, 12,855 people in a population of 100,000 people aged 65 years and older, have a diagnosable mental health problem, ranging from mild (6,680) to moderate (4,200) to severe (1,975). Thus, from a population-based planning perspective, for every 100,000 people aged 65 years and older, the following SMHSOP services would be required:

**Table 1. MH-CCP SMHSOP service planning benchmarks per 100,000 people aged 65 years and over**

	Community	Acute inpatient	Non-acute inpatient (rehabilitation and extended care) and community residential care
Beds		26.5	51.1
FTE	52.2	39.8	50.1

*MH-CCP Version 1.11.*<sup>14</sup>

As noted earlier, the current version of MH-CCP does not fully address the needs of older people with severe BPSD and may therefore be an underestimate of the population need for access to SMHSOP. This issue will be considered in the review of MH-CCP currently underway, and in SMHSOP service planning.

Older people represent 10 per cent of all people suffering from mental health disorders. This is relevant in terms of the balance of mental health service provision, although the complex needs of older people with mental health problems should also be taken into account.

Under the Mental Health Network initiative, the Centre for Mental Health facilitated arrangements between AHSs to link non-acute inpatient services in ways that optimised coordination, access and flow. Whilst the Network model has been superseded by the AHS restructure, the principles of intra-AHS and inter-AHS bed coordination will inform planning for SMHSOP. These principles, which have been adopted by NSW Health in the establishment of the Sustainable Access Program, underpin the bed access arrangements to be developed in Phase 1 of the implementation plan outlined in Section 5.

### Ageing and aged care policy frameworks

There is a division of responsibility between the Australian Government and State and Territory Governments for aged care policy, planning, funding and service provision. Indeed, the success of the Australian health and aged care system depends on, and is characterised by, a high degree of cooperation between all levels of government, a range of service providers and the community. Jurisdictional responsibilities and key services for older people are outlined in Section 3.

The major national strategies and policy frameworks regarding the care of older people include the following:

- *National Strategy for an Ageing Australia (2001)*<sup>15</sup>
- *The Way Forward: A New Strategy for Community Care (2004)*<sup>16</sup>

- *National Framework for Action on Dementia* (under development).

In addition to *Caring for Older People's Mental Health*, the major NSW Health and NSW Government strategies and policy frameworks regarding the care of older people are:

- The NSW Dementia Strategy, *Future Directions for Dementia Care and Support in NSW 2001–2006* (2002), jointly led by NSW Health and the NSW Department of Ageing, Disability and Home Care<sup>17</sup>
- *Framework for the integrated support and management of older people in the NSW health care system (2004)*, NSW Health.<sup>18</sup>

Both the Australian Government *A new strategy for Community Care: the way forward* and the NSW Health *Framework for the integrated support and management of older people in the NSW health care system* articulate the importance of an integrated, multidisciplinary approach to assessment and management of older people with complex health needs – a key principle underpinning the SMHSOP service model and implementation strategies in this plan.

## 2.2 Demographics: The ageing population

### Australia

The Australian population is ageing. Both the number of older Australians and the proportion of the Australian population who are older are expected to increase substantially. For the purposes of this document, 'older

Australians' are defined as people aged 65 years and over, consistent with Australian Bureau of Statistics (ABS) data parameters and the SMHSOP target population. According to ABS census data, there were 2.37 million older people across Australia in 2001. By 2041, 5.7 million or one quarter of Australia's population will be aged 65 years or over.<sup>19</sup>

The numbers and proportion of people in the oldest age groups (80 years and over) are also growing, with increases in life expectancy. This is significant in terms of the higher rates of chronic diseases (including neurodegenerative diseases) and disability associated with increasing longevity and the complex health needs of older people with co-morbid conditions.<sup>20</sup>

### NSW

Over one third of Australia's older people live in NSW.<sup>21</sup> As for the Australian population, the numbers and proportion of older people in the NSW population are increasing, and this is significant for health, aged and community care service planning. In 2003, 889,514 people or 13 per cent of the NSW population were 65 years and over. It is projected that the number of older people in NSW will grow to 1,079,516 (15 per cent of the NSW population) by 2011 and 1,489,735 million (19.4 per cent of the NSW population) by 2022.<sup>22</sup> Thus, using current population-based MH-CCP prevalence estimates, the number of older people in NSW with a diagnosable mental health problem would be expected to increase from 114,347 in 2003 to 191,504 in 2022.

**Table 2. Demographic profile of NSW population 65 years and over by Health Area (AHS)**

Health Area (AHS)	Total population	Population 65 years and over	Percentage (%) of total population 65 years and over	Population 80 years and over	% of older population (65 years +) that are 80 years and over
Sydney South West	1,310,282	142,050	10.8	34,200	24.1
South Eastern Sydney and Illawarra	1,154,072	162,350	14.1	43,265	26.6
Sydney West	1,068,322	101,102	9.5	24,147	23.9
Northern Sydney and Central Coast	1,097,775	163,246	14.9	49,189	30.1
Hunter and New England	825,536	125,989	15.3	32,129	25.5
North Coast	463,453	83,815	18.1	21,404	25.5
Greater Southern	462,434	68,049	14.7	16,561	24.3
Greater Western	304,883	42,913	14.1	10,488	24.4
All NSW	6,686,757	889,514	13.0	231,383	26.0

Note: Population estimated as at 30 June 2003.

Source: NSW Health. *Report of the Chief Health Officer, 2004*. Data based on ABS estimated resident populations (ABS unpublished). For planning purposes, see NSW Health DIPNR projections at Appendix 3.

## NSW Area Health Services

Most of the older population in NSW live in metropolitan and regional areas, although the coastal areas of the State, particularly in the north, have relatively high concentrations of older people. Table A provides a demographic profile of the older population by AHS.

As this table indicates, the Health Areas (AHSs) of Northern Sydney/Central Coast, South Eastern Sydney/Illawarra and Sydney South West have the highest numbers of older people, estimated to be 163,246, 162,350 and 142,050 respectively. The rural and regional Health Areas of Hunter/New England and North Coast also have relatively high numbers of older people, estimated to be 125,989 and 83,815 respectively. In the majority of Health Areas, the proportion of older people (65 years and over) who are in the oldest age group (80 years and over) is around 25 per cent, with the exception being Northern Sydney/Central Coast AHS which has a proportionately high proportion of 'older old' people (30 per cent of people 65 years and over).

It is also worth noting that a number of sectors within these Health Areas have relatively high numbers of older people. These sectors (based on old AHS structures) are Northern Sydney (109,700), South Eastern Sydney (106,560), South Western Sydney (82,380) and Hunter (83,485). Coastal AHS sectors such as Illawarra (57,740), Central Coast (53,585) and Northern Rivers (48,475) have older populations that are almost as large as metropolitan AHS sectors such as Central Sydney (60,230).<sup>23</sup>

Whilst the greatest *numbers* of older people live in metropolitan Health Areas, a number of regional and rural Health Areas have higher proportions of people 65 years and over than these metropolitan Areas. These regional and rural Health Areas are the North Coast (18.1 per cent), Hunter/New England (15.3 per cent) and Greater Southern (14.7 per cent). In particular shires such as the Great Lakes, Tweed Heads and Eurobodalla, approximately one in four people are 65 years or over. Taking into account MH-CCP estimates of population need, weightings for remoteness and social disadvantage, and current limitations in access to specialist resources, these regional and rural Areas will be particularly affected by projected increases in the older population.

The projected numbers of older people in each AHS in NSW by 2011 are outlined in Table 3:

**Table 3. Projected population 65 years and over by Health Area (AHS) by 2011**

Health Area (AHS)	65 years + population
Greater Southern	86,488
Greater Western	51,641
Hunter and New England	155,189
North Coast	107,705
Northern Sydney and Central Coast	180,658
South Eastern Sydney and Illawarra	188,639
Sydney South West	170,103
Sydney West	130,407
<b>Total</b>	<b>1,070,830</b>

As this table indicates, the Health Areas of South Eastern Sydney/Illawarra, Northern Sydney/Central Coast and Sydney South West are projected to have the highest numbers of older people by 2011, estimated at 188,639, 180,658 and 170,103 respectively. Amongst rural and regional Health Areas, Hunter/New England is projected to have the highest number of older people by 2011 (155,189). Demographic projections for the older population by AHS for each year to 2011 are in Appendix 3.

These population statistics and projections highlight the significant imperative for planning and service development in SMHSOP in NSW, guided by this plan.

### 2.3 Population health issues: The mental health of older people

Most people in Australia enjoy a healthy, independent and interactive older age. The incidence of cancer and related diseases is decreasing for people up to 80 years and many older people try to ensure they remain physically fit, socially active, living in their own homes and economically independent for as long as possible. Nevertheless, mental health problems are a significant health risk for many older people. The causes, presentation and management of mental disorders in older people are complex, related to the ageing of the body and the brain, quantitative differences in body chemistry and psychological stressors.

The incidence of disease is significantly higher amongst older people than other age groups and multiple disease conditions are more common. Physical illness, disability and mental health disorders are closely linked in old age. Mental health problems affect physical health and rates



of mortality, increasing the burden of disease for older people. Increasing social isolation and physical health problems in turn impact on the mental health status of older people. Older people often have a range of chronic and complex care needs and may require longer recovery times. Older people may also respond differently to medications compared with younger people and there are appropriate precautions and differences in the way medications – types, amounts, frequency and combinations – should be administered.

Older people who have lived through traumatic experiences such as war and economic depression, such as veterans and war widows, as well as older immigrants who may have experienced war, occupation, torture and trauma, persecution, displacement, migration and settlement, can experience associated mental health problems. Such traumatic experiences and memories can resurface and become debilitating issues in older age. They can also be manifested in the behavioural and psychological symptoms associated with dementia.

Depression, anxiety and severe BPSD are relatively common in old age and are key areas in which SMHSOP have clinical expertise.<sup>24</sup> Schizophrenia and psychotic disorders, substance abuse disorders and delirium are also important mental health issues for older people. As the population ages, the development of effective services to treat these conditions in older people is becoming increasingly important.

## Depression

Depression is a significant mental health issue for older people. An Australian cross-sectional national survey estimated the prevalence of affective disorders (of which depression is the most common type) in older people at 1.7 per cent.<sup>25</sup> However, this figure is generally considered to be a significant underestimate, as it excludes key populations such as people with significant medical problems (eg stroke) or cognitive impairment, and people living in residential aged care facilities (where rates of depression are typically over 20 per cent).<sup>26</sup> Inclusive longitudinal studies in Europe have found much higher overall prevalence rates, rising with age. For example, Skoog et al (2004) found rates using DSM-IV-R diagnostic criteria of 5.6 per cent for people 70 years and over, rising to 12.6 per cent for people over 85 years.<sup>27</sup>

Some people experience depressive symptoms for the first time in old age. Depression in older people has been shown to be likely to persist if untreated and takes longer to resolve. It is strongly associated with psychiatric

co-morbidity, physical ill health (eg cardiovascular disease), greater dependence and earlier death through suicide or illness.<sup>28</sup> Depression thus contributes significantly to the burden of disease in older people.

Risk factors for depression in older people include: previous episodes of depression or mania, personality disorder, other psychiatric disorders and/or chronic illness, cognitive change, and substance dependence and/or abuse. Bereavement, particularly the loss of a partner, and other recent major life events such as a life-threatening illness or move to residential aged care facility can lead older people to loneliness, isolation, introspection and withdrawal. Increased physical frailty and caring for another person can also have such effects. Depression has a strong correlation with these life changes and may occur in combination with an adjustment disorder. Depression can mask, accompany or be a precursor to dementia and may accompany delirium. It frequently occurs in combination with anxiety.

Depression is one of the major mental health disorders managed by SMHSOP and adult mental health services.<sup>29</sup> However, depression can often go untreated in the community and in residential aged care facilities (where rates are high, as noted above). Under this plan, SMHSOP community teams will further develop the capacity and strategies to address depression in older people, including prevention and early intervention through capacity building with GPs, primary health and aged care services, community support services and residential aged care staff.

## Anxiety

Anxiety disorders are a significant issue amongst older people. A 1998 study by the ABS reported that 3.5 per cent of males and 5.4 per cent of females over 65 years or older had anxiety disorders. A recent European study found higher prevalence rates of anxiety disorders of 6.1 per cent for people 70 years and over, rising to 10.3 per cent for people 75 years and over.<sup>30</sup> Anxiety often occurs in association with or prior to the onset of depression in older people, and may also be a presenting symptom of depression.<sup>31</sup> In fact, older people with depression exhibit higher levels of anxiety than younger people.<sup>32</sup> Anxiety and depression may occur in the context of adjustment disorder. Causes of anxiety disorders may include physical illness and changes in social circumstances or life events. Symptoms can include fearfulness, panic attacks, social phobias, fear of falling and agitation. Given the relationship between anxiety and depression in older people, it is imperative that

appropriate assessment and treatment for these conditions is provided in an integrated manner.

## Suicide

In Australia, the suicide rate among older men has generally been high when compared with other age and gender-specific population groups, but has fallen for men aged 60–80 years in recent decades. In 2001, there were 13.2 suicides per 100,000 older people in NSW. The rate for older men (22.8 per 100,000) was considerably higher than the rate for older women (6.3 per 100,000).<sup>33</sup> Whilst 2001/02 ABS data shows that suicide rates in men 70 years and over were relatively low (21.63 per 100,000 compared with 29.3 for men aged 30–49 years), the rate in the oldest age groups was high (32.7 per 100,000 men aged 85 years and over).<sup>34</sup> This may be related to a range of factors including dismay or despair over being physically and economically dependent on others and over irreversible functional deterioration in later old age. Older women have a similar suicide rate to the general female population.

An epidemiological study by McDonald and Steel indicates that older people from non-English speaking countries have significantly higher suicide rates than the general older population in NSW.<sup>35</sup> Some factors that contribute to increased risk of suicide for this cohort are increased levels of social isolation, breakdown in the family unit and family support structures, traumatic experiences prior to immigration, settlement experience and lack of English language proficiency.

Personality, personal resilience, health, education and socio-economic status all impact on a person's response to changes that occur in older age. However, the most significant risk factors for suicide in older people are physical ill health and pain, social isolation and loneliness, depressive disorders, recent losses, recent or previous history of suicide attempts and family history of suicide. Low socio-economic status and alcohol/substance abuse can also contribute to suicide risk. Most people who die from suicide have experienced a mental health problem prior to death. Depression is strongly correlated with suicide risk in older people, accounting for two thirds of suicide deaths in people over 50 years.<sup>36</sup>

Protective factors that contribute to reduced risk of suicide in older people include personal resilience, social connectedness, financial security, good physical health and physical activity. These factors are suggestive in terms of mental health promotion and illness prevention programs for older people. Older people are more likely

to die from suicide attempts (4:1) than younger age groups (300:1),<sup>37</sup> highlighting the need to respond early to signs of distress, including suicidal ideation, in older people.

A significant proportion of people who die by suicide have seen a health care provider in the three months prior to death.<sup>38</sup> Older people are high users of health services such as GPs, community health services and hospitals, so there are significant opportunities for intervention by these various health care providers to prevent suicide in older people. However, attitudes about ageing, mental health and suicide (eg higher tolerance of suicidal behaviour in older people compared with younger people and reluctance of older people to discuss sad feelings or mental health concerns) mean that many older people do not recognize or seek help for mental health problems, and that depression and suicide risk are often not detected or treated in older people.<sup>39</sup> Moreover, in consultations with older people, presenting concerns are often complex and physical symptoms may take attention over mental health concerns, making it difficult to detect depression and possible suicide risk.

Given the strong association between depression and suicide in older people (particularly older men), increased vigilance, early responses and appropriate treatments for depression and other affective disorders are considered effective suicide prevention strategies.<sup>40</sup> The evidence also indicates that more assertive early intervention services are required. Community awareness strategies to address issues of ageism and the stigma that many older people feel about disclosing their feelings will also be important.<sup>41</sup> Since older people do not generally access mental health services, SMHSOP will need to work with other primary health care providers such as GPs, community health nurses and hospital staff to develop their capacity to recognize depression and other suicide risk factors in older people and refer appropriately.

Further priorities and strategies for suicide prevention in older people are outlined in the NSW *Suicide Prevention Strategy* (currently being updated), the NSW Health training manual on *Suicide Prevention for Older People* (2000) and the Australian Government LIFE Framework (*Living is for Everyone: a Framework for the Prevention of Suicide and Self Harm in Australia*, 2000). Further models and strategies for mental health promotion, mental illness prevention and early intervention are outlined in Section 4.

## Substance use disorders

A small but significant cohort of older people, predominantly men, is affected by substance use disorders. A 1998 ABS study of mental health and wellbeing of adults found that 2.1 per cent of older men and 0.2 per cent of older women suffered from substance use disorders.<sup>42</sup> However, it should be noted that there are limitations to prevalence information regarding substance use disorders in older people because the diagnostic criteria were developed and validated on young and middle-aged adults. Some of these people are currently living in boarding houses or supported accommodation in the community. Some are homeless or at risk of homelessness. They may have developed dementia and have BPSD, complicated by their substance use disorder. They may be difficult to place in residential aged care facilities when they require high levels of nursing and physical care. This group has traditionally been the clients of adult mental health teams, drug and alcohol services and adult-oriented mental health non-government support services. They will require appropriate models of care and accommodation.

Another important group is those who are dependant upon prescription drugs or suffering from significant side effects from inappropriate prescribing of psychotropic medication. Older people in nursing homes are particularly at risk in this regard, especially if they have dementia. Specialist medical practitioners in SMHSOP have an important role to play in reviewing medication regimes and advising on appropriate prescribing for older people.

## Schizophrenia and psychotic disorders

People with schizophrenia and psychotic symptoms present complex clinical challenges. Schizophrenia is one of the most disabling mental illnesses and is associated with poor physical health status.<sup>43</sup> It affects approximately 0.5 per cent of the Australian population and may affect a person throughout their lifetime or emerge later. Some older people with schizophrenia are long-stay patients in mental health non-acute units or Confused and Disturbed Elderly (CADE) units, or are living in supported accommodation. Others may be homeless. A 2004 study of homeless men and women in inner Sydney found that the prevalence rate for schizophrenia was 23 per cent among men and 46 per cent among women.<sup>44</sup> Older people with schizophrenia who have high physical health needs may have difficulty gaining access to residential aged care facilities, where staff may not have the skills and expertise to provide appropriate care. Despite these access difficulties, a 1997 Australian

study found that approximately 5 per cent of people in nursing homes had schizophrenia or a paranoid disorder.<sup>45</sup> Further consideration needs to be given to appropriate long-term care models for this group of vulnerable older people, and to strategies to facilitate training and skills development for residential aged care staff and specialist outreach to the residential aged care sector.

## Delirium

Delirium is an acute confusional state characterised by disorientation and a fluctuating level of consciousness. It is often due to an acute medical condition and may have similar symptoms to delusional presentations. Delirium is not a diagnostic category for the purposes of medical records and is therefore under-represented patient data. However, a number of Australian studies have shown an incidence of delirium of up to 50 per cent amongst older people in acute hospitals.<sup>46</sup> Delirium is associated with increased length of stay, increased morbidity and poor prognosis. There are significant risks for patients if delirium goes untreated.

Whilst delirium is not a psychiatric disorder, the “3 D’s” of depression, dementia and delirium can create complex clinical presentations and may occur individually or in combination in older people. These illnesses and their interactions are complex, and appropriate, safe and effective care relies on expert differential diagnosis, assessment and management by specialists in geriatric medicine, assisted by specialists in older people’s mental health, when required.

## Dementia

Dementia is a syndrome due to disease in the brain, usually chronic and progressive, which affects memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The most common causes of dementia are Alzheimer’s disease and vascular disease. Other causes of dementia include frontal lobe syndromes, Pick’s disease, Lewy Body disease, acquired cognitive impairment (alcohol-related brain damage) and AIDS. Dementia is very disabling and has a significant impact on the lifestyle of people with the disease and their families and carers. It is projected to overtake depression as the leading cause of disability burden in Australia by 2016.<sup>47</sup>

The risk of dementia, particularly Alzheimer’s disease, increases with age. Current estimates indicate that approximately 1.4 per cent of people 65–70 years old will have dementia, and that the rate increases to

10.5 per cent for people 80–84 years old, and 20.8 per cent for people 85–89 years old. A relatively small but significant number of people develop dementia at younger ages. Recent estimates are that there are 1,700 Australians under 60 years with dementia.<sup>48</sup> As the population ages, the number of people with dementia in NSW is projected to grow from approximately 71,400 in 2005, to 83,200 by 2010 and 110,300 by 2020.

### *Dementia and mental health problems*

Dementia affects each person in a unique way, but is frequently associated with mental health problems such as depression or psychosis, and with a range of behavioural symptoms. These non-cognitive symptoms and behaviours are often referred to as Behavioural and Psychological Symptoms of Dementia (BPSD). Whilst cognitive dysfunction in dementia progressively worsens over time, many BPSD tend to be episodic and to fluctuate over time. BPSD include aggression, screaming and shouting, inappropriate sexual behaviour, restlessness and agitation, intrusiveness and resistance to care, and, at the severe end of the spectrum, physically violent or aggressive behaviour, severe depression, psychosis and suicidal symptoms.

The epidemiology of dementia is a difficult issue in its own right. The epidemiology of BPSD and the degree of overlap between BPSD and functional psychiatric illness are even more complicated. However, it is recognised that people with severe behavioural and psychiatric symptoms associated with dementia may require intervention from SMHSOP. Prevalence estimates for BPSD vary widely. Brodaty, Draper and Low have estimated that dementia is complicated by BPSD in over 90 per cent of cases during the course of the disease.<sup>49</sup> International research suggests that about one third of community-dwelling people with dementia and 80 per cent of people in residential facilities experience clinically significant BPSD.<sup>50</sup> However, these figures have not been specifically applied in an Australian service system context.

Brodaty et al have estimated that one third of people with dementia will experience moderate-severe behavioural and psychiatric symptoms and would benefit from input from SMHSOP at some level, including joint assessment with aged care services (see Appendix 4).<sup>51</sup> Applied to current dementia prevalence estimates, this equates to approximately 23,800 people across NSW in 2005. This is the broad target group for the 'severely and persistently challenging behaviours' model outlined in Section 4.1.5, particularly the Behavioural Assessment

and Intervention Service (BASIS) model. However, the priority target group for SMHSOP is the smaller group of those with severe behavioural and psychological symptoms, estimated at 7,850 across NSW in 2005.

BPSD presents significant challenges for families and carers, primary health and community care services, residential aged care staff, and acute care hospital services. Differential diagnosis and pharmaceutical and behavioural management issues for people with severe BPSD are complex and coordinated intervention from a range of services is required. Mental health services in general and SMHSOP in particular will need to further develop service capacity to respond to the complex needs of older people with severe behavioural and psychiatric symptoms associated with dementia, including assessment and case management services. It will be important for mental health services to develop effective partnerships with aged care services (ACATs, geriatric medical services, Home and Community Care services), GPs and residential aged care services. Service model and implementation issues regarding development of the SMHSOP role in the care of this group are addressed in the SMHSOP service model in Section 4 and the SMHSOP implementation plan in Section 5.

## 2.4 Specific needs issues: Groups requiring special attention

Certain population groups have special needs regarding service appropriateness and accessibility and present particular service delivery and service coordination challenges for mental health services. Some older people have special needs relating to cultural and linguistic background, co-morbidity and complex needs issues, and life circumstances. Disadvantage caused by social, economic and geographical factors may also impact on the need for and access to mental health services.<sup>52</sup> These special needs issues should be addressed in SMHSOP policy development, planning and service delivery processes. In some instances, targeted strategies and programs may be required to offer appropriate service responses, increase access to mental health services and promote a coordinated approach to care.

Population groups with special needs relating to the planning and development of services that are culturally and age appropriate include Aboriginal peoples, CALD communities, people living in residential aged care facilities, 'functionally old' younger people with mental health needs, and people with recurrent or life-long

mental illness who are ageing. Groups that may require special attention due to disadvantage and geographical factors include people living in rural and remote areas, older people with mental health problems who are living in squalor, and older people who are homeless or at risk of homelessness. The needs of older people in the criminal justice system warrant particular attention. Families and carers of older people with a mental illness are also an important part of the SMHSOP target group. These so-called 'special needs groups' are discussed below.

## Aboriginal people

There are particular issues associated with service delivery for Aboriginal people. These issues need to be understood within a context which recognises the complex inter-relationship of individuals, historical, social, cultural, economic, environmental, mental and physical factors that affect the social and emotional well-being of Aboriginal people.<sup>53</sup> The life expectancy of Aboriginal people in NSW is, on average, 20 years below that of the general population. Of all population groups in Australia, Aboriginal and Torres Strait Islander peoples are most affected by an early onset of the diseases and conditions generally associated with ageing. This has led to the targeting of aged care services to these people from the age of 50 years, whereas the general target groups for aged care programs are people aged 65 years or 70 years and over. According to the Department of Health and Ageing (DoHA) data, there were 12,000 Aboriginal people and Torres Strait Islanders aged 50 years or more in NSW in 2001.<sup>54</sup>

While accurate and reliable data on the mental health and social and emotional well being of Aboriginal people is limited, a number of surveys and studies have shown high levels of psychological distress, high rates of suicide and self-harm, and high prevalence of grief, loss and trauma.<sup>55</sup> Depression and complex co-morbid mental health problems are significant issues for older Aboriginal people. The only dementia prevalence study conducted with Aboriginal communities found a higher prevalence of dementia in Aboriginal people 65 years and over, with cerebrovascular disease, alcohol use and injury being common underlying causes. Significantly, these causes are potentially preventable.<sup>56</sup> Aboriginal people may also suffer from earlier onset of dementia and other age-related mental health problems.

Aboriginal Elders, who are often older Aboriginal people, hold a unique position of respect, leadership and status within Aboriginal communities. Many Elders have

carried the excessive burden of grief, loss and trauma of Aboriginal people, removal of children and the breakdown of family and community structures, and this may affect their health and wellbeing. Many older Aboriginal people, especially Elders, continue to play a key role in providing care and support within extended families and households, as well as carrying the responsibility for leadership, consultation and negotiation processes. These responsibilities, which may occur within the context of high levels of psychological distress, alcohol abuse and violence, can take their toll on the physical and mental health of older Aboriginal people, and mental health services will need to take this into account in developing service responses.

In addressing the social and emotional well being of older Aboriginal people, it will be important to improve the responsiveness and appropriateness of both mainstream and Aboriginal mental health services. This will require a range of strategies integrating prevention, promotion and early intervention activities, the provision of care across the lifespan and the promotion of holistic approaches to health care. These strategies should be consistent with the *NSW Aboriginal Mental Health Policy (1997)* and its successor, the *NSW Aboriginal Mental Health and Well Being Policy (forthcoming)* and other key NSW Health documents outlined in Section 4.2.<sup>57</sup>

## Older people from culturally and linguistically diverse (CALD) backgrounds

Approximately 20 per cent of people aged 65 years and over in NSW come from non-English speaking (NES) backgrounds. Amongst the Australian population born overseas from a NES country, the proportion of people 65 years and over is high compared with the older population in the general community. Moreover, the CALD population is ageing at a faster rate than the general population. The proportion of older Australians who come from NES backgrounds is projected to increase from 17.8 per cent in 1996 to 22.5 per cent in 2011.<sup>58</sup> While the older population from CALD backgrounds is heterogeneous in its composition and needs, there are some specific factors that may directly or indirectly impact on the mental well being of this population group and have implications for effective assessment, intervention and management strategies.

Factors such as low English proficiency,<sup>59</sup> cultural and religious issues, lack of social supports, breakdown in extended family networks and the older person's role within the family, low awareness of public health

services and the lack of culturally and linguistically appropriate service delivery models and information can all impede access to mental health services by older people from CALD backgrounds. These issues can place a significant emotional and psychological burden on this population group. The refugee population may develop specific psychiatric disturbances associated with pre-migration experiences such as war, persecution, torture and trauma. Post Traumatic Stress Disorder (PTSD) for this group is not uncommon.

The mental health needs of older people from CALD backgrounds may vary according to years of residency in Australia, level of social and geographic isolation and loneliness, health status, whether migration was voluntary or involuntary, and their pre and post migration experiences. Mental health services and SMHSOP will need to enhance their recognition of symptoms that may be presented or described differently by older people from CALD backgrounds and develop strategies and service models that are responsive to the particular needs of this group, particularly in light of the more rapid ageing of the CALD population. These strategies will require collaborative partnerships with aged care services, multicultural agencies, interpreter services, bilingual workers, specialist transcultural mental health services and families and carers. They should be consistent with the *NSW Multicultural Mental Health Plan 2006–2010* (forthcoming).<sup>60</sup>

### **'Functionally old' younger people with mental health needs**

Some younger people develop age-related functional disability associated with dementia, acquired cognitive impairment and other conditions. A range of services, such as primary health care services, disability services, aged care services, community support services and supported accommodation services, have a role in the provision of appropriate care and support for this group, and there are currently significant issues impacting on their health and welfare. In some cases, these people may benefit from some mental health input to assessment processes and care planning as part of a coordinated response with other key services. Further work between relevant jurisdictions, agencies and services will be required to develop assessment, care planning and referral processes and service models for people with an intellectual disability that are appropriate to their needs, age and circumstances.

### **Older people with recurrent or life-long mental illness and age-related problems**

There is a small but significant cohort of older people who have had life-long or recurrent mental illness such as schizophrenia or a substance use disorder, and develop physical and neurological problems associated with ageing. Some of these people are currently living at home with ageing parents, in boarding houses or supported accommodation in the community. Some are homeless or at risk of homelessness. They are difficult to place in residential aged care facilities if they require high levels of nursing and physical care due to their disturbed behaviour. There is a small number who are resident in the long stay non-acute mental health facilities. These people can have mixed morbidity and have traditionally been the clients of adult mental health teams, drug and alcohol services and adult-oriented mental health non-government support services. They will require specialised aged care support and medical interventions, and appropriate models of care and accommodation. Programs such as the Housing and Accommodation Support Initiative (HASI) jointly provided by NSW Health and the NSW Department of Housing, and DoHA's Assistance with Care and Housing for the Aged (ACHA) Program and Housing-Linked Community Aged Care Packages (CACPs) may provide some opportunities for developing appropriate partnership models.

### **Rural and remote communities**

Whilst there is no evidence of higher levels of psychological distress or mental health problems in rural and remote areas in NSW Health survey data, there are high levels of socio-economic disadvantage in many rural and remote areas, particularly in the GWAHS and NCAHS<sup>61</sup> and access to specialised health and mental health services can be limited in these areas. There is a notable absence of old age psychiatrists and other SMHSOP medical staff such as geriatricians in rural areas for appropriate assessment, diagnosis and treatment. Mental health nursing and allied health staff are also limited in most rural and remote areas. Whilst there are shortages of rural GPs, they are a key element of the service system for older people with mental health problems in rural and remote areas. Partnerships between mental health services and GPs (including consultation and shared care arrangements and training strategies) will be fundamental to improving responses to the mental health needs of older people in these areas. Workforce development strategies will also be critical.

Rural communities often generate innovative solutions to health service issues, but isolation, service access issues, mobility and transport issues and lack of specialist mental health teams are major concerns for delivering equitable services to meet the needs of older people in rural and remote areas. Despite the availability of telehealth, further strategies are required to appropriately utilise this service to support the mental health workforce and promote access to specialist services by older people with mental health problems living in rural and remote areas.

### People in residential aged care facilities (RACFs)

Residents of nursing homes and hostels are a relatively small percentage of older people but they are a vulnerable group. In 2003, there were approximately 52,000 people living in RACFs in NSW.<sup>62</sup> Numerous surveys have reported the high prevalence of mental health disorders in these facilities. Australian studies have confirmed US findings concerning the high rates of anxiety disorders and BPSD in aged care facility residents and found rates of major depression of over 20 per cent and rates of schizophrenia or paranoid disorder of 5 per cent.<sup>63</sup>

This group of older people may not receive diagnosis or treatment of their mental health problems, particularly if their symptoms are not obviously displayed through behavioural disturbance or expressions of distress.

In some cases, chemical and/or physical restraint may be used inappropriately to manage disturbed behaviour. Section 4 outlines proposed strategies to improve mental health care for older people in RACFs by enhancing SMHSOP support to these facilities in a targeted way. These strategies include capacity building and training with RACFs by Elderly Suicide Prevention workers and SMHSOP community teams, and enhanced SMHSOP consultation-liaison and case management to RACF residents through the BASIS model and through the development of long-term care options. The NSW Health *Guidelines for working with people with challenging behaviours in residential aged care facilities* (currently being finalised) and the DoHA *Decision-making tool: responding to issues of restraint in residential aged care* (2005)<sup>64</sup> will complement and support these strategies. Planning and service development in the residential aged care sector and relevant Australian Government programs will also be required to support these initiatives.

### People who are homeless or at risk of homelessness

Age-related health and mental health problems can compound the difficulties of maintaining housing. A study of homeless people in Sydney found that 73 per cent of men and 81 per cent of women met the criteria for at least one mental disorder in the past year and there was considerable co-morbidity between mental disorders.<sup>65</sup> Whilst a broad definition of mental health disorder was used for this study, it indicates a strong association between mental health problems and risk of homelessness. Various factors can place people at risk of homelessness. People on low incomes in the rental market may be placed under housing stress or pushed into homelessness by rising rents or loss of tenancy. This could be precipitated by a partner dying or increasing gentrification of an area and the landlord wanting to sell. People who have few or no family networks are particularly at risk in these circumstances. These people are often reluctant to ask for support and become increasingly isolated with poor self-care.

There is a significant cohort of older people at risk of homelessness who are reliant on social, public health and housing services and have been so for many years. They are usually single, predominantly male and experience poor health, poor nutrition, premature ageing, loneliness, marginalisation and social isolation. Many also have cognitive problems and significant levels of functional disability. A 1993 study found that the prevalence of cognitive impairment among homeless men in a hostel in inner Sydney was 25 per cent.<sup>66</sup>

Older homeless people, especially those who have been transient for long periods, age prematurely, often experiencing poorer health and early death. To address the needs of this vulnerable group of older people, mental health services and SMHSOP will need to provide specialist clinical input to services catering to people who are homeless or at risk of homelessness, and to develop and provide appropriate models for accommodation and support in partnership with these services. Key services in this area include:

- Supported accommodation providers such as Support Accommodation Assistance Program (SAAP) providers, ACHA providers and providers of CACPs targeting people who are homeless or at risk of homelessness.
- Boarding houses and social housing providers.
- Residential aged care providers.

A number of agencies have developed models and frameworks that may have some application to older

people in this situation, such as DoHA's ACHA Program Guidelines and NSW Health's *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders*.<sup>67</sup>

### People living in severe domestic squalor

People living in severe domestic squalor, often referred to as Diogenes syndrome, are a small but significant group that present particular challenges to mental health and other health care professionals, social services, local councils and environmental health officers, families and neighbours. The condition of severe domestic squalor is more common in older people, although it is not limited to older people. Whilst epidemiological data regarding this group is limited, the referral rate over four years to a Sydney-based SMHSOP indicates an annual incidence rate of 10 per 10,000 people aged over 60 years.<sup>68</sup> This is likely to be an underestimate of incidence, since many cases may never be referred to health services.

The majority of people who live in severe domestic squalor appear to have a mental health disorder or associated condition, with the most common conditions being alcohol abuse, dementia (fronto-temporal, Alzheimer's disease, alcohol-related), chronic schizophrenia, depression and intellectual disability. Most studies have also indicated that this group has moderate-high rates of associated physical co-morbidity.<sup>69</sup>

The NSW Department of Ageing, Disability and Home Care (DADHC) is developing guidelines to assist frontline staff in meeting the needs of people living in severe domestic squalor and these will be relevant for mental health services and SMHSOP. Programs such as NSW Health and the Department of Housing's (DoH) HASI Program and DoHA's ACHA Program and Housing-Linked CACPs may provide some opportunities for developing appropriate partnership models.

### Older people in the criminal justice system

The number and proportion of older people within the Australian criminal justice system is relatively small but growing and this group presents complex challenges in relation to care and support, both within the criminal justice system and at the interface with mainstream services. The number of inmates aged 50 years and over in the Australian prison population rose from 12,113 people in 1987 (4.1 per cent of the total prison population) to 19,082 people in 1997 (7.4 per cent of the total prison population). The majority of older inmates (95 per cent) are male and most are first time inmates imprisoned at an older age (73.8 per cent) rather than

repeat offenders or inmates imprisoned at a younger age who grow old in prison due to long sentences. Violent offences and sexual offences are the most common offence categories for older inmates.<sup>70</sup>

For the purposes of aged care and SMHSOP planning within the NSW Justice Health system, 'older people' are defined as 55 years and over rather than 65 years and over. This definition is commonly accepted internationally (eg US Department of Justice) and is based on the poorer health status and higher mortality rates of inmates, relative to the general population.

A 2004 Justice Health survey of aged care needs in NSW identified 283 older inmates with higher care needs than their age-matched peers. The majority of these are located at the Long Bay prison complex, where they can be suitably accommodated separately from younger, active inmates who may present a risk of injury, and many have complex medical and mental health needs. According to Mental Health Outcome and Assessment Tool (MH-OAT) data, the most common mental health disorders amongst older inmates are schizophrenia and psychotic disorders and depression, and this group requires appropriate identification, assessment and treatment from mental health staff, appropriate clinical pathways and clear discharge planning processes. Some are unable to self-care and require assistance with activities of daily living (ADLs) such as showering. This is a significant issue for Department of Community Services (DCS) staff and there is a need to develop appropriate facilities and supported accommodation models for this group.

In relation to discharge, there are particular issues around accessing residential aged care placement for frail offenders (many of whom have mental health problems) when eligible for parole, particularly ageing sex offenders, and there are limited options for community placement for ageing forensic patients. Justice Health has identified a range of strategies to address these needs and issues, in partnership with DCS, ACATs and SMHSOP, and these are outlined in Section 4.2.

### Families and carers

The families and carers of older people with mental health problems are an important group for SMHSOP. According to 2003 ABS figures, 11 per cent of the total NSW population are carers.<sup>71</sup> Whilst there is no specific data on the number of carers of older people with mental health problems, most would have a carer or family member interested in their welfare and/or providing some level of care and support.



Families and carers provide valuable care for older people with mental health problems, but they need skills, resources and support to effectively carry out this role. Caring for someone can be a positive experience, and contribute to personal growth and life satisfaction. However, many carers find that this role can lead to emotional overload, dissatisfaction, frustration, anger and ultimately poor health.<sup>72</sup>

Families and carers of older people with mental health problems are faced with understanding the symptoms and needs of their loved one, navigating a complex service system, and finding appropriate information, services and supports. In a national survey in 2000, families and carers of people with mental health problems reported extremely low satisfaction with services in a range of areas including: access to information; availability of education and training; availability of emotional and social supports; not being consulted with by professionals; little opportunity to participate in policy decision-making; difficulty taking a break from caring; little back up help, and availability of information about carer rights and responsibilities.<sup>73</sup>

Any caring role can be difficult, but caring for an older person who develops severe behavioural and psychological symptoms associated with dementia or other mental health problems for the first time in older age presents specific challenges. These include dealing with the shock of diagnosis, and need for adjustment to role changes in the relationship with the consumer, and possibly changes in working and/or living arrangements. The range of additional physical problems and functional disabilities that may be associated with ageing can also impose additional requirements for physical support.

The stressors that families and carers experience can adversely impact on their own mental and physical health and well-being. A range of studies has shown that many carers of older people with mental illness, or moderate to severe dementia, experience clinically significant levels of depression. A UK study involving a small but representative urban community sample of carers of older people with functional psychiatric illness found that 24 per cent had depression.<sup>74</sup> A large US cross-sectional study of caregivers of people with moderate-severe dementia found that 32 per cent had symptoms consistent with clinical diagnosis of major depression.<sup>75</sup> These symptoms are also consistent with adverse outcomes such as functional decline, hip fracture and residential care placement. Whilst caregiver depression is a complex process, affected by cultural factors, patient characteristics and caregiver characteristics,

clinicians should be vigilant in considering the presence of depression in carers of older people with dementia and/or psychiatric illness.<sup>76</sup> Respite is a key issue, and SMHSOP should provide information about and referral to appropriate respite services, where appropriate.

It is important that mental health services respect the carer's role and expertise (which is often born of a long-standing relationship with and knowledge of the older person), and seek and support their participation in assessment and care for the person with mental health problems, whilst respecting any limitations they may express. Carers' goals and choices should be supported.

Services need to engage in a meaningful way with carers and families to enlist their support, cooperation and trust. This means acknowledging and respecting that carers and families bring a diversity of cultural, linguistic and religious backgrounds, family experiences, values and beliefs, and attitudes to mental illness to their caring role. For Aboriginal families and carers, participation in assessment, case conferences, decisions and care planning relating to family members is particularly important. Such participation serves to promote and respect the principles of self-determination for Aboriginal families and carers in the delivery of health services. For consumers and families and carers from CALD backgrounds, services should consider the provision of translated information materials, and the involvement of interpreters, bilingual workers and/or multicultural agencies. Effective partnerships with families and carers can reduce their stress and support them in their caring role, as well as contributing to positive clinical outcomes for consumers.

The NSW Health Family and Carers Mental Health Program, to be implemented across NSW over the next two years, will assist services to address these issues. The Program will be guided by the *Framework for Family and Carer Support in NSW Mental Health Services* (currently under development) and will focus on three key priority areas: development of family-sensitive mental health services; provision of mental health family and carer support services (via the non-government sector), and facilitation of access to generic family and carer supports and programs (including respite).

# Current services and service planning challenges

This section outlines current services and programs providing care for older people with mental health problems, strategic priorities relating to pressures on the service system and current NSW Health initiatives addressing these strategic priorities.

## 3.1 Current services for older people with mental health problems

All levels of government, along with a range of other service providers, have responsibilities in the provision of assessment, treatment, accommodation and support services for older people with mental health problems. Primary responsibility for aged care policy, planning, funding and service provision rests with the Australian Government and State/Territory Governments, and the interfaces between different jurisdictional programs require ongoing attention to avoid duplication of effort and resources and ensure an integrated approach to care.

### Government responsibilities and programs

The **Australian Government Department of Health and Ageing (DoHA)** is responsible for the funding, regulation, planning and monitoring of residential and community aged care services. In addition, the Australian Government is responsible for funding medical services, including treatment by GPs and private psychiatrists, through fee-for-service arrangements under Medicare.

The **Australian Government Department of Veterans' Affairs (DVA)** provides a range of health, aged and community care services for the entitled veteran community, either directly or through arrangements with government and non-government service providers.

**NSW Health** is responsible for acute care facilities (public hospitals), community health services and public health programs. In addition, it directly operates some residential and community care services, and provides some longer-term hospital care through public sector mental health and aged care services.

AHSs provide a range of population-based aged care, mental health and rehabilitation services that complement general health services available for older people.

NSW Health shares responsibility with the Australian Government DoHA for the operation of ACATs under the Aged Care Assessment Program. NSW Health also administers the health component of the HACC Program, under which it provides community nursing, allied health and some day care services.

The **Department of Ageing, Disability and Home Care (DADHC)** has an agreement with the Australian Government for the funding and administration of the HACC Program. DADHC is responsible for the delivery of services and supports (particularly home-based services) for older people, people with a disability and their carers in NSW.

**Local governments** provide some hostel and community care services, as well as having a regulatory role. They may also provide funding and coordinate service provision.

The *non-government sector* is the major provider of residential and community care services, and comprises private (for profit) operators, and not-for-profit (religious, charitable and community) organisations. Private hospitals and private psychiatrists are key providers of mental health care in some areas.

There are a number of key services and programs operating in NSW, administered by various agencies and jurisdictions, that are targeted to older people and may be relevant for older people with mental health problems. These include the following:

- Specialist Mental Health Services for Older People (SMHSOP) – NSW Health
- Specialist geriatric/aged care teams in hospital and community settings – NSW Health
- Aged care Services Emergency Teams (ASET) – NSW Health
- Dementia Clinical Nurse Consultants (DCNCs) – NSW Health

- Dementia Advisory Services (DAS) – DADHC
- Confused and Disturbed Elderly (CADE) Units – NSW Health
- Aged Care Assessment Program (ACAP) – DoHA and NSW Health
- Multi Purpose Service (MPS) Program – NSW Health
- Community Packages (Compacks) – NSW Health
- Community Acute/Post Acute Care (CAPAC) Program – NSW Health
- Chronic and Complex Care Programs – NSW Health
- NSW Carers Program – NSW Health
- Home and Community Care (HACC) Program – DoHA and DADHC
- Residential Aged Care Facilities (RACF) – DoHA
- Psychogeriatric Unit (PGU) Program – DoHA
- Aged Care Innovative Pool Program – DoHA and NSW Health
- Transitional Aged Care Program – DoHA and NSW Health
- Extended Aged Care at Home (EACH) packages and Dementia EACH packages– DoHA
- Community Aged Care Packages (CACPs), including packages targeting older people who are homeless or at risk of homelessness and housing-linked packages targeting older people who are financially disadvantaged – DoHA
- Assistance with Care and Housing for the Aged (ACHA) – DoHA
- Commonwealth Carer Respite Program – DoHA
- Commonwealth Carelink Program – DoHA

Details of these services and programs are at Appendix 5. Other relevant services include disability services, public housing and supported accommodation services.

## Mental health care

Primary mental health care is provided most frequently by GPs, and also by community health services, including aged care services. In NSW, secondary or specialist mental health services are in place in the public sector and also in the private sector. AHSs provide mental health services across the age spectrum, including crisis response, assessment, inpatient and community treatment, rehabilitation and support to people experiencing mental health problems and disorders, and their families and carers.

## Specialist mental health services for older people

In a number of AMHSs, there are designated Specialist Mental Health Services for Older People, as noted above. These services have a specialist capacity to assess, treat and manage a complex range of mental health disorders in older people, including severe Behavioural and Psychological Symptoms of Dementia. SMHSOP clinical service components and clinical functions are outlined in Section 1.4 of this document.

Most rural and remote Areas, some regional AHSs and some metropolitan AHS zones of up to 250,000 people have limited or no SMHSOP and have limited access to acute and sub-acute units for older people with complex mental health problems. Telepsychiatry and outreach clinicians currently serve some rural/remote AMHSs but these services generally operate on a primary health care model, founded on strong capacity building work and partnerships with primary health care services. SMHSOP service options outlined in Section 4 address the issues around service delivery in rural and remote areas.

NSW Health's first step in developing a statewide approach to addressing the specific mental health needs of older people was the establishment of specialist elderly suicide prevention workers in all AHSs across NSW, focussing on suicide and depression prevention in older people. The NSW Elderly Suicide Prevention Network (ESPN) was formed in 1998 to support collaboration between these staff and facilitate a coordinated approach to their activities across NSW. This initiative was a response to the Burdekin Report (or Human Rights and Mental Illness Report of the National Inquiry into the Human Rights of People with a Mental Illness, 1993), which identified that depression and suicide were major health issues for older people. Elderly suicide prevention workers in AMHSs and the ESPN remain a key component of SMHSOP across NSW, providing a specialist response to the mental health needs of older people with respect to the priority areas of mental health promotion, illness prevention and early intervention.

From a statewide perspective, however, there is currently limited capacity in SMHSOP across NSW, particularly in dedicated SMHSOP community teams, which are operating (on average) at approximately one quarter of MH-CCP service planning benchmarks across NSW. There is also significant variation in capacity between AHSs in all clinical service components. Whilst it should be noted that older people with moderate-severe mental health problems can generally access appropriate care

through generalist or adult mental health teams and inpatient services and other key health services, SMHSOP service development strategies are required to improve the quality and effectiveness of mental health care for older people. Responses to these key issues are prioritised in Phase 1 of the SMHSOP implementation plan in Section 5. At the AHS level, the response to these issues will be led by Area SMHSOP Clinical Coordinators funded by NSW Health, as outlined in Section 3.2.

In some Areas, there are SMHSOP clinical service structures or streams, with SMHSOP Clinical Directors and teams, specialist service delivery models, and formalised partnership arrangements and referral protocols with other key services. These structures and arrangements will provide a strong basis for further planning and service development by Area SMHSOP Clinical Coordinators, guided by this plan.

Despite recent Australian Government initiatives to enhance access to private psychiatry services for residents of aged care facilities, older people have lower rates of utilisation of private services due to factors such as affordability issues, reduced mobility and medical co-morbidity. This issue is addressed in MH-CCP planning benchmarks for SMHSOP and will need to be considered by AMHSs in SMHSOP service development, as well as in policy and planning by DoHA.

### 3.2 Key issues and strategic priorities in older people's mental health

It is clear that pressures on the system of care for older people with health problems have increased across Australia and will continue to do so. There are challenges ahead for all government jurisdictions and the range of care providers as services attempt to manage more complex presentations in the elderly and keep pace with the growth of the older population.

For NSW Health, there are a number of strategic priorities associated with addressing the needs of particular cohorts within the broader target group of older people with mental illness, with continuity of care and with sustainable access to public mental health services. Policy and planning to address these strategic priorities will need to be coordinated with developments under the *Framework for the integrated support and management of older people in the NSW health care system*, the *NSW Dementia Strategy*, AHS Sustainable Access Plans and the programs and initiatives of other government agencies, particularly DoHA. The role of SMHSOP in addressing these issues is outlined in Section 4.

#### Addressing the needs of older people with recurrent, life-long or emerging mental illness who are ageing

In order to respond to the needs of the growing number of older people with recurrent, life-long or emerging mental illness who are ageing, there is a need to:

- Develop targeted and indicated mental health promotion, prevention and early intervention initiatives for older people, building on the work of the Elderly Suicide Prevention Network and initiatives such as the elderly suicide prevention training and depression programs developed by CMH.
- Develop a greater focus on programs, services and facilities appropriate for older people within mental health planning and service development.
- Address barriers for older people with mental illness in accessing aged care, community support and supported accommodation services and improve care options within these mainstream services.

#### Addressing the needs of older people with severe and persistent behavioural disturbance related to dementia and/or mental illness

Strategies to improve the assessment, management and long-term care of older people with severe behavioural disturbance related to dementia and/or mental illness and/or an acute medical or mental health problem are a further strategic priority. This patient group presents a particular challenge to the aged care and mental health service system. Their behaviours and symptoms may be difficult to manage within a mainstream community or residential aged care setting, and specialist aged care and mental health services and facilities are limited. Behavioural assessment and management may be complicated by cultural and linguistic factors. Behaviourally disturbed older people who are physically robust and ambulatory do not mix well with those who are physically frail, and these different groups require specialised service responses and care environments that are not currently available in many areas.

To address the care needs of this group, it will be important to:

- Establish protocols for effective collaboration between SMHSOP and other key services and an integrated SMHSOP/Aged Care behavioural assessment function in each AHS.
- Develop SMHSOP consultation/liason and some case management outreach capacity and

arrangements with the residential aged care sector, as per the BASIS model, to support sustainable long-term care for this group.

- Develop interim or transitional care services to provide intensive specialist behavioural assessment and intervention, building on current health service infrastructure such as CADE units, and in partnership with the Australian Government DoHA and the residential care sector.

In all of these areas, SMHSOP and aged care services will need to work in close partnership to meet local needs, particularly in rural areas where both aged care and mental health services are limited.

### **Addressing the needs of older people with acute behavioural disturbance and/or acute mental health problems**

Another strategic priority is to improve the care and management of older people with acute behavioural disturbance and/or an acute mental health problem. This includes care for people with acute behavioural disturbance related to dementia, which may be complicated by delirium. Psychiatric symptoms in elderly patients admitted to both psychogeriatric and general acute facilities are frequently accompanied by co-morbid physical illness. Acute and sub-acute mental health facilities are limited in number and not generally appropriate to older, frailer patients and acute hospitals are generally not well set up to support optimal treatment for this group. Occupational health and safety concerns, staff training, aggression management and patient safety are key issues. The acute care system, and particularly the Emergency Departments of public hospitals, caters to a large and increasing number of older people with complex health conditions. Patients with dementia currently have an average length of stay that is four times greater than patients with other diagnoses, and often exhibit behaviours and symptoms that present difficult management issues in an acute setting.<sup>77</sup>

For this group of older people experiencing acute behavioural disturbance and/or mental health problems, there is a need to:

- Develop and support sustainable access arrangements to acute facilities across NSW.
- Develop strategies to improve clinical assessment and management by adult mental health crisis teams and in Emergency Departments, acute hospital wards and mental health facilities.

- Promote appropriate physical environments for this group in acute hospitals and mental health facilities and develop appropriately designed acute psychogeriatric units.

### **Promoting continuity of care**

Although there is a range of services to meet the needs of older people, there is a significant need to improve coordination between key services across jurisdictional, program and professional boundaries to improve continuity of care for older people with complex mental health problems. Care coordination is often poor across the range of care settings and between the many partners in care – family and carers, HACC services and other community-based services, GPs, ACATs, geriatricians, old age psychiatrists, SMHSOP, hospitals and RACFs. It can be quite difficult for consumers and carers to access and navigate the service system.

*The Framework for the integrated support and management of older people in the NSW health care system* is indicative of NSW Health's commitment to addressing the issue of care coordination within the NSW health system. AMHSs will need to develop strong collaborative partnerships with aged care services and other key services to improve continuity of care for older people with complex mental health needs.

### **Workforce development and capacity building**

The workforce issues are critical in mental health and in the health and aged care sectors generally. There are considerable issues in recruitment and retention of nursing, medical, allied health and other staff, and this is particularly so for SMHSOP. The specialist area of old age psychiatry is small but growing, and the Faculty of Psychiatry of Old Age (FPOA) is developing a leadership role in this regard. There is a shortage of GPs in many areas, and a limited number of GPs and mental health professionals are willing to work with RACFs. In many cases, SMHSOP will be developing from relatively limited bases. Workforce development strategies, both at the AHS and state levels, will therefore be critical to the implementation of this plan. Given the large numbers of older people from CALD backgrounds, it will be important to incorporate cultural competency training into these strategies.

Capacity building initiatives will be an important complement to specialist workforce development and recruitment, particularly in rural and remote areas and in the areas of prevention and early intervention.



SMHSOP will need to incorporate an education and training focus to enhance skills in older people's mental health amongst the existing workforce and amongst carers, families and communities. This may include training strategies targeting community health and aged care staff, mental health workers and other NSW Health staff, GPs and the residential aged care sector.

## Developing partnerships

Partnerships between specialist mental health services and other health aged care and community support services will be fundamental to improving care for older people with complex mental health problems. Partnerships between aged care and mental health services will be particularly important in the care of older people with BPSD and people with co-morbid physical and mental health issues. Whilst there is good collaboration between SMHSOP and aged care services in many Areas, functional collaboration needs to be strengthened.

The development of referral protocols, joint or common intake and assessment procedures, formal liaison processes, and consistent data collections and outcome measures will optimise working relationships between mental health and aged care services. Joint consultation and planning processes such as aged care-mental health committees will also facilitate a partnership approach. Co-location of mental health and aged care services is a priority under this plan, as is co-location of SMHSOP acute and non-acute services with acute health and adult mental health services. The development of the BASIS model across NSW (outlined in Section 4.1.5) is proposed under this plan to provide a formalized, multidisciplinary and integrated approach to assessment and case management for older people with severe and complex behavioural issues, building on existing ACAT and SMHSOP service structures.

Partnerships between specialist mental health teams and GPs will also be critical to improving mental health care for older people. GPs have a pivotal role in detecting psychiatric illness in their elderly patients and providing ongoing case management and are often the primary source of medical advice, treatment and referral. Initiatives to promote collaboration and shared care between SMHSOP and GPs will be a priority for SMHSOP community teams, as they develop under the Plan, particularly in rural areas.

The interface between SMHSOP and residential aged care services is a developing and important partnership. It will be critical to promote access to residential aged

care services by older people with a mental illness and to enhance the capacity of residential aged care staff to manage people with increasingly complex illnesses and behavioural issues. The 'severely and persistently challenging behaviours model' outlined in Section 4.1.5 provides the framework for these partnership arrangements. These partnerships may also involve the development of formal arrangements for referral, and the provision of SMHSOP consultation/liaison services, clinics and training to RACFs.

Particular partnerships will be important in addressing the issues for 'special needs groups' such as Aboriginal people and people from CALD backgrounds, and these partnerships are highlighted in Section 4.2.

## 3.3 Current NSW Health responses

There are a number of current NSW Health initiatives aimed at improving care and support for older people with complex mental health conditions. NSW Health is working with the Australian Government DoHA and other key stakeholders in progressing these initiatives to promote an integrated approach. Current NSW Health initiatives to address the strategic priorities outlined above are as follows:

### Area clinical coordinators and area strategic plans for SMHSOP

Area SMHSOP Clinical Coordinator positions have been established in all Area Health Services across NSW to provide clinical and strategic leadership in the development of SMHSOP at the Area level. Area Clinical Coordinators are developing AHS Strategic Plans for SMHSOP, aligned with this statewide plan, to guide clinical practice, training and workforce development, partnerships, service development and referral pathways locally. These Area Coordinators and Strategic Plans will be fundamental to the development of the SMHSOP service delivery model across NSW.

### Models of care for older people with severe behavioural disturbance

NSW has undertaken a number of projects to develop models of care to promote service development and continuity of care for older people with severe behavioural disturbance. These projects have informed the SMHSOP service model outlined in this plan.

They are as follows:

- *The management and accommodation of older people with severely and persistently challenging*

*behaviours* undertaken by FPOA. This project examined issues and approaches to the management and accommodation of older people with severely and persistently challenging behaviours, and has proposed an integrated model of assessment and care for this group which is incorporated into the SMHSOP service delivery model in this plan. NSW Health has commenced implementation of two components of this best practice model: Behavioural Assessment and Intervention Services (BASIS) and interim specialist assessment and treatment facilities.

- A review of NSW CADE Units has examined the current operations of these units, and developed recommendations for NSW Health policy and planning directions for their safe, effective and cost-efficient operation within the continuum of care for older people with behavioural disturbance associated with dementia and/or mental illness across NSW. The review recommendations have informed the SMHSOP service delivery model outlined in Section 4, and will be implemented through a clinical service redesign initiative.

### **Initiatives with the housing, supported accommodation and residential aged care sectors**

In line with the community residential and transitional care service models identified in this plan, NSW Health has committed funding to support two Special Care Units and Programs in residential aged care facilities for people with severely and persistently challenging behaviours associated with dementia and/or mental illness. These pilot initiatives, involving partnerships between AHSs and residential aged care providers, will inform the development and implementation of similar partnership services across NSW.

Top-up funding has also been provided to community-based aged care hostels such as Frederic House to ensure support for aged homeless men with mental health, drug and alcohol and age-related health problems. Further partnership models with the housing, supported accommodation and residential aged care sectors are being considered for groups identified in this plan.

The Department has revised its *Guidelines for Working with People with Challenging Behaviours in Residential Aged Care Facilities*. This is intended to assist residential aged care staff and other health professionals in using appropriate interventions and minimising restraint.

### **Telepsychiatry**

Following a feasibility study for introducing comprehensive telepsychiatry services across rural and remote NSW for specialist psychogeriatric consultation and treatment a project is being undertaken to pilot a telepsychiatry clinical support model for staff working with older people in remote regions in the Greater Southern Area. The outcomes of this project will inform the development of telepsychiatry in the implementation of the SMHSOP service delivery model.

### **'Teams of Two' initiative**

The Teams of Two initiative undertaken by the Alliance of NSW Divisions with support funding from NSW Health, has fostered partnerships between public sector mental health services and GPs. The program has included a focus on depression and other mental health issues for older people.

### **Mental health clinical care and prevention (MH-CCP) model**

The MH-CCP model is currently being revised, taking into account new prevalence estimates for dementia and BPSD and the role of SMHSOP (as these services develop) in the care of people with severe BPSD, as outlined in this plan.

### **The mental health outcome and assessment tool (MH-OAT)**

The MH-OAT for all mental health clinicians has been updated to include specific items related to older people. Strategies to promote the use of MH-OAT by SMHSOP and other recommendations from the National Mental Health Outcomes Expert Group will be developed in the implementation of this plan.

Further initiatives will be developed over the life of the *Plan* in response to emerging needs, priorities and the broader policy context for older people's mental health.

## SECTION 4

# Service delivery model for specialist mental health services for older people

Section 4 describes the various clinical service components and functions of SMHSOP, and proposes a SMHSOP service delivery model for development across NSW. It also outlines the evidence base, service delivery options and MH-CCP service planning benchmarks for particular clinical service components, key partnerships that will be important in the development and delivery of these services, and service models and strategies for particular special needs groups.

It is understood that this model will need to be developed across NSW in phases, taking into account existing SMHSOP service levels and infrastructures in each Area. These developmental phases are detailed in the implementation plan in Section 5. Clearly, service planning and resource allocation, workforce development and effective partnerships will be fundamental platforms to support clinical service delivery. Strategies addressing these service delivery platforms are also outlined in the implementation plan.

### 4.1 SMHSOP clinical service components

As outlined in Section 1, the major clinical service components of SMHSOP are multidisciplinary community or ambulatory teams, designated acute and non-acute inpatient facilities and long-stay community residential facilities. Linked to and integrated with these clinical service components is the specialist integrated BASIS function and other elements of the 'severely and persistently challenging behaviours' model proposed for development under this plan.

SMHSOP clinical functions may include:

- Capacity building (outreach services and education and training to adult mental health staff, primary health and aged care services, HACC services, residential aged care facility staff, GPs and other health professionals).
- Specialist clinical assessment and treatment services, including treatment in acute, non-acute inpatient or interim care facilities such as CADE Units, or long-stay community residential facilities.

- Specialist mental health assessment through consultation/liaison by SMHSOP community staff with primary health and aged care services, community care services, RACFs and other services.
- Joint care planning and case management with GPs, aged care services, adult mental health teams and general hospitals, and case management for patients in RACFs in line with the 'severely and persistently challenging behaviours model'.
- Mental health promotion and prevention programs (eg suicide prevention initiatives and health ageing programs).
- Early intervention programs such as memory clinics.
- Rehabilitation and recovery programs (eg peer support).
- Research and evaluation to promote service quality and innovation.

The service delivery environment (eg whether the service is based in a rural, remote, regional or metropolitan area and the other health and aged care service infrastructure in the area) and the stage of SMHSOP service development will determine service structures and priority functions.

Emergency response for older people with acute mental illness, both in-hours and after-hours will be provided by adult mental health crisis teams.

The most widely accepted model of care for SMHSOP consists of multidisciplinary, comprehensive, integrated service delivery to a defined catchment area. This model has been supported by the Geriatric Psychiatry Section of the World Psychiatric Association, the World Health Organisation (WHO), and the International Psychogeriatric Association (IPA) in a consensus statement published in the *International Journal of Geriatric Psychiatry* (1997, see Appendix 6).<sup>78</sup>

Common features of an effective system of care include:

- A single point of entry into the system.
- Case management.
- Specialist geriatric/psychogeriatric assessment and multidisciplinary teams.



- Use of financial incentives to encourage less expensive, community-based care.<sup>79</sup>

These key effectiveness factors are reflected in the SMHSOP service model described in this section. Further priorities and models will be developed as the evidence base for SMHSOP develops further.

The importance of clear, coordinated arrangements for consumers, carers, families and service providers to access appropriate services is well recognised and a number of current initiatives are designed to address this. These include the NSW Health *Framework for the integrated support and management of older people in the NSW health care system* (2004), Commonwealth Carelink Program, HACC comprehensive assessment initiatives and the comprehensive assessment services being developed under the *Commonwealth Community Care Strategy: The Way Forward*. For their part, SMHSOP will need to develop clear triage, intake and referral protocols with adult mental health teams and aged care services, and ensure that referral processes are clear for consumers, as well as GPs and other services referring to SMHSOP.

#### 4.1.1 SMHSOP community teams

##### *Service description*

The SMHSOP community team (or identified SMHSOP key worker in some rural and remote areas) will be a fundamental component of SMHSOP and will be central to the provision of coordinated services to older people with mental health problems. These community teams will have three major clinical functions: specialist mental health assessment, care planning and case management. They will provide specialist consultation and liaison services (ie assessment, referral and training with primary care workers and GPs, residential service providers and others) to address the needs of the SMHSOP target group. They will also provide case management (ie conduct, monitor and review specialist mental health interventions) where indicated, for older people with severe mental health problems, in partnership with their families and carers, across different service settings.

AMHSs will ensure that an emergency response capacity for older people and service providers is available through the adult mental health and Emergency Department services.

Wherever possible, SMHSOP community or ambulatory care should be provided 'in situ', or in the person's normal place of residence (whether that is a residential aged care facility, supported accommodation or a private

residence), with the appropriate health and community care services and social supports. Delivery of care should also develop the capacity of existing carers (informal or professional) to care for the person. SMHSOP community teams aim to promote independence and quality of life by ensuring coordination of community-based support and specific clinical interventions.

For older people with severe behavioural disturbance with complex causes, SMHSOP community teams will develop the capacity and arrangements with aged care services to provide an integrated assessment and intervention function, as per the BASIS model outlined in Section 4.1.5.

A synthesis report on the effectiveness of various components of SMHSOP produced for the WHO Regional Office for Europe's Health Evidence Network (HEN) in 2004 found that there is strong evidence to support the effectiveness of multidisciplinary, individualized SMHSOP community teams and SMHSOP outreach services to RACFs. In an Australian case series involving interventions with patients with a range of psychiatric disorders by a predominantly community-based, multidisciplinary SMHSOP team, significant mental health improvements were reported between assessment and discharge on HoNOS.<sup>80</sup> The HEN report found that there is good evidence from a systematic review and Randomised Control Trials (RCTs) for the effectiveness of multidisciplinary SMHSOP community teams providing consultation/liaison and case management, relative to usual care (adult mental health teams, GPs, aged care services etc), in the management of depression, BPSD and other mental health problems in older people. A number of studies of SMHSOP outreach services to community-based residential care facilities have found that these services are particularly effective where there is a liaison style with a strong educational component.<sup>81</sup>

There will be a significant role for SMHSOP in clinical intervention and support for families and carers of older people with mental health problems. This may include respite care, where appropriate. There is considerable evidence demonstrating the positive impacts of appropriate information, support and skills training on the health and wellbeing of families and carers, as well as consumers.<sup>82</sup> In addition to effective health outcomes, such partnership approaches with families and carers can also lead to reductions in mental health service utilization and improved work satisfaction for mental health service providers. Work with families and carers of older people with mental health problems should be consistent with the *Carer Life Course*

*Framework (2005)*<sup>83</sup> and the NSW Health *Framework for Family and Carer Support in NSW Mental Health Services*, currently under development.

Prevention and early intervention strategies will be part of the SMHSOP community team's activity, and elderly suicide prevention workers in these teams will play a key role in this area. This work will generally be progressed through a primary health care model, in partnership with primary health and aged care services, community support services and GPs, and will encompass:

- Promotion of self-care and peer support approaches.
- Capacity building with families, carers and communities to recognise early warning signs and to support older people with mental health problems.
- Education and training with relevant services to promote early and effective responses to mental health problems in older people and appropriate referral for more serious problems.

To promote prevention and early intervention for CALD communities and Aboriginal communities, it will be important to work in collaboration with community organisations and services that have ongoing contact with these communities, such as ethnic organizations, Aboriginal Community Controlled Health Services and community groups.

Key factors in successful capacity building, as outlined in the NSW Health *Capacity Building Framework*, include workforce development (eg upskilling of the health and aged care workforce), organisational development (incorporation of approaches such as early intervention into everyday practices in key services), dedicated drivers/staff and funding to support activities (eg ESPN), formal and informal partnerships and leadership.<sup>84</sup>

Collaborations between SMHSOP and GPs are particularly important in improving mental health outcomes for older people. A number of studies have provided good evidence to support the effectiveness of collaboration between specialist services and GPs in mental health care for older people, particularly in the identification and management of late-life depression.<sup>85</sup> The PROSPECT study in the US has demonstrated the effectiveness of onsite mental health case managers in GP surgeries.<sup>86</sup> Such shared care models are also important in suicide prevention approaches for older people. Strategies to promote effective collaboration between SMHSOP and GPs will be an important priority for SMHSOP community teams in Phase 1 of the implementation plan. Such strategies may include the development of

appropriate referral protocols, training strategies and shared care models, and will need to be linked to Australian Government primary health care initiatives such as the Enhanced Primary Care, Better Outcomes in Mental Health and MedicarePlus aged care initiatives.

The community team should be involved in hospital admission and discharge processes for older people and provide consultation during inpatient treatment, where appropriate. The core inpatient consultation-liaison role of SMHSOP lies in assisting in the management of patients known to the service and in supporting staff of adult mental health and geriatric medical wards (or their equivalents in rural areas) in managing older people with mental health disorders. In some areas, additional roles may be appropriate, providing they do not detract from the overall functioning of SMHSOP.

There is some evidence for the effectiveness of liaison-style SMHSOP consultation-liaison services in medical wards, particularly in relation to recognition of and treatment outcomes for depression. Two RCTs have also demonstrated reduced length of stay and costs, and one of these has demonstrated fewer nursing home admissions.<sup>87</sup> Although there have been only a few studies focusing on integrated post-discharge hospital and community care, these studies indicate that the involvement of SMHSOP in discharge planning and follow-up care may be an important factor in preventing readmission and improving patient outcomes, particularly for older people with depression. These studies also support the integrated role of acute and non-acute inpatient teams in providing post-discharge community care. Further investigation of community mental health rehabilitation programs for older people will be required in Phase 1 of implementation to inform developments in Phase 2.

### *Service structure*

The development of a SMHSOP clinical service stream or SMHSOP team and program structure within AMHSs is a key aim of this plan. At the AHS level, Area SMHSOP Clinical Coordinators will lead these service developments. For rural areas with limited specialist staff, the SMHSOP community team will be a part of the generic mental health service rather than a discrete team. Co-location of SMHSOP community teams and ACATs is a priority. Where co-location is not feasible, strong partnerships and referral protocols between SMHSOP and ACATs will be important.

In rural areas, the links with the aged care service in the Area will be vital and the SMHSOP community team or

key worker may be functionally integrated with the aged care team though still operationally responsible to the mental health service. The primary roles of this service will be community development and capacity building and SMHSOP input to ACAT assessments for older people with severe BPSD, as per the BASIS model outlined in Section 4.1.5. It will also provide the link between specialist outreach consultation and liaison by Visiting Medical Officers and the case management functions of the generic mental health and aged care teams. Telepsychiatry services may be used for specialist consultation in rural and remote areas and for providing clinical support to mental staff working in these areas. Service models and approaches for rural and remote areas are discussed in more detail in Section 4.2.

### *Service planning benchmarks*

Under current MH-CCP service planning benchmarks, it is estimated that 52.2 community staff are required to meet the needs of 100,000 older people (65 years and over). As noted earlier, the needs of older people with severe BPSD for SMHSOP assessment and treatment services require some review. The development of SMHSOP community teams, underpinned by resource allocation and workforce development strategies, is the major priority in Phase 1 of the SMHSOP implementation plan in Section 5.

### *Service partners*

SMHSOP community teams will need to develop linkages and referral pathways with adult mental health services, aged care teams, private psychiatrists, GPs, community support services (Home And Community Care services, DAS), community agencies such as ethnic organisations, AHS health promotion units, key non-government organisations in mental health, aged care and dementia care, and residential aged care services. It will be important to develop and support strategies to improve access to private psychiatrists and public-private sector integration through partnerships and service delivery arrangements. Families and carers are also partners in care.

## **4.1.2 Acute SMHSOP inpatient services**

### *Service description*

Acute services provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms that have potential for prolonged dysfunction or risk to self or others. Clients may have no previous history of psychiatric illness

or may be individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of clinical symptoms.

Acute inpatient units provide multidisciplinary assessment of a person's mental and behavioural status, along with physical health and psycho-social issues. This period of hospitalisation ensures short-term clinical treatment, voluntary or involuntary, for the acute phase of an illness that cannot be managed in the community. Treatment is focused on clinical symptom reduction with a reasonable expectation of substantial improvement in the short term.

Acute mental illness in older people may be accompanied by co-morbid physical health or medical issues and is sometimes complicated by delirium. Acute episodes of illness frequently persist much longer than the four or five days common in adult mental health or general acute inpatient units, and patients require follow-up care. Acute SMHSOP inpatient units thus need to be supported by acute and non-acute services for older people with medical issues (eg delirium), non-acute mental health inpatient facilities, and specialist RACFs with specialist mental health support.

### *Service structure*

Acute SMHSOP inpatient units may be discrete facilities or sub-units within acute mental health facilities or acute hospitals. Staff of these units will be part of an integrated SMHSOP team extending across both community and inpatient settings. This will facilitate appropriate support for patients following discharge.

Some older people with an acute mental illness may be well managed in a generalist adult acute mental health unit. However, older people who are physically frail and/or confused do not generally mix well with robust, ambulatory adults with acute mental illness and disturbed behaviour, and the physical layout and care arrangements in adult mental health units will need to address this issue.

Service options for acute inpatient treatment will depend on the population size and needs of the catchment area, the infrastructure, workforce and resources of the Area, and the Area's Mental Health Clinical Services Plan. The development of acute SMHSOP inpatient units, in line with MH-CCP benchmarks and capital planning processes, is a priority in Phase 2 of the SMHSOP implementation plan.

In Phase 1 of the implementation plan, AHSs with limited or no SMHSOP inpatient facilities will develop arrangements for older people with acute mental illness

to access acute facilities and referral protocols between SMHSOP/mental health teams and appropriate acute facilities or units. These arrangements will need to be supported by appropriate training and support of staff in Emergency Departments, acute hospitals and acute inpatient facilities. The following service options will be explored:

- SMHSOP community team consultation/liaison in-reach or telepsychiatry services to acute mental health and general hospital facilities, for identified patients.
- Assignment of identified acute facility staff to the care of older people with acute mental illness and training and support of these identified staff by the SMHSOP or adult mental health team, with whom they are formally linked, or
- Special care suites or sub-units within acute adult mental health facilities or acute hospitals with appropriate specialist staffing and physical environments.

Adult mental health crisis teams will continue to provide emergency response for older people with acute mental illness and SMHSOP will need to facilitate relevant training and support for these teams to ensure appropriate responses for older people.

There have been no RCTs of acute hospital treatment for older people with mental disorders comparing the type of ward (psychogeriatric, adult mental health or medical) or hospital versus community care. However, a number of studies in different countries have demonstrated positive discharge treatment outcomes for depression and BPSD from SMHSOP acute wards, particularly where the service has a community orientation and post-discharge follow-up arrangements.<sup>88</sup>

### *Service Planning Benchmarks*

Under the MH-CCP model, it is estimated that 0.6 per cent of older people with mental health problems (or 600 people per 100,000) will require acute inpatient care in acute psychiatric facilities or acute hospitals in a 12 month period. This care will include assessment, treatment and review. For the purposes of the planning model, length of stay is estimated at 28 days in an acute psychiatric unit and 17 days in an acute geriatric or medical inpatient unit. It is worth noting that these lengths of stay are only likely to be achievable if community SMHSOP teams, non-acute inpatient or rehabilitation services and long-term care options are available.

The MH-CCP service planning benchmarks for acute inpatient services for older people with mental illness are

26.5 beds and 39.8 staff per 100,000 people aged 65 years and over. As with other SMHSOP clinical service components, these benchmarks will be higher if older people with acute behavioural disturbance associated with dementia are included in the target group, and AHS planning will need to take into account the local aged care service context and Area Aged Care Plan. The development of these units or sub-units in identified Areas is a focus of Phase 2 of the SMHSOP implementation plan outlined in Section 5. In the first phase of implementation, the priority for acute services will be to develop access arrangements to appropriate facilities and consultation/liaison for the SMHSOP target group and to undertake capital planning processes for Phase 2.

### *Service partners*

SMHSOP will need to develop linkages with adult mental health teams and acute units, acute geriatric and medical inpatient facilities and staff, private psychiatric facilities and staff, ED staff (including Mental Health Clinical Nurse Consultants, Aged care Services Emergency Teams) and hospital discharge planners to promote access to appropriate acute care for older people with mental health problems. Families and carers are also partners in care.

#### **4.1.3 Non-acute SMHSOP inpatient services**

### *Service description*

Non-acute mental health inpatient services or rehabilitation services have a primary focus on intervention to reduce functional impairments that limit the independence of patients and promote recovery. These services provide specialist clinical assessment, treatment and rehabilitation in a non-acute inpatient setting, where patients are not able to be managed in the community, with an expectation that patients will improve sufficiently for discharge to a mainstream service or community setting with additional support from SMHSOP and other services. Continuing review of a patient's status and strong linkages with residential and community services are critical to facilitating discharge of patients, when appropriate, and throughput in non-acute facilities. Community outreach teams with a consultation-liaison and educational role have been found to be effective in this regard.<sup>89</sup>

For patients with severe BPSD, specialist interim care inpatient facilities may be required for the purposes of intensive, iterative behavioural assessment and treatment by SMHSOP and aged care services. Treatment in these facilities may include medication planning, psycho-social interventions and environmental approaches. A number

of CADE Units provide this model.<sup>90</sup> The specialist interim assessment and treatment facility model is described in Section 4.1.5.

### *Service structure*

Currently, non-acute SMHSOP and adult mental health inpatient units are concentrated in large stand alone psychiatric hospitals such as Kenmore Hospital, Goulburn (Greater Southern AHS), Macquarie Hospital, Ryde (Northern Sydney/Central Coast AHS), Morrisset Hospital (Hunter/New England AHS) and Bloomfield Hospital, Orange (Greater Western AHS). A significant proportion of beds in these facilities are currently utilized for very long stay older patients with dementia and/or mental illness (and some younger patients with mental illness and age-related problems) who no longer require specialist mental health inpatient treatment but who are unable to be discharged because of difficulties in accessing appropriate residential or community aged care services. These facilities therefore provide limited access to rehabilitation care for the SMHSOP target group.

AHSs will need to consider arrangements for redesigning these services for rehabilitation care for older people, in line with the non-acute SMHSOP inpatient functions described above, the 'severely and persistently challenging behaviours model', the recommendations from the NSW Health review of stand alone psychiatric hospitals, and developments in non-acute, chronic and continuing care and rehabilitation under the *NSW Mental Health Planning Framework*. Promoting access to these services across new AHS structures and developing appropriate extended care arrangements for current and future SMHSOP clients, in line with Area Mental Health Clinical Services Plans, will be a priority.

In line with the recommendations of a 2005 review of CADE Units, the majority of these units will undergo clinical service redesign to perform a specialist interim assessment and treatment function for older people with severe BPSD. These facilities will require clinical support from both specialist mental health services and specialist aged care services to support appropriate care.

Service options for the provision of mental health rehabilitation care for older people with mental illness may include non-acute inpatient facilities and specialist longer-stay interim 'special care units' within RACFs.

Service options for non-acute inpatient facilities would include:

- Utilisation of CADE Units to provide interim or transitional care for older people with severely and persistently challenging behaviours (intensive,

iterative behavioural assessment and treatment by SMHSOP and aged care services), which will involve clinical service redesign in some cases.

- Development of SMHSOP sub-units, or appropriately supported and designed care environments within mental health non-acute facilities.

Service options for longer-stay interim care models are outlined in Section 4.1.4 (community residential facilities) and Section 4.1.5 (severely and persistently challenging behaviours model). These models will be trialled in Phase 1 for full implementation in Phase 2 of the Plan.

### *Service planning benchmarks*

Under the MH-CCP model, non-acute inpatient (rehabilitation and extended care) and community residential care are grouped together for the purposes of planning benchmarks, since these models are still developing and the appropriate mix of these service types is not yet clear. It is estimated that 51.1 such beds and 50.1 staff are required for a population of 100,000 people 65 years and over. The adequacy of SMHSOP non-acute inpatient services will be very much affected by the availability of appropriate residential or extended care facilities.

### *Service partners*

Partners in the provision of non-acute inpatient services and appropriate supported discharge from these services will include aged care services (ACATs, geriatric medical services, CADE Units, transitional aged care services), adult mental health services, residential aged care services, supported accommodation services, HACC services and GPs. Families and carers are also partners in care.

## 4.1.4 Community SMHSOP residential services

### *Service description*

Some older people with high-level, complex and persistent psychiatric symptoms will require an extended period of care. Residential or extended care services provide long-term care for patients who have a stable but severe level of functional impairment and are unable to function independently, thus requiring extensive care and support. Treatment is focused on preventing deterioration and reducing impairment. The primary target group for these services comprises: older people with life long or recurring mental illness (eg chronic schizophrenia and psychotic disorders) who now experience age-related problems causing significant functional disability, and older people with severely and



persistently challenging behaviours associated with dementia and/or mental illness.

A number of CADE Units currently provide extended care for older people with moderate-severe behavioural disturbance associated with dementia and older people with lifelong, recurring or late-onset mental illness. In rural areas, district hospitals and Multi-Purpose Services may provide such extended care. However, there are few residential care facilities providing the type and level of care required for appropriate longer-term management and accommodation of older people with mental health problems, including people with moderate-severe BPSD.

The provision of residential care for older people with significant physical care needs is the responsibility of the Australian Government, which funds residential aged care providers for this purpose. Given the significant association between physical and mental health needs in older people, residential aged care services are key services for the SMHSOP target group and key service partners for SMHSOP. Dementia care is core business for the residential aged care sector and challenging behaviours are very common in RACFs. Challenging behaviours are a common precipitant for nursing home admission, yet paradoxically, they can also prove a barrier to accessing residential aged care services and delay discharge from acute medical and psychiatric facilities. The residential aged care sector in NSW currently has limited capacity and limited support from SMHSOP and aged care services to provide appropriate longer-term management and accommodation for older people with severely and persistently psychiatric symptoms associated with dementia and/or mental illness.

The evidence-based 'severely and persistently challenging behaviours model' outlined below provides a framework for service development for the provision of extended care for people with severe and persistent psychiatric symptoms associated with dementia and/or mental illness through partnerships between SMHSOP, aged care services/ACATs and the residential aged care sector.

Public housing and non-government organisation (NGO) supported accommodation providers are also important partners in the provision of appropriate long-term accommodation for older people with mental health problems, particularly those with less significant physical care needs or with specific needs, for whom residential aged care may be inappropriate. This group may include older people who are homeless or at risk of homelessness and people with recurrent or life-long mental illness who are ageing. SMHSOP will need to work with adult

mental health teams, public housing services and NGO accommodation providers to develop appropriate models of accommodation and support for this group. The HASI Initiative, a joint initiative of NSW Health and the NSW Department of Housing, provides a potential framework for service development.

The development of community residential care services for appropriate longer-term management and accommodation for the SMHSOP target group (including older people with severe BPSD) is a priority under this plan. Service options include:

- 'Special care units' within RACFs (including State Government RACFs) with specialist consultation/liaison and case management support from SMHSOP and aged care services/ACATs, and supported transition to mainstream RACFs and community care.
- Provision of community residential care services for the SMHSOP target group through partnerships between SMHSOP, aged care services/ACAT, residential aged care providers (including State Government RACFs), public housing services and non-government accommodation providers.

These models will be developed across the life of the Plan, with a number of pilots to be conducted in Phase 1 of the SMHSOP implementation plan and full implementation across all AHSs in Phase 2.

Service evaluations undertaken in a range of countries as deinstitutionalisation and transinstitutionalisation policies have been introduced have shown that purpose-built, community-based residential facilities have benefits over long-term psychogeriatric inpatient facilities for less dependent patients with dementia and chronic schizophrenia.<sup>91</sup> Benefits included:

- better quality of life
- more social interactions
- more privacy, resident choice and control
- improvement or stabilisation of symptoms (for schizophrenic patients)
- improved cognition, communication, self-care skills, activity participation, mobility, and behavioural disturbance
- fewer depressive symptoms
- less use of physical and chemical restraints.

However, it is important to note that these facilities may not be suitable for patients with very severe, aggressive behaviours. The tertiary 'intensive care

neurobehavioural unit' described in Section 4.1.5 for scoping and possible development in Phase 2 of the *Service Plan* is designed to cater for this group. Acute and non-acute mental health inpatient services will need to continue to cater for the needs of this small group of patients until this model is developed.

### *Service planning benchmarks*

As noted previously, non-acute inpatient (rehabilitation and extended care) and community residential care are grouped together for the purposes of MH-CCP planning benchmarks. It is estimated that 51.1 such beds and 50.1 staff are required for a population of 100,000 people 65 years and over.

### *Service partners*

Partners in the provision of community residential care services and associated support services will include aged care services (ACATs and geriatric medical services), adult mental health services, residential aged care services, supported accommodation services and GPs. Families and carers are also partners in care.

#### **4.1.5 Model of care for older people with 'severely and persistently challenging behaviours'**

### *Service description*

Aged care services in NSW play a major role in the assessment and management of older people with behavioural disturbance related to dementia. However, as noted in Section 2.3, people with severe behavioural and psychiatric symptoms are likely to benefit from SMHSOP input to their assessment and care. Integrated aged care/mental health assessment processes and improved care and management across the continuum of care are priority issues in improving service responses to the needs of this group.

In line with the recommendations from a project conducted by the Faculty of Psychiatry of Old Age with funding from NSW Health,<sup>92</sup> an integrated model of care for older people with severely and persistently challenging behaviours in residential care settings is proposed for development across NSW. This best-practice model comprises an integrated specialist assessment function (the BASIS function noted in relation to the service description for SMHSOP community teams) and a number of other service model elements. These proposed service model elements are described below. Their place within the SMHSOP service model and implementation plan is outlined under 'Service Structure'.

#### **1. Integrated specialist behavioural assessment and intervention services**

These services will build on existing ACATs and SMHSOP community teams, taking on a more structured, integrated and intensive role in assessment and case management for older people with severe and complex behavioural and psychological symptoms and/or unclear aetiology. In their fully developed form, BASIS would offer integrated, comprehensive, multidisciplinary (psychogeriatric, medical, psychological, social and environmental) assessment, intervention and referral for the target group.

Key functions of the BASIS model are:

- To further the development of formal links between SMHSOP and aged care services (particularly ACATs).
- To provide integrated assessment and intervention services for older people with severely and persistently challenging behaviours.
- To provide consultation, liaison and case management services to identified clients in community and residential aged care settings.

BASIS could also perform gatekeeping functions (with SMHSOP community team and other clinical services, and ACAT) to specialist service model elements outlined below, as they develop.

2. Special residential aged care service packages  
Specialist residential aged care packages are proposed to provide time-limited, flexible, innovative care in situ, which is not currently available through tertiary consultative or other community services for specific assessed residents of aged care facilities. These residents will manifest behaviours that jeopardize their accommodation arrangements or threaten others in their environment. Packages would include:

- specific additional assessments
- development of specific behavioural management protocols, and associated staff training, trialling and evaluation
- monitoring of specific medication trials
- short term nurse 'specialling', and minor environmental modifications.

#### **3. Interim specialist assessment and treatment facilities**

These facilities are proposed to provide specialist interim assessment and treatment for older people who do not require acute medical or psychiatric care but are considered unsuitable for care in mainstream

facilities. They would provide additional resources and expertise to assess and manage severe behavioural challenges, and to support the eventual transfer of the resident to a community-based care setting such as a residential aged care facility, other supported accommodation facility or private home with support. Key elements of this service include:

- Increased level of staffing consistent with current Australian benchmarks.
- A multidisciplinary approach, encompassing nursing, medical and allied health input.
- Enhanced staff psychiatric knowledge and skill in behavioural management.
- Access to specialist psychogeriatric and geriatric medical support and advice and clear clinical governance arrangements regarding personal, medical and specialist care needs of clients.
- Prosthetic architectural and interior design.

#### 4. An intensive care behavioural unit

This unit is proposed to cater for the most disturbed and aggressive older people in NSW. Current clinician estimates are that 25–50 people at any one time in NSW require such care. Most of these people will have frontal lobe pathology, some due to head injury, some related to alcohol abuse and some to other causes. It is proposed that this level of care would provide specialist accommodation for the length of time it is required.

### *Service structure*

#### 1. BASIS

The development of SMHSOP consultation/liaison and case management functions for older people with severe behavioural and psychiatric symptoms associated with dementia and/or mental illness as part of SMHSOP community team services is a priority in Phase 1 of this plan. The target group for these services will include older people who are living in or awaiting assessment for placement in RACFs. The BASIS model will thus facilitate and support long-term care arrangements for the SMHSOP target group. While the model develops, it may simply comprise enhanced psychogeriatric/SMHSOP and other input to ACAT assessment processes, the development of partnerships and protocols between SMHSOP community teams and aged care services for joint assessment of older people with complex behavioural issues, and enhanced support to RACFs. BASIS will be developed in each Area of NSW with reference to the existing service structure and continuum of services in the AHS, and existing service gaps.

Whilst this plan provides for the enhancement of SMHSOP capacity to provide assessment and case management for older people with severe, persistent and complex behavioural symptoms, it is acknowledged that ACAT input would be limited to current capacity, in the absence of funding enhancements.

#### 2. Special residential aged care service packages

This model currently operates in the Illawarra region under the auspices of the Dementia Support Team funded by the Australian Government DoHA under the PGU Program. The development of a program of specialist behavioural support packages for coordination by SMHSOP and/or aged care services across NSW is a key priority for negotiation between NSW Health and the Australian Government DoHA during Phase 1 of this plan. These packages would facilitate and support long-term care arrangements for the SMHSOP target group.

#### 3. Interim assessment and treatment facilities

Both non-acute inpatient facilities and longer-stay 'special care units' within RACFs and community residential services will be required to address the needs of older people for specialist assessment and treatment. The best models of inpatient care and 'special care units' will be further developed and trialled in Phase 1 of the implementation plan.

As outlined in Section 4.1.3, service options for non-acute inpatient facilities would include:

- Service redesign of CADE Units to provide interim or transitional care for older people with severely and persistently challenging behaviours (intensive, iterative behavioural assessment and treatment by SMHSOP and aged care services).
- Development of SMHSOP sub-units within mental health non-acute facilities.

Longer-stay interim care models would include 'Special Care Units' developed within RACFs through partnerships between SMHSOP, aged care services/ACATs and residential aged care providers. Both of these service models will require access to acute mental health or SMHSOP inpatient facilities for acute mental health care of patients when clinically required.

#### 4. Tertiary intensive care behavioural unit

This would be a new service, and the target group and service model will be scoped in Phase 1 of implementation. However, this service might utilize an existing AHS facility catering to this group, and enhance its capacity to provide a statewide service. The benefits of a centralized, tertiary model, as distinct from a more



localized model, for responding to the needs of this very disturbed group of older people are yet to be established.

### *Service planning benchmarks*

Service planning benchmarks for the SMHSOP staffing associated with **BASIS** (over and above SMHSOP community team benchmarks) and special residential aged care packages are yet to be developed. However, it is noted that the target group for the assessment component of the BASIS model, based on the tiered model developed by Brodaty et al, is approximately 23,800 people across NSW.

As noted previously, non-acute inpatient (rehabilitation and extended care) and community residential care are grouped together for the purposes of MH-CCP planning benchmarks. It is estimated that 51.1 such beds and 50.1 staff are required for a population of 100,000 people 65 years and over. Any revisions to MH-CCP to further address the needs of older people with severe BPSD – estimated at 7,850 across NSW – will affect these benchmarks, increasing the estimated need for these services. These benchmarks would apply to non-acute inpatient facilities, **interim specialist assessment and treatment facilities** proposed under the ‘severely and persistently challenging behaviours model’ and community residential care services for older people with severe BPSD.

Current clinician estimates are that 25–50 people at any one time in NSW may require care in an **intensive care behavioural unit**. Further scoping of the target group and model for this service will be conducted in Phase 2 of implementation.

### *Service partners*

Key partners in the delivery of **BASIS services** will be aged care services (ACATs and geriatric medical services), adult mental health services, GPs and residential aged care services. Families and carers are also partners in care.

Partners in the provision of **interim facilities** will include aged care services (ACATs, geriatric medical services, CADE Units, transitional aged care services), adult mental health services, residential aged care services, supported accommodation services, HACC services and GPs.

To a large extent, particularly in rural NSW, the assessment and management of older people with severe and persistent psychiatric symptoms associated with dementia will be new business for mental health services. Whilst existing SMHSOP provide some assessment and short-term case management for people with BPSD, and dementia is a source of mental health inpatient admissions for people 65 years and over, the needs of people with dementia with moderate to severe behavioural disturbance in NSW currently are currently met predominantly by aged care services, acute hospitals (including geriatric medical wards) and the residential aged care sector. The gradual development of mental health services to take on a greater role in the care of this group will require careful planning and management. A small change in the availability of residential aged care beds, or in the criteria for admission to acute inpatient care or specialist psychogeriatric units, could have an enormous impact on demand for SMHSOP.<sup>93</sup>

It will be important to develop strong protocols between mental health and aged care services and between adult mental health teams and SMHSOP (as they develop) regarding relative roles in the care of this group and to develop integrated assessment and intervention processes.

Service partners for the **intensive care behavioural unit**, if a case and model were established for its development, would include adult mental health services, aged care services (ACATs and geriatric medical services), Brain Injury Rehabilitation Program services, drug and alcohol services, Justice Health and disability services.

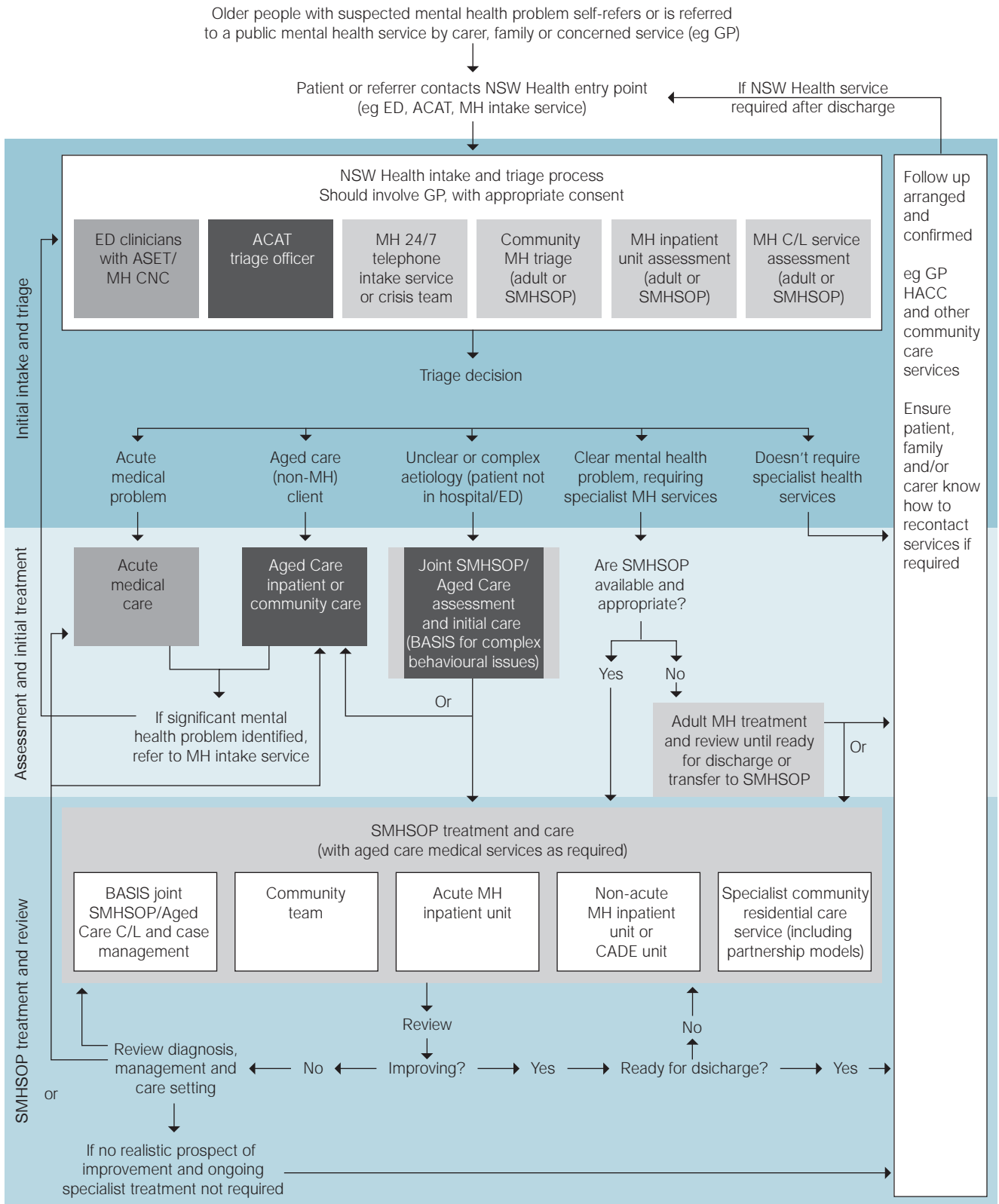
Table 4 provides a summary of the five clinical service components of the SMHSOP service model.

**Table 4. Summary of SMHSOP service model**

Clinical service	Service description	Service planning benchmarks	Service partners
<b>SMHSOP community team</b>	<ul style="list-style-type: none"> <li>■ Provide specialist mental health assessment, community team care planning and case management for SMHSOP target group</li> <li>■ Provide consultation/liason to other key services</li> <li>■ Conduct capacity building with other key services</li> <li>■ Conduct activities with a prevention and early intervention focus</li> </ul>	<p>52.2 SMHSOP community staff per 100,000 older people (MH-CCP Version 1.11)</p> <p><i>Note. Service needs re severe BPSD underestimated.</i></p>	<p>Adult mental health teams, aged care services, private psychiatrists, GPs, community support services, community agencies such as ethnic organisations, AHS health promotion units, key NGOs and residential aged care services.</p> <p>Families and carers are partners in care.</p>
<b>Acute SMHSOP inpatient service</b>	<ul style="list-style-type: none"> <li>■ Provide specialist mental health assessment and treatment for older people with acute mental illness in an inpatient setting</li> </ul>	<p>26.5 beds and 39.8 staff per 100,000 older people (MH-CCP Version 1.11)</p> <p><i>Note. Service needs re severe BPSD underestimated.</i></p>	<p>Adult mental health teams and acute units, acute geriatric and medical inpatient facilities and staff (including discharge planners), private psychiatric facilities and staff, ED staff (incl. ED Mental Health CNCs, Aged care Services Emergency Teams) and GPs.</p> <p>Families and carers are partners in care.</p>
<b>Non-acute SMHSOP inpatient service</b>	<ul style="list-style-type: none"> <li>■ Provide specialist mental health assessment and treatment for older people with mental health rehabilitation needs in an inpatient setting</li> <li>■ Develop capacity to provide specialist assessment and intervention for older people with severe BPSD (as per Severely and Persistently Challenging Behaviours model)</li> </ul>	<p>Components 3 and 4 combined: 51.1 beds and 50.1 per 100,000 older people (MH-CCP Version 1.11)</p> <p><i>Note. Service needs re severe BPSD underestimated.</i></p>	<p>Adult mental health services, aged care services (ACATs, geriatric medical services, CADE Units, transitional aged care services), residential aged care services, supported accommodation services, HACC services and GPs.</p> <p>Families and carers are partners in care.</p>
<b>SMHSOP community residential care service models</b>	<ul style="list-style-type: none"> <li>■ Provide extended specialist mental health care (assessment and treatment) for older people with complex and persistent behavioural and psychological symptoms, including severe BPSD, in a residential setting</li> <li>■ May include provision of longer-term interim special care for older people with severely and persistently challenging behaviours in residential aged care settings</li> </ul>	<p>Components 3 and 4 combined: 51.1 beds and 50.1 per 100,000 older people (MH-CCP Version 1.11)</p> <p><i>Note. Service needs re severe BPSD underestimated.</i></p>	<p>Aged care services (ACATs and geriatric medical services), adult mental health services, residential aged care services, supported accommodation services and GPs.</p> <p>Families and carers are partners in care.</p>
<b>Severely and persistently challenging behaviours model</b>	<ul style="list-style-type: none"> <li>■ BASIS – Provide specialist, multidisciplinary mental health (and aged care) assessment and some case management for older people with complex and severe behavioural and psychological symptoms in community settings</li> <li>■ May include extended inpatient care for older people with extreme behavioural symptoms who cannot be managed in other inpatient or community settings</li> </ul>	<p>Benchmarks yet to be developed</p>	<p>Aged care services (ACATs and geriatric medical services), adult mental health services, GPs and residential aged care services.</p> <p>Families and carers are partners in care.</p>

Figure 1 provides an overview of the clinical pathway through the service system for the SMHSOP client, highlighting the intake and triage, assessment, treatment and review processes that are undertaken by SMHSOP.

**Figure 1. Clinical Pathway for SMHSOP Client**



KEY:  MH service     Aged Care service     ED and acute hospital     Primary health, aged care, community support and residential service

**Figure 2. System of care and support for older people with mental health problems**

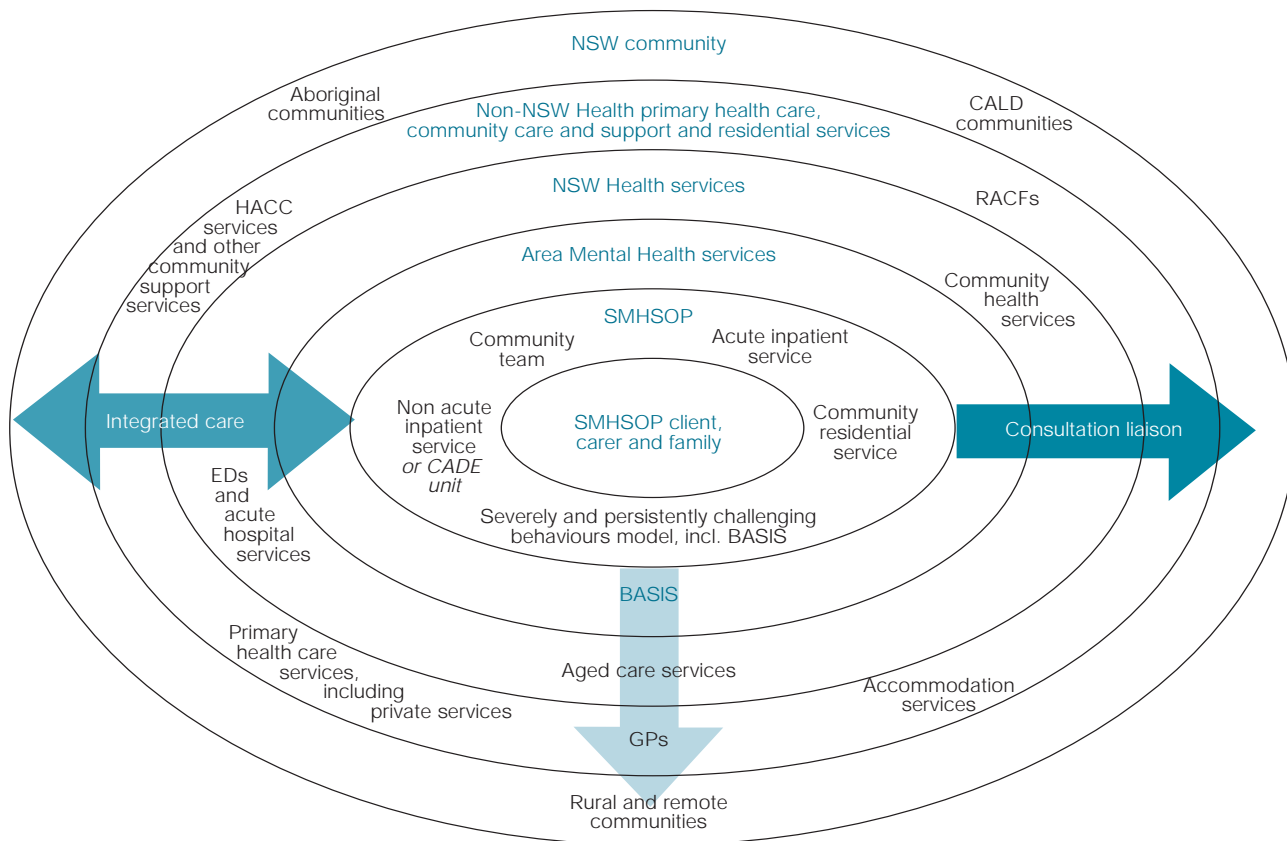


Figure 2 provides an overview of the broader system of care and support for older people with mental health problems, comprising families and carers, the broader community, primary health care services, community care and support services, residential services and NSW Health services, including AMHSs and SMHSOP, as they develop across NSW. The diagram shows the integrated BASIS function and the consultation-liaison function to be developed by SMHSOP in partnership with aged care services under this plan. It also highlights the importance of an integrated approach to the care of older people with mental health problems across the continuum of care – a key focus of this plan.

#### 4.2 Strategies and service models for 'special needs groups'

##### Aboriginal communities

###### Policy directions

Work with Aboriginal services and communities should be undertaken within the collaborative framework provided by the NSW Aboriginal Health Partnership Agreement between NSW Health and the Aboriginal Health and Medical Research Council (AH&MRC).

Strategies to address the social and emotional well being of older Aboriginal people should be consistent with the *NSW Aboriginal Mental Health and Well Being Policy* and the following NSW Health policies:

- *Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System* (1998).
- *NSW Aboriginal Health Impact Statement and Guidelines* (2003).<sup>105</sup>

Mental health services will need to work in partnership with Aboriginal Community Controlled Health Services, aged care services (both Aboriginal and mainstream) and other key services to promote the principles and aims articulated in the *NSW Aboriginal Mental Health and Well Being Policy*. Key principles include:

- Recognizing and respecting the role of older Aboriginal people, particularly Aboriginal Elders, as leaders and spokespeople for their communities.
- Consulting with older Aboriginal people in planning and service development and being flexible in responding to their needs and preferences.
- Developing service responses that reflect the relationship between social and emotional wellbeing and a healthy lifestyle.

Key aims include:

- Increasing access to health and community care services for older Aboriginal people with mental health needs.
- Establishing clear linkages between mental health services, primary health and aged care services working with Aboriginal communities to ensure coordinated services to older Aboriginal people with mental health needs.

### *Service models*

Experience with Aboriginal health initiatives suggests that successful approaches to addressing the mental health needs of older Aboriginal people include the following:

- Training primary health care workers working with Aboriginal clients and communities around mental health issues for older people to enhance early detection and treatment of mental health problems.
- Health promotion with older Aboriginal people through primary health care workers, in partnership with a range of agencies and community groups.
- Establishment of strong, clearly articulated professional development and support structures for these primary health care workers, including the provision of specialist mental health support. This support will be critical to the effective operation and sustainability of this generalist model.

A number of initiatives developed in NSW may provide the basis for further work to improve service responses for older Aboriginal people. These include:

- The Aboriginal Elders Yarn Up Day piloted by the former Greater Murray AHS (now part of Greater Southern AHS) in partnership with Aboriginal services in the region. This initiative involved a gathering of Aboriginal communities and relevant services. It was successful in meeting many of its objectives, such as the coming together of Elders in a culturally sensitive, 'positive and healing way'; providing information to assist in increasing participants' knowledge of mental health issues such as depression, grief and loss, their capacity to care for themselves and their communities and their knowledge of available services, and developing connections and partnerships for further initiatives.<sup>105</sup>
- The Aboriginal Dementia Awareness Training Program Training (ADAP-T) conducted by the former Home Care Service of NSW (now part of DADHC). This program was delivered in a train-the-trainer

format and continues to be delivered in many areas through DAS and other health, aged and community care services. It aims to develop increased awareness of dementia in Aboriginal communities and access to appropriate services, and increased capacity and partnerships between Aboriginal and mainstream services in dementia care and support.

- Development of Aboriginal-specific dementia information materials and community awareness campaigns such as the Mind your Memory events, focussing on health ageing messages, held in conjunction with Yarn Up activities.

### *Service partners*

Partners in the development of effective, culturally appropriate service responses for older Aboriginal people with mental health problems will include primary health care workers providing care to Aboriginal communities, Aboriginal mental health workers, Aboriginal aged care services, Aboriginal Community Controlled Health Services, DAS, and NSW Health Aboriginal health services. In pursuing health promotion and early intervention, further partners may include: Land Councils, National Parks and Wildlife Services, the Police and other services and agencies with whom older Aboriginal people may have contact in their roles within their families and communities.

## **Culturally and linguistically diverse communities**

### *Policy directions*

Key NSW policies that provide the framework for strategies to address the needs of older people from CALD backgrounds are:

- The *NSW Ethnic Affairs Priorities Statement*.
- The *NSW Health Multicultural Mental Health Plan* (forthcoming).

Key focus areas in responding to the specific needs of older people from CALD backgrounds, as outlined in the NSW Health *Multicultural Mental Health Plan* include the following:

- Establishing consultation processes and mechanisms for CALD communities and service providers to provide input to SMHSOP planning and service development.
- Embedding cultural competency in care provided by SMHSOP through cross-cultural training of SMHSOP staff and use of interpreter services and bilingual workers in assessment, treatment and care planning.

- Sourcing and disseminating relevant translated, culturally appropriate information materials for older people from CALD backgrounds and their families and carers.
- Developing partnerships with multicultural agencies and bilingual workers (including bilingual GPs) in service provision, care planning and care coordination for older people from CALD backgrounds with mental health needs.
- Developing culturally appropriate approaches and service models for older people from CALD backgrounds.
- Collecting ethnicity data within SMHSOP documentation and reporting in mental health data collections to inform further planning and service development.

### *Service models*

There is a limited evidence base concerning service models for older people with mental health problems from CALD backgrounds, and it is anticipated that culturally appropriate models will be developed, piloted and reviewed in Phase 1 of implementation to inform service developments in Phase 2. However, the following initiatives may provide some basis for strategies to improve assessment for older people from CALD backgrounds:

- Rowland Universal Dementia Assessment Scale (RUDAS): A multicultural cognitive assessment scale developed by SSWAHS and UNSW with NSW Department of Health funding that is valid across cultures, portable and easily administered by primary health and mental health care workers.<sup>106</sup>
- The Sensitive Assessment Framework for Frail Ethnic Elderly (SAFFEE): A framework developed by SES/IAHS with DoHA funding, aimed at ACATs, that provides good practice protocols in planning, service provision, developing partnerships, consultation, information and personnel practices, along with a list of relevant resources and contacts.

### *Service partners*

Partners in the development of effective, culturally appropriate service responses for older people from CALD backgrounds with mental health problems include transcultural and ethno-specific mental health and aged care services (eg Transcultural Mental Health Service; Services for Treatment and Rehabilitation of Torture and Trauma Survivors), ethnic community organizations and workers, bilingual health workers and GPs, and interpreter services.

## **Rural and remote communities**

The major NSW Health plan that provides the framework for strategies to address the needs of older people with mental health problems in rural and remote areas is the NSW Rural Health Plan (2002).<sup>107</sup> The NSW Centre for Rural and Remote Mental Health has been established by NSW Health to undertake a lead role in mental health research and service development in rural and remote NSW.

### *Service models*

Rural and remote mental health services generally operate on a primary health care model, founded on strong capacity building work and partnerships with primary health care services. In these areas, SMHSOP responses may be provided by discrete SMHSOP staff who carry only older people in their caseloads or by SMHSOP key workers in generalist mental health teams, with the specialist skills to support team members in the care of older patients. The primary roles of small SMHSOP teams or key workers will be community development and capacity building and SMHSOP input to ACAT assessments for older people with severe BPSD. These staff will also provide the link between specialist outreach consultation and liaison by Visiting Medical Officers and the case management functions of the generic mental health and aged care teams.

Telehealth provides a potential model for supervision and professional development for SMHSOP staff working individually or in small teams in rural areas.

Rural and remote mental health services may be unable to meet the needs of the SMHSOP target group with local or visiting (fly in) psychiatrists with expertise in treating older people. A Faculty of Psychiatry of Old Age project to explore the feasibility of utilizing telepsychiatry for SMHSOP found that telepsychiatry can be effectively used in patient assessment and case conferencing as an adjunct to face-to-face psychiatry services but not as an alternative to these services. Agreed protocols are required for patient referral, selection, prioritization, preparation and reporting. Administrative and technical support, space for equipment and conferencing and staff training and time for contributing to the telepsychiatry service are also required for this model to operate effectively. Operational management and clinical governance of telepsychiatry services for older people should reside with SMHSOP (or adult mental health services) and/or aged care services. The *NSW Health Telehealth Initiative Service Planning and Evaluation Framework 2003–2007* and Telehealth Program provide guidance and opportunities for developing services in this area. The operational options for telepsychiatry services – a centralized or



decentralized model – will be further examined in Phase 1 of implementation.

A specialist medical workforce development strategy that has been successfully trialled in Australia and overseas is to provide outreach specialist old age psychiatry training to GPs who are already working in rural communities and therefore have established relationships and community ties. This model has been successfully utilized in GSAHS (Greater Murray region), where a geriatric medical mentorship program, conducted in conjunction with metropolitan-based, university-linked geriatricians has addressed a workforce gap. This strategy should be considered in SMHSOP workforce development strategies in rural and remote areas.

Bloom and Schmeide have argued that successful models to improve access to specialist medical services in rural and remote areas fall into three main categories:

- **Extenders** – such as outreach models that extend the reach of existing medical specialist providers.
- **Enhancers** – such as the GP training model outlined above, that upskill GPs and other clinicians to enhance the available medical specialist services.
- **Enablers** – such as e-health and telehealth programs that facilitate virtual access.<sup>108</sup>

This analysis is suggestive for SMHSOP workforce development strategies in rural and remote areas.

### *Service partners*

Key service partners in addressing the needs of older people in rural and remote areas will include generalist mental health teams, ACATs and other aged care services, GPs, primary health care workers such as community nurses, pharmacists, community support services, hospitals and Multiple Purpose Services (MPS).

## **Older people in the criminal justice system**

### *Policy directions*

As for Area SMHSOP in general, planning and service development for older people with health and mental health needs within the criminal justice system will be consistent with the *NSW Mental Health Planning*

*Framework, Framework for integrated support and management of older people in the NSW health care system* and other relevant NSW policy and planning frameworks relating to mental health and aged care. However, specific strategies to address the needs of this group are outlined in the *Justice Health Aged Care Plan* (forthcoming). Key areas of focus are summarized below.

### *Service models*

Strategies to address the health and mental health needs of older people in the criminal justice system and at the interface with mainstream health and aged care services will include the following:

- Development of tertiary referral clinics (male clinic to be located at the Long Bay Complex and female clinic to be located in the purpose-designed Dilwynia facility at Windsor), and clinical pathways within the criminal justice system for the identification, assessment and treatment of 'functionally old' people with mental health problems.
- Establishment of a 15-bed aged care and rehabilitation unit for older people with complex medical and mental health needs within the new prison hospital to be developed at the Long Bay Complex.
- Piloting of a joint Justice Health and Department of Community Services hostel-type supported accommodation model for older inmates with complex needs, including mental health needs.
- Further development of discharge processes for older inmates, including completion of risk assessments for Justice Health clients whilst in custody, to be provided to relevant services in the discharge planning process.

### *Service partners*

Key partners in addressing the needs of older people with complex health and mental health needs in the criminal justice system and at the interface with community-based health and aged care services will include the Department of Community Services, the NSW Police, Area SMHSOP and Mental Health Services, ACATs and aged care services.

# SMHSOP implementation plan

This section outlines the key principles that will underpin the implementation of the SMHSOP service delivery model across NSW. These principles align with the various domains of mental health service performance outlined in a recent report on *Key Performance Indicators for Australian Public Mental Health Services*, produced under the auspices of the National Mental Health Working Group (see Appendix 7).<sup>109</sup> It should be noted that recent evaluations of Australian public mental health services have confirmed the effectiveness of these services. The National KPIs provide a broader framework for measuring and benchmarking the performance of these services in areas such as accessibility, safety and efficiency.

A detailed two-phase implementation plan outlines the strategies to be pursued under the *Plan* and sets out performance indicators and reporting mechanisms for monitoring progress with implementation. The KPIs for Phase 1 are focused on assessing the key impacts of the *Plan* in domains where agreed national KPIs are in place. The reporting, monitoring and evaluation processes that will provide the accountability framework for the *Plan* are outlined in Section 5.3.

## 5.1 Service delivery and implementation principles

The development of SMHSOP through the implementation of this plan will be guided by the following key principles:

1. **Promote the accessibility of SMHSOP** – this principle includes a number of aims:
  - **Increase access to SMHSOP for the SMHSOP target group** – Currently, SMHSOP are at an early stage of development in many Area Health Services and there is limited access to these services. In the implementation of this plan, NSW Health aims to improve access to these specialist mental health services for older people with mental health problems, recognising the need to prioritise access according to clinical need and as services develop.
  - **NSW Health services currently providing services to older people with mental health problems, including adult mental health services and aged care services, should take steps to prevent any diminution of the services provided to the SMHSOP target group** – This plan aims to promote better care for older people with complex mental health problems by building on existing services for this group and developing specialist services to work in partnership with these services.
  - **Promote equity in access to SMHSOP across NSW** – Currently, access to SMHSOP is varied across NSW. The development of SMHSOP under this plan aims to improve access to SMHSOP across the State and thereby promote a more equitable service system. In promoting equity, it is recognized that targeted responses and specific strategies may be required to address the mental health needs of particular priority population groups, including Aboriginal communities, people from CALD backgrounds, rural and remote communities and older people in the criminal justice system.
2. **Promote effective and appropriate services** – In the development of SMHSOP under this plan, AMHSs should promote service and care models that are effective (informed by the developing evidence base) and appropriate (in line with *National Standards for Mental Health Services* and *National Practice Standards for the Mental Health Workforce*).
3. **Promote an integrated approach to the care and support of older people with mental health problems and improve continuity of care** – SMHSOP should work with other key services, particularly aged care services, to promote an integrated approach to assessment, care and support of older people with mental health problems, in line with NSW Health and national policy directions and evidence-based best practice. This approach is aimed at improving the quality and continuity of care for this group.



4. **Promote services that are responsive to the needs and preferences of consumers and carers** – SMHSOP should have a client and carer focus and should promote and support participation by consumers, carers and families in care, planning, evaluation and quality improvement.
5. **Promote services and service models that are efficient for the NSW public health system** – Services developed under this plan should be underpinned by the principle of delivering value for public money for which NSW Health is accountable.
6. **Develop services that are capable and sustainable** – In developing SMHSOP community teams and other clinical service components, it will be important to promote the capabilities of those services through staff training and skills development and other strategies. Workforce planning, supportive organisational and team structures, support for professional development, and a focus on research and evaluation will all contribute to the sustainability of these services.
7. **Promote quality and safety in the provision of SMHSOP** – Services should be delivered in ways that promote quality of care and safety for consumers, carers, families, staff and the community. SMHSOP should have clinical governance arrangements that include well-articulated processes for clinical risk management, audit, performance and evaluation, professional development and quality improvement. SMHSOP should provide treatment interventions that are evidence-based and informed by clinical practice guidelines and professional standards, in line with the *National Standards for Mental Health Services*, *National Practice Standards for the Mental Health Workforce* and *National Action Plan for Safety Priorities in Mental Health*.

## 5.2 SMHSOP implementation plan

The implementation plan for the development of SMHSOP across NSW over the next ten years is set out below.

The strategies outlined reflect the current evidence base, clinical service models and service development priorities identified throughout the *Service Plan*. The implementation plan incorporates two major phases of service development. Broadly, these phases are as follows:

- **Phase 1** focusses on the development of community SMHSOP teams and community-based SMHSOP initiatives in partnership with other key services such as adult mental health services, primary health and aged care services, GPs, community care services and residential aged care services. In this phase of service development, SMHSOP will also develop and support arrangements for older people with acute mental illness to access appropriate inpatient services, but major service developments in acute and non-acute inpatient care will occur in Phase 2.
- **Phase 2** entails the consolidation of planning and service developments in Phase 1, with new service developments to focus on the areas of acute and non-acute inpatient care, rehabilitation and recovery programs for older people and statewide service development and quality improvement initiatives.

The implementation plan also outlines key strategies relating to workforce development, planning and resource allocation (three service delivery platforms that will be fundamental to the development of SMHSOP clinical services) and key strategies to support appropriate accountability for SMHSOP service development and service delivery under the *Service Plan*. Table 5 provides an overview of the implementation plan, highlighting the phased development of the SMHSOP service delivery model and the alignment between the *Service Plan for SMHSOP* and the *NSW Mental Health Planning Framework*. The full SMHSOP implementation plan follows this overview (Tables 6.1 and 6.2).

**Table 5. Overview of implementation plan for SMHSOP service delivery model mapped against NSW Mental Health Planning Framework strategic priority areas**

Priority Areas	Implementation Phase 1	Implementation Phase 2
	<p>Clinical service components:</p> <ul style="list-style-type: none"> <li>■ SMHSOP community teams</li> <li>■ Severely and persistently challenging behaviours model: <ul style="list-style-type: none"> <li>– BASIS (full implementation)</li> <li>– interim specialist care facilities (development and trialling)</li> <li>– specialist community residential models (development and trialling)</li> </ul> </li> </ul>	<p>Clinical service components:</p> <ul style="list-style-type: none"> <li>■ SMHSOP community teams</li> <li>■ Acute inpatient facilities</li> <li>■ Non-acute inpatient and specialist interim care facilities</li> <li>■ Specialist community residential facilities and longer term specialist interim care facilities</li> <li>■ Severely and persistently challenging behaviours model: <ul style="list-style-type: none"> <li>– Tertiary intensive care neurobehavioural unit (to be determined)</li> </ul> </li> </ul>
Prevention and early intervention	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Prevention and early intervention work through community capacity building and education and training to adult mental health staff, geriatric/aged care services, HACC services, residential aged care facility staff, GPs and other health professionals</li> <li>■ Case conferencing and care planning through C/L to GPs by SMHSOP community teams</li> </ul>	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Further functions/initiatives in the areas of: <ul style="list-style-type: none"> <li>– Mental health promotion and prevention programs (including suicide prevention initiatives and health ageing programs)</li> <li>– Early intervention programs such as memory clinics</li> </ul> </li> </ul>
Care of people with/or at risk of recurring mental illness	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Specialist mental health assessment through C/L with aged care services, RACFs, primary health and community care services by SMHSOP community teams</li> <li>■ Joint care planning and case management with adult mental health teams, GPs and ACATs</li> <li>■ C/L and case management to RACFs in line with the BASIS 'severely and persistently challenging behaviours model'</li> </ul>	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Further functions/initiatives in the areas of: <ul style="list-style-type: none"> <li>– Rehabilitation and recovery programs for older people with mental illness</li> <li>– Specialist clinical assessment and treatment through non-acute inpatient or interim care facilities and community residential (or extended care) facilities</li> </ul> </li> </ul>
Emergency and acute care	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Bed access arrangements for the care of older people with acute mental illness in adult mental health inpatient facilities, acute geriatric units and acute hospitals</li> <li>■ After-hours emergency response to be provided by adult mental health crisis team</li> </ul>	<p>Clinical functions:</p> <ul style="list-style-type: none"> <li>■ Further functions/initiatives in the areas of: <ul style="list-style-type: none"> <li>– Specialist clinical assessment and treatment through acute facilities</li> <li>– After-hours emergency response to be provided by adult mental health crisis teams</li> <li>– Specialist intensive care for older people exhibiting extreme and violent behavioural symptoms</li> </ul> </li> </ul>



**Table 6.1 SMHSOP implementation plan: Phase 1 2005–2010**

Strategies	Performance or process indicators	Data collection and reporting mechanisms
<b>1. SMHSOP clinical services</b>		
1.1 Develop SMHSOP community teams across NSW to address access and equity issues	<p>SMHSOP resource allocation, utilisation and staffing (against MH-CCP benchmarks)</p> <p>Community team activity</p> <p>Client outcomes</p>	<p>NSW Health Financial Allocation Monitoring; NSW Health Admitted Patient collection (AP collection); National Mental Health Survey (NMHS)</p> <p>NSW Mental Health Ambulatory collection (MH-AMB)</p> <p>Standard outcomes measures (MH-OAT)</p>
1.2 Develop and support partnership arrangements to improve access to private psychiatric services for older people with mental health problems	<p>Arrangements in place</p> <p>Access to private psychiatric services by older people</p>	<p>Qualitative reporting to CMH</p> <p>Health Insurance Commission data</p>
1.3 Develop service agreements or protocols in all AHSs for collaboration between NSW Health mental health and aged care services in the care of older people with severe BPSD	<p>Formal agreements or protocols in place</p>	<p>Area Mental Health Service Agreements 2005/06</p>
1.4 Develop BASIS function in all AHSs for older people with severe and complex behavioural disturbance	<p>BASIS staff and service arrangements in place</p> <p>Client contacts with people with dementia</p> <p>Assessment, care planning and care conference activity</p> <p>Partnership and training activity</p>	<p>Qualitative reporting to CMH and NMHS</p> <p>MH-AMB</p>
1.5 Develop and support arrangements for older people with acute psychiatric symptoms to access acute inpatient care, including training and support to ED staff, acute hospital and mental health inpatient facility staff and mental health crisis teams	<p>Local access to inpatient care for SMHSOP clients</p> <p>SMHSOP activity in acute inpatient settings</p>	<p>AP collection</p> <p>MH-AMB</p>
1.6 Develop and support arrangements that promote continuity of care between inpatient and community settings for the SMHSOP target group, including clinical pathways	<p>Cross-setting continuity</p>	<p>NSW Health Information Exchange (HIE) (once UPI in place)</p>
<p>1.7 Develop service models and arrangements to support improved access to long-term care options for the SMHSOP target group, including the following strategies:</p> <ul style="list-style-type: none"> <li>– Pilot ‘special care units’ within RACFs in partnership with NSW Health aged care services and residential aged care providers</li> <li>– Develop collaborative relationships and arrangements with RACFs (including education and training strategies, C/L activities) to support improvements in RACF capacity to care for SMHSOP target group</li> <li>– Develop service models and arrangements with government and non-government providers for the provision of community residential services for the SMHSOP target group</li> </ul>	<p>Pilot models established</p> <p>C/L and training activity</p> <p>Service models and arrangements in place</p>	<p>Qualitative reporting to CMH and evaluation</p> <p>MH-AMB</p> <p>Qualitative reporting to CMH and evaluation</p>

<p>1.8 Implement strategies to improve access to non-acute inpatient or rehabilitation services for the SMHSOP target group (and investigate community mental health rehabilitation models) through:</p> <ul style="list-style-type: none"> <li>- Clinical service redesign of CADE Units to provide an interim specialist behavioural assessment and treatment function, in line with the CADE review recommendations</li> <li>- Development of SMHSOP sub-units, or appropriately supported and designed care environments within mental health non-acute facilities, in line with SMHSOP non-acute inpatient functions outlined in the <i>Service Plan</i> and the interim specialist behavioural assessment and treatment facility outlined under the 'severely and persistently challenging behaviours model'</li> <li>- Arrangements with aged care services (including transitional aged care service models and flexible care service models)</li> </ul>	<p>Implementation of CADE review recommendations</p> <p>Arrangements with CADE Units and aged care services in place</p> <p>Access to CADE Units and rehabilitation services for SMHSOP clients</p> <p>SMHSOP activity in CADE Units</p> <p>Service redesign of MH non-acute inpatient units</p> <p>New SMHSOP clients to MH non-acute inpatient units and length of stay</p>	<p>Qualitative reporting to CMH and evaluation</p> <p>HIE</p> <p>MH-AMB</p> <p>Qualitative reporting to CMH and evaluation</p> <p>AP collection</p>
<p>1.9 Conduct education and training activities regarding older people's mental health issues with primary health, aged care, community care and residential aged care staff to enhance capacity for prevention and early intervention and appropriate referral. (Training to cover depression, suicide risk assessment and suicide prevention as priority issues.)</p>	<p>Education and skills training activity</p>	<p>MH-AMB</p>
<p>1.10 Conduct community development activities with health promotion, prevention and early intervention goals</p>	<p>Community development activities conducted</p>	<p>Qualitative reporting to CMH and evaluation</p>
<p>1.11 Provide information and support to carers of older people with mental illness</p>	<p>Carer information and support activity</p>	<p>MH-AMB</p>
<p>1.12 Develop collaborative strategies with GPs to promote early intervention and referral, and effective primary health care for older people with mental health problems, including:</p> <ul style="list-style-type: none"> <li>- Training activities</li> <li>- Provision of information and development of protocols to promote appropriate referral</li> <li>- Shared care approaches</li> </ul>	<p>Training activity</p> <p>Referrals from GPs</p> <p>Care conference and care planning activity</p>	<p>MH-AMB</p> <p>MH-AMB</p> <p>MH-AMB</p>
<p><b>2. Special needs groups</b></p>		
<p>2.1 Develop and implement strategies to improve responses by mental health services to older Aboriginal people with mental health problems, including opportunistic mental health promotion, training with mental health staff regarding culturally appropriate assessment and treatment, capacity building with primary health care workers and establishment of professional development and support structures (including specialist back up)</p>	<p>Strategies implemented</p> <p>Training activity</p> <p>Access to SMHSOP by Aboriginal people</p>	<p>Qualitative reporting to CMH and evaluation</p> <p>MH-AMB</p> <p>AP collection</p>
<p>2.2 Develop and implement strategies to improve responses by mental health services to older people from culturally and linguistically diverse backgrounds with mental health problems, including consulting with CALD organisations and communities, developing culturally competent assessment and care, disseminating appropriate information resources and developing partnerships with multicultural organisations and bilingual workers</p>	<p>Strategies implemented</p> <p>Relevant activity</p> <p>Access to SMHSOP by people from CALD backgrounds</p>	<p>Qualitative reporting to CMH and evaluation</p> <p>MH-AMB</p> <p>AP collection</p>

2.3 Examine and develop operational models for the effective use of telepsychiatry for SMHSOP to support improved access to specialist consultation/ liaison for older people in rural and remote areas and other appropriate service delivery models	Model developed Use of telepsychiatry by SMHSOP	Qualitative reporting and evaluation MH-AMB
2.4 Implement strategies to address the needs of older people with complex mental health problems in the criminal justice system, including: <ul style="list-style-type: none"> <li>– developing tertiary referral clinics and clinical pathways</li> <li>– establishing an aged care and rehabilitation unit within the new Long Bay Prison Hospital</li> <li>– piloting a joint DCS/JH supported accommodation model</li> <li>– improving pre-release risk assessment and other discharge planning processes</li> </ul>	Clinics and clinical pathways established Hospital aged care and rehabilitation unit established Supported accommodation model established Assessment, care planning and discharge activity Client outcomes	Qualitative reporting and evaluation Qualitative reporting and evaluation Qualitative reporting and evaluation MH-AMB Standard outcome measures (MH-OAT)
<b>3. Workforce</b>		
3.1 Develop and implement a SMHSOP training package and orientation program and core competencies (including cultural competency) for new SMHSOP staff to support recruitment and quality of care (to be mandatory)	Training package and orientation program developed Core competencies developed Participation in training activity Core competencies met by SMHSOP staff SMHSOP staffing against resources allocated	Qualitative reporting Qualitative reporting MH-AMB Qualitative reporting NSW Health Financial Allocation Monitoring; MH-AMB; NMHS
3.2 Conduct training with adult mental health teams and SMHSOP key workers to improve knowledge of and responses to older people's mental health clinical issues	Training activity	MH-AMB
3.3 Develop and implement clinical guidelines to support SMHSOP staff in clinical care	Guidelines developed and implemented	Qualitative reporting and evaluation
3.4 Develop and support workforce training and recruitment programs to increase the supply of appropriately qualified medical, nursing and allied health staff for SMHSOP, in partnership with peak professional bodies and education and training organisations	Workforce training and recruitment initiatives conducted Training activity SMHSOP staffing against resources	Qualitative reporting MH-AMB NMHS
<b>4. Planning</b>		
4.1 Develop AHS SMHSOP Strategic Plans for 2005–2010 to guide the implementation of the SMHSOP Service Plan in AHSs, in line with AHS service gaps, priorities and population needs	Area SMHSOP Strategic Plans produced and disseminated to key stakeholders	Area Mental Health Service Agreements 2005/06
4.2 Establish consultation and planning processes at the state level and AHS level to facilitate stakeholder input to and partnerships in SMHSOP service development	Consultative processes in place Consultation and joint planning activity	Qualitative reporting MH-AMB
4.3 Review current inpatient care services, including clinical quality and safety, effectiveness, appropriateness and efficiency, and develop appropriate inpatient care models for the SMHSOP target group	SMHSOP inpatient care model developed	Qualitative reporting

4.4 Influence and advise on capital planning processes at the state and AHS level to promote development of SMHSOP acute and non-acute inpatient services in Phase 2 of the SMHSOP implementation plan (based on effective inpatient care models and in line with MH-CCP benchmarks) and appropriate environments for the SMHSOP target group in existing and new inpatient facilities catering to older people	New SMHSOP acute and non-acute inpatient beds on NSW Health capital plans  Environmental modifications (including capital works) to existing inpatient facilities  Utilisation of and compliance with relevant NSW Health guidelines	NSW Health capital plans  Qualitative reporting  Qualitative reporting and compliance monitoring
4.5 Participate in planning with aged care services and other relevant services to develop joint initiatives and coordinated responses to the needs of older people with mental health problems	MH partnership activity	MH-AMB
<b>5. Resource allocation</b>		
5.1 Increase resource allocation to support the development of SMHSOP and improve responses to needs of older people with MH problems	NSW Health funding for SMHSOP  Funding for SMHSOP partnership activities and other programs targeting older people mental health by other agencies	NSW Health Financial Allocation Monitoring  Program reporting
<b>6. Accountability</b>		
6.1 Implement strategies to increase MH-OAT standard outcome measure reporting by SMHSOP clinicians, maintain reporting quality and provide feedback on reports to SMHSOP	MH-OAT reporting by SMHSOP against CMH targets  Feedback provided to SMHSOP staff	MH-OAT documentation  Qualitative reporting
6.2 Implement strategies to facilitate streamlining of SMHSOP activity reporting (through data linkages between mental health, aged care and community health data collection systems), increase activity reporting by SMHSOP clinicians, facilitate reporting quality and consistency, and provide feedback on reports to SMHSOP staff	MH-AMB reporting by SMHSOP against CMH targets  Feedback provided to SMHSOP staff	MH-AMB documentation  Qualitative reporting
6.3 Implement Mental Health Unique Patient Identifier (MH-UPI) in SMHSOP, in line with NSW Health UPI development and implementation process	MH-UPI completion	MH-UPI reporting
6.4 Develop and support effective clinical governance arrangements and quality improvements to promote quality and safety in clinical care	Clinical governance arrangements in place  Reportable incidents	Qualitative reporting  Incident Management System
6.5 Implement benchmarking initiatives involving like services within and across AHSs and participate in state and national benchmarking processes to inform data collection developments, performance monitoring and evaluation, clinical service development and quality improvement	Benchmarking conducted  SMHSOP participation in state and national benchmarking	Qualitative reporting  Qualitative reporting

The reporting mechanisms and processes for the implementation of the *Plan* are outlined in Section 5.3, along with an overview of the monitoring and evaluation plan.

**Table 6.2 SMHSOP implementation plan: Phase 2 2010–2015**

A mid-term review and evaluation of Phase 1 of implementation will inform the Phase 2 implementation plan. However, broad strategies in key priority areas are outlined below. Performance indicators, reporting

mechanisms and performance targets will be developed in line with developments in data collection and information systems, planning and benchmarking processes and performance monitoring frameworks.

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## Strategies

### 1. SMHSOP clinical services

- 1.1 Continue to develop and maintain SMHSOP community service capacity across NSW to address access and equity issues, based on evaluation of community care models and service development in Phase 1
- 
- 1.2 Develop SMHSOP acute inpatient capacity across NSW to address access and equity issues, based on effective inpatient care models
- 
- 1.3 Scope need and model for intensive care behavioural unit for older people with extremely severe, violent behavioural symptoms
- 
- 1.4 Develop SMHSOP non-acute inpatient capacity across NSW to address access and equity issues, and rehabilitation and recovery programs for older people with mental illness, based on effective inpatient care models and rehabilitation and behavioural management models
- 
- 1.5 Continue development and maintenance of service models and arrangements to support access to long-term care options for the SMHSOP target group, including the following strategies:
- Full implementation of 'special care units' within RACFs across NSW, pending the success of pilots in Phase 1.
  - Maintenance of collaborative relationships and arrangements with RACFs (including education and training strategies, C/L activities) to support RACF capacity to care for SMHSOP target group
  - Further implementation of service models and arrangements with government and non-government providers for the provision of community residential services for the SMHSOP target group across NSW, in line with MH-CCP benchmarks
- 
- 1.6 Implement mental health promotion and prevention programs for older people across NSW, building on initiatives in Phase 1.
- 
- 1.7 Implement early intervention programs across NSW, building on initiatives in Phase 1 and other relevant models

### 2. Special needs groups

- 2.1 Develop and implement further strategies to improve responses by mental health services to older Aboriginal people with mental health problems, building on initiatives in Phase 1
- 
- 2.2 Develop and implement further strategies to improve responses by mental health services to older people from CALD backgrounds with mental health problems, building on initiatives in Phase 1
- 
- 2.3 Develop and implement further strategies to improve responses by mental health services to older people with mental health problems in rural and remote areas, building on initiatives in Phase 1
- 
- 2.4 Develop and implement further strategies to improve responses by mental health services to older people with complex mental health problems in the criminal justice system, building on initiatives in Phase 1

### 3. Workforce

- 3.1 Review SMHSOP training package and orientation program and core competencies for new SMHSOP staff and revise as necessary
- 
- 3.2 Continue to conduct training with adult mental health teams and SMHSOP key workers to improve knowledge of and responses to older people's mental health clinical issues
- 
- 3.3 Review clinical guidelines for SMHSOP staff and revise as necessary to reflect changes in clinical best practice
- 
- 3.4 Continue to support and further develop workforce training and recruitment programs to maintain and increase the supply of appropriately qualified medical, nursing and allied health staff for SMHSOP, in partnership with peak professional bodies and education and training organisations
-



## 4. Planning

- 4.1 Develop new five year AHS SMHSOP Strategic Plans to guide the implementation of Phase 2 of the SMHSOP Service Plan in AHS, in line with AHS service gaps, priorities and population needs and the evaluation of Phase 1
- 4.2 Review consultation and planning processes at the state level and AHS level to ensure effective stakeholder input to and partnerships in SMHSOP service development, in line with the evaluation of Phase 1
- 4.3 Influence and advise on capital planning processes at the state and AHS level to promote development of SMHSOP acute and non-acute inpatient services (based on effective inpatient care models and in line with MH-CCP benchmarks) and appropriate environments for the SMHSOP target group in existing and new inpatient facilities catering to older people
- 4.4 Participate in planning with aged care services and other relevant services to develop joint initiatives and coordinated responses to the needs of older people with mental health problems

## 5. Resource allocation

- 5.1 Increase resource allocation to support the development of SMHSOP and improve responses to needs of older people with MH problems

## 6. Accountability

- 6.1 Maintain effective activity reporting for SMHSOP community services and develop and maintain effective activity reporting for SMHSOP inpatient services
- 6.2 Develop a statewide SMHSOP benchmarking network
- 6.3 Develop a statewide research and evaluation network, strategic plan and program to support research, innovation and evaluation by SMHSOP, linked to tertiary education institutions
- 6.4 Develop and support effective clinical governance arrangements and quality improvements to promote quality and safety in clinical care

## 5.3 Reporting, monitoring and evaluation

### Reporting and monitoring

The reporting on the implementation of the *Plan*, as outlined in the implementation plan above, comprises a number of types:

- Client clinical outcomes reporting through standard outcomes measures (MH-OAT data collection system).
- Activity reporting through the Mental Health Ambulatory (MH-AMB) collection (SCI MH-OAT, CHIME and CERNER) and NSW Health Admitted Patient collection.
- Financial reporting and monitoring through the NSW Health Financial Allocation Monitoring System.
- Program reporting through the National Mental Health Survey.
- Qualitative reporting to the Centre for Mental Health by Area Mental Health Services on particular strategies and initiatives, either on request or through Area Mental Health Service Agreements.

- Qualitative reporting by CMH on statewide policy, planning and service development initiatives through relevant forums and mechanisms.

These NSW Health data collection and reporting systems link to relevant national collections such as the National Outcomes and Casemix Collection (NOCC) and the National Mental Health Minimum Data Set (MDS).

The majority of data required by CMH to monitor implementation of the *Plan* can be provided by AMHSs through compliance with existing reporting systems such as MH-OAT, SCI MH-OAT (and other activity reporting systems such as CHIME and CERNER), standard financial reporting and program reporting for the National Mental Health Survey. Therefore, Area SMHSOP Clinical Coordinators will need to promote appropriate reporting at the AHS level, supported by CMH, in order to promote effective monitoring of the *Plan*. CMH will provide feedback to AHSs on their progress in particular areas or strategies on an annual basis through Area Mental Health Service Agreement reporting processes.

Financial and program reporting will occur on an annual basis, in line with current practice.

Monitoring of some strategies progressed under the *Plan* will necessitate qualitative reporting and evaluation to be undertaken, as appropriate.

Performance targets will be developed and negotiated with AHSs, based on benchmarking data and other relevant performance frameworks, statewide priorities and AHS priorities, as articulated in Area SMHSOP Strategic Plans. Performance will be monitored through Area Mental Health Service Agreements.

## Evaluation

A mid-term evaluation will be conducted in 2010 to:

- Review progress with implementation of the *Plan*.
- Evaluate the outcomes from Phase 1.
- Review the strategies and service models outlined for development in Phase 2, based on learning from Phase 1 and any further developments in the evidence base, policy and planning context for the *Plan*.

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

In Phase 1 of implementation, the focus of SMHSOP services and service development will be on improving SMHSOP service accessibility, continuity of care and effectiveness in delivering good clinical outcomes and community-based care for older people with mental health problems. Community-based services developed under the *Plan* will need to demonstrate their efficiency, in line with public sector accountability. Aligning with these areas of focus, and with the National Key Performance Indicators for Australian Public Mental Health Services, the Key Performance Indicators for SMHSOP in this phase of implementation will be as follows:

## Key performance indicators

Domain	Sub domain	Indicator
Accessibility	Access for those in need	Population receiving care
Accessibility	Access for those in need	New SMHSOP clients
Accessibility	Local access	Local access to care for SMHSOP clients
Effectiveness	Consumer outcomes	Clinical outcomes for SMHSOP clients on specified MH-OAT scales
Effectiveness	Community tenure	28 day readmission rate to inpatient care for SMHSOP clients
Appropriateness	Compliance with standards	National Service Standards compliance
Continuity of care	Cross-setting continuity	Pre-admission community care
Continuity of care	Cross-setting continuity	Post-discharge community care for SMHSOP clients
Efficiency	Community care	Cost per 3 month community care period
Efficiency	Community care	Treatment days per 3 month community care period

The mid-term evaluation of the *Plan* will cover these 10 KPIs, along with any further relevant and valid performance indicators that are developed under the *National Mental Health Plan* or for the purposes of evaluating the *Plan*.

# Acronyms

## Services and programs

ACAP	Aged Care Assessment Program
ACATs	Aged Care Assessment Teams
ASETs	Aged care Services Emergency Teams
AHSs	Area Health Services
AMHS	Area Mental Health Service
ACHA	Assistance with Care and Housing for the Aged Program
BASIS	Behavioural Assessment and Intervention Services
CAPAC	Community Acute/Post Acute Care Program
CACPs	Community Aged Care Packages
Compacts	Community Packages
CADE	Confused and Disturbed Elderly Units
DAS	Dementia Advisory Services
DCNCs	Dementia Clinical Nurse Consultants
Dementia EACH	Dementia Extended Aged Care at Home
ED	Emergency Department
ESPN	Elderly Suicide Prevention Network
EACH	Extended Aged Care at Home
HACC	Home and Community Care Program
HACC	Home and Community Care services
HASI	Housing and Accommodation Initiative
IPP	Aged Care Innovative Pool Program
MPS	Multi Purpose Service Program
OPMH	Older People's Mental Health
PGU	Psychogeriatric Unit Program
RACF	Residential Aged Care Facilities
RACFs	Residential aged care facilities
SMHSOP	Specialist Mental Health Services for Older People
SAAP	Support Accommodation Assistance Program
TACP	Transitional Aged Care Program

## Agencies and organisations

DoHA	Australian Government Department of Health and Ageing
DoCS	Department of Community Services
DVA	Department of Veterans' Affairs
FPOA	Faculty of the Psychiatry of Old Age
NGO	Non-government organisation
DADHC	NSW Department of Ageing, Disability and Home Care
DoH	NSW Department of Housing
NMHWG	National Mental Health Working Group

## Research, planning, monitoring and evaluation

CHIME	Community Health Information Management Exchange
KPIs	Key Performance Indicators
MH-CCP	Mental Health Clinical Care and Prevention
MH-OAT	Mental Health Outcome and Assessment Tool
MDS	National Mental Health Minimum Data Set
NMHS	National Mental Health Survey
NOCC	National Outcomes and Casemix Collection
AP	NSW Health Admitted Patient collection
HIE	NSW Health Information Exchange
MH-AMB	NSW Mental Health Ambulatory collection
RCTs	Randomised Control Trials
UPI	Unique Patient Identifier

# Consultative groups that have provided advice on the *Service Plan for SMHSOP*

## Area SMHSOP clinical coordinators network

**Dr Kate Jackson** (Chair) – Centre for Mental Health, NSW Department of Health

**Dr Mike Bird** – Area SMHSOP Clinical Coordinator, Greater Southern AHS

**Mr Ian Rawson** – Area SMHSOP Clinical Coordinator, Greater Western AHS

**Mr Brendan Hedger** – Area SMHSOP Clinical Coordinator, Greater Western AHS

**Dr Stephen Ticehurst** – Area SMHSOP Clinical Coordinator, Hunter/New England AHS

**Ms Cate Fairfull-Smith** – Area SMHSOP Clinical Coordinator, North Coast AHS

**Dr Doug Subau** – Area SMHSOP Clinical Coordinator, Northern Sydney/Central Coast AHS

**Dr John Dobrohotoff** – Area SMHSOP Clinical Coordinator, Northern Sydney/Central Coast AHS

**Ms Elizabeth Abbott** – Area SMHSOP Clinical Coordinator, South Eastern Sydney/Illawarra AHS

**Prof John Snowdon** – Area SMHSOP Clinical Coordinator, Sydney South West AHS

**Dr Rod McKay** – Area SMHSOP Clinical Coordinator, Sydney South West AHS

**Dr Rasiyah Yuvarajan** – Area SMHSOP Clinical Coordinator, Sydney West AHS

**Ms Dennise Allen** – Area SMHSOP Clinical Coordinator, Justice Health

**Dr Beth Kotze** – Area Mental Health Director, South Eastern Sydney/Illawarra AHS

**Dr Angelo Virgona** – Area Mental Health Clinical Director, North Coast AHS

**Dr Russell Roberts** – Area Mental Health Director, Greater Western AHS

**Ms Emanuela D'Urso** – Centre for Mental Health, NSW Department of Health

## Older people's mental health working group (2005)

**Dr Rod McKay** (Chair) – Chair, Faculty of Psychiatry of Old Age (NSW) and Area SMHSOP Clinical Coordinator, Sydney South West AHS

**Prof John Snowdon** – Area SMHSOP Clinical Coordinator, Sydney South West AHS

**Dr Mike Bird** – Area SMHSOP Clinical Coordinator, Greater Southern AHS

**Dr Beth Kotze** – Area Mental Health Director, South Eastern Sydney/Illawarra AHS

**Dr Angelo Virgona** – Area Mental Health Clinical Director, North Coast AHS

**Prof Henry Brodaty** – Faculty of Psychiatry of Old Age (NSW)

**Dr Stephen Ticehurst** – Faculty of Psychiatry of Old Age (NSW)

**Ms Regina McDonald** – Psychogeriatric Nurses Association (NSW)

**Ms Margaret Dalmau** – NSW Health Elderly Suicide Prevention Network

**Dr Sue Kurrle** – Director of Aged and Extended Care, Northern Sydney/Central Coast AHS

**Dr Narelle Shadbolt** – General Practitioner and Director of Clinical Training, Academic General Practice Unit, Hornsby Hospital

**Ms Sue Macri** – Aged Care Association Australia, NSW (formerly Australian Nursing Homes and Extended Care Association)

**Ms Jill Pretty** – Aged and Community Services Association, NSW and ACT

**Ms Rhoda Immerman** – ARAFMI NSW

**Mr Douglas Holmes** – Consumer Advisory Group, Mental Health Inc

**Ms Emma Jobson** – Australian Government Department of Health and Ageing (NSW Office)

**Ms Roberta Flint** – Australian Government Department of Health and Ageing (NSW Office)

**Ms Lorraine Lovitt** – Primary Health and Community Partnerships Branch, NSW Department of Health

**Ms Elena Manning** – Inter-Government and Funding Strategies Branch, NSW Department of Health

**Ms Emanuela D’Urso** – Centre for Mental Health

**Dr Kate Jackson** – Centre for Mental Health, NSW Department of Health

### **Older people’s mental health planning group (2003/04)**

**Professor Beverley Raphael** (Chair) – Centre for Mental Health, NSW Department of Health

**Dr Megan Alle** – old age psychiatrist, Bloomfield Hospital

**Prof Henry Brodaty** – Professor of Old Age Psychiatry, Prince of Wales Hospital and University of NSW

**Dr Hugh Fairfull-Smith** – Director of Rehabilitation and Aged Care Services, former Northern Rivers AHS

**Dr David Kitching** – old age psychiatrist, Concord Hospital

**Dr Robert Llewellyn-Jones** – Director, Aged Care Psychiatry, Hornsby Ku-ring-gai Hospital

**Dr Rod McKay** – Director, Aged Care Psychiatry, Braeside Hospital

**Dr Jeff Rowland** – Director of Aged Care, former South West Sydney AHS

**Prof John Snowdon** – Director, Aged Care Psychiatry, Rozelle Hospital

**Dr Stephen Ticehurst** – Clinical Director, Psychogeriatrics, James Fletcher Hospital

**Dr Sid Williams** – old age psychiatrist, former Greater Murray AHS and New England AHS

**Ms Emanuela D’Urso** – Centre for Mental Health, NSW Department of Health

**Ms Robyn Murray** – Centre for Mental Health, NSW Department of Health

# Summary of key national and state mental health and aged care policies

## National mental health strategy

This Strategy provides the framework for national reform of mental health services and comprises the first and second *National Mental Health Plans* (1992 and 1998), the Third National Mental Health Plan (2003–2008), the Mental Health Statement of Rights and Responsibilities and the National Standards for Mental Health Services.

### *National Standards for Mental Health Services*

The *National Standards for Mental Health Services* emphasise:

- protection of individual rights
- principles of access and equity
- recognition of the role of carers
- importance of consumer and carer participation
- provision of cross-cultural training and education for mental health workers
- provision of supported accommodation that promotes choice, safety and maximum quality of life for the consumer, and appropriate data collection and information systems.

## Third National Mental Health Plan, 2003–2008

This plan builds on the priorities and reforms of the first and second National Mental Health Plans. It provides a national policy and implementation framework for a coordinated approach to improving mental health across Australia. It adopts a population health approach and emphasises the importance of linkages with other sectors such as housing, employment, justice, welfare and education.

The *Plan* is guided by four priority themes:

- promoting mental health and preventing mental health problems and mental illness
- increasing service responsiveness

- strengthening quality, and fostering research, innovation and sustainability.

Older people are a priority population group under the *Plan*, and it is recognised that some key challenges in older people's mental health relate to service responsiveness to people with diverse and complex needs and promoting continuity of care.

## National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000)

This plan outlines a strategic framework for action to address the promotion, prevention and early intervention priorities and outcomes outlined in the Second *National Mental Health Plan*. It articulates strategies to promote mental health, to reduce mental health problems and mental disorders through enhancing protective factors and reducing risk factors for mental disorders, and to intervene as early as possible to minimise the impact of the symptoms of mental health problems and mental disorders.

## Caring for Mental Health: a framework for mental health care in NSW (1998)

*Caring for Mental Health* provides a policy framework for mental health care in NSW. It aims to promote a focus on mental health issues that is equivalent and complementary to the attention given to physical health issues. The policy sets out six strategic directions relating to:

- development of partnerships in mental health care
- emergency mental health response
- mental health promotion, prevention and early intervention
- best practice, quality and effectiveness in mental health care, and the development of 'building blocks' for mental health service development.



The so-called 'building blocks' for mental health service development are:

- Development of appropriate service models to ensure a comprehensive service network is available in each AHS, supported by specialist statewide services where appropriate.
- Deployment of resources in a fair and cost-effective manner to optimise mental health outcomes of service delivery.
- Development and support of enhanced information systems to monitor, plan and evaluate mental health care.

### **Mental Health Clinical Care and Prevention model (MH-CCP)**

MH-CCP is an epidemiological, population-based service model developed by the NSW Department of Health (Centre for Mental Health) to guide mental health planning and service provision and thus assist in improving the mental health of the people of NSW. It incorporates an evidence-based approach to service provision. It is built from a set of explicit and quantified statements of 'who needs what services from whom', based on the projections of the prevalence of mental illnesses in a standard NSW population and an assumed standard of care over a 12 month period.

### ***Caring for Older People's Mental Health: a strategy for the delivery of mental health care for older people in NSW (1998)***

This strategy was an important step in focussing attention on the specific mental health needs of older people in NSW. The *Strategy* provides a policy framework for detailed service planning, highlighting the following key themes:

- Partnerships for the mental health care of older people.
- Better mental health care for older people.
- Mental health promotion, prevention and early Intervention for older people.
- Strategic directions for quality and effectiveness.

This document aims to ensure that NSW has a progressive, long-term strategy for the prevention and treatment of mental health problems in older people.

### **National Strategy for an Ageing Australia (2001)**

This strategy provides the framework for a national response to the challenges and opportunities that an ageing Australian population will present. It aims to deliver the best outcomes for all Australians regardless of age and provides the vehicle for ongoing leadership by the Australian Government in engaging the Australian community on this important issue.

The *Strategy* recognises the breadth and complexity of social, economic, cultural and service provision issues that an ageing society raises and highlights the importance of effective and coordinated planning to address these issues. Key focus areas under the Strategy are:

- independence and self provision (including employment for mature age workers)
- attitude, lifestyle and community support
- healthy ageing, and world class care.

The *Strategy* is intended to guide activity by a range of stakeholders – governments, businesses, communities and others – to rise to the challenges of demographic change.

### **A new strategy for community care: the way forward (2004)**

The Community Care Strategy outlines the action that the Australian Government will take from 2004–2005, in consultation with state and territory governments, service providers and consumer representatives to pursue a reform agenda to improve community care. The *Strategy* aims to achieve a simplified, streamlined and better coordinated community care system that is able to meet the needs of older people and people with disabilities who require assistance, and their carers. To achieve these aims, five broad priority areas are identified for action:

- addressing gaps and overlap in service delivery
- easier access to services
- enhanced service management
- streamlining of Australian Government programs, and a partnership approach.

## National Framework for Action on Dementia

In January 2005, Australian Health Ministers jointly agreed to the development of a *National Framework for Action on Dementia* to facilitate a coordinated, strategic, collaborative and cost-effective response to dementia prevention, assessment, treatment and care across Australia. The aims of the National Framework are to:

- improve the quality of life of people living with dementia, their families and their carers
- develop a shared vision for action on dementia
- coordinate existing dementia care and support activities, and share good practice service models.

Five key priority areas will be addressed under the Framework:

- research
- information and education
- access and equity
- quality, integration and continuum of care
- workforce and training.

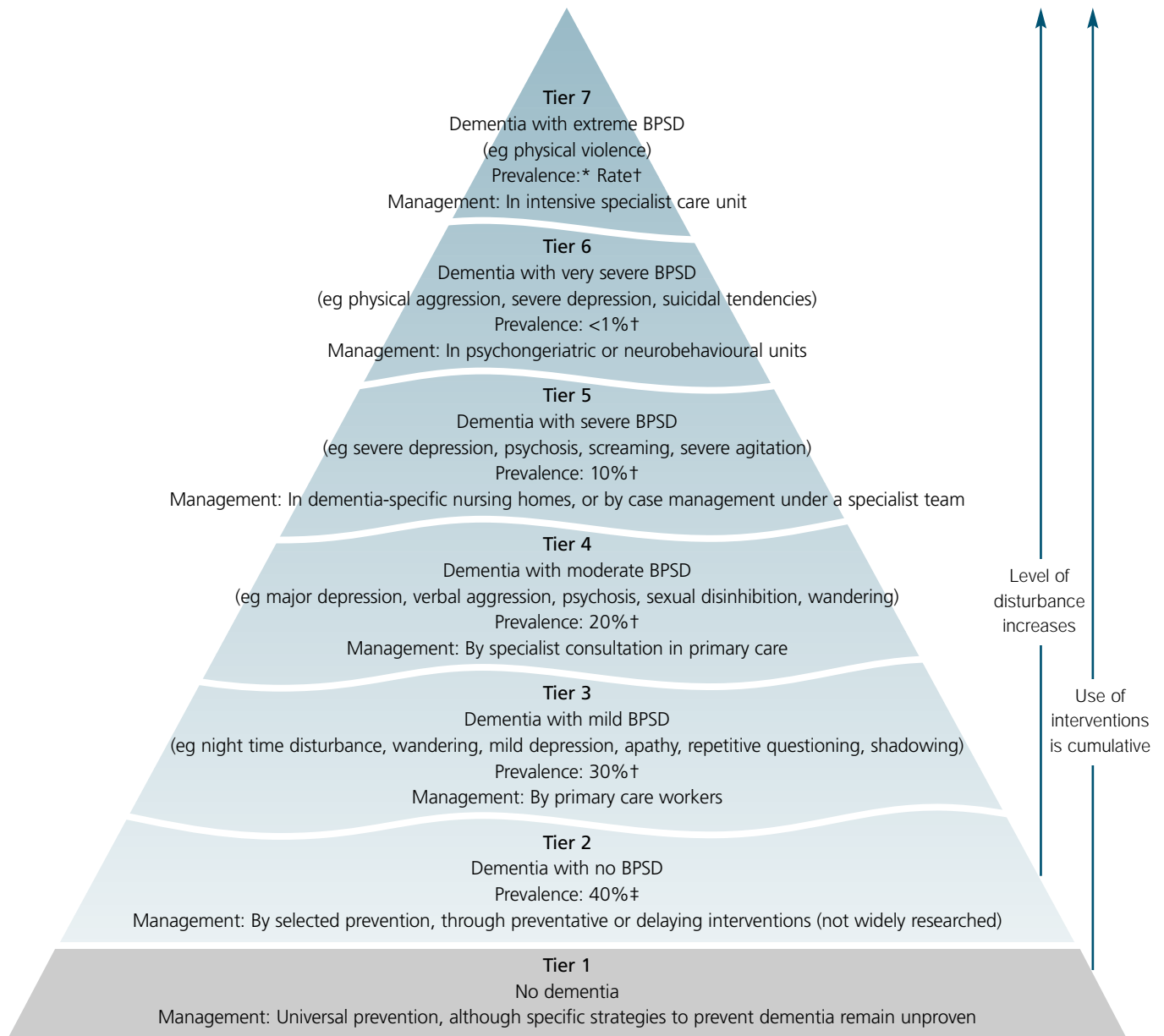
## APPENDIX 3

# Annual population projections for older people (65 years and over) by Area Health Service

Area Health Service	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Sydney South West AHS	140,033	142,610	145,186	147,763	150,860	154,477	158,094	161,711	165,329	170,103
South Eastern Sydney/Illawarra	162,089	164,300	166,512	168,723	171,456	174,711	177,966	181,221	184,475	188,639
Sydney West	100,255	102,865	105,475	108,085	111,232	114,916	118,600	122,284	125,968	130,407
Northern Sydney/Central Coast	162,267	163,285	164,303	165,321	167,102	169,646	172,190	174,734	177,278	180,658
Hunter/New England	125,134	127,710	130,286	132,862	135,983	139,649	143,315	146,981	150,647	155,189
North Coast	83,006	85,130	87,254	89,378	91,937	94,931	97,925	100,919	103,913	107,705
Greater Southern	67,575	69,325	71,075	72,825	74,814	77,042	79,270	81,498	83,726	86,488
Greater Western	42,332	43,180	44,028	44,876	45,850	46,950	48,050	49,150	50,250	51,641
<b>Total NSW population 65 years+</b>	<b>882,691</b>	<b>898,405</b>	<b>914,119</b>	<b>929,833</b>	<b>949,234</b>	<b>972,322</b>	<b>995,410</b>	<b>1,018,498</b>	<b>1,041,586</b>	<b>1,070,830</b>
<b>Total NSW population</b>	<b>6,667,045</b>	<b>6,725,755</b>	<b>6,784,465</b>	<b>6,843,175</b>	<b>6,902,096</b>	<b>6,961,228</b>	<b>7,020,360</b>	<b>7,079,492</b>	<b>7,138,624</b>	<b>7,196,776</b>

NSW Health DIPNR Projections, Version 1.11, December 2004. Projections as at December of each year.

# Service delivery model for behavioural and psychological symptoms of dementia (BPSD)



\* Prevalence is expressed as estimated percentage of people with dementia who currently fall into this category.

† Estimate based on clinical observations.

‡ Estimate based on Lyketsos et al<sup>2</sup>

Brodsky H et al. 'Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery', MJA 2003; 178: 231-234. Copyright 2003. The Medical Journal of Australia – reproduced with permission.

# Summary of relevant national and state mental health and aged care services and programs

## **Specialist geriatric/aged care teams in hospitals and community settings – NSW Health**

Specialist geriatric medical units were established in Australian hospitals in the 1960s to address the need for comprehensive holistic management approaches to the complex and interrelated medical, functional, mental health, cognitive and social needs of frail older people. The scope of these specialist services was expanded in the 1980s following the introduction of multidisciplinary Geriatric/Aged Care Assessment Teams, comprising specialised medical, nursing, physiotherapy, occupational therapy and social work staff. Multidisciplinary aged care assessment and management aims to uncover the multidimensional problems of at risk, frail older people, with the purpose of planning and/or implementing coordinated medical, psychosocial and rehabilitative care tailored to the older person's specific needs.

## **Aged care Services Emergency Teams (ASETs) – NSW Health**

Aged care Services Emergency Teams (ASETs) were established by NSW Health in late 2002 in order to improve the care and management of the increasing numbers of older people presenting to Emergency Departments (EDs). ASEts are multidisciplinary teams comprising medical, nursing and allied health practitioners experienced in aged care. ASEts employ a model of care based on early identification of older people likely to benefit from access to specialised, multidisciplinary aged care services. This is consistent with the NSW Health *Framework for integrated support and management of older people in the NSW health care system 2004–2006*.

## **Dementia Clinical Nurse Consultants (DCNCs) – NSW Health**

Dementia Clinical Nurse Consultants (DCNCs) were established in a number of acute hospitals across NSW in 2003 under the *NSW Dementia Strategy*. The role of the DCNC is to provide expert nursing support and advice to staff in acute hospital wards. In particular, the

Dementia CNC is responsible for developing assessment and management protocols and education strategies for staff working with patients having a known diagnosis of dementia, difficult and challenging behaviours, or cognitive impairment related to undiagnosed dementia and delirium.

## **Dementia Advisory Services – DADHC**

Dementia Advisory Services (DAS) have been established across NSW by DADHC under the *NSW Dementia Strategy* and the HACC Program to provide information and support to people with dementia and their carers and to improve access to quality dementia support services.

DAS are responsive to the needs of local dementia services users and service providers. They directly provide information, education, referral and support services to people with dementia, their families and carers. Through their strong local services networks, DAS also facilitate access to assessment, support and care services and build the capacity of local services to respond to the needs of clients. DAS are involved in promoting community awareness of the early signs of dementia, as well as the benefits of early diagnosis and intervention. They are a resource for local dementia services, providing information and advice on dementia management and facilitating dementia educational and training opportunities locally.

## **Confused and Disturbed Elderly (CADE) units – NSW Health**

Confused and Disturbed Elderly (CADE) Units were established by NSW Health in some AHSs in the late-1980s as facilities for the 'confused and disturbed elderly' – primarily older people with dementia who were resident in stand alone NSW Health psychiatric facilities. Some of these units have been developed as interim specialist assessment and treatment facilities for older people with severe behavioural disturbance associated with dementia and/or mental illness. Following a review of CADE Units in 2005, the majority of these units are to be redesigned to undertake an

interim specialist assessment and treatment clinical function, as part of the continuum of care for older people with mental health problems and SMHSOP service model outlined in this plan.

### **Aged Care Assessment Program (ACAP) – DoHA and NSW Health**

The Aged Care Assessment Program (ACAP) is a joint NSW and Australian Government program. It involves multidisciplinary Aged Care Assessment Teams (ACATs) comprehensively assessing the health and support needs of frail older people and facilitating access to available care services best suited to their needs. ACATs assess an older person's eligibility for Australian Government funded packaged care including residential aged care and flexible care. ACATs may also make referrals to a range of medical or health services and to other community-based services.

### **Multi Purpose Service (MPS) – NSW Health**

The Multi Purpose Service (MPS) Program is a joint initiative of the NSW and Australian Governments which brings together a range of health and aged care services under a single management structure, generally in a single rural or remote location. The model has led to highly innovative and cost-effective health and aged care solutions for rural and remote communities, able to be adapted to local situations. MPSs manage the full range of services including home-based and residential care, community health and primary health care services. They are required to meet the challenge of providing ongoing health care to their entire local population.

### **Community Packages (ComPacks) – NSW Health**

The ComPacks initiative was established in 2004 to ensure that people with complex discharge care needs could return home from hospital safely with appropriate care in place. ComPacks is a case-managed package of care for up to six weeks after discharge from hospital for people who need two or more community services. Under this program, community-based case managers work with a multidisciplinary hospital team to facilitate post-discharge support, starting before discharge and continuing for a short time after discharge, with the aim of facilitating access to mainstream community services.

The service (together with the hospital clinical team) involves:

- Community assessment and case management of targeted people being discharged from public hospitals.

- Rapidly assembling individualised community care packages.
- Designing a package to meet each person's assessed clinical and support needs.

### **Community Acute/Post Acute Care (CAPAC) in NSW**

Hospital in the Home, Post Acute Care, Community Ambulatory Care.

CAPAC programs give acutely ill patients the opportunity to be cared for in the community rather than in hospital either by replacing hospital care or reducing the amount of time spent in hospital. CAPAC programs can provide a comprehensive range of services across a range of clinical specialities with large multidisciplinary teams or can be disease-specific specialist programs (eg infectious diseases) drawing on input from a multidisciplinary group of health professionals.

### **NSW Chronic Care Program – NSW Health**

The NSW Chronic Care Program aims to reduce avoidable and unplanned Emergency Department presentations and admissions to hospital, and improve quality of life for people with chronic conditions and their family and carers. This is achieved through strategies such as facilitating smooth transitions from acute care services to the community setting, supporting optimal management of chronic illness (both medical and self-management approaches), engagement of GPs and incorporation of rehabilitation approaches.

### **NSW Carers Program – NSW Health**

The NSW Carers Program is a cross-agency initiative led by NSW Health, in partnership with DADHC, established in 1999/2000 to enhance supports for informal carers of people with a disability, mental illness or chronic condition and frail older people.

The key priorities for the program are to provide support and training to carers and to improve professional practice in working with carers. The program has a number of components, including:

- A grants program to enable non-government organisations, local government and incorporated community groups to deliver local carer support, as well as statewide carer support programs to specific carer populations.
- Carer Support Officers in Area Health Services to increase the responsiveness of health services to the



needs of informal carers and improve carers' access to appropriate services.

- Specific initiatives to support family carers of people with mental illness and young carers.
- Educational opportunities for health care and community service providers through Carers NSW, the peak statewide non-government organisation for carers.

The mental health component of this program – the Family and Carers Mental Health Program – is described in Section 2 of this plan.

### **Home and Community Care (HACC) program – DoHA and DADHC**

The Home and Community Care (HACC) Program is a joint State/Commonwealth program administered in NSW by DADHC.

The program is designed to provide basic community support services to frail older people and younger people with a disability to prevent their inappropriate admission to residential care and to enhance their quality of life, and to support carers of these groups. Services provided under the HACC Program include transport, meals services, social support, some counselling, home modification and home maintenance. NSW Health provides and administers a range of HACC services including community nursing services, allied health services and centre-based day care services.

### **Residential Aged Care Facilities (RACF) – DoHA**

Residential aged care is designed for older people who can no longer live at home for various reasons such as illness, disability, bereavement, an emergency, the needs of their carer, family or friends, or just because it is harder to manage at home without help. Australia's aged care system aims to ensure that all older people receive support and quality care when they need it.

### **Psychogeriatric Unit (PGU) program – DoHA**

The Psychogeriatric Unit Program provides ongoing special help for people with dementia and their carers to improve the quality of care of residents and potential residents of aged care homes who have dementia and who display challenging behaviours. The role of PGUs is to provide support and training for residential care staff and family carers caring for people with dementia.

The program was reviewed in 2004/05 and it is the Australian Government's intention that Dementia Management Advisory Services (announced in the 2005 Federal Budget) will refocus and build on the role of PGUs by providing increased national coverage, expanding their role and ensuring consistency in program delivery and services to residential and community aged care providers.

### **Aged Care Innovative Pool Program – DoHA and NSW Health**

The Aged Care Innovative Pool, established in 2001/02, is a national pool of flexible care places available for allocation to innovative services outside of the Aged Care Approvals Round. The Innovative Pool allows the Australian Government, in partnership with State and Territory Governments and other stakeholders, to allocate flexible aged care places to services that will:

- provide aged care services in new ways/testing new approaches
- provide aged care services to client groups for whom current services are limited or to newly-emerging client groups
- provide aged care via new models of partnership and collaboration.

### **Community Aged Care Packages (CACPs) – DoHA**

CACPs are individually planned and coordinated packages of community aged care services, designed to meet the daily care needs of older people in the community. CACPs are targeted at frail older people living in the community who require case-management of services as a result of their complex care needs. These individuals would otherwise be eligible for low level residential care. To access a CACP, older people must first be assessed by an ACAT as requiring the type and level of assistance a Package delivers.

### **Community Aged Care Packages (CACPs) targeting older people who are homeless or at risk of homelessness – DoHA**

A small number of organisations in NSW operate specialised and tailored CACP services for older people who are homeless or at risk of homelessness. While these organisations provide the same services as those provided by a general CACP provider, they have special expertise in catering to older people who are homeless or at risk of homelessness.

## **Housing-linked Community Aged Care Packages (CACPs) targeting older people who are financially disadvantaged – DoHA**

Some CACP services in NSW are targeted specifically at people who are financially disadvantaged.

Individuals receiving these services are assessed by the service provider as meeting DoHA's classification of People with Financial Hardship and may live in public housing or private rental accommodation.

## **Assistance with Care and Housing for the Aged (ACHA) – DoHA**

The ACHA program is targeted at financially disadvantaged older people who are homeless or at risk of homelessness. The program aims to assist frail, low-income older people who are homeless, renting or living in insecure housing to remain in the community, by linking them with appropriate housing and/or community care services. Typically, the ACHA program provides short-term case management and transitional/interim support for clients, while in the process of linking them to aged care and/or housing services.

## **Extended Aged Care at Home (EACH) packages – DoHA**

EACH packages provide a flexible range of care services to older people living in the community, who would otherwise have been approved for admission to a residential high care facility (or nursing home). Services included in the package represent the range and type of services that the older person would receive if he/she was admitted to a high care facility (eg nursing services), as well as other services necessary

to permit the older person to remain at home. To access an EACH package, older people must first be assessed by an ACAT as requiring the type and level of assistance an EACH package delivers.

## **Dementia EACH packages – DoHA**

EACH Dementia packages, announced in the 2005/06 Federal Budget, will provide the equivalent of high-level care at home for people living with a diagnosis of dementia which has contributed significantly to their high care needs.

## **National Respite for Carers Program – DoHA**

The National Respite for Carers Program (NRCP) is one of several initiatives designed to support and assist relatives and friends caring at home for people who are unable to care for themselves because of chronic illness, disability or frailty. The program provides information and support for carers and respite care services. The Program funds the following services:

- Respite services
- Commonwealth Carer Respite Centres
- Commonwealth Carer Resource Centres
- National Carer Counselling Program.

## **Commonwealth Carelink Program – DoHA**

Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia.

# Clinical consensus statement in the organisation of care in the psychiatry of the elderly (World Psychiatric Association and World Health Organisation)

## Introduction

*'Psychiatry of the Elderly is a complex discipline, confronted with intricate problems pertaining not only to mental health and behaviour but also the physical health and relational, environmental, spiritual and social matters. The situations, which this discipline is facing, are thus closely linked to the family nucleus, the local customs and culture, the general organization of Public Health and social assistance. The organization of care in Old Age Psychiatry must be worked out along the perspective of the Primary Health Care Strategy of the WHO (Declaration of Alma Ata, 1978), focus on the patients and their families, and yet be integrated into the medical and social network designed for the population in general and the elderly in particular. However, this integration must not be synonymous with dilution and loss of specificity. On the contrary, since collaboration is necessary, it is therefore indispensable that competencies, specific care and structures adapted to Old Age Psychiatry, be solidly developed. Care of the elderly requires a strong contribution from Old Age Psychiatry.'*

Jean Wertheimer in the Introduction to the Consensus Statement

*Older people with mental health problems and their families and carers have the right to participate individually and collectively in the planning and implementation of their health care.*

*Services should be designed for the promotion of mental health in old age as well as for the assessment, diagnosis and management of the full range of mental disorders and disabilities encountered by older people.*

*Governments need to recognize the crucial role of non-government agencies and work in partnership with them.*

*Preparing for increasing life expectancy and ensuing health risks calls for significant social innovations at the individual and societal level, which must be founded on a knowledge base drawn from contributions by, and collaboration among, the medical, behavioural, psychological, biological and social sciences.*

*In developing countries it may be difficult to provide resources for the provision of care. This, however, does not invalidate the aims of helping the elderly by the application of the principles listed above and the specific principles that follow.'*

Consensus Statement pp.2-3

## General principles

*'Good health and life of good quality are fundamental human rights. This applies equally to people of all age groups and to people with mental disorders.*

*All people have the right of access to a range of services that can respond to their health and social needs. These needs should be met appropriately for the cultural setting and in accordance with scientific knowledge and ethical requirements.*

*Governments have a responsibility to improve and maintain the general and mental health of older people and to support their families and carers by the provision of health and social measures adapted to the specific needs of the local community.*

## Specific principles of best practice

Good quality care for older people with mental health problems is:

- Comprehensive
- Accessible
- Responsive
- Individualized
- Transdisciplinary
- Accountable
- Systemic.

*'A comprehensive service should take into account all aspects of the patient's physical, psychological and social needs and wishes and be patient-centred.*

*An accessible service is user-friendly and readily available, minimizing the geographical, cultural, financial, political and linguistic obstacles to obtaining care.*

*A responsive service is one that listens to and understands the problems brought to its attention and acts promptly and appropriately.*

*An individualized service focuses on each person with a mental health problem in his or her family and community context. The planning of care must be tailored for and acceptable to the individual and family, and should aim wherever possible to maintain and support the person within their home environment.*

*A transdisciplinary approach goes beyond traditional professional boundaries to optimize the contributions of people with a range of personal and professional skills. Such an approach also facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community orientated services.*

*An accountable service is one that accepts responsibility for assuring the quality of the service it delivers and monitors this in partnership with patients and their families. Such a service must be ethically and culturally sensitive.*

*A systemic approach flexibly integrates all available services to ensure continuity of care and coordinates all levels of service providers including local, provincial and national governments and community organizations.'*

Consensus Statement, pp 3–4

# National key performance indicators for Public Mental Health Services

The NMHWG Information Strategy Committee Performance Indicator Drafting Group's report on *Key Performance Indicators for Australian Public Mental Health Services* proposes a set of key performance indicators to be introduced in two phases:

**Phase 1 – indicators for initial trial.**

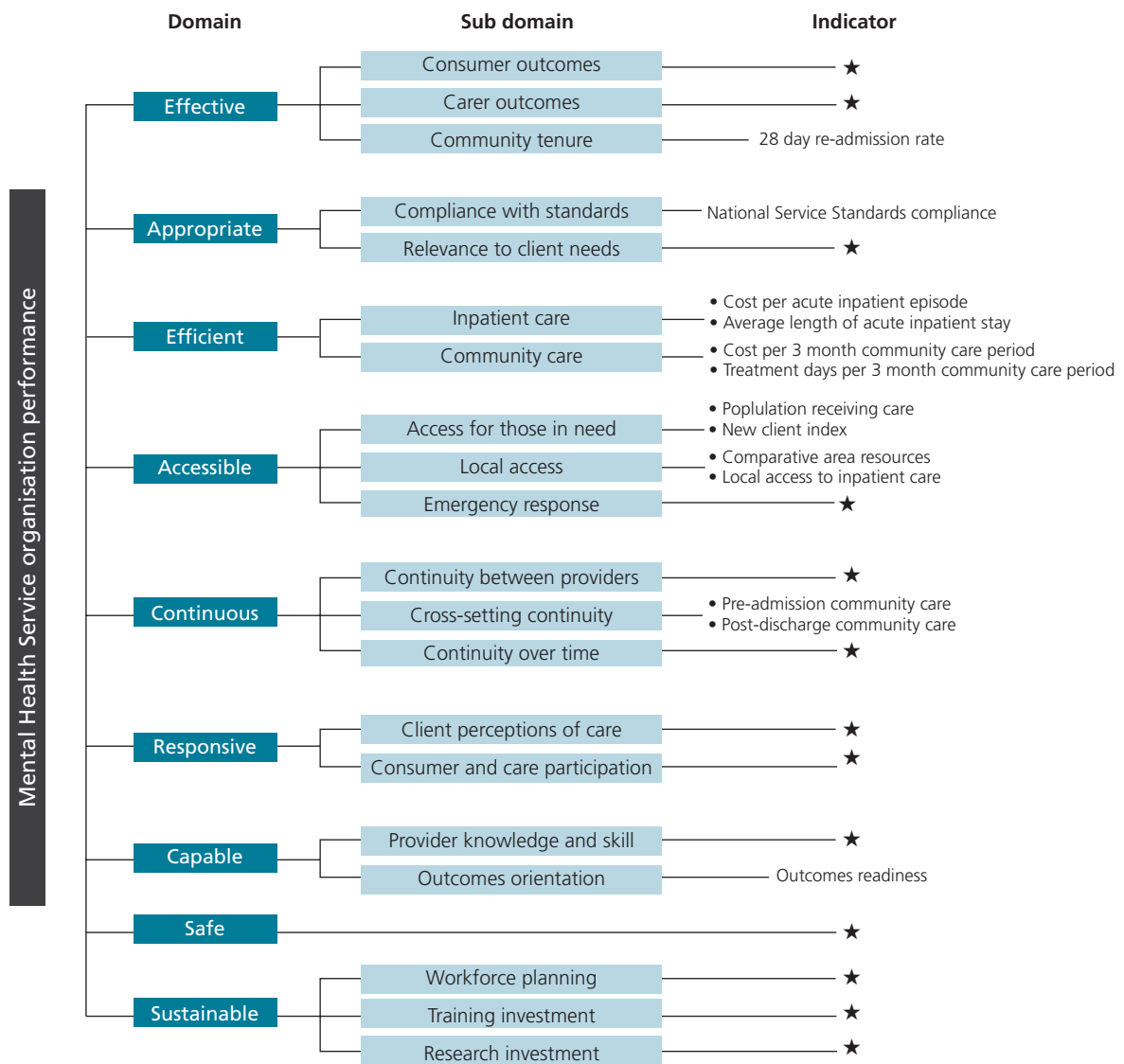
Thirteen indicators are proposed as suitable for immediate introduction based on available data collected by all States and Territories.

**Phase 2 – indicators for development.**

These cover performance sub-domains identified as important for monitoring overall mental health service performance but for which specific indicators are not proposed due to lack of available data.

The figure below summarises the proposed indicator set.

NMHWG information strategy committee performance indicator drafting group



Key ★ = Phase 2 Indicators for development

Key Performance Indicators for Australian Public Mental Health Services, Australian Government Department of Health and Ageing, Canberra, 2005

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