HEALTH POLICY ANALYSIS

NSW Ministry of Health

Older People's Mental Health Service Plan 2017–2027 Mid-Term Evaluation

Summary Report

NSW Ministry of Health
1 Reserve Road
ST LEONARDS NSW 2065
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

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

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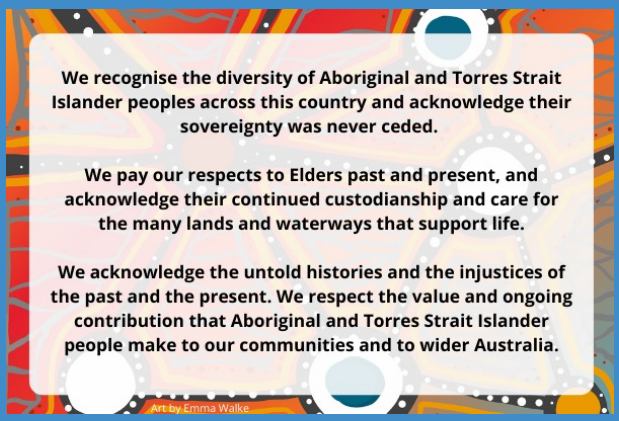
Health Policy Analysis Pty Ltd
Unit 26, 45 Chandos Street, St Leonards New South Wales 2065
PO Box 403, St Leonards NSW 1590
ABN: 54 105 830 920
ACN: 105 830 920
www.healthpolicy.com.au
Phone: +61 2 8065 6491



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Health Policy Analysis (HPA)

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Foreword

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

As the NSW population ages, the number of older people with mental illness is projected to increase. The NSW Older People's Mental Health Service Plan 2017-2027 was developed to guide the delivery and further development of older people's mental health (OPMH) services across NSW to help meet the mental health needs of our ageing population.

The Plan included a commitment to a mid-term evaluation to ensure that the priorities and strategies for the second five-year phase of implementation built on progress and learnings from Phase 1 and reflected changes in the strategic and operational environment. This evaluation report delivers on that commitment. The report highlights some of the positive progress in implementing the NSW OPMH Service Plan, as well as key changes in the strategic and operational environment, and the implications of these changes for the second phase of implementation.

There has been significant change in many areas relevant to older people's mental health over the last five years, including aged care reform, developments in the mental health services and programs commissioned through Primary Health Networks, and developments in Commonwealth-funded dementia services. Suicide prevention has been a major focus nationally and in NSW, with NSW Health progressing a number of targeted, innovative older people's suicide prevention initiatives.

The Pathways to Community Living Initiative has enabled the expansion of innovative mental health-residential aged care partnership services for older people with complex mental health needs in NSW. There has been significant progress in improving older people's access to community living and psychosocial support through the Housing and Accommodation Support Initiative (HASI) and Community Living Support (CLS) programs, and in improving service responses for people experiencing extreme behavioural and psychological symptoms of dementia (BPSD).

However, the COVID-19 pandemic has been a significant disruptor for OPMH services and other key partner services such as aged care services, and this has impacted on progress under the Plan. At the same time, the pandemic has brought older people's mental health into greater focus, underlining the importance of OPMH services and the range of other services and supports for older people with mental illness.

The report highlights some significant changes in OPMH service capacity and service delivery in the context of these changes in the operational environment. It notes the OPMH workforce challenges in relation to recruitment, retention and capability reflected in a statewide OPMH workforce survey conducted by Mental Health Branch.

The report notes that both inpatient and community clinical teams have reported an increase in the acuity and complexity of clients in care with observed increases in inpatient average length of stay and community occasions of service. Nevertheless, OPMH community services across the state have been successful in delivering relative equity of access to mental health services for older people.

However, the balance of care delivery has shifted in both inpatient and community settings, with adult mental health services delivering proportionately more mental health care to older people and OPMH services proportionately less. This has implications for efficient, effective, and appropriate care in both adult and OPMH services (inpatient and community) for older people with mental illness that will need further consideration.

A key direction of the statewide model of care for OPMH community services care is to increase the role of these services in providing specialist assessment for

older people with mental illness, with facilitated access to the most appropriate services following assessment. The evaluation found that 'assessment only' activity has remained stable and represents a relatively small proportion of the overall OPMH community activity statewide, with variation between LHDs. This warrants further exploration.

There has been continued progress in improving OPMH service responses and service partnerships to meet the needs of Aboriginal and culturally and linguistically diverse (CALD) older people, driven and supported by state-level Aboriginal and CALD OPMH working groups. However, there have been limited targeted developments to improve services for other specific population groups and this will be considered further in Phase 2 implementation.

In relation to changes in OPMH service coordination with other partner services, the evaluation report notes that LHDs reported increased collaboration with residential aged care providers, partly driven by the Pathways to Community Living Initiative and mental health-residential aged care partnership service expansion. However, aged care reform and the COVID-19 pandemic have impacted some of this partnership work, and some refocusing is needed. Responsive and flexible funding streams have fostered increased collaboration between OPMH services and PHNs, with some improvements in mental health care and support for older people, and this is an area to build on.

Consumers and clinicians providing input to the evaluation recognised the contribution of peer workers with a lived experience, particularly in navigating the complexities of the mental health, aged care and disability service systems. However, it was noted that there were challenges in recruiting OPMH peer workers. Initial work in this area will be continued and expanded in Phase 2.

The OPMH Service Plan promotes a focus on recovery-oriented practice in OPMH services, as well as good practice in a range of other areas. The evaluation report finds that OPMH service self-auditing in the context of statewide benchmarking and quality improvement shows high levels of achievement of 'good team practice' in community and inpatient OPMH services. Some areas of practice such as partnerships and transitions of care have been negatively impacted by the COVID-19 pandemic but are now returning to pre-pandemic levels.

Consumer and carer experience surveys indicate high levels of satisfaction with OPMH services in both community and inpatient settings, including from culturally and linguistically diverse (CALD) and Aboriginal consumers. OPMH services will continue to monitor and seek to improve consumer and carer experience.

The evaluation identifies a number of key areas of focus in Phase 2 implementation, based on the progress and changes over Phase 1:

- Enhancing responses for consumers with complex needs, including people with severe and extreme BPSD
- Knowledge sharing and expanded implementation of older people's suicide prevention and aftercare
- Anticipating and responding to ongoing changes in key partner services

The Ministry of Health welcomes these evaluation findings and will work to build on the significant progress in implementing the NSW OPMH Service Plan, with consideration of the key areas of focus highlighted in the evaluation. The Ministry's Mental Health Branch has commenced discussions with local health district OPMH service leads, consumer and carer peak organisations, and key partner services and stakeholders about the evaluation findings and potential strategies in the key focus areas highlighted in the evaluation report.

I would like to acknowledge the work of the OPMH service staff across NSW who have continued to develop and improve services for older people with a mental illness in the face of many challenges over the last 5 years. I also acknowledge all of those who provided input to this evaluation to inform our work in OPMH services and partnerships, particularly the consumers and carers who have provided valuable perspectives from their lived experiences. As our population ages and the need for health services for older people grows, the continued development of OPMH services in NSW will be increasingly important.

Deb Willcox AM
Deputy Secretary,
Health System Strategy and Patient Experience
NSW Ministry of Health

Background and methodology

The Mental Health Branch of the NSW Ministry of Health (**the Ministry**) engaged Health Policy Analysis (**HPA**) to conduct a mid-term evaluation of the Older People's Mental Health (**OPMH**) Service Plan 2017–2027 (**the OPMH Service Plan**).

The service plan intends to guide NSW OPMH services over the ten years of the plan. The plan itself acknowledges pressure on specialist OPMH services will grow over the course of the plan and as the population ages, with the plan itself estimating the number of older people with a diagnosable mental illness in NSW will grow from 190,000 in 2016 to 260,000 in 2026.[1]

The Service Plan outlines the purpose, scope, target groups and key elements of OPMH services, along with evidence-based service models and key strategic priorities for the development, delivery, and improvement of OPMH services over the period.

This mid-term evaluation focuses on the Phase One of the OPMH Service Plan from late 2017 through to 2023. It also provides guidance to inform the priority actions during Phase 2 implementation.

Phase One focused on expanding and improving community OPMH services and community partnership models, a review of the OPMH acute inpatient unit model of care, and the service development strategies for specific population groups, including older people with co-existing mental health and alcohol and other drug issues, older people with co-existing mental health problems and intellectual disability, older people in the criminal justice system and communities.

A mixed methods approach was used in the evaluation, including the following evaluation activities:

Document review

- **LHD survey:** The LHD survey was completed by OPMH service managers/service leads, with input from other key staff as needed, with 13 of the 18 LHDs (including specialty networks) providing complete and valid responses.
- **Interviews with key stakeholders:** Interviews were conducted with selected key stakeholders from the Mental Health Branch and OPMPH advisory groups. The interviews were used to obtain details on OPMH Service Plan implementation and the local and national policy context.
- **Consumer and carer focus group:** The evaluation team collaborated with the Being – Mental Health Consumers NSW and Mental Health Carers NSW, to conduct a consumer and carer focus group to canvass their perspectives.
- **LHD case studies:** Involving face to face interviews with staff from OPMH services and service partners, such as relevant community managed organisations, PHNs, Commonwealth-funded services, and aged care providers.
- **Quantitative data analysis:** Quantitative data analysis and descriptive statistics (e.g. representation of people in different geographic regions and age groups and other relevant characteristics). Changes in measures and trends over time were derived from Mental Health Ambulatory and Admitted Patient data collections.

[1] NSW Ministry of Health - Mental Health Branch. (2017). *NSW Older People's Mental Health Services Service Plan 2017-2027.*

Strategic and operational environment impacting OPMH services

OPMH services operate in a complex environment intersecting with aged care, disability care, mental health care, and medical health care. Stakeholders suggest it is common for OPMH policy to be within 'someone else's remit', given OPMH services often traverse across these areas of care. Stakeholders suggested that without a specific focus, especially at a national level, OPMH issues can fall between the gaps of mental health and aged care policy. They observe that there is a risk that neither policy area really deals with the full range of issues confronting older people experiencing mental illness.

Further, Primary Health Networks have a clear role in local mental health service planning and commissioning. Their focus is on those with moderate mental illness, or what has been described as the "missing middle". PHN initiatives include suicide prevention and some specific programs for older people with mental health needs. For example, the *psychological treatment* services program has a goal to improve access to psychological support services for residential aged care residents.

Due to the complexity of interacting systems, state run OMPH services can be required to go well beyond direct care and a 'see and treat' therapeutic relationship and take on the responsibility to assist consumers in navigating the complex web of disparate services and programs available.

Issues of ageing, its sequalae, and the way in which older people interact with the health system require specialist knowledge, training, and skill from the OPMH services and their clinicians. While these specialist skills are important now, they will become increasingly more important as Australia's population ages and the aged and disability care sectors undergo further reform.

COVID-19 pandemic

Phase One of the OPMH Service Plan coincided with the COVID-19 pandemic, arguably the largest disruptor to the health, aged, and disability care sectors in generations - to which OPMH services were not exempt.

The pandemic required swift adoption of processes, procedures, and public health measures and these were coupled with increased scrutiny from government bodies, the media, aged care consumers, and the public at large. The pandemic drew on significant resources and prevented progress on, and in part regressed, aspects of the OPMH Service Plan.

The speed at which adaptations needed to be made had significant impact on the priorities in residential aged care. Many stakeholders suggested that the COVID-induced realignment that occurred in residential aged care impacted on the extent and quality of support and collaboration between OPMH services and residential aged care providers.

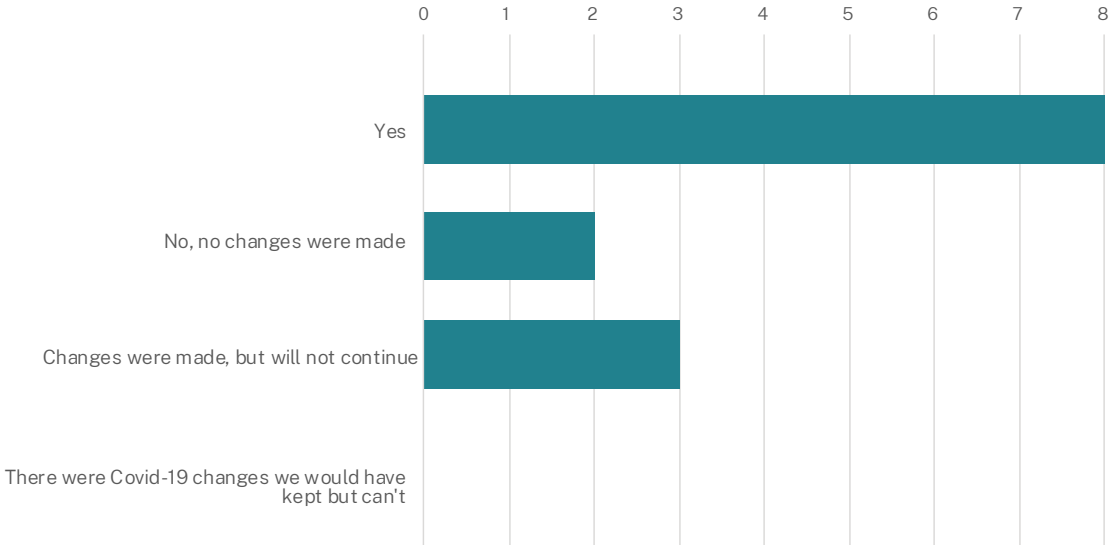
Statewide self-audit data collected in the context of the OPMH benchmarking strategy indicates that partnerships with other services and carers fell during the height of the COVID 19 pandemic and only started to return to pre COVID levels during 2022. However, while the self-audit data shows a recent overall improvement, stakeholders indicated that there are instances where OPMH partnerships have not yet returned to the level of participation or collaboration experienced pre-COVID.

While overall the pandemic had a negative effect, out of necessity, it did spawn many new, and some not so new, ways of doing things. For example, improved acceptance of video conferencing and telehealth is now generating improvements in service access and efficiency. Stakeholders report staff are now more comfortable in providing online care, particularly where it is well supported by additional IT services. Stakeholders noted that the capacity to provide telehealth was already available, however, it took a pandemic to jolt systems into offering it more widely, and for consumers to increasingly accept it as an alternative to face-to-face consultations.

Results from the OPMH LHD evaluation survey suggest changes made by LHDs during the pandemic are here to stay as part of normal practice (see Figure 1). For example, most stakeholders suggested a degree of remote care or telehealth will continue, while others have formally adopted a "hybrid service

delivery model", combining direct contact and virtual care in psychiatry clinics. This includes a mixture of direct contact with residential aged care facilities and some outreach via virtual care.

Figure 1: OPMH service survey: Did your service make changes to service models or delivery in response to the COVID 19 pandemic that you will continue?



While generally a welcome enhancement, stakeholders did point out that over reliance on technology can create barriers for OPMH consumers, in particular, consumers from CALD backgrounds. Stakeholders urged that technology be used as a 'value add' and not the default option.

Common barriers to telehealth include lack of access to infrastructure, limitations from not being physically present at patient assessments, and concerns regarding privacy and confidentiality. For older people, issues around digital literacy, trust, and familiarity are particularly important, as is the impact of physical and psychological health conditions.[2]

Beyond technology, COVID-related flexible funding streams have fostered additional OPMH service collaboration with PHNs. Specific examples include initiatives like "Live Well" in the South Western Sydney LHD and the exploration of peer worker collaborations in the South Eastern Sydney LHD. COVID also reinvigorated staff awareness of infection control processes and the use of personal protective equipment, which are particularly important when working with this older vulnerable patient cohort.

[2] Hall Dykgraaf, S., Desborough, J., Sturgiss, E., Parkinson, A., Dut, G., & Kidd, M. (2022, 09/01). Older people, the digital divide and use of telehealth during the COVID-19 pandemic. *Australian Journal for General Practitioners,* 51, 721-724. https://www1.racgp.org.au/ajgp/2022/september/older-people-and-use-of-telehealth

Dementia care

Dementia has a strong association with ageing. OPMH services are often the front door for consumers (and their carers) experiencing more severe behavioural and psychological symptoms associated with dementia. The OPMH Service Plan estimates some 175,000 people in NSW will have dementia by 2025.[3] The health and aged care needs of older people with dementia and behavioural and psychological symptoms of dementia (BPSD) are growing and creating pressure on OPMH services.

Dementia Support Australia

The recognition of dementia as a national priority stretches back decades, with Australia being one of the first countries to launch a National Dementia Policy in 1992.[4] Since then, the Commonwealth has played an active role in dementia services and currently funds Dementia Support Australia (DSA) to provide several national dementia related services including:

- Dementia Behaviour Management Advisory Service **(DBMAS)**
- Severe Behaviour Response Teams **(SBRT)**
- Specialist Dementia Care Program **(SDCP)**

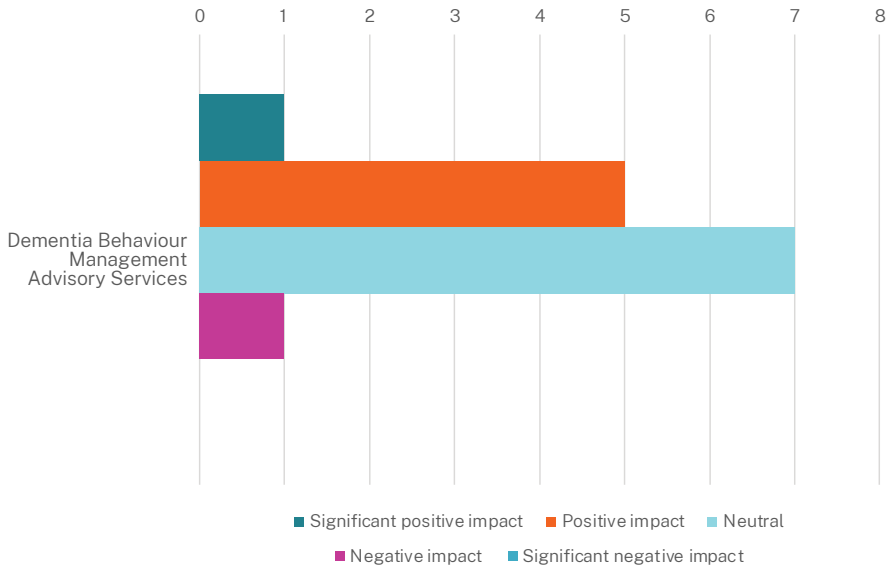
Dementia Behaviour Management Advisory Service

NSW LHDs have seen a significant increase in interactions between local OPMH services and regional DBMAS services. While DBMAS is a national service, LHDs report varied levels of consumer service, due to differences in experiences with regional DBMAS teams.

On the one hand, OPMH services praised regional DBMAS teams for providing dementia action plans to consumers, carers and/or aged care facilities, walking all those involved through the plan, identifying roles and escalation points, and providing updates and modifications as needed. OPMH services acknowledged that this support has had a positive effect on their capacity and enables them to focus on other aspects of care.

On the other hand, OPMH services have observed some regional DBMAS teams only provide an initial plan, leaving them to assist with implementation and any required modifications. In worse-case reports, OPMH Services report DBMAS teams refusing referrals where individuals were already consumers of OPMH services.

Figure 2: LHD survey Q64 – Rate the impact of DBMAS on your OPMH Service



[3] NSW Ministry of Health - Mental Health Branch. (2017). NSW Older People's Mental Health Services Service Plan 2017-2027.

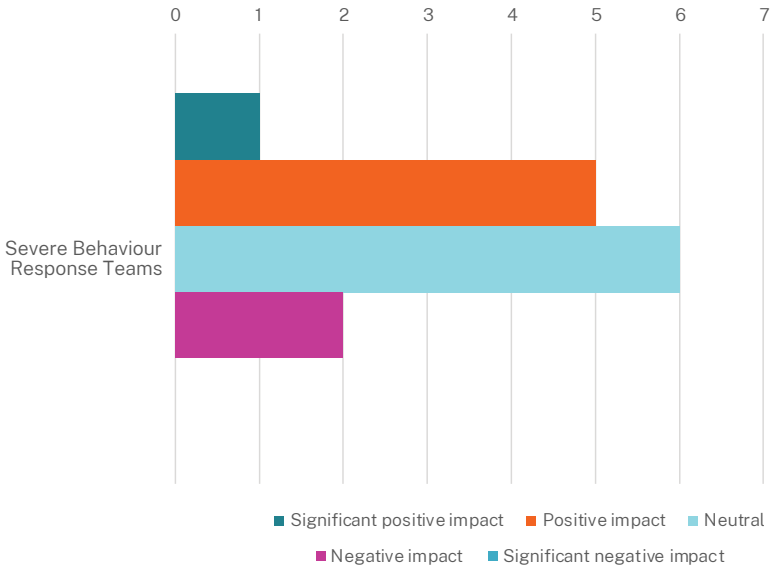
[4] Cecily, H., & Colleen, D. (2014). Dementia Policy in Australia and the ‘Social Construction’ of Infirm Old Age. Health and History, 16(2), 44-62. https://doi.org/10.5401/healthhist.16.2.0044

Figure 2 shows that LHDs' generally rate the impact of DBMAS service as positive. Stakeholder consultation, including the Older Peoples Mental Health Services Advisory Group, suggests that greater engagement between NSW Health and Demetia Support Australia may provide an opportunity to identify service responsibilities and expectations between the services. This would help to reduce duplication, and close gaps for consumers.

Severe Behaviour Response Teams (SBRT)

SBRT are specialist clinical support teams that provide advice and support to organisations and aged care staff caring for people living with severe BPSD. SBRT provide a 24/7 mobile service, responding onsite within 48 hours.[5] LHD rating of the impact of SBRT on local OPMH services were positive overall, but most often neutral (see Figure 3).

Figure 3: LHD survey Q64 – Rate the impact of Severe Behaviour Response Teams on your OPMH Service



Specialist Dementia Care Program (SDCP)

The SDCP funds specialist dementia care units in residential aged care homes. The program aims to provide care to people exhibiting very severe BPSD who are unable to be effectively cared for by mainstream aged care services.[6]

One Specialist Dementia Care Unit (SDCU) was established in NSW during Phase One of the OPMH Service Plan (HammondCare Cardiff), and an established SDCU transitioned to the SDCP program arrangements (HammondCare Hammondville). A further two SDCUs became operational during 2023, and a grant process commencing in late-2023 targets four further regions in NSW.[7]

Figure 4 shows LHDs rated SDCP to have a positive impact on OPMH services where these services were operational. However, even with additional units becoming operational, SDCP in its current form will only be able to service a small fraction of consumers expected to experience very severe or Tier 6 BPSD in 2025.[8] As the Extreme Behavioural and Psychological Symptoms Project identified, extreme BSPD is beyond the service capacity of residential aged care and Specialist Dementia Care Units.[9]

[5] Australian Government Department of Health and Aged Care. (2023b). *Severe Behaviour Response Teams (SBRT)*. Retrieved 15 June 2023 from https://www.health.gov.au/our-work/severe-behaviour-response-teams-sbrt

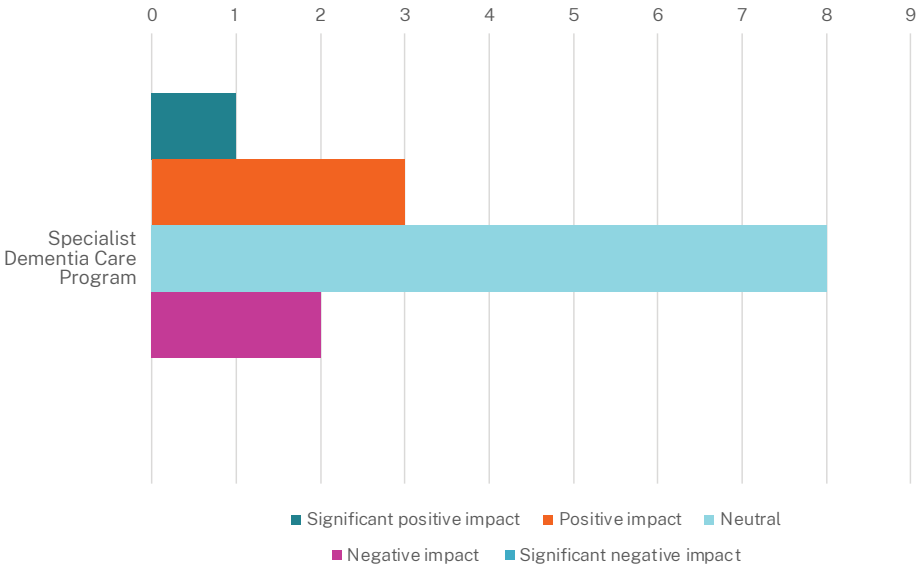
[6] Australian Government Department of Health. (2020). *Specialist Dementia Care Program Framework*.

[7] Deloite Access Economics. (2023). Evaluation of Phase One of the Specialist Dementia Care Program Summative Report. https://www.health.gov.au/sites/default/files/2023-09/evaluation-of-phase-one-of-the-specialist-dementia-care-program---summative-report.pdf

[8] Estimation based on NSW OPMH Service Plan estimates of 175,000 people living with dementia in Australiaa, and Brodaty et al 2003b estimates that 1% of the Dementia population will experience tier 6 very severe BPSD, requiring management in psychogeriatric or neurogeriatric units. Therefore, up to 1,750 individuals would fall in tier 6 very severe BPSD. a: NSW Ministry of Health - Mental Health Branch. (2017). NSW Older People's Mental Health Services Service Plan 2017-2027. b:Brodaty, H., Draper, B. M., & Low, L. F. (2003, Mar 3). Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery. Med J Aust, 178(5), 231-234. https://doi.org/10.5694/j.1326-5377.2003.tb05169.x .

[9] NSW Ministry of Health - Mental Health Branch. (2021). Extreme Behavioural and Psychological Symptoms of Dementia (BPSD) Project Report.

Figure 4: LHD survey Q64 - Rate the impact of SDCP on your OPMH Service



The implication of this is that NSW Health will need to still provide care where symptoms and behaviour are such that no other care options are suitable. The issues here extend beyond the remit of OPMH services. However, these services will still need to be front and centre in helping meet need in this area, particularly given the OPMH Service Plan positions these services as providers of specialist assessment and secondary triage and need in the community is continuing to grow.[10]

Overall, LHDs reported that Commonwealth dementia initiatives have had a net positive impact on their OPMH services, even though stakeholder feedback indicates some variation in approach and service offering from DBMAS and SBRT teams serving different regions of NSW. Improved collaboration and coordination between OPMH and DSA (which clearly articulates the respective service responsibilities) will be important in reducing duplication and in some instances demand pressures experienced by OPMH services. However, this alone is unlikely to be sufficient - dementia prevalence is expected to more than double between 2023 and 2058.[11]

Aged care

Aged care is undergoing further reform after the report from the Royal Commission into Aged Care Safety in Quality (**the Aged Care Royal Commission**) was handed to Government in 2021.

Royal Commission into Aged Care Quality and Safety

The raft of reforms is leading to fundamental changes that aim to improve access to and funding of services, along with initiatives to improve safety and quality through new models of care, both in residential facilities and home care and support in the community.

Broadly, the Aged Care Royal Commission reported the needs of older people with mental health conditions were not being adequately addressed across the aged care system. The Commission noted it was often difficult for people living in residential aged care to access specialist mental health services, such as psychologists and psychiatrists, and that aged care staff were not sufficiently skilled or trained to identify and support people living with mental health conditions.[12]

[10] NSW Ministry of Health - Mental Health Branch. (2017). NSW Older People's Mental Health Services Service Plan 2017-2027.

[11] Dementia Australia. (2023). Dementia in Australia 2023-2058 Dementia Prevalence Data Estimates and Projections – All forms of dementia. https://www.dementia.org.au/sites/default/files/2023-03/Prevalence-Data-2023-Updates.pdf
, ibid.

[12] Briggs, L. (2021). Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity, and Respect.

A brief discussion of the key findings, recommendations, and possible implications of the Aged Care Royal Commission for OPMH is provided below:

- **Recommendation 16** called for a review of the Commonwealth funded Specialist Dementia Care Services (see relevant section on page 7 for descriptions of the programs included). OPMH services by and large assess the Commonwealth specialist dementia care initiatives as having a positive impact on OPMH services. Services do note some variability in service quality and offering across these teams, as well as the level of engagement and overlap they have with OPMH services.
- In response, the Government noted the Specialist Dementia Care program was already being evaluated.[13] The evaluation has now concluded that the Specialist Dementia Care Program in its current form was not suitable for people experiencing Extreme BPSD, nor did they consider that the program in its current form would be appropriate for short-term respite care.[14] The evaluation did not make comment on whether the Specialist Dementia Care Units established or planned were sufficient to address need within the areas and populations they are designed to cover. It is understood that the grant round to fund four additional units closed in November 2023. In total, there are four units (36 beds) currently open in NSW, with an additional four units (36 beds approx.) proposed. This will have a beneficial impact on local OPMH services in NSW where those Specialist Dementia Care Units are located.
- **Recommendation 17** Resulted in the Quality of Care Principles 2014 (Commonwealth) being updated in June 2021 . These relate to restricting the use of restraint to emergency use only, or where an independent assessment deemed it necessary as part of a behaviour support plan. Clinical stakeholders have suggested that this amendment appears to have driven demand for OPMH services to provide the required independent expert assessment and support plans.
- **Recommendation 59** Stated that the Commonwealth and State and Territory Governments should separately fund OPMH services to provide outreach into aged care, along with performance indicators and benchmarks. OPMH services in NSW largely align with recommendation 59. Key informants note however that the recommendation has led to heightened pressure to increase OPMH outreach services to residential aged care facilities.
- **Recommendation 65** Sought an amendment to the Pharmaceutical Benefits Scheme Schedule to ensure that only a psychiatrist or geriatrician can initiate treatment with antipsychotic medicines. While services suggested that they saw an increase in specialist assessments, ultimately the changes to the Pharmaceutical Benefits Scheme Schedule were rejected by the Pharmaceutical Benefits Advisory Committee (PBAC) in their November 2021 meeting.[16] The PBAC noted substantial risk of unintended consequences as the reason for not implementing this recommendation. They went on to say Pharmaceutical Benefits Scheme restrictions for risperidone – the only medicine registered in Australia for the treatment of BPSD – had reduced use in Australia.[17] Aa a result, no impact on OPMH services is expected in the near term in relation to recommendation 65.

Stakeholders suggested that recommendations to reduce the use of chemical and other restraints, coupled with funding reforms in aged care, have disincentivised residential facilities from accepting consumers with any history of mental ill health, dementia, or BPSD. As a result, OPMH services are not only feeling an increased demand for independent specialist assessment, but also experiencing significant difficulty in placing OPMH consumers in aged care.

Psychological Treatment Services

Under the Psychological Treatment Services program, PHNs are required to commission services to provide residential aged care residents a level of access to

[13] Australian Governmnet Department of Health. (2021). Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety. https://www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

[14] Deloite Acess Economics. (2023). Evaluation of Phase One of the Specialist Dementia Care Program Summative Report. https://www.health.gov.au/sites/default/files/2023-09/evaluation-of-phase-one-of-the-specialist-dementia-care-program---summative-report.pdf

[15] Aged Care Legislation Amendment (Royal Commission Response No. 1) Bill (2021).

[16] Pharmaceutical Benefits Advisory Committee. (2021). Meeting Outcomes November 2021 PBAC Meeting.

[17] Ibid.

mental health services that is like those available in the community through the Better Access to Psychologists, Psychiatrists and General Practice through the Medicare Benefits Schedule initiative (Better Access).[18]

The target population for the Program is residents with, or at risk of, mild to moderate mental illness, and/or those with severe mental illness who are not more appropriately managed by OPMH services. [19]

A 2022 evaluation of the PHNs' Improved Access to Psychological Services in Aged Care Facilities initiative found that implementation was more challenging than expected, and while 29 of the 31 PHNs had commissioned services (the remaining two PHNs were in a trial phase at the time of the evaluation) less than half (48%) of the aged care facilities across Australia had taken part.[20] The evaluation found that residential aged care facility (**RACF**) uptake was affected by:

- The limited capacity of the psychological service providers
- RACF belief that residents are sufficiently supported without additional care.
- RACF concerns about external personnel onsite.
- RACF concerns about additional workload on their staff.

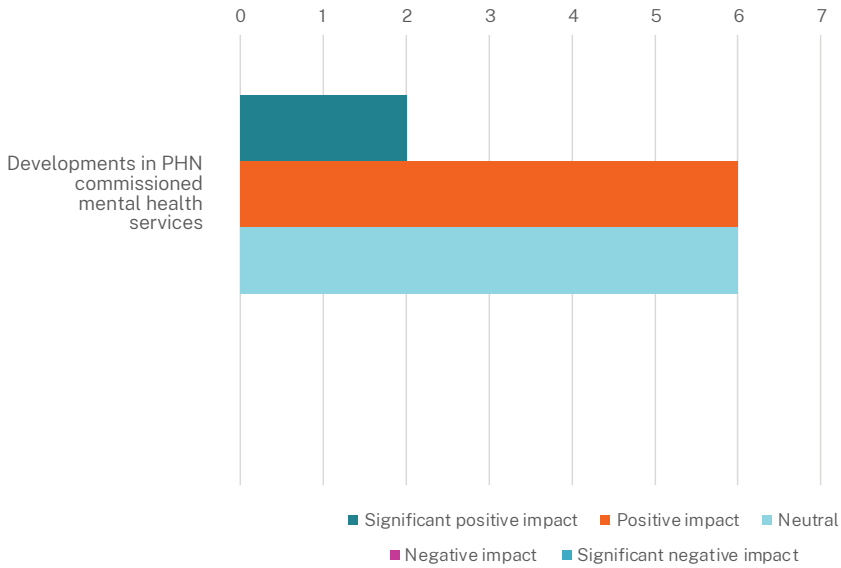
Information derived from the Primary Mental Health Care Minimum Data Set (PMHC MDS) suggests there has been a substantial impact on the number of residents in aged care facilities receiving psychological services, with nearly 3,400 clients per year recorded since its introduction, compared to just 78 in the 12 months prior to the start of the Program. While a marked improvement, stakeholders suggest this remains well below the level of engagement required by residents.

Primary Health Networks

PHNs play a broad role in the design and planning of primary health care services, including joint service planning with LHDs, commissioning localised mental health services (including Head to Health services) and suicide prevention activities.

The LHD survey (see Figure 5) identified that PHN activities have had an overall positive impact on OPMH services. The Psychological Treatment Services Program is only one aspect, with funded and unfunded collaborations and regular engagement between OPMH services and PHN Mental Health and Aged Care leads also contributing to the overall impact.

Figure 5: LHD survey Q64 – Rate the impact of PHN commissioned mental health services on your OPMH Service



[18] Australian Government Department of Health. (2018). Psychological Treatment Services for people with mental illness in Residential Aged Care Facilities.
[19] Australian Healthcare Associates. (2022). Evaluation of the PHNs Improved Access to Psychological Services in Aged Care Facilities Initiative: Final Report. Australian Government Department of Health.
[20] Ibid.

Changes in service capacity

The OPMH Services Plan estimated the number of older people with a diagnosable mental illness in NSW would grow from 190,000 in 2016 to 260,000 in 2026.[21]

Since 2015–16, the NSW Government has invested over $7.7 million in expanding community mental health care and support for older people under the NSW Mental Health Reform. Aimed at improving equity in access across the state, the reform package funding targeted LHDs with higher unmet needs. As a result, the bulk of the 46 additional community OPMH FTE staff were delivered across just 6 of the 15 LHDs (i.e. Central Coast, Mid North Coast, Nepean Blue Mountains, Northern NSW, South Western Sydney, and Sydney Local Health Districts).

In addition, Pathways to Community Living Initiative (**PCLI**) Stage 1 saw $3.21 million added annually to support 17.3 clinical FTE again across 6 LHDs (Western Sydney, Northern Sydney, Hunter New England, Western NSW, Sydney, and Nepean Blue Mountains Local Health Districts) with the goal of supporting care of older people with complex mental health needs in the community and residential aged care facilities and providing an alternative to prolonged hospital stays.

Despite increased FTE, stakeholders and staff reported feeling stretched in their capacity to deliver services to meet care needs. Services reported seeing a greater complexity in the patient mix they service (discussed later in this chapter), difficulties in placing clients in aged care, and difficulty in recruiting staff to open positions. Predictably, services reported a lack of capacity or resource constraints as the main barrier in attending to service and quality improvement initiatives.

Service patterns during this period

Figure 6 shows that community occasions of service for older people have risen steadily in both OPMH and Adult and General mental health services since 2018. The level of community services provided to specific population groups is shown in Figure 7 for CALD and Figure 8 for Indigenous people. The data presented included Indigenous people 50 years and older in line with the OPMH service target population.

Figure 9 shows that OPMH inpatient separations have fallen over the period, while Adult and General mental health separations for the OPMH target age groupings have increased and overtaken OPMH admissions. The level of hospital inpatient services provided to specific population groups is shown in Figure 10 for CALD and Figure 11 for Indigenous people.

Figure 12 and Figure 13 show OPMH inpatient average length of stay has trended upward since 2018, including for specific population groups (i.e. CALD and Indigenous). Lastly, Figure 14 shows the average occasions of service for community consumers has also trended upward since 2018.

Consumers in the OPMH target age group receiving services from Adult or General mental health teams provides some indication of the potential demand as consumers develop age-related problems.

Figure 9 shows an almost direct relationship between falling OPMH inpatient separations and increased Adult and General mental health separations for the same period.

[21] NSW Ministry of Health - Mental Health Branch. (2017). *NSW Older People's Mental Health Services Service Plan 2017-2027.*

Figure 6: Community occasions of service for consumers in the OPMH age categories, Older Persons MH teams compared with Adult MH teams*

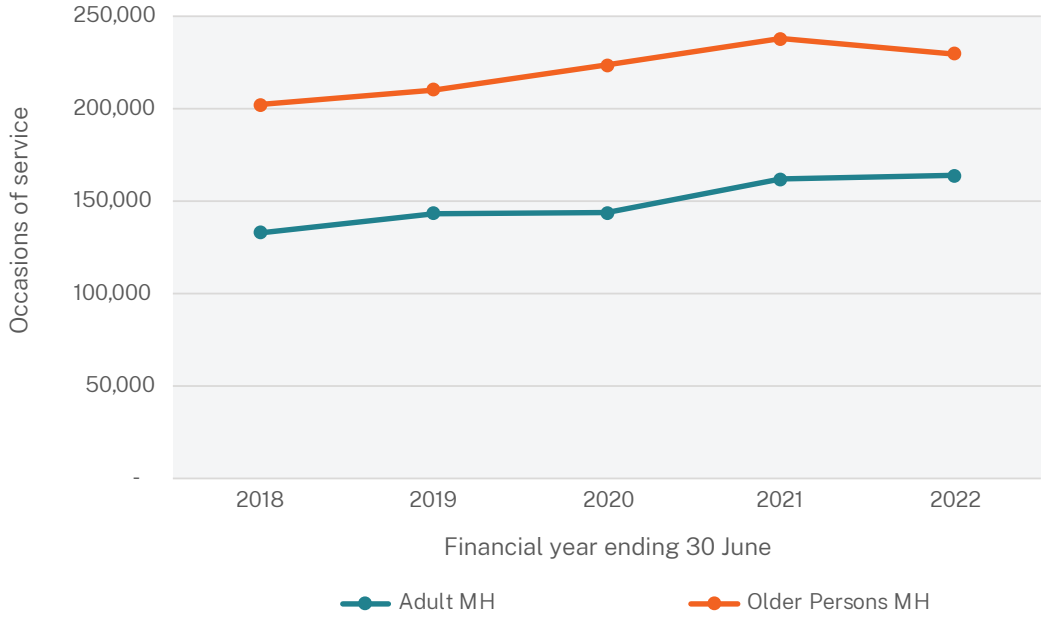


Figure 7: Community occasions of service by specific population group - CALD people

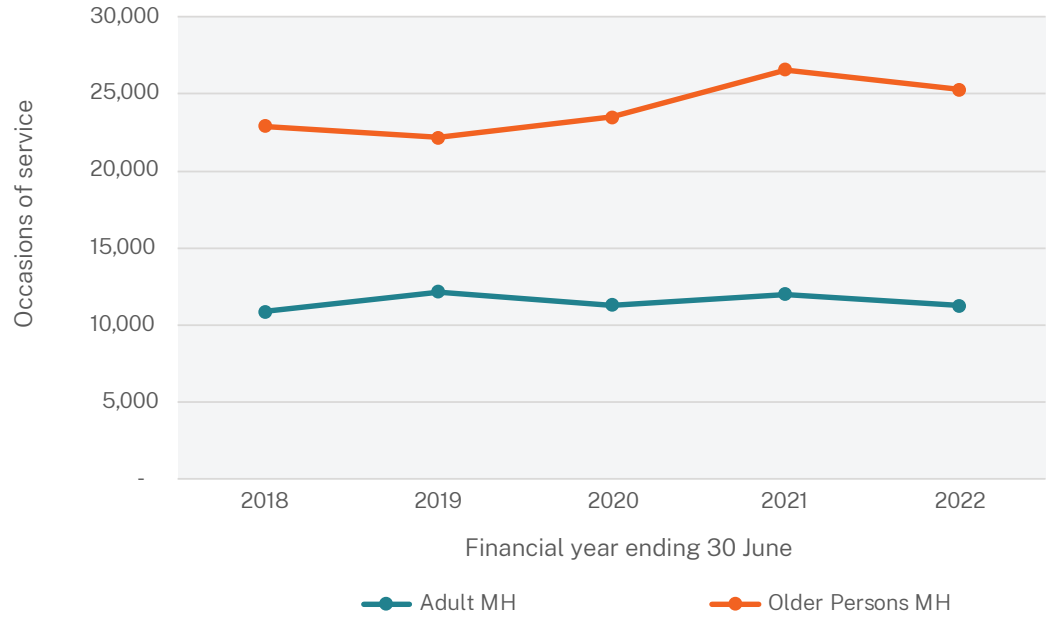


Figure 8: Community occasions of service by specific population group - Indigenous people 50+ years

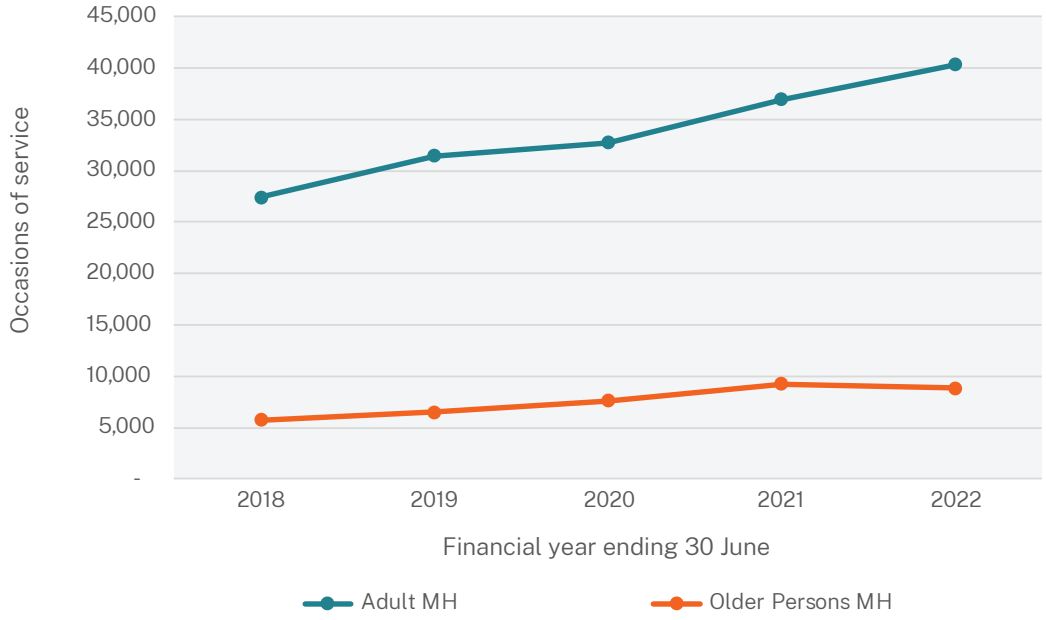


Figure 9: Inpatient separations for consumers in the OPMH age categories, OPMH specific compared with General MH inpatient services

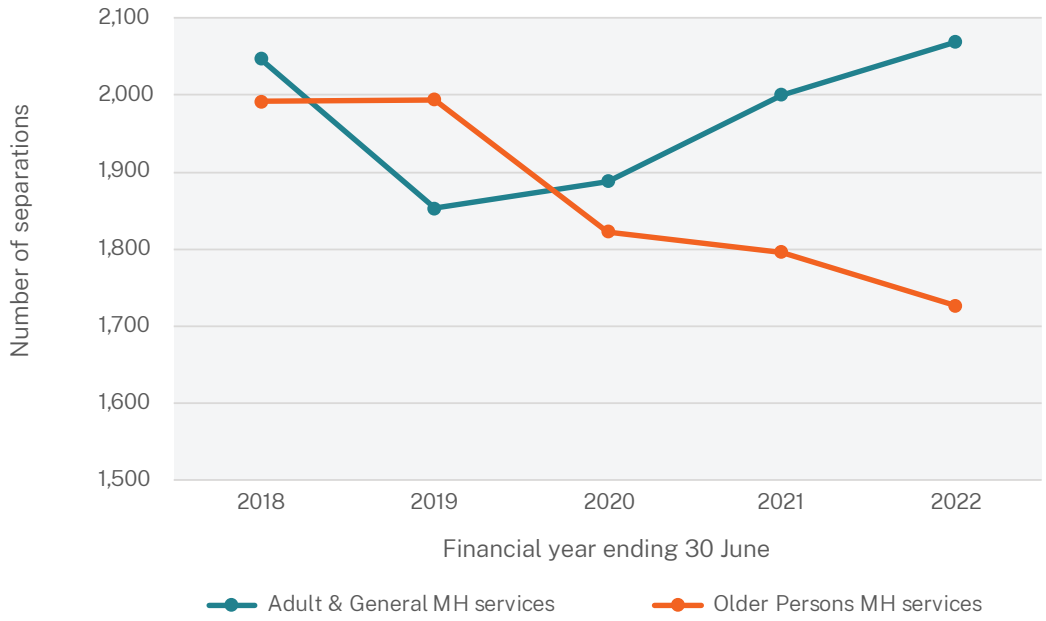


Figure 10: Number of separations by specific population group - CALD people

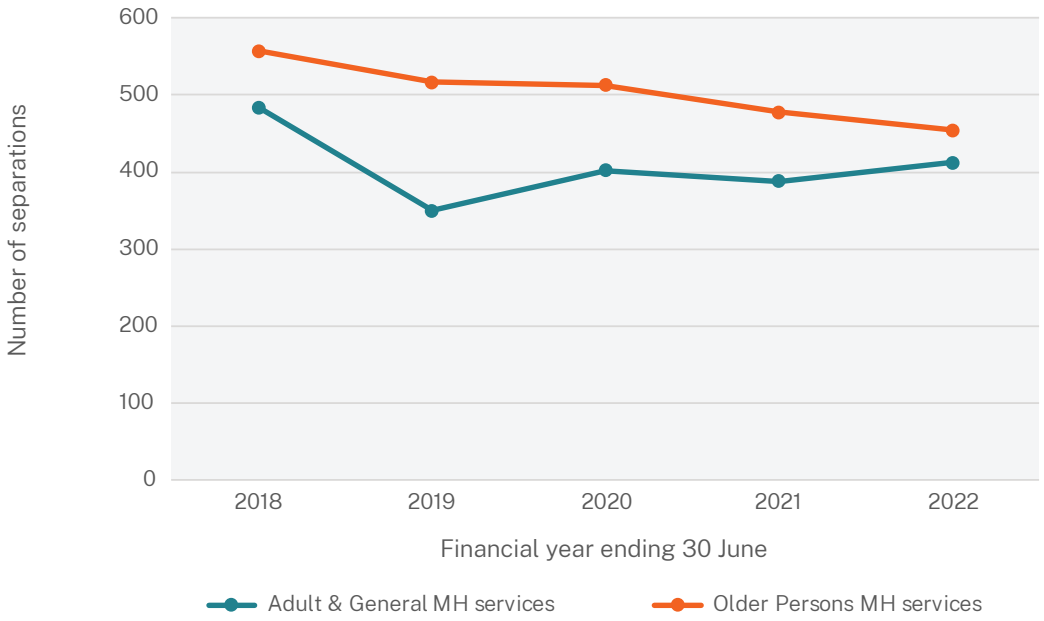


Figure 11: Number of separations by specific population group - Indigenous people 50+ years

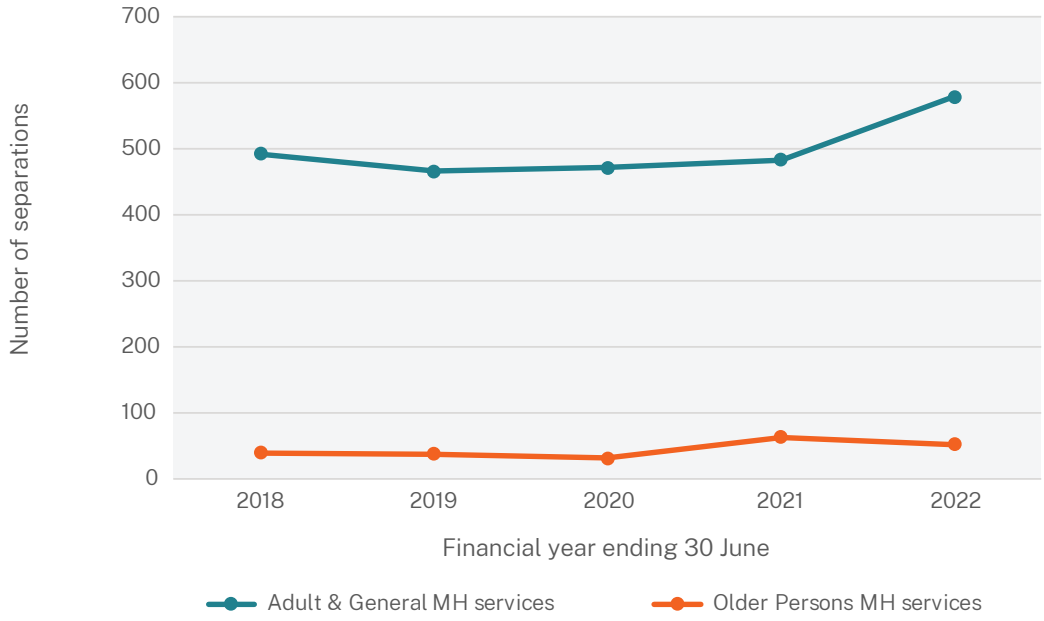


Figure 12: Mental Health inpatient average length of stay (for OPMH target age groupings)

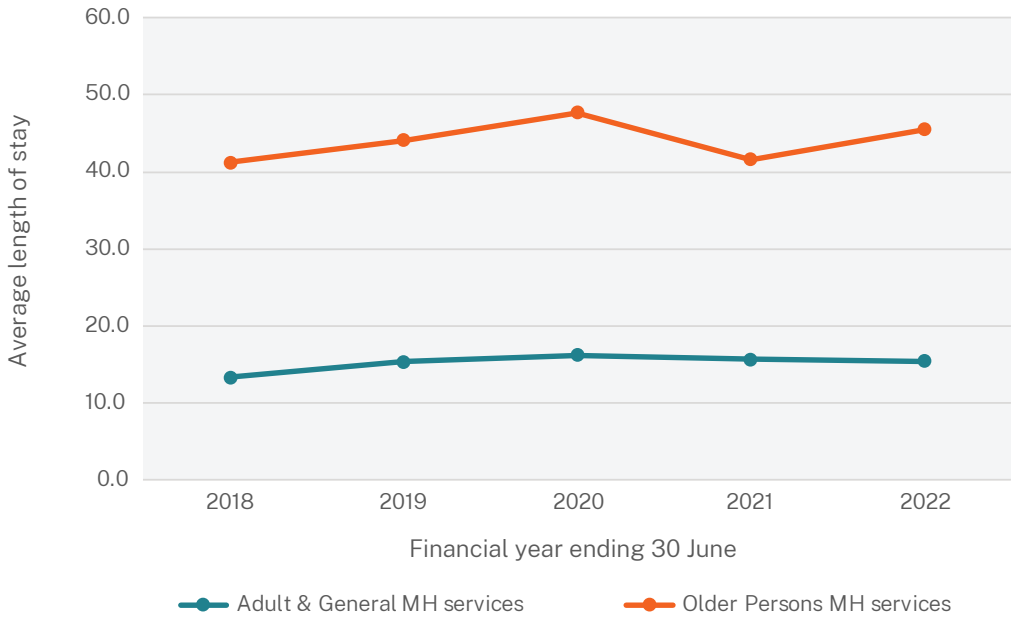


Figure 13: OPMH specific inpatient average length of stay by specific population groups: CALD and Indigenous

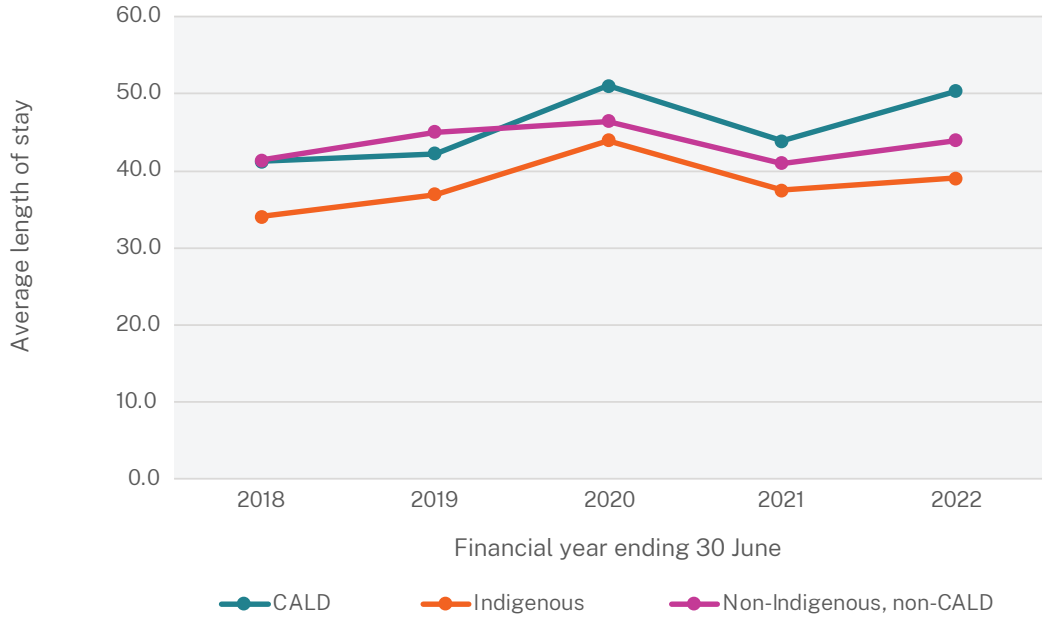
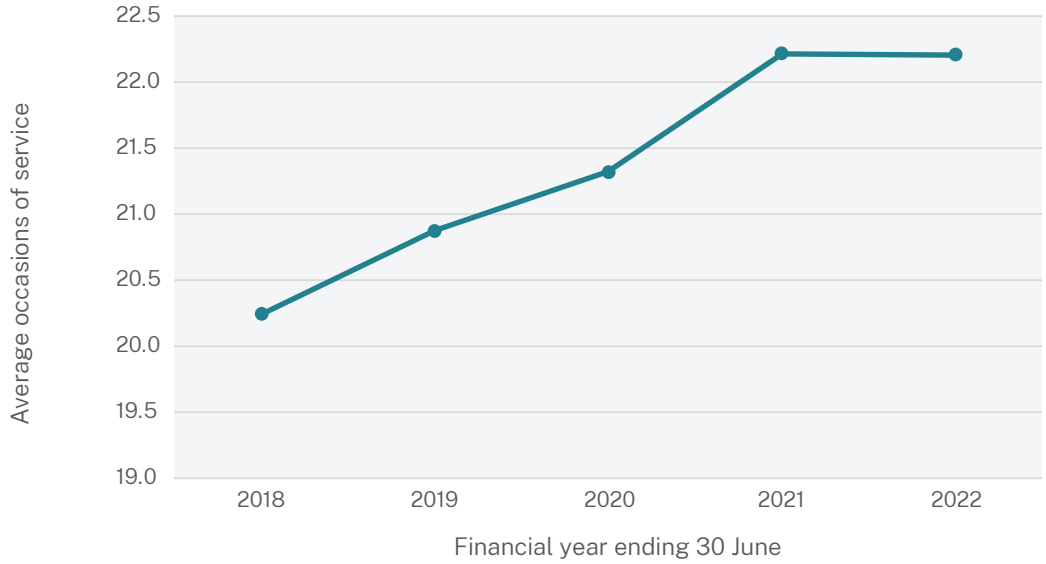


Figure 14: Average number of Community OPMH occasions of service per client (excluding Assessment-only clients defined as 1 visit in 6 months)

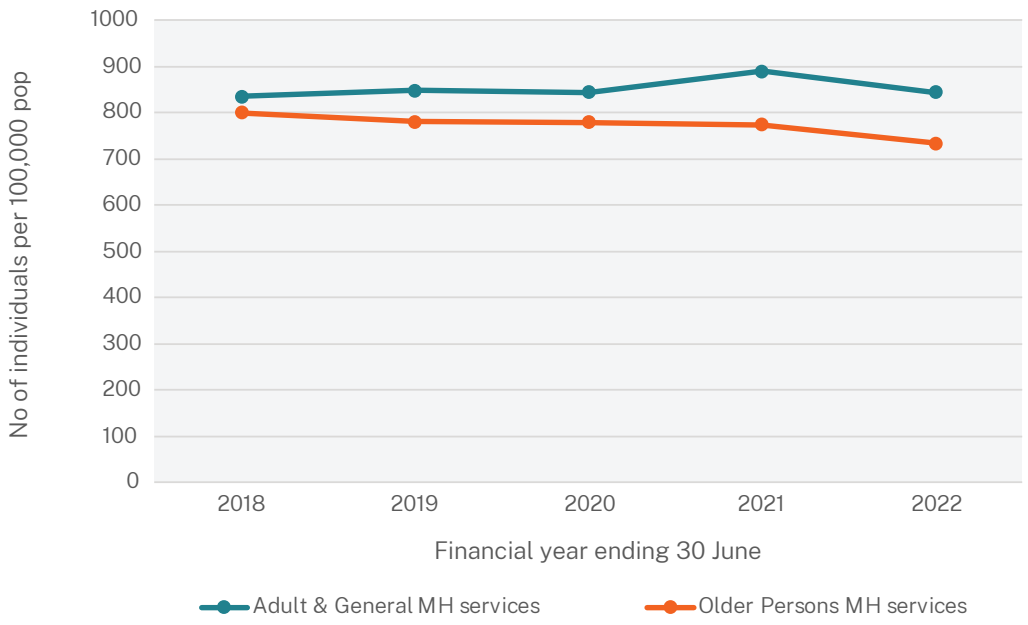


Examining these patterns within community teams further, Figure 15 shows that the proportion of consumers serviced by community mental health teams (OPMH and Adult and General) per 100,000 population has remained relatively stable across the state throughout Phase One of the OPMH Service Plan. Figure 16 compares the rates of metro v rural/regional OPMH consumers per 100,000 population and shows that quite similar trends and proportions have prevailed during Phase One.

In the case of the Western and Far Western regions, their lower overall population poses challenges in analysis, even when adjusted to a rate rather than a simple count. Conversely, Sydney and Southern LHDs cater to a higher proportion of OPMH aged consumers in relation to their respective populations.

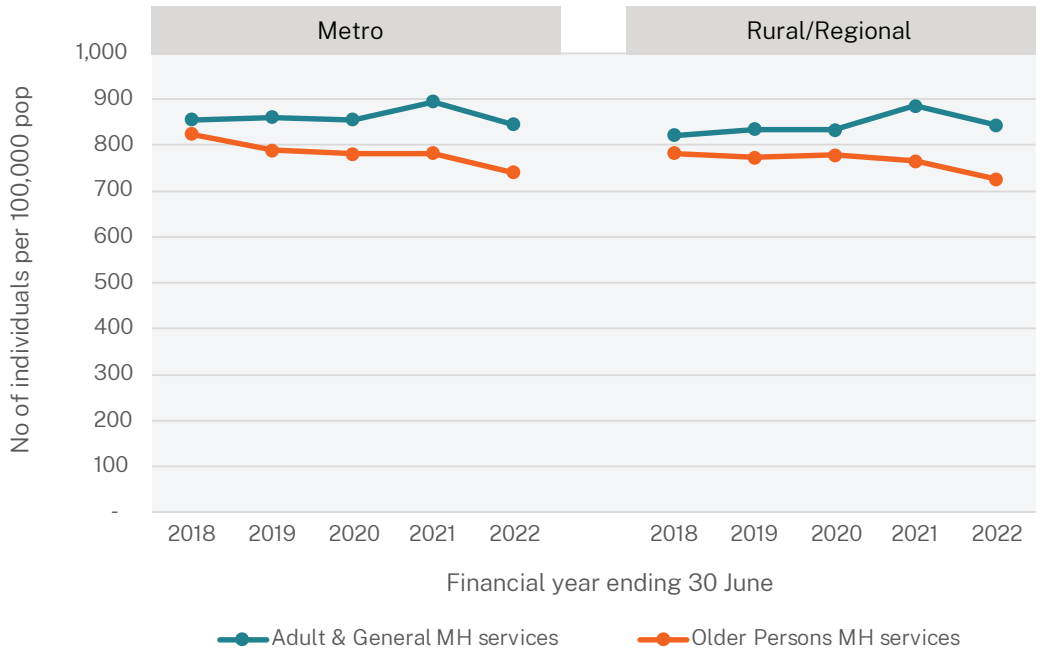
In approximately half of the LHDs (Sydney, South Western Sydney, Nepean Blue Mountains, Hunter New England, Northern NSW, Mid North Coast, and Far West), Adult and General mental health teams attended to a greater proportion of OPMH consumers.

Figure 15: Number of community individuals per 100,000 population 65 plus, by team type, 2018-2022*



*Note Sydney and South Western Sydney LHDs had data errors in unique identifiers that meant data for 2018 could not be accurately provided.

Figure 16: Number of community individuals per 100,000 population 65 plus, by rurality and team type, 2018-2022*



*Note Sydney and South Western Sydney LHDs had data errors in unique identifiers that meant data for 2018 could not be accurately provided.

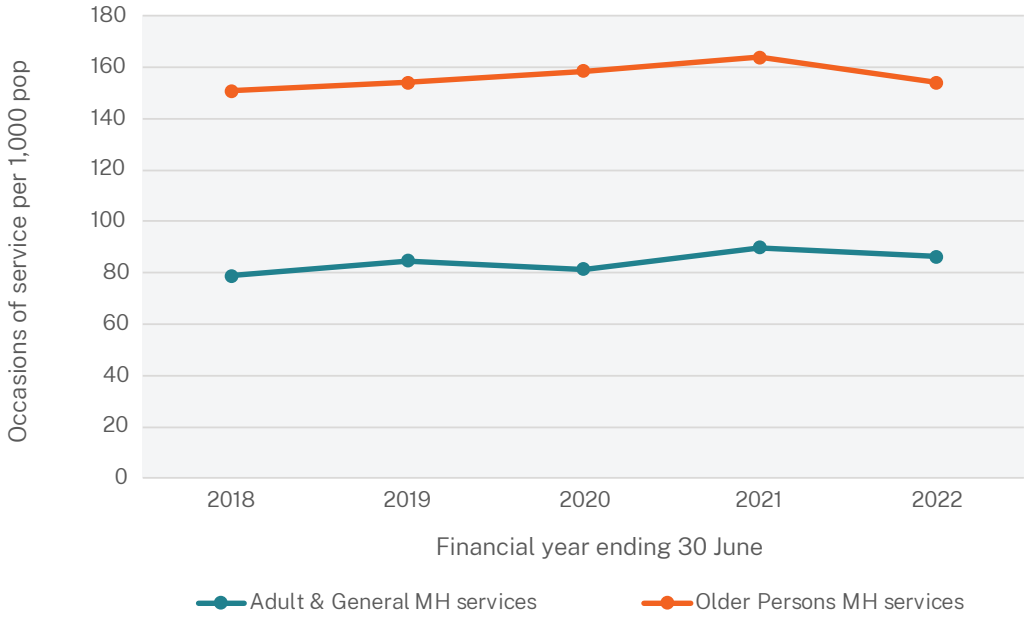
There was only a modest variation in the rates of OPMH Community consumers per 100,000 population across LHDs. Figure 16 also shows no discernible difference between rates of OPMH consumers being served in metro vs rural /regional LHDs. Taken together, this suggests that reform funding and other initiatives aimed at improving equity across NSW has had the desired impact.

The number of OPMH managed consumers appears to be declining over time, while the rate of OPMH aged consumers being seen by Adult and General mental health teams is climbing (See Figure 15, Figure 16, Figure 17, and Figure 18). This suggests demand is outpacing supply, resulting in the need for some OPMH consumers to be managed in general mental health settings.

These observed trends have significant implications for efficient, effective, and appropriate care. OPMH services (inpatient and community) are specifically designed to maximise consumer engagement, choice, and control through access to appropriately trained and experienced staff and specialised assessment and care delivered in appropriate service environments.

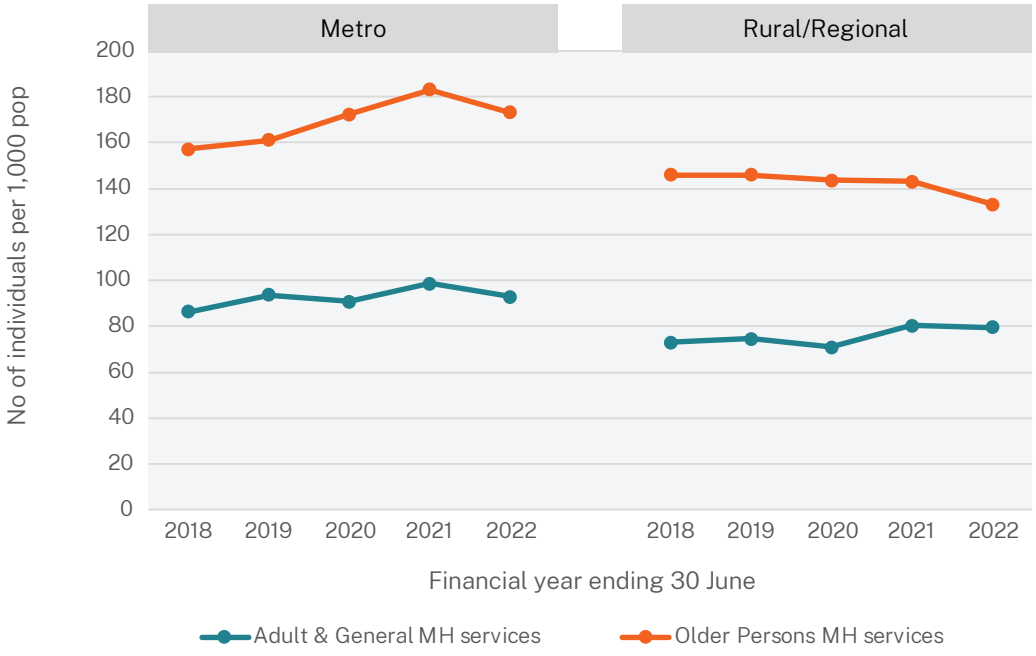
A key direction of the NSW OPMH Community Model of Care is to increase the role of OPMH community services in providing specialist assessment for more older people with mental illness, with facilitated access to the most appropriate services following assessment. The evaluation found that 'assessment only' activity has remained stable and represents a relatively small proportion of the overall OPMH community activity statewide (5% consumers seen by OPMH community services in 2022), this varies by LHD from 2% to 10% in 2022, and this warrants further exploration.

Figure 17: Statewide community mental health occasions of service per 1,000 population 65 plus, by team type, 2018-2022*



*Note Sydney and South Western Sydney LHDs had data errors in unique identifiers that meant data for 2018 could not be accurately provided.

Figure 18: Community mental health occasions of service per 1,000 population 65 plus, by rurality* and team type, 2018-2022



*Note Sydney and South Western Sydney LHDs had data errors in unique identifiers that meant data for 2018 could not be accurately provided.

OPMH inpatient separations per 100,000 population trended down over the period (see Figure 19 and Figure 20). Despite the fall, OPMH teams tended to deliver more inpatient separations than Adult and General mental health inpatient teams (with notable exceptions in South Western Sydney, Southern NSW, and Northern NSW). Inpatient trends in Sydney LHD show OPMH falling and Adult and General mental health services rising, nearing a convergence point in 2022.

Inpatient data does not demonstrate that significant variation in equity of access exists across LHDs. However, marked declines in OPMH separations with matched growth in Adult and General mental health services across specific LHDs may suggest that OPMH inpatient services are reaching capacity or finding it hard to discharge patients into appropriate care.

Figure 19: Inpatient separations per 100,000 population 65 plus, by unit type, 2018-2022

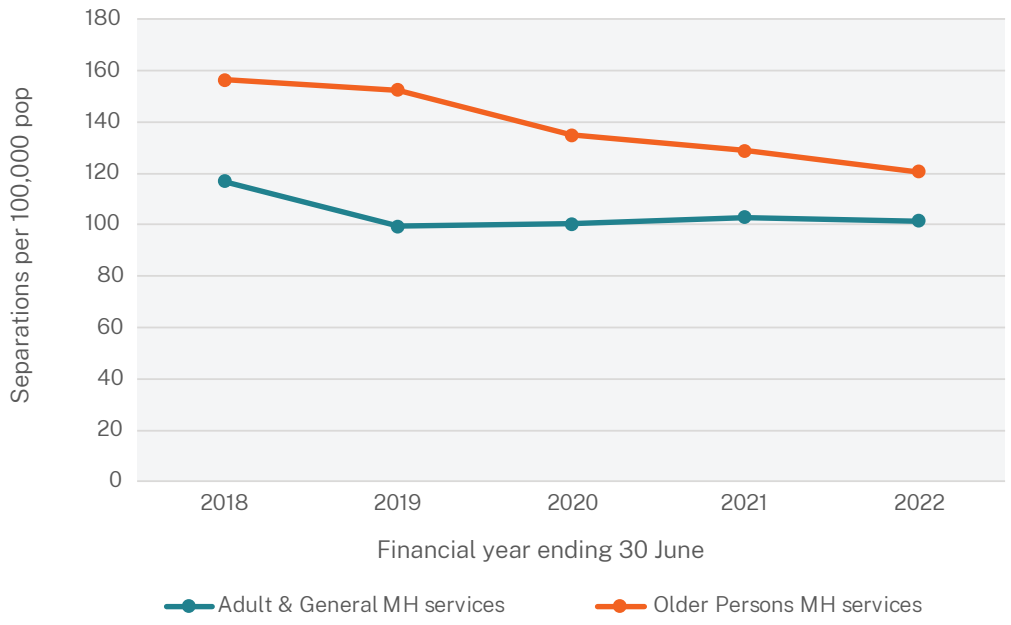
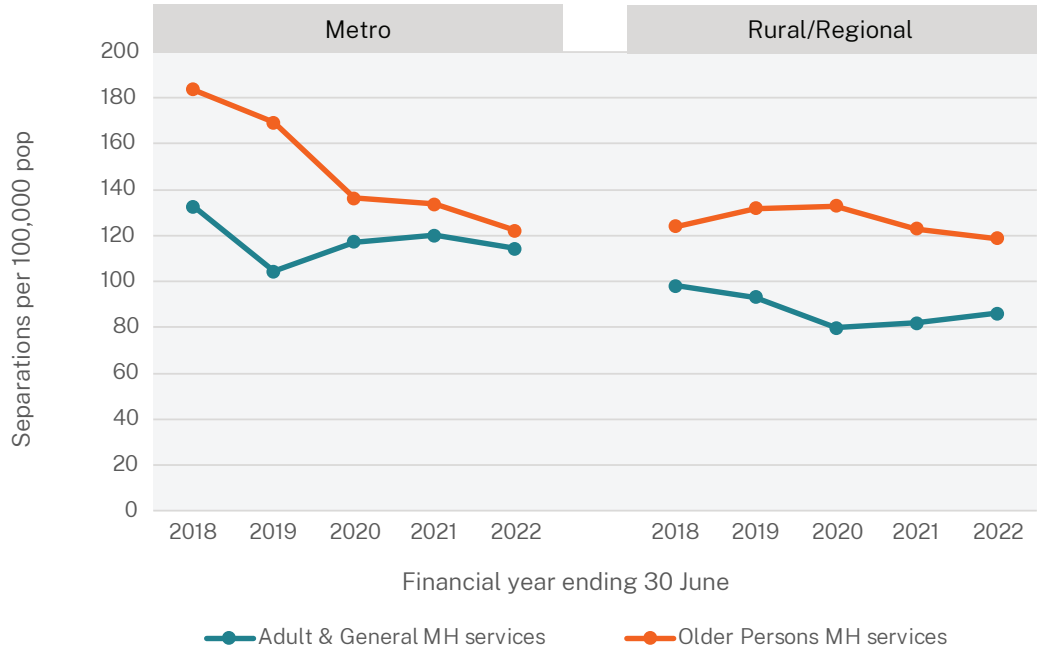


Figure 20: Inpatient separations per 100,000 population 65 plus, by rurality and unit type, 2018-2022



Changes in workforce during this period

The Mental Health Branch OPMH policy team within the NSW Ministry of Health conducted a workforce survey in mid-2023. The survey identifies several challenges facing OPMH services. Chief among these challenges are staff education and retention. The survey reports 49% of staff responding to the survey have plans to leave OPMH services within five years, with almost 20% planning to leave within the next two years. The age of OPMH staff is skewed to older cohorts with 56% of respondents aged 45+, and 27% aged 55+. However, the staff profile is younger than that reported from a similar NSW OPMH workforce survey conducted in 2013 (64% aged 45+, 34% aged 55+).[22]

Consultation with OPMH services identified similar issues around training, skills, and experience. Managers suggested a perceived lack of requisite skills, experience and training among potential candidates is preventing them from applying and making recruitment more difficult.

The forthcoming OPMH workforce survey report should provide a more detailed analysis on these issues and more. Responding to workforce issues will likely be an important priority in the 2nd phase of the plan.

Patient mix during this period

Both inpatient and community clinical teams have reported an increase in the acuity and complexity of clients in care during Phase One of the OPMH Service Plan. Clinicians attribute a significant part of this increase to the growing number of consumers with BPSD. Furthermore, it has become more challenging for clinicians to find appropriate ongoing care options, such as aged care, and thereby discharge patients effectively. Clinicians reported spending more time working with consumers, a trend supported by the observed increases in inpatient average length of stay and community occasions of service. Stakeholders observe, at least the clinicians interviewed, that the consideration of the risk of harm, either to the consumer or others, now plays a more prominent role in decisions regarding care in inpatient and community settings.

The recent Phase One Evaluation of the Specialist Dementia Care Program[23] identified that there is a "risk appetite" issue across Specialist Dementia Care Units (SDCU) resulting in many units being slow to reach capacity and declining placement for otherwise eligible residents based on a "poor fit" and creating unnecessary risk for the provider. Clinical stakeholders also report a lower threshold for 'risk' by aged care providers following the COVID-19 pandemic and the Aged Care Royal Commission.

As a result, inpatient services are feeling 'bed blocked' as they try to place consumers in residential care facilities. Figure 12 (p 18) suggests the average length of stay has increased over Phase One.

[22] Forthcoming report on NSW OPMH Workforce survey conducted in 2023.

Changes in coordination with other service providers

The health and aged care sectors have experienced considerable disruption over the past five years. The combined impact of the COVID-19 pandemic, Aged Care Royal Commission and other reforms has significantly affected the ability of OPMH services to build and extend partnerships across services and sectors, particularly residential aged care.

Relationships with aged care

OPMH services noted that early in Phase One that the Pathways to Community Living initiative (PCLI), along with the Mental Health Aged Care Partnership Initiative (**MHACPI**) and Specialist Residential Aged Care Facilities, helped significantly improve collaboration with residential aged care. However, it was also noted that higher level strategic relationships with residential aged care providers had generally suffered through Phase One, even though the LHD survey (see Figure 21) reported that 10 of the 14 responding LHDs increased day to day collaborations.

OPMH Community services are now rebuilding relationships with residential aged care, and this should remain a focus through Phase Two to rebuild and improve the relationships developed prior to the COVID-19 pandemic.

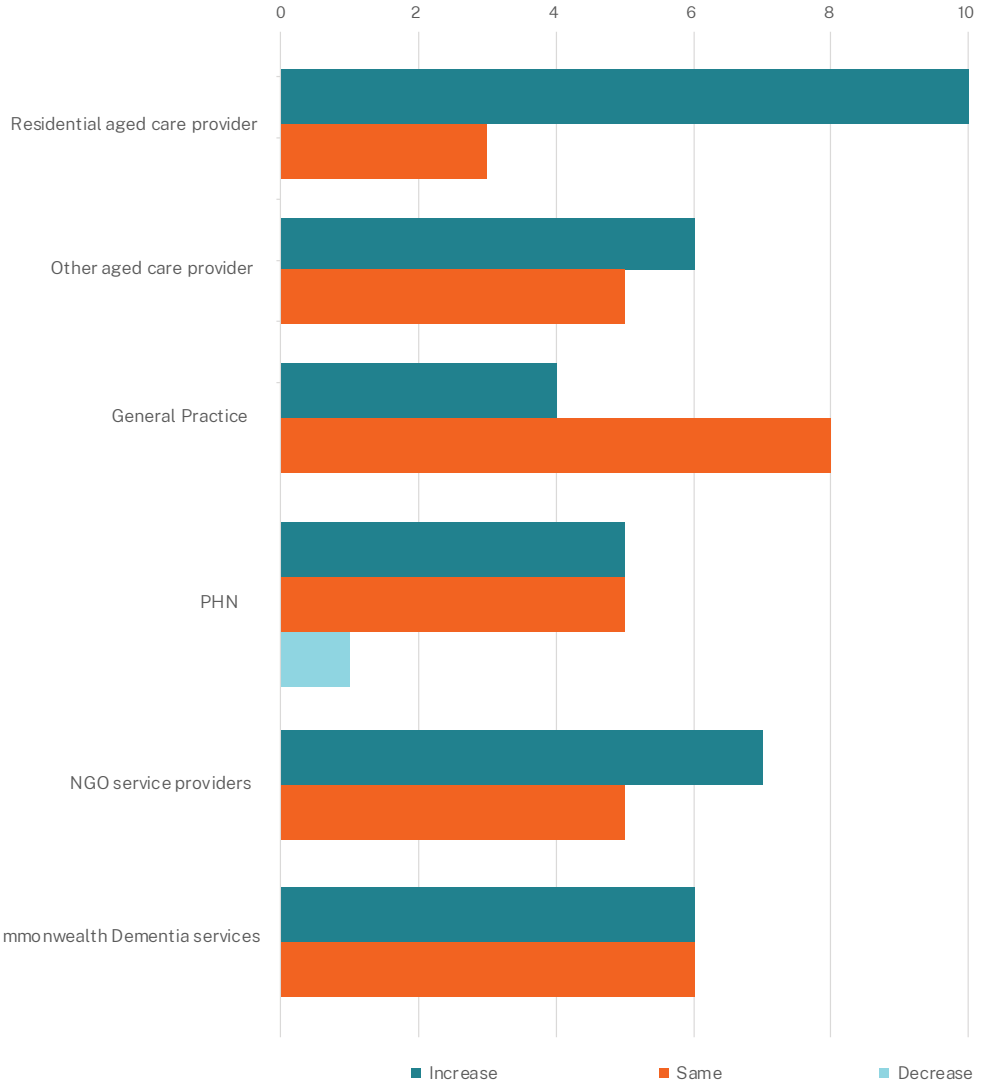


Figure 21: LHD survey Q30 How have the number of collaborations changed since the commencement of the OPMH Service Plan 2017–2027?

Relationships with Primary Health Networks

Responsive and flexible funding streams established in response to the COVID-19 pandemic have fostered increased OPMH service collaboration with Primary Health Networks. Specific initiatives include "Live Well" in South Western Sydney LHD and the exploration of peer worker collaborations in the Hunter New England and South Eastern Sydney LHDs. Beyond these specific programs, LHDs and OPMH services have worked closely with PHNs, and their mental health and aged care leads, to identify and address services gaps. The LHD survey (Figure 21) reports PHN collaboration grew in 5 LHDs, with another 5 LHDs reporting continued relationships with their PHNs.

Relationships with Commonwealth dementia services

With the prevalence of dementia rising, NSW OPMH services are interacting more with Commonwealth dementia services. There have been mixed reports regarding the quality of interactions OPMH services and DBMAS, SBRT, and SDCU teams/units. Survey results (see Figure 22) suggest OPMH services receive a net positive impact form DBMAS and SBRT programs and services.

Because there can be significant service overlap between DBMAS, SBRT teams and Community OPMH services,[24] improved communication, coordination, and role delineation may lead to better outcomes for, at least, those LHDs who reported neutral or even negative impact on local services.

Figure 22: LHD survey Q64 Rate the impact of DBMAS and SBRT initiatives on local OPMH services

[24] NSW Ministry of Health - Mental Health Branch. (2021). *Extreme Behavioural and Psychological Symptoms of Dementia (BPSD) Project Report.*

Perspectives on consumer partnerships

OPMH consumers face a complex service environment that includes aged, disability, medical, and mental health care. Assisting OPMH consumers to navigate the system is a large part of the role of Community OMPH services. Consumers and clinicians described the contribution of peer workers with a lived experience of navigating aged care and/or the NDIS service system as invaluable.

LHDs reported difficulty recruiting to peer worker positions, noting that the candidate pool of older "peer workers" with lived experience of mental ill health is very limited. LHDs are now exploring approaches that include carer peer workers with specific knowledge and experience of aged care, disability care, and/or mental health care systems. This workforce assists with service navigation, as well as individual and systemic consumer advocacy.

Recovery-oriented person-centred care

Recovery-oriented care is a pivotal element of the philosophy of care within the OPMH framework. The approach focuses on striking a balance between maximizing choice and endorsing positive risk-taking, which requires simultaneously upholding the dignity of conscious risk-taking and the duty of care and safety promotion.

The results of an annual OPMH service self-audit (in the context of statewide OPMH benchmarking processes against the standards) shows that, despite some fluctuations, processes and monitoring to create an environment that is supportive of recovery-oriented practice have improved and are at a high level across the state. However, clinical stakeholders have observed a lowering in clinical staff appetite for risk, which may compromise the recovery-oriented care approach. Findings within the Community Self Audit Standard 3, along with the OPMH workforce survey, suggests there is room for further training of staff in recovery-oriented practices in an OPMH context.

OPMH services self-auditing and service benchmarking show high levels of achievement of 'good team practice' across all the 10 Community and the 9 (2017-2021) or 7 (2022) Inpatient domains of practice. Some fluctuations were seen in *Community Domains of Partnerships, Access and intake*, and *Transitions of care* & crisis care through the pandemic years but appear to be now returning to pre-pandemic levels. Self-audits of Acute inpatient units showed similar fluctuations, which are now returning to, or improving on, pre-COVID results.

Finally, consumer and carer experiences using the consumer 'your experience of service' (YES) and 'carer experience of service' (CES) surveys indicate high levels of satisfaction with OPMH services in both community and inpatient settings. Areas for potential improvement are in the *Impact* and *Info & Support* domains.

The changes to consumer and carer experiences during the pandemic highlight the need for contingency plans that ensure continuity of care and support even when faced with disruptions. This may require strengthening of telehealth services, remote counselling, and robust communication channels to address the unique needs of older persons and carers during crises.

Policy and service model development and progress

There has been a lot of activity in suicide prevention and aftercare throughout Phase One of the OPMH Service Plan. While the Older People's Suicide Prevention Pathway has brought together lessons from the Older People's Aftercare Service Delivery Model and Towards Zero Suicide initiatives, it has only been explored in 4 LHDs. The Towards Zero Suicide initiatives have enabled many prevention and aftercare services that are focussed on older people. However, there's a need to build on these initiatives to achieve statewide coverage.

The OPMH Acute Inpatient Model of Care Guideline was updated in 2022, and this was welcomed by inpatient clinicians as a timely and beneficial update.

The MH-RAC (Mental Health Residential Aged Care) model and PCLI expansion continues, with NSW Health committed to funding 7 mental health-residential aged care partnerships services. While two providers were lost through a difficult period for aged care, one of these providers has been replaced, with procurement planning underway in relation to the second provider.

Further, the MH-RAC model provided the basis for the Commonwealth Specialist Dementia Care Program and its funded specialist dementia care units. These programs will require further expansion and deepening of collaborations with residential aged care to address growing demands in BPSD.

The CLS (Community Living Supports) and HASI (Housing and Accommodation Support Initiative) evaluation found that while older people were not an original target of the CLS-HASI programs, they were now accessing the program and receiving age-appropriate and useful support which they did not receive elsewhere. This is important, as it can free up OPMH community services from delivering psychosocial support type activities and to enable them to focus on other aspects of care.

Responsibility for the care of people experiencing extreme BPSD is likely to fall primarily on state government services. The Extreme BPSD project identifies actions for an all-of-NSW Health response to provide for the needs of this growing cohort.

Developments to improve services for target populations

The OPMH Service Plan identifies consumers with co-existing mental health and alcohol and other drug issues, co-existing intellectual disability, within or who have had contact with the criminal justice system and within LGBTI communities as specific target populations under the current plan.

The OPMH Service Plan also notes that initiatives for targeted populations that commenced under the previous plan (including, for Aboriginal, CALD and regional and rural populations), should be continued. Current OPMH service self-audit reports contain standards relating to Aboriginal and CALD communities.

A significant number of Local Health Districts (LHDs) reported a lack of staff and resources to develop service improvements in these target populations during Phase One. Where developments were identified, the following examples are noted:

- **Drug and Alcohol** Some LHDs are strengthening existing liaison with drug and alcohol services and collaborating with them to deliver education programs.
- **Intellectual Disability** One LHD has developed a productive relationship between the intellectual disability service and the mental health clinical lead in the area. However, more generally, OPMH services did point out that slow response times from intellectual disability services following OPMH discharge continued to pose challenges for consumers.
- **LGBTIQA+ community** Some OPMH services have been conducting LGBTIQA+ focussed needs assessments, providing inclusivity training for staff, and participating in local LGBTQI+ committees.
- **Criminal Justice** Some LHDs reported positive collaboration with the Justice Health and Forensic Mental Health Network. However, the network has experienced increased demand for OPMH services, particularly from those experiencing BPSD. The Justice Health and Forensic Mental Health Network have found it increasingly difficult to find appropriate accommodation for OPMH consumers, including those held on remand. They feel residential aged care facilities will require some form of incentivisation to strengthen acceptance of forensic patients and improve the transition for OPMH consumers from the criminal justice system.
- **Aboriginal People** Initiatives for Aboriginal people have been much further reaching, including the Aboriginal OPMH Champions Network and the Mental Health First Aid for Elders program. Although individual LHDs still report resource limitations as a major constraint, the statewide Aboriginal OPMH Working Group is a key vehicle in driving reform and sharing knowledge.
- **CALD Population** More than half of the LHDs surveyed have taken part in CALD population policy or service developments. Much of this activity centred around staff education and translation of written resources. LHDs note the Transcultural Mental Health Centre plays a key role in supporting these efforts. As with Aboriginal people, a statewide CALD OPMH Working Group is seen as a key vehicle in driving reform and sharing knowledge to support care for the CALD population.

Key findings and priorities for phase two

This chapter outlines the key findings from across the broad themes of the evaluation and identifies priorities for action during Phase Two of the plan over the next 5 years.

Key Findings

Strategic and operational environment

- **Aged care**

Phase One of the OPMH Service Plan coincided with the COVID-19 pandemic, causing substantial disruptions to the healthcare system and OPMH services. It appears services are now returning to 'normal' although faced with an aged care system that is quite different to that when the OPMH Service Plan was developed.

The Royal Commission into Aged Care Safety and Quality triggered significant reforms in the aged care sector. This has led to some increase in demand for independent specialist assessments from OPMH services. However, the biggest impact has been the interface between residential aged care and OPMH services and residential aged care's reduced ability and/or wiliness to take on consumers with a history of mental ill health and/or BPSD.

- **Dementia care**

The impending release of the National Dementia Action Plan (delayed until 2024) poses opportunities and challenges for OPMH in NSW. Aligning OPMH services with dementia-related initiatives will be increasingly important as the population ages and prevalence increases. The needs of those experiencing severe and extreme behavioural and psychological symptoms are already creating pressure points in the system, with demand growing in the medium term.

The groundwork for NSW Health and OPMH's response has been achieved through the NSW Health Extreme BPSD Project in providing clear recommendations. The planned expansion of the Commonwealth Specialist Dementia Care program, among others, will compliment NSW OPMH and other health services, but will require some coordination and alignment locally to maximise utility. Similarly, the continuation of Commonwealth Dementia Behaviour Management Advisory Services, Severe Behaviour Response Teams also provides opportunities for collaboration and improved continuity of care for OPMH consumers.

Service capacity

Community OPMH service staff levels have not seen significant increases since the NSW Mental Health Reform in 2015–16. The Reform funding appears to be achieving its goal of improving equity in community OPMH service access across the state, with the level of community access across metro and rural settings now broadly consistent.

Many issues have coalesced, and this has precipitated an increase in the complexity and resource intensity of consumers. This shift is manifest in reduced OPMH inpatient separations, longer lengths of stay and increased numbers of OPMH community service contacts. This has led to OPMH patients being increasingly managed by Adult and General mental health services.

Coordination with other service providers

OPMH services operate in a complex environment, bridging aged care, disability care, medical health care, and mental health care. Peer workers with OPMH specific lived experience have played a valuable role in supporting the care of consumers and carers, but also in navigating the system. Peer workers are in short supply. LHDs are exploring the use of carer peer workers with experience across aged, disability, and mental health care to address this gap.

Disruptions in the health and aged care sectors over the past five years have affected partnerships, although they have now rebounded and, in some cases, even improved as they establish a new normal. Commonwealth-funded dementia services have had a positive impact, but closer working relationships are required to prevent duplication and emergence of service gaps.

Person-centred care

Recovery-oriented care remains central to the OPMH philosophy. OPMH service self-audit results show high compliance with standards related to recovery-oriented care and practice, albeit with strengthening of staff training in recovery-oriented care an area for future action. Self-auditing and service benchmarking indicate strong team practice in both community and inpatient settings.

Consumers and carers have been impressed by the level of engagement they have had in service development and codesign activities at state and local levels. They view this involvement as a particular strength of OPMH services in NSW.

The COVID-19 pandemic and, to some extent, the Aged Care Royal Commission impacted on available resources and shifted service priorities for OPMH services. Although their capacity to undertake quality improvement initiatives was reduced during this period, statewide quality improvement work was still progressed, and this contributed to strengthening physical health assessment and the care for OPMH consumers.

Policy and service model development

Efforts have been made in suicide prevention and aftercare, with the Older People's Suicide Prevention Pathway and Towards Zero Suicide initiatives showing promise. Although it is unclear how LHDs have made local modifications or adaptations to the Towards Zero Suicide initiatives to improve their appropriateness for OPMH consumers.

The updated OPMH Acute Inpatient Model of Care Guideline has been well-received. The PCLI program continues, although it has been affected by competing priorities within aged care. Despite this it may provide a blueprint for how BPSD may be managed into the future, particularly as state governments are called upon more and more to provide appropriate services.

Developments to improve care for target populations

Disruptions, including the COVID pandemic, have meant resources have been limited in Phase One of the OPMH Service Plan to enable achievement of improvements for target populations. There were some pockets of activity but limited collective action and opportunities to share knowledge. However, Aboriginal and CALD OPMH Working groups were still able to drive and progress beneficial change for these priority populations throughout the period. The level of service coordination and accountability achieved by these working groups provides a model that could be explored for other priority population groupings into the future.

Priorities for Phase Two

1. Enhancing responses for complex consumers including people with severe and extreme BPSD

Inpatient and community OPMH demand is increasing. Inpatient OPMH care has seen delays in discharge leading to reduced separations with increased length of stay. As a result, **Adult and General mental health inpatient services have seen an increase in demand from consumers in the OPMH target age groups**. The increasing number of OPMH consumers being treated in Adult and General mental health settings has **implications for efficient, effective, and appropriate care for consumers**.

Inpatient and community demand will continue to grow as the population ages, and the population experiencing the behavioural and psychological symptoms of dementia grows. The interplay in the management of BPSD between OPMH, aged care and disability care will require significant coordination to effectively align the many different programs and initiatives that support those experiencing BPSD and their carers. Effectively **addressing BPSD will require OPMH services to establish renewed partnerships with residential aged care, as well as the development of stronger purposeful collaboration with other community partners, including PHNs and Commonwealth Dementia services**.

Careful consideration will need to be given to how NSW's provision of health services (in particular, the mental health services) can best be arranged to effectively and efficiently meet the changing needs of people with BPSD in the community.

Focus of action

Deeper exploration of the drivers behind the increasing mental health contacts and admissions for older people across all settings is needed. Increases in management of OPMH patients by Adult and General mental health services and emergency departments has implications for the efficient, effective, and appropriate care of older persons experiencing mental ill health. BPSD is a current pressure and a clear driver of demand for

OPMH services, and one that will grow considerably into the future.

This requires the focus of action in the following areas:

- OPMH services play only part of the state's response to BPSD. However, as community needs grow, so too will demand on OPMH services, including specialist assessment and secondary triage.
- The Extreme BPSD project, and its recommendations, provides a good starting point to address the growing need in the community.
- Clinical and other staff will need training to equip and empower them to meet the service needs of complex consumers, including those experiencing severe and extreme BPSD.
- Commonwealth programs have had a positive effect and reduced burden on OPMH services. Collaboration in establishing ongoing service responsibilities will help to avoid duplication and service gaps.

2. Knowledge sharing and expanded implementation of older people's suicide prevention and aftercare

The recent COVID 19 Pandemic and Royal Commission into Aged Care Quality and Safety have understandably demanded the attention of OPMH services during Phase One. The attention and resources required to navigate the pandemic and the changing policy environment has meant OPMH services have had less capacity to improve and innovate OPMH services during the initial 5-year period of the plan. However, during this period quality improvements and innovations were still achieved, including the MH-RAC partnerships services, improvements in physical health practice and ongoing PHN partnership work.

The next five years needs to refocus and strengthen the continual improvement and innovation that have been a mainstay of OPMH services in the past, with a heightened priority and focus on addressing the growing demand in managing BPSD.

Suicide prevention and aftercare has undergone significant development during Phase One. However, while there has been a degree of coordination of these developments across the system, much of the work has been LHD-centric. There is scope for greater sharing and learning across LHDs on local OPMH specific suicide prevention initiatives and thereby facilitating broader and more uniform implementation of effective initiatives.

Focus of action

- There has been significant work done in OPMH suicide prevention and after care through Phase One. Phase Two should focus on collaboration and knowledge sharing between LHDs to expand implementation.

3. Anticipating and responding to ongoing changes in key partner services

This will require a **refresh and renewal of partnership work with residential aged care** that saw great progress up until 2019-20 when the COVID-19 pandemic commenced. **Partnership work needs to build on and expand relationships with other services including Primary Health Networks, Commonwealth Dementia Services, NDIS providers, and adult mental health units**.

Focus of action

As aged care continues to go through significant change:

- It is important for NSW Health and the OPMH services to refocus and rebuild the partnership work impacted by COVID-19 pandemic and still hampered by workforce challenges across related sectors.
- It will be important for NSW Health to keep abreast of the ongoing aged care reforms and seek opportunities to provide feedback and be involved at higher policy levels.

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