ACT Government | Canberra Health Services

Model of Care

Older Persons Mental Health Community Team

Draft v 0.1

Contents

Approvals

Position	Name	Signature	Date

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue
V0.1	24/9/21	Project Officer	Operational Director, Senior Manager, OPMHCT	Feedback and edits
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1. Introduction

A "Model of Care" (MoC) broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury, or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place.[1] This MoC provides a framework for delivery of community mental health services for older people and how they integrate with other older persons mental health services to ensure the right care is provided to people at the right time, by the right team.

In line with the Canberra Health Services (CHS) vision to create exceptional health care, and to meet the future health care demands of an ageing population, the Older Persons Mental Health Community Team (OPMHCT) MoC will optimise the effectiveness, efficiency, and multidisciplinary responses of specialist older persons mental health community based services in the Australian Capital Territory (ACT). This MoC aims to ensure equitable access to evidence-based and recovery-oriented mental health treatment for older people reflecting the stepped care approach, which allows the person's needs to be met at the most appropriate level of intensity within the broader health system. he MoC was developed in collaboration with consumers, carers, internal and external stakeholders to ensure:

- A streamlined and coordinated service for patients accessing the OPMHCT through:
    - clear role definition for specialist OPMHCT services,
    - seamless interfaces and clear pathways for referral in and out of the service within the stepped care approach.

    - revision, consolidation, and enhancement of existing programs,
    - identification of new services or programs,

- An evidence based workforce model that supports a skilled workforce, with delineated roles, responsibilities and that ensures adequate resources to meet the needs of the service
- Future directions for the specialist OPMH community-based services will meet the increasing demands of an ageing population.

The MoC provides a framework for CHS older persons mental health (OPMH) operational activity in the context of the stepped care approach across the spectrum of older persons mental health services in the ACT. The OPMH inpatient unit is a clinical unit of Calvary Public Hospital Bruce (CPHB), therefore outside the scope of this MoC, however as a key partner, the pathways and interfaces with the older persons inpatient unit at Calvary are considered.

A MoC is a dynamic document and will be updated over time to support new evidence and improved ways of working. Any updates will include relevant change management principles and processes to ensure clear engagement and communication.

2. Principles

The MoC is underpinned by legislation including, but not limited to the Mental Health Act 2015, Human Rights Act 2004, the ACT Charter of Rights for People who Experience Mental Health Issues. The vision and principles define the nature of service delivery under the model of care, and what must be enabled to meet the needs of older people experiencing mental illness and disorders. They have been developed by the OPMHCT through consultation with key stakeholders to align with CHS Clinical Governance frameworks and national frameworks and plans including the:

- Fifth National Mental Health and Suicide Prevention Plan 2017,
- National Framework for Recovery-Oriented Mental Health Services 2013,
- National Safety and Quality Health Service Standards,
- National Standards for Mental Health Services (NSMHS) 2010
- Territory wide Health Service Plan (in draft)
- ACT mental health and suicide prevention plan 2020-2025
- Older persons mental health and wellbeing strategy (in draft)
- ACT Aboriginal and Torres Strait Islander Agreement 2019-2028

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on this promise.

Vision

"We are a person centred, specialist mental health service that provides holistic, safe, compassionate, evidence-based care which promotes living with dignity and wellbeing."

Principles

Collaborative care in partnership.

The role of family, carers and other supports are acknowledged as important partners in provision of care. The OPMHCT works with the person, their carers and other health providers to improve mental health through clear and effective communication, supported decision making and involvement in their care. Comorbidities and physical health needs are identified and addressed through appropriate referrals and coordination of care. The roles of each component of the broader health system are recognised and valued, and pathways between providers and supports outside the OPMHCT are enabled to ensure care is responsive to each person's needs.

Person centred care that embraces diversity and complexity.

Each person is recognised as having unique origins, life experiences, relationships and needs. OPMHCT recognises and embraces this diversity and supports each person to identify their own care needs, treatment, and recovery goals. Equity of access and general wellbeing are promoted through care that is non-judgemental, kind, and respectful of each person's uniqueness such as culture, gender, language, spiritual and physical needs.

Strengths based approach.

The OPMHCT take a holistic, biopsychosocial approach and understand that mental health recovery is individual and personally defined. People are supported to identify their values, strengths, and resources to maintain their identity, define a meaningful life and engage in activities that allow them to live well. Self-determination is encouraged through building on individual strengths, lived experience, and grounded in an understanding of the mental, physical, and social impacts of trauma on mental health and recovery.

Accessible and responsive.

Information about the role of the OPMHCT and how to contact the service is easily accessible to health care providers and the community. The MHJHADS 'no wrong door' philosophy means people are supported when seeking help and referrals are triaged, directed, and followed up as appropriate. Receipt of referrals will be acknowledged, and the outcome of the referral communicated where privacy laws allow. Access to the most appropriate level of care is supported by making linkages between people and services. Treatment services are provided in a timely and equitable manner that meets the needs of older people, their family and carers in the least restrictive environment.

Focus on safety, quality and evidence-based care.

The OPMHCT is continually finding ways to improve care through developing and utilising research, quality improvement activities, best practice care and evidence-based guidelines. Ongoing education and professional development are supported to enable staff to work within and to their full scope of

practice and provide the highest level of care. The physical, psychological, and emotional safety of staff, older persons and anyone involved with the service is safeguarded through appropriate assessment and management. Staff have an advocacy role which supports and protects their clients and themselves and promotes positive attitudes to ageing and mental health.

Interdisciplinary, multidisciplinary, and holistic approach to care.

Holistic, biopsychosocial and discipline specific interventions are supported through a range of expertise and a combined interdisciplinary and multidisciplinary approach to care. The combined approach means team members of different disciplines may work in an integrated way in a consultation or utilise discipline specific skills and expertise to undertake assessment, diagnosis, intervention, goal setting and care planning. Both approaches include the person and their family and carers where appropriate.

3. Benefits to be realised

The implementation of the model of care aims to achieve the following changes:

- Improved community and service provider awareness and understanding of the OPMHCT role, functions and how to contact them
- Improved efficiency through standardised and revised pathways and processes supporting increased capacity of the team
- Identification of specialised roles within service components to appropriately target interventions to different needs
- Increased support to other service providers including General Practitioners (GPs) and residential Aged Care Facilities (RACFs) to recognise and act on mental health issues early, reduce the need for referrals to OPMHCT or admission to hospital
- Identified workforce needs, including recruitment and retention of qualified staff across a range of disciplines, linguistically and culturally diverse, and Aboriginal and Torres Strait islander staff for the future needs

These changes should realise the following benefits:

- Defined roles, target cohorts and intake and exit criteria for service components will ensure the right care at the right time by the right team
- Effective community-based care that supports keeping people out of hospital
- Improved patient journey/experience through equitable access to streamlined and coordinated services with clear pathways, interfaces, enhanced collaboration and partnerships with other service providers.
- A workforce that is appropriately skilled and balanced to provide care in line with the vision and principles.

4. Description of service

Context

Some older people will have aged with mental illness, while for others it emerges for the first time later in life. Risk factors for poor mental health in older people include physical impacts of ageing and physical comorbidities, loss of independence and function, a sense of vulnerability, economic and social changes, loss of friends and family, and taking on caring roles. Older people are more likely to have comorbidities or chronic health conditions, and those with moderate to severe illness are more likely to have psychosocial impairments, loss of social supports and be in lower socioeconomic groups. Physical health is often impacted by metabolic side effects of medications, smoking and alcohol.

Mental ill health in older people is not always well recognised by health professionals and the broader community particularly where there are contributing factors adding complexity to the assessment and recognition of mental illness, for example neurological decline. The most commonly diagnosed mental illnesses in the over 65 age group are depression and anxiety, and there are high levels of self-harm/suicide in this group[2]. According to the Australian Institute of Health and Welfare (AIHW), 17.3% of males and 22.4% of females over 65 had a current long term (lasting 6 months or more) mental or behavioural condition in 2017-18.[3] Older people face unique issues of elder abuse, which may be financial, psychological, or physical, with estimates of the prevalence between 2-14% in any year.[4]

Older people who have experienced trauma, and those from refugee or non-English speaking backgrounds are at higher risk of poor mental health yet may have a poor understanding of mental illness or strong stigma attached and may be more socially isolated. As a result, they may present with vague physical symptoms complicating the correct identification of mental health as the issue. Older people who identify as LGBTIQ are likely to have experienced discrimination and stigma over their lifetime, impacting their willingness to publicly identify as LGBTIQ, and adding to the difficulty seeking appropriate health care. [5] People living in RACFs have a higher prevalence of dementia and poor mental health than people living in their own homes. [6]

Aboriginal and Torres Strait Islanders across all age groups have high levels of psychological distress and prevalence of grief, trauma and loss impacting their mental and physical wellbeing and other determinants of health. Mental health is built around a holistic approach to social and emotional wellbeing determined by many factors including connection to land, culture, family, and community. This is not always recognised, respected, or well supported by mental health services.[7]

The proportion of the population who are over 65 is increasing. Current projections are that the 65 to 84 age group will increase from 11% to 15% of the ACT population by 2032.[8] Some suburbs will have a higher number of older people, however there will be a general increase across the ACT. A snapshot of active OPMHCT clients in April 2021 found that 53% clients lived northside, and 47% southside.

The Older Persons Community Mental Health Team (OPMHCT) provides community based specialist assessment, care planning and treatment for older adults experiencing or suspected of experiencing a mental illness or mental disorder, and who are living at home or in a Residential Aged Care Facility (RACF) within the ACT. The OPMHCT also provide specialist advice, expertise, and consultation to other health care providers.

The OPMHCT provides a range of interventions including assessment, advice, advocacy, short term treatment and interventions, intensive or assertive outreach treatment, clinical management, physical health review, care coordination and case review. Following an assessment, recommendations will be made to the person, their family/carer and care providers (such as GP or geriatrician) about treatment options. Services are mostly delivered in people's place of residence, and some community and outpatient settings.

Key access criteria.

The OPMHCT works with people who are:

- ACT residents including those living in residential aged care aged 65 years and over or 50 years for Aboriginal and Torres Strait Islander people, who are experiencing either:
  - a mental illness with moderate to severe impact on psychosocial functioning **and/or**
  - moderate to severe behavioural issues related to dementia (behavioural and psychological symptoms of dementia -BPSD) **and/or**
  - are at risk of suicide

- People aged under 65 with mental illness and significant functional impairment caused by an age-related condition are eligible for the OPMHCT.

People who have recently or are currently using adult mental health services, and now have significant functional impairment caused by an age related condition should be managed by the team that best meets their needs when reaching age 65. Conditions that may prompt transfer of care from the adult to older persons mental health service include:

- Diagnosed neurodegenerative disorder
- Frailty
- Residing in a residential aged care facility

Where a person has one (or more) of these age related conditions and is therefore eligible for transfer, the person's preferences, physical and psychosocial needs will be considered, and their care provided by the team that best meets their needs. A collaborative assessment by the adult and older persons team can be undertaken to inform this decision.

Exclusion criteria

A small number of exclusion criteria have been identified to support appropriate referrals to specialist older persons mental health services. Age should not be a hard inclusion or exclusion criteria. The OPMHCT generally do not accept referrals for:

- Primary diagnosis of drug and alcohol disorder
- Acute medical illness
- Dementia unless there is coexisting mental illness or moderate to severe behavioural and psychological symptoms of dementia (BPSD)
- Cognitive impairment not related to diseases of ageing or progressive neurodegenerative condition e.g., Acquired Brain Injury, Korsakoff's Syndrome, cognitive impairment due to chronic psychotic illness

Key exit criteria

Once a person no longer meets the access criteria for the OPMHCT they will be supported to move to a more appropriate level of service in line with the stepped care approach. A person who is progressing well in their recovery goals will be suitable to step down to a less intensive service. Transitions out of the OPMHCT are planned in partnership with the person, their GP, and family/carers where appropriate. Stepping down will occur when their needs can be adequately met by another service and specialist mental health care is no longer required, they have a recovery and discharge plan including information on how to re access OPMHCT if needed, or if they have moved outside the ACT.

A person becoming more unwell may require admission to hospital. The OPMHCT will work collaboratively with the person, their family/carer, and the inpatient unit to facilitate admission and discharge planning.

Functional impairment

Symptoms of mental illness and disorders can impact psychosocial functioning in a range of ways. Cognitive, behavioural, emotional, and physical symptoms can affect a person's relationships, capacity to work, ability to engage in social interactions or recreation, and capacity for self-care and activities of daily living. Functional impairment can also add complexity to mental health assessment, treatment, and engagement with services.

Psychosocial functional impairment will be measured through:

- a clinical assessment of a person's functioning, considering their premorbid history
- collateral information from family, carers, nominated people and/or other stakeholders or involved parties (e.g., GP, other government services, community agencies etc.).

Complexity

Some older people will have significant impairment, high risk of harm to themselves or others, or complex case management or care coordination needs that are not responding to common interventions. Age related conditions and decline also impact complexity.

Complex presentations may include, but are not limited to:

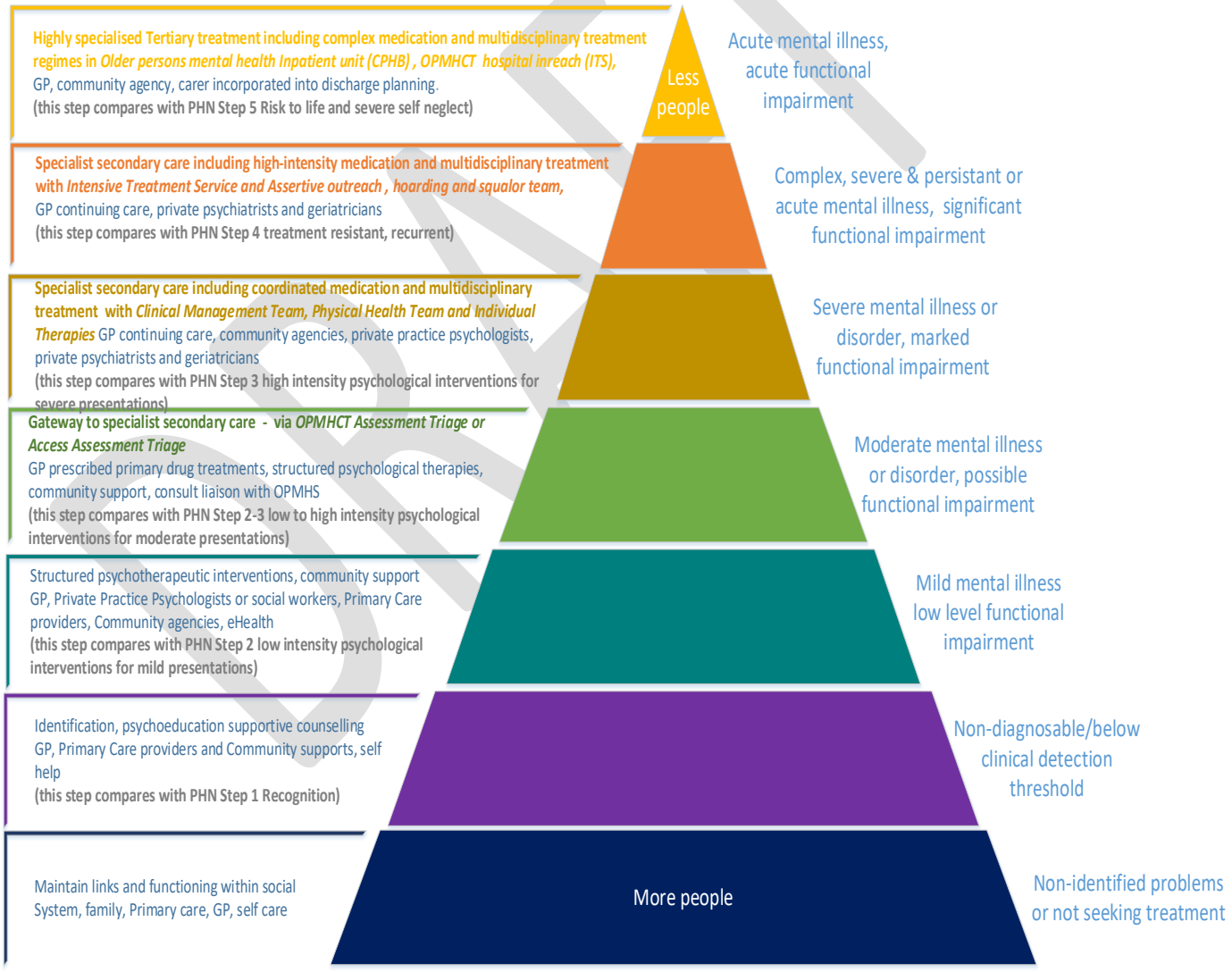
- Debilitating symptoms of mental illness that has not responded to lower intensity interventions (such as psychological or pharmacological treatments including, for example, GP management and/or Mental Health Care Plans)
- High risk of harm to self or others or misadventure
- Significant psychosocial functional impairment such as in the areas of interpersonal relationships, social isolation, and activities of daily living
- Multiple agencies involved
- Psychosocial impairments/circumstances with associated vulnerability to abuse, neglect, or exploitation
- Complex comorbidities (such as drug and alcohol misuse, age related physical/neurological conditions)

Stepped care approach

The stepped care approach to service delivery is defined as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs.'[9] The mental health system comprises a full spectrum of services from low intensity early intervention to high levels of coordinated complex care. All people should have access to mental health triage and primary care, then be matched to the level of intensity that best meets their needs, stepping up or down in service intensity at any stage according to need.

The stepped care model diagram gives an overview of service providers, level of illness and impairment and where people might fit along the spectrum of needs. The OPMHCT provides the higher intensity component of these steps and works with other agencies and providers to ensure smooth transitions and pathways.

Figure 1 Stepped care model for older persons mental health services



(Adapted from Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, 2015; NICE 2011 Stepped Care Model for People with Common Mental Health Disorders; and Project Report on the Redesign of the ACMHS MoC O'Halloran et al 2015).

Primary health care is generally the first point of contact for patients, and referral is often not needed, e.g., GPs, ambulance, community based organisations and self-help organisations. Secondary health care often requires referral for specialists, hospital care or ambulatory services. OPMHCT fit under the secondary care definition and provide care for people with moderate to severe mental illness, as determined by functional impairment. This is reflected in the access criteria. However, due to a range of factors such as lack of knowledge of availability or how to access services people may be seeking help at any level regardless of the appropriateness. The OPMHCT has a 'no wrong door policy' and will support a person seeking mental health care to find the right service to meet their needs.

5. Components of care and functions

The OPMHCT model of care organises key functions through sub teams for different service components. These are the Assessment team (Ax), Clinical Management (CM), the Intensive Treatment Service (ITS) and Physical Health Intervention Team (PHIT).

The core functions of the OPMHCT include:

- specialist mental health assessment and care planning
- specialist mental health treatment using evidence-based interventions
- care coordination
- crisis resolution, short and longer term clinical management
- clinical advice to other key services, health professionals and programs
- collaborative activities to support early intervention and recovery for older people with mental health problems.
- Clinical support for severe hoarding and squalor
- advocacy

These functions are delivered by a team of health professionals from a range of disciplines who bring a breadth of skills, knowledge, and expertise to the service.

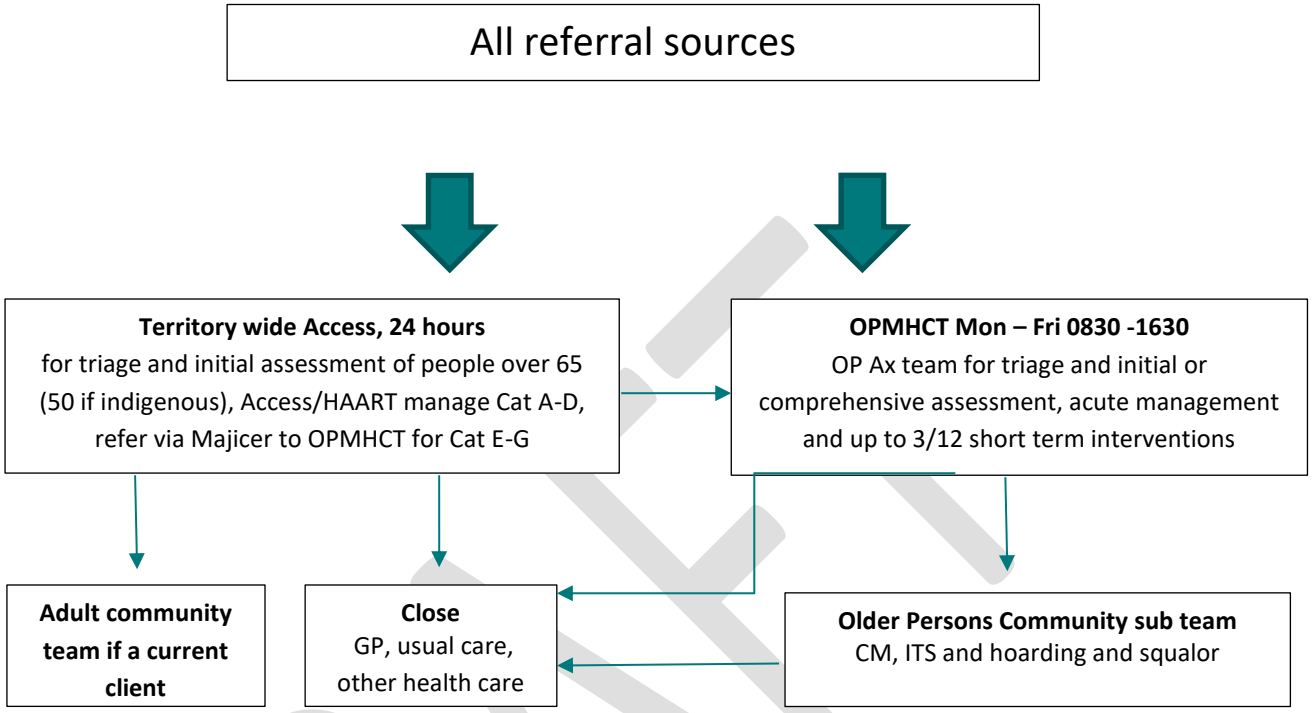
Summary of sub team function and referral source.

Sub team	Function	Expected time frame	Referral source
Assessment Ax Team	Specialist mental health assessment, care planning, crisis resolution and brief interventions. Primary goal is diagnosis and diagnostic clarification, risk assessment, crisis resolution and short term interventions Assess, stabilize, treat, and facilitate transfer of care at the earliest possibility to the most appropriate service in the least restrictive environment.	Up to three months	Anyone can refer. Access Mental Health 24-hour team triage and pass on referrals. Adult community teams, Consultation Liaison Services, interstate referrals, inpatient unit referrals for transition to community care.

	Responds to new referrals at triage category E-G and redirects higher category triage to Access MH.		
Clinical Management CM Team	Community recovery service that provides ongoing specialist care and treatment beyond the acute episode of illness. Ongoing assessment and review, care planning, goal setting and interventions, clinical care, coordination, and case management using a strengths-based approach. Strengthens psychosocial functioning, living skills and relapse prevention. Facilitate access to therapeutic interventions. Mental health support for a small number of people with severe hoarding and squalor issues as part of a multiagency approach to managing these complex situations.	3-12 months Long term, may be >12 months	Assessment team
Intensive treatment service ITS	Highly specialised home or RACF based treatment to a small number of clients experiencing an acute phase of their illness. An alternative to a psychiatric hospital admission for people with complex needs, those who are deteriorating in the community or need additional support on discharge.	Up to 3 months, can be longer when clinically indicated.	Assessment team or Clinical Management team.
Physical health Intervention Team (PHIT)	Physical health screening and health promotion.	3-12 months	Clinical Management Team

Triage, intake, and referral pathways (access and intake)

Referral pathway for older people in the community



Intake

Intake to the OPMHCT is either through direct referral or the Access Mental Health 24 hour line. Referrals may be made by anyone concerned about the mental health of an older person, and acceptance of the referral is based on the eligibility criteria. The OPMHCT respond to new referrals in triage categories E-G, Access Mental Health and HAART respond to new referrals for triage categories A-D. To support appropriate referrals and timely access to care, information about the role and function of the OPMHCT is readily available for referrers and the public with links to multilingual and culturally appropriate resources provided. Interpreters are utilised whenever needed.

Referral management

The OPMHCT recognise that other health care providers and mental health teams without older persons mental health expertise may have a low threshold for referring to the OPMHCT. In line with the 'no wrong door' philosophy, acknowledgement of receipt of a referral is standard and all referrals will be assessed for suitability. Triage and acceptance of referrals is aligned to the core business of the OPMHCT as defined by the eligibility criteria and the Mental Health triage scale. Referrals that fall outside the core business will be acknowledged with respect and proactively directed to the relevant service. The OPMHCT have documented processes for acknowledging receipt of referrals, providing an estimated time until contact, providing feedback on referral outcomes when privacy allows, and pathways for alternate care when OPMHCT is not the most

suitable option. People who have been recently discharged from the OPMHCT service will be supported to have easy re-access to the same clinicians if appropriate.

Routine screening for delirium or medical deterioration informs the decision on whether a referral needs to be redirected for medical review.

Assessment team.

Function of the team: assessment, care planning and brief interventions.

The Assessment team (Ax) are the entry point for all people referred to the OPMHCT, including from Consultation Liaison Services, interstate referrals and people transitioning from an inpatient admission to community care. The centralised entry point is easily identified and ensures consistency and standardisation of all referrals to the team which supports equity of access to services. Centralised assessment supports smooth workflow between other sub teams and facilitates external referrals when appropriate. To ensure comprehensive triage and assessment of all referrals, the team is comprised of senior nursing, allied health and medical staff with expertise and experience in older persons mental health assessment.

The Assessment team provides specialist assessment and short-term therapeutic interventions for people presenting with moderate to severe mental illness. The primary goals of the Assessment team are supporting a person to get the right care, diagnosis or diagnostic clarification and short term reduction of severity of symptoms and distress. Initial assessment may be done by a nurse, allied health clinician or psychiatrist depending on the issues the person is experiencing and will include a comprehensive biopsychosocial assessment of mental health history, symptoms, available supports, mental state, and risk to understand the person's needs, issues, and perspectives. In collaboration with the person, the GP, and their carer where appropriate, the clinician will determine appropriate treatment and therapy options and develop an agreed plan with the person considering all aspects of their situation. Acknowledging that some referrals do not meet the eligibility criteria for acceptance by the OPMHCT, advice may be provided to support ongoing care by other health service providers.

Crisis resolution and short term interventions up to 3 months may be offered to people where this can't be provided by a less intensive service such as a GP or private counsellor. If ongoing specialist mental health care is needed, the person may be referred for clinical management. People who no longer require specialist care will be closed to the OPMHCT, with clinical handover to a receiving service such as the GP, RACF or other service.

In line with CHS policy the team use validated assessment tools and nationally mandated outcome measures for older people, routine screening for alcohol and substance use, falls risk, physical issues, delirium screening and cognitive screening. Additional input such as from Aboriginal Liaison Officers, the alcohol and drug comorbidity clinician, and neuropsychology are available and offered as appropriate.

The Assessment team operates 5 days per week from 0830 to 1700. After hours people can leave a message, or for urgent care call the 24 Access line. The majority of assessments are done through an

initial phone call then a face to face assessment when clinically indicated with ongoing care provided in the person's place of residence, by phone or in community health facilities.

Clinical management

Function of the team: clinical care, coordination and case management using a strengths based approach.

The Clinical Management (CM) team are a multidisciplinary team comprising of nurses, social workers, psychologists, occupational therapists, allied health assistants and psychiatrists who bring a range of expertise and skills to the team. The CM team facilitate specialist care and treatment beyond the acute episode of illness by providing or organising clinical treatment and psychosocial interventions. The focus is on improving psychosocial function, living skills and participation, preventing relapse, avoiding hospitalisation, and managing risk. A multidisciplinary approach allows for a full range of interventions that are comprehensive, holistic and evidence based including a proportion of discipline specific interventions along with general clinical management and assessment.

People determined by the Assessment team as having severe mental illness and complex health and social needs which cannot be met through primary care settings will be referred to the Clinical Management team for a person centred approach to treatment and support. Severity of illness, functional impairment and complexity are the key guide for determining whether a person needs clinical management. The OPMHCT will prioritise clinical management for people who:

- Are experiencing a complex mental illness/disorder or psychological distress which is associated with significant functional impairment and/or significant risks
- May be subject to a Psychiatric Treatment Order (PTO) under the Mental Health Act 2015
- Have multidisciplinary treatment needs that cannot be met elsewhere in the community or a less intensive service
- Require regular service contact over a medium to longer-term episode of care.

There is also a sub team with targeted focus on older people living in severe domestic squalor and/or experiencing significant compulsive hoarding issues as a consequence of mental illness.

Referral pathway

Referrals for clinical management all come through the OPMHCT Assessment team. This allows for consistency of decision making about who needs clinical management, control over allocation of resources and mirrors the Adult Mental Health Community Team model of care in having one point of entry for clinical management. A comprehensive assessment is undertaken to determine the person's needs and whether CM is the most appropriate service to meet them. Onward referral from the CM team occurs when a person requires a more intense service or hospital admission or can be stepped down to a lower intensity service. If hospital admission is needed, the clinical manager will maintain contact with the inpatient unit in line with operational guidelines.

People who have been clinically managed by adult community teams and now meet the criteria for the OPMHCT may have a joint assessment by a clinician from each team to determine which service

best meets their needs, and to plan for transitions between teams outside an acute episode of illness.

Once accepted for clinical management, the team leader will allocate a CM and a psychiatrist (consultant, or registrar under supervision of a psychiatrist) to the person. The CM is the key point of contact for everyone involved in the person's mental health care. CMs possess core and specialist skills to inform appropriate interventions, and will also refer to, coordinate and collaborate with other service providers as required. Where needed, the CM will facilitate additional input from the ALO and other mental health specialities and services.

Most people need CM for a period of 3 to 12 months and are then able to transition to a lower intensity level of care. It is recognised that a small number of people need longer term engagement. People whose needs increase will be facilitated to step up to a more intense level of service such as the Intensive Treatment Service or hospital admission. Intensity of contact is determined by the person's needs, and may be weekly, fortnightly, or longer. A limited component of CM Team resources is quarantined for people with significant hoarding and/or squalor presentations and these services are provided by specially recruited staff. Where resources are unavailable to meet demand, recommendations will be given to referrers on where the person may be able to source alternative supports. The CM team works Monday to Friday 0830 to 1700, and interventions may be provided in the person's home, community health centre or clinic.

Key services provided by the clinical managers are:

- Regular phone or face to face contact with the clinical manager
- Ongoing assessment and review with their clinical manager and psychiatrist to develop and renew care plans and recovery plans,
- Clozapine clinic
- Case reviews every three months
- Pharmacological and psychosocial interventions
- Facilitating access to therapies, or providing therapies where a person is unable to access them externally
- Care coordination and carer support
- Liaison with other care providers and agencies
- Assessing for comorbidities such as alcohol misuse and physical health problems
- Support where there is capacity to complete documents that set out the persons treatment preferences should they lose capacity in the future, such as Advanced Agreements and Advanced Consent Directive
- Support to transition to higher or lower intensity services as clinically indicated.

Crisis and emergency mental health care is provided by the Access 24 hour mental health line. Where a person is already engaged with the OPMHCT, the OPMHCT will respond to a mental health crisis during business hours. Outside business hours, Access Mental Health provide the crisis response.

Access to therapies

The primary function of the OPMHCT is to facilitate clinical recovery, and to support clients with their recovery goals, for example by making referrals to appropriate external clinicians and services, psychosocial supports, and community services. There are limited options for older people across the spectrum of mental health services despite the effectiveness of therapies in older people. The OPMHCT utilises the strengths, diversity, and expertise of clinicians in the multidisciplinary team to provide therapeutic interventions, however there is limited resourcing and capacity to directly provide specific advanced therapies to clients in addition to holistic clinical management. In line with the CHS policy "Use of psychological interventions in MHJHADS", clients who are identified as potentially benefitting from therapies will have a discussion with an appropriately qualified therapist. They will provide information on types of therapy, availability, cost, likely benefits, time frames and limitations in evidence, and provide written recommendations to the person and/or their GP. The decision to engage in a particular therapy lies with the person.

People will be encouraged to access therapy externally and supported to find appropriate providers. Most clients will be recommended to access private therapy. The CM Team has limited resources to provide advanced therapies to a small number of clients based on stringent criteria, and clients may experience wait times. Increasing the use of psychological therapies within the OPMHCT for this group of people will provide a mix of supports and services based on need rather than availability.

Older people may also be referred to the Adult MH day service programs where they are assessed for suitability against the same criteria as adult clients. The OPMHCT and the adult mental health day service will seek increased opportunities to collaboratively run programs and support older people to access existing programs when possible and suitable. The OPMHCT ensure that age is not a barrier to accessing highly specialised treatment such as clozapine, ECT and depot and work closely with providers of these services to ensure seamless care for older people.

Hoarding and squalor

A small number of people with severe hoarding and squalor issues have their mental health needs supported by two specialist CM clinicians as part of a multiagency approach to managing these complex situations. The goal of engagement is a clinical focus through:

- Assessment and care planning, risk assessment and management
- Building rapport which then leads to all other direct interventions
- Linking people to other services
- Working with other services to engage with the person e.g., psychoeducation
- Providing support to the person at times of interventions (such as forced cleans).

Decluttering is considered a nonclinical component and is provided by appropriate NGOs.

Physical Health Intervention team (PHIT)

Function of the team: to provide physical health screening to people in the CM team.

Physical health screening is part of the holistic approach to clinical management and care coordination to detect physical health issues, risk factors and promote physical health interventions.

The OPMHCT clinical management clinicians offer physical health screening within their discipline scope of practice and in accordance with CHS operational guideline 'Providing physical health care across MHJHADS' and report these outcome measures regularly. PHIT also provide health promotion and referrals to other services to support the physical health care of their clients.

Referrals for PHIT come through the CM team, and all clients receiving CM are offered PHIT. The team works Monday to Friday 0830 to 1700.

Intensive Treatment Service

Function of the team: to provide an alternative to a psychiatric hospital admission and assertive outreach for people who need an intensive level of ongoing care.

The Intensive Treatment Team (ITS) provide highly specialised secondary and tertiary treatment to a small number of clients in an acute phase of their illness who can be safely treated at home. Eligibility for the ITS service is that a person is at risk of deteriorating in the community with possibility of a hospital admission or needs intensive community support as a step down to facilitate early discharge from hospital. The team provide rapid face to face assessment and can visit up to twice a day Monday to Friday between 0830 and 1700. The service is looking to expand to a seven day service model in the future with timing dependent on available resourcing. Assertive outreach is offered to people with complex and continuous symptoms who may be more vulnerable or less willing to engage with the clinical management team.

Referrals for all components of ITS come through the Assessment Team or Clinical Management Team, including referrals from the inpatient unit for people getting ready for discharge, to support consistency in assessment and to manage caseload allocation. The ITS prioritise care for people who:

- are assessed as requiring a psychiatric admission, or where a psychiatric admission is imminent due to escalating circumstances, or
- are appropriate for early discharge from a psychiatric admission but require intensive community support, and
- can be safely treated at home within the ITS hours of operation

Assertive outreach is considered for people who:

- Have a primary diagnosis of a psychotic illness, such as schizophrenia, psychotic depression, BPAD that is severe and enduring in nature and involving complex and continuous symptoms
- Have experienced multiple admissions or long duration of admissions to the inpatient unit or ITS
- Are unwilling or unable to engage with services
- Are vulnerable and/or with multiple complex needs, such as
    - Frequent relapses
    - History of poor adherence with treatment including medication
    - Poor response to previous treatment
    - Significant and ongoing risks requiring careful management
    - Requiring very regular weekly follow up on an ongoing basis

- Increased co-morbidities

Crisis and emergency mental health care is provided by the Access 24 hour mental health line. Where a person is already engaged with the ITS, they will respond to a mental health crisis during business hours. Outside business hours, Access Mental Health provide the crisis response.

Clinical review

Clinical review occurs informally during regular contact, and through a formal process by the treating team every three months or earlier if needed, as required by national standards and CHS operational guidelines. The review is by the multidisciplinary team and involves the person, carer (with consent) and the GP to review health status, clinical presentation, personal goals and update the care plan. The clinical review process ensures a person centred approach with multidisciplinary input to determine the effectiveness of an individual person's current plan and interventions.

Transitions of care

The OPMHCT work with a person to improve their mental health and wellbeing through identifying and supporting their recovery goals and care needs. During this process there may be times where higher intensity care is needed, or where recovery goals are being met and the person no longer needs specialist mental health care so can move to a lower intensity service. Where a consumer has an enacted guardian or Enduring Power of Attorney, the OPMHCT where able, will seek and respect the values, views and wishes of the consumer in care planning and delivery of interventions.

Transition to lower intensity services such as GP or community managed care is based on the person's individual care and treatment needs, available supports, and is planned in collaboration with the person, their family, or carers, GP, and other agencies. Discharge planning should begin at the time of acceptance into the service and the care plan will include identifying and addressing any barriers to stepping down intensity. A clinical handover will be given to the service providing ongoing care.

Transitions between the OPMHCT and the inpatient units will be managed collaboratively between both services, with the care plan and clinical handover clearly articulated. If a person has an allocated clinical manager, they will maintain contact with inpatient teams and the person to support continuity and comprehensive discharge planning in line with operational procedures. The transitional care clinician provides an integral liaison between inpatient and community based services to support discharge planning for people identified as potentially needing ongoing specialist care. Assessment by the OPMHCT Assessment team will determine the appropriate service or sub team to meet their needs.

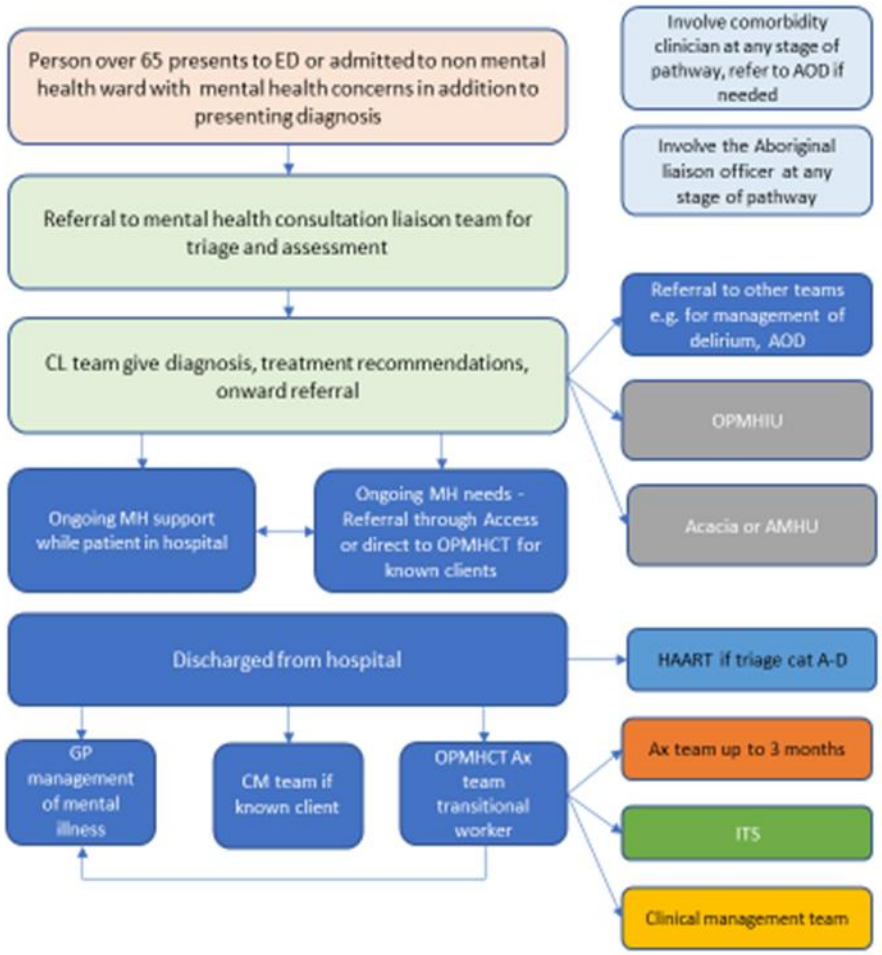
People who have been using the adult mental health services and are now 65 (50 if Aboriginal) should have their care provided by the team that best meets their needs. This may mean continuing with the adult team, or where they meet the key access criteria, they will be assessed for transition to the OPMHCT. Where there is uncertainty a joint assessment can be undertaken by the adult community team and the OPMHCT, with consideration of the persons needs and preferences, to determine the most appropriate service. This should be planned when the person is not in an acute phase of illness.

Specialist consultation and liaison in the inpatient setting

The OPMHCT is based at University of Canberra Hospital (UCH) and will respond to referrals from medical wards at UCH for inpatients aged 65 and over (or 50 if Aboriginal) who are referred to UCH CL. Ward staff may refer to UCH CL through the AMHRU reception, the referral is then reviewed and actioned by a senior clinician in the Ax team and passed on to a psychiatrist if indicated.

The focus of the OPMHCT is community based services, so consultation liaison to patients of Calvary Public Hospital and Canberra Hospital is provided by dedicated hospital based teams. An older person presenting to ED or admitted to a ward with mental health concerns in addition to their primary diagnosis can be referred to the Mental Health Consultation Liaison team who liaise with older persons mental health inpatient and community based teams as needed. In the future, dependent on OPMHCT staff and resourcing, there may be opportunity for the OPMHCT to support the Canberra Hospital MHCL with specialist older person referrals.

Referral pathway for inpatient with mental health concerns secondary to their admission diagnosis.



Promotion, prevention, and early intervention

Mental health promotion and prevention is integral to all levels of service for older people. The OPMHCT play a role in increasing community awareness and understanding of mental ill health in older people, recognising signs, symptoms and risk factors and relapse prevention. Promotion activities may include support and capacity building for carers and families to understand and recognise illness and know where to get help, advocacy and working in partnership with other service providers such as primary care and Non-Government Organisation (NGO) providers to deliver education and training opportunities. Health promotion and prevention is delivered in a culturally relevant and safe manner, with an understanding that Aboriginal and Torres Strait Islanders have different concepts of mental health and wellbeing to non-indigenous people. People from other cultural backgrounds may also have different concepts of mental health and illness, and levels of stigma or acceptance of discussions about mental health.

6. Interdependencies and partnerships

There are a range of determinants of good mental health, not all of which fall under the remit of the OPMHCT. To provide a seamless and integrated health service to clients, the OPMHCT engages with other healthcare services, agencies, and service providers to ensure a person's range of needs are met. A key partnership is the older persons mental health inpatient unit at Calvary Public Hospital, Bruce and the CHS Adult Mental Health Unit, and close relationships and linkages are maintained through regular formal contact. The OPMHCT will support smooth transitions for older people meeting the eligibility criteria who discharged from other hospital wards such as medical or geriatric units. Smooth transitions between inpatient and community based services are enabled through development and review of formal guidelines and referral pathways which support integrated planning for admissions and discharges.

GPs are a key partnership as they remain the prescribing clinician for the majority of consumers and manage mental health in conjunction with other health conditions. The OPMHCT will discuss referrals with the GP and include them in ongoing management and clinical review of people already in the service. The older persons psychiatrists are available at set times each week to provide an advisory phone service to GPs. This service is for advice only, it is not a referral pathway or crisis service.

The 24 hour Access Triage team, and the Home Assessment and Acute Response Team (HAART) have an immediate relationship with the OPMHCT as they are the point of contact after hours, provide the crisis service and may be the also first point of contact during business hours. They provide crisis response for older people and a referral pathway into the service.

The majority of referrals to the OPMHCT are for new clients, but for those who have been clients of the adult mental health teams it is important to manage the transfer between adult and older persons teams in a timely, person centred approach. Clear criteria, processes and the option for joint assessments support a smooth transition at the appropriate time. Other mental health services that may provide input to an older person's care include the Mental Health Day Service, Justice and Forensic Mental Health, the Mental Health Rehab Unit, and AOD services. The increasing numbers of incarcerated older people may see increased requests to the OPMHCT for mental health advice and specialist input to support Justice Health staff.

The OPMHCT is committed to formalising and maintaining these relationships, developing processes, pathways and delivering joint programs where possible to maximise options available to their clients. Maintaining and further developing relationships with both internal and external stakeholders such as the aged care assessment team, geriatric medicine, private mental health care providers, non-government and other agencies is needed to meet the clinical and social needs of consumers. Ongoing engagement with carers and consumers around a person's care and older persons mental health service provision is important to ensure the OPMHCT is meeting the needs of their consumers. The OPMHCT strive to continue to improve in this area.

Recognising that there are high levels of mental illness in Residential Aged Care Facilities (RACFs), the OPMHCT Nurse Practitioner or senior clinician from the Ax team can provide a quick response, advice, and early interventions to mentally unwell residents through assessment and a care plan inclusive of physical health, pharmacological and imaging considerations. The Nurse Practitioner can, where indicated, provide short term follow up. RACF residents requiring longer term follow up will be referred to the appropriate team in the OPMHCT. The OPMHCT can provide education and collaborative care planning to address mental illness or BPSD to RACF staff when requested. The RADAR, GRACE and community nursing teams responding to medical concerns work collaboratively with OPMHCT for any known clients or where mental health concerns are identified.

As a specialist service within the broader mental health system, the sustainability of the MoC is dependent on collaboration between all services who are caring for older people with mental illness. Changes in this MoC that improve and build on these partnerships include promoting awareness and understanding of the role and functions of the OPMHCT and facilitating increased access to support for GPs and RACFs.

Different ways of working/Settings

The safety and wellbeing of the clients and staff must be foremost in decisions about where care is provided. Providing care in the home is supported by evidence and is often, but not always the preference of older people. The OPMHCT recognise the need for balance between a preference for home based care and increasing team capacity through efficiency measures. Looking to the future, services may also be offered in outpatient settings at UCH and other community health centres to give people additional options and reduce travel time, thereby increasing capacity within existing resources.

Different methods of communication and modes of delivery such as telehealth to increase options and access will be supported where possible by the OPMHCT. The Royal Commission into aged care has provided recommendations to address and improve the mental health of older people, particularly those in RACFs. The OPMHCT will identify how the recommendations relate to OPMHCT consumers and what additional services are needed to meet the needs of older ACT residents.

The OPMHCT is open to the use and benefits of new technology to increase availability of a range of options for older people. Where appropriate they will support people to consider the suitability of E-mental health services in addition to their current service provision. Future changes such as the digital health record also open up possibilities for new ways of working with technology to support service efficiency.

7. Service support

The OPMHCT service has administrative offices at UCH and use the UCH outpatient areas to provide some outpatient clinics, therapies and appointments. The team utilise infrastructure to support operational functions such as cars, phones and computers to provide care in people's homes, RACFs, and some community health centres.

8. Workforce, leadership, and culture

Staffing and Workforce development

The OPMHCT multidisciplinary staffing profile incorporates the expertise of psychiatry, nursing, psychology, social work, and occupational therapy with support from administrative staff to provide comprehensive mental health services for older people. Additional expertise is available from Aboriginal Liaison Officers, other specialist teams such as the Mental Health Intellectual Disability Team, Neuropsychiatry and the AOD comorbidity clinician. The feasibility of age appropriate consumer and carer peer workers will be considered within future MHJHADS peer workforce planning.

The CHS Strategic plan and the OPMHCT MoC support actions that improve collaboration, develop workforce capability, support recruitment and retention of suitable staff and improve overall workplace culture. THE OPMHCT is committed to seeking out and building on opportunities to build the cultural security and awareness of the team to ensure the service is respectful of diversity, safe for Aboriginal and Torres Strait Islanders, and people from culturally and linguistically diverse backgrounds. The OPMHCT as a division of MHJHADS actively support a diverse workforce through workforce planning and recruitment.

Core business of the OPMHCT also includes building capacity and contributing to the development of the older person mental health workforce external to the community team, such as in primary care and RACFs. There is a commitment to continue to provide education, specialist advice and input to these providers. The OPMHCT recognise the importance of building partnerships with the tertiary education sector to provide opportunities for students and interns to gain experience and be exposed to the subspecialty of OPMH to support long term workforce development and viability.

Governance, leadership, and culture

There is a tiered decision making hierarchy and organisational structure within the MHJHADS division of CHS, with older persons mental health services as a distinct specialty sub stream of broader mental health services. Clinical governance and the provision of a high quality service is the responsibility of all staff within their role and scope of practice. This model of care, and the underlying principles provide a framework for staff to deliver high quality mental health care.

The OPMHCT Clinical and Operational Directors and the Senior Manager provide leadership to ensure service delivery is in line with the strategic direction, organisational accountability targets and corporate governance processes. Senior clinicians provide leadership and guidance within their discipline, promote professional standards, competencies and contribute to the development of less

experienced staff. Discipline leads provide clinical and academic leadership, and ensure clinical decision making and treatment is delivering quality clinical outcomes through evidence based practice.

Clinicians who are qualified to provide specific therapies ensure clients have appropriate information and support to make decisions about engaging with specific therapeutic interventions. The Chief Psychiatrist has a statutory function under the *Mental Health Act 2015* to oversee the provision of assessment, treatment, care, and support for people subject to the Act, and to make recommendations about mental health service delivery. The Chief Psychiatrist is also responsible for setting out the functions of mental health officers, which may include OPMHCT staff.

The MDT is a clinical decision making body comprised of all staff involved with a person's case that gives equal respect and weight to the professional opinion and findings of all staff to get a holistic view of a person's needs. It also provides opportunities for cross discipline learning and development, and a supportive peer review environment.

The OPMHCT staff are appropriately qualified and credentialled or registered professionals with relevant training and expertise, working to their full scope of practice and drawing on individual strengths. The team strive for a culture of trust where people's contributions are valued, knowledge is shared, innovation is supported, and professionalism is integral. Staff are committed to the CHS values and the underlying principles of this model of care, to support each other, and support the attraction and retention of quality clinicians. Opportunities are provided to ensure people can develop professionally, and contribute to planning, development, and quality improvement activities.

The description of the underlying principles was decided on by the OPMHCT as reflecting their commitment and how they go about their business. New staff are oriented to the values and principles of the team, and how these are embedded into day to day practice. Staff wellbeing is supported through CHS staff wellbeing initiatives, resolution training, promotion of peer support and Employee Access Programs. A focus on staff health, safety and wellbeing is included in team and divisional meetings and the OPMHCT also develop their own team building and wellbeing activities.

9. Accreditation and Training

It is recognised that there are core skills needed to provide specialist older persons mental health care. The OPMHCT promotes ongoing training and professional development for staff, including clinical supervision, peer review, education and training opportunities through individual performance plans, training and education based on identified areas of need, advice from discipline leads and the NSHQS standards. Professional development activities specific to older persons mental health will be available to other mental health teams who provide care to older people such as Access, HAART, and adult mental health teams to build confidence and capacity.

New staff have access to an orientation package that has a focus on service components, work roles and the vision and principles underlying the MoC. Where indicated, clinicians will be credentialled as meeting mandatory competencies. Clinical staff are encouraged to undertake training and accreditation to increase capacity of the workforce in providing evidence based care.

In addition to core skills, staff bring a variety of discipline specific skills and competencies that allow a range of biopsychosocial interventions to be offered. Work practices allow clinicians to work to their scope of practice and discipline specific strengths, particularly clinicians with recognised psychosocial intervention competencies. This includes quarantined time for discipline specific individual intervention when needed in conjunction with general clinical management and assessment in accordance with CHS policy and OPMHCT operational guidelines. There are currently very limited alternative options available for older people, and it is expected that demand for individual interventions will increase as the proportion of older people in the population increases.

Clinical supervision is a formal process of professional support to enable continuous development of competencies through critical conversations, education, and reflection on clinical practice. It can support evaluation of a clinician's skills, identify areas needing development and is a key aspect of quality assurance. All OPMHCT clinicians will have appropriate clinical supervision arrangements to support professional practice and development in line with the CHS operational procedures. Credentialing of allied health staff and nurse practitioners is undertaken according to the CHS policy.

The OPMHCT is committed to culturally safe and responsive care for Aboriginal and Torres Strait Islanders and recognises they have unique challenges, influences and perspectives on mental health and wellbeing. Training and education in cultural awareness, competency and safety is mandatory, and staff are encouraged to develop working partnerships where possible with Aboriginal communities and organisations. Training and education to increase understanding and awareness of issues for people from multicultural backgrounds and the LGBTIQ community is also provided to staff to support culturally safe and appropriate care for all older people.

CHS have links with universities and research organisations through jointly appointed staff and the Office of Research and Education. The OPMHCT are keen to contribute to or collaborate with researchers in the area of older persons mental health. Research projects stimulate new ideas and learning opportunities while improving the evidence base for older persons mental health care. Review and consideration of research findings and quality improvement projects ensure the service is up to date and evidence based.

10. Implementation

The MoC outlines the aspiration, intent, approach to service delivery and strategic direction for the OPMHCT. Operational guidelines will be developed to provide the detail on how to achieve the intent of the model of care. The guidelines will set out how the service operates, how it is organised, staff roles, documentation, and pathways, and how it will demonstrate outcomes and accountability.

Some components of the MoC have been implemented and embedded in practice during the development process. Full implementation of specific changes is dependent on executive endorsement and success in securing additional FTE funding and recruitment. Further data and evidence will be collected to support the case for expanding the ITS to a seven day service. Change management will involve engagement with and timely communication to key stakeholders in the process, and strong leadership from the Operational Director and team manager to embed changes into the model of care.

11. Monitoring and Evaluation

The model of care should be reviewed a year after it has been implemented to evaluate the extent to which it has been implemented, and whether the objectives have been achieved. Regular monitoring and review of outcome measures and accountability indicators provides opportunity to identify whether the MoC is working as effectively as possible and any areas of the service where small changes or alterations may be needed. A range of mechanisms including the CHS Clinical Governance structure and committees, data collection and analysis allow for ongoing monitoring of the process.

Evaluation of the benefits realisation can be done through existing data capture and analysis processes as set out in legislation, standards, and policies. Demographic data is captured through ACTPAS, clinical data through the MHJHADS electronic clinical record (MAJICeR), and de-identified data is processed through the ACT data warehouse for national and local reporting. The NSQHS and Mental health care standards provide a framework for minimum standards and continuous improvement to ensure safe, effective, and high quality services. Analysis of key performance indicators, operational reporting and performance monitoring will be used to assess the impact of changes to service delivery. The OPMHCT will use and report on mandated KPIs and data reporting platforms to measure the clinical impact of the MOC. These may include:

- HONOS 65+ to measure improvement from acceptance to closure
- Timeliness of review according to triage scale
- Frequency of contact according to need
- Physical health monitoring
- 3-month clinical review
- Length of stay in team/program

The effectiveness of strategies to reduce psychiatric hospital admissions in older people will be monitored through measures including:

- Referrals to ITS for step up or step-down care
- Occasions of service for ITS
- Bed occupancy and inpatient average length of stay

Consumer and carer feedback should be undertaken regularly to support evaluation of the outcomes. This perspective may be evaluated through:

- Monitoring the involvement of person and carers in care planning,
- Consumer feedback including compliments and complaints, or introduction of measurement tools such as YES or CES survey

Staff culture and satisfaction with the model of care will be monitored through staff meetings, performance discussions and active engagement in planning education, training, and quality improvement programs. Staff surveys and the CHS culture survey provide a platform to assess the workforce culture and alignment to the vision and values.

12. Records management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site – 'Models of Care', to ensure accessibility for all staff.

13. Abbreviations

AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
Ax team	Assessment team
BPSD	Behavioural and psychological symptoms of dementia
CES survey	Carer's experience of service survey
CHS	Canberra Health Service
CL	Consultation liaison
CM	Clinical management/er
CPHB	Calvary Public Hospital, Bruce
ED	Emergency Department
FTE	Full time equivalent
GP	General practitioner
HAART	Home assessment and acute response team
ITS	Intensive treatment service
KPI	Key performance indicators
LGBTIQ	Lesbian, gay, bisexual, trans, intersex and queer
MAJICeR	Mental Health, Alcohol and Drug Service, Justice Health, Integrated Care electronic Record
MHJHADS	Mental health, Justice health, alcohol, and drug services
MOC	Model of care
NGO	Non-Government organisation
NP	Nurse practitioner
OPMHCT	Older persons mental health community team
OPMHS	Older persons mental health services
PTO	Psychiatric treatment order
RACF	Residential aged care facility
UCH	University of Canberra Hospital
YES survey	Your experience of service survey

14. Summary of main OMHCT changes for MOC implementation

- Revision of eligibility criteria and service information to inform a package including website information, brochure, letter of welcome
- Defined vision and principles
- Clarity of service components and functions
- Increased scope of the ITS to include Assertive Outreach and identifying the need and benefits of future expansion of ITS to 7 days per week.
- Framework and guidelines for qualified team members to provide therapies
- Additional support for GPs seeking advice from an older person's psychiatrist during a designated time each week.
- Improved support for RACFs through streamlined referral and quick response from the NP or senior clinician, education, and advice from OPMHCT when requested.
- Review of the NP role to maximise use of clinical expertise
- Joint assessments with adult mental health teams when there is uncertainty about transitioning from adult to older persons community teams
- Pathways, processes, and documentation to be revised as part of the development of operational guidelines
- OPMHCT will continue to provide Consultation Liaison at UCH to patients within the age criteria.
- Move to increase efficiency and options for clients through increased clinics at UCH or community health centres
- Further consideration of the need and feasibility of older persons peer workforce in line with MHJHADS peer workforce planning

15. Reference List

Several literature reviews were prepared for internal MHJHADS use to inform and guide decisions in relation to the development of the model of care. The project planning group, working groups and the executive committee used this information to conceptualise and define components of the model of care. A combined reference list is available on request.

The NSW Health Older Persons' Mental Health Policy Unit has developed a comprehensive approach to service planning including a plan informing the development of community based OPMHS. The research, planning and guidance in the NSW Health document has been instrumental in the development of this model of care.

NSW Ministry of Health, NSW older persons specialist mental health community model of care guideline, 18 Jan 2017, Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care Guideline (nsw.gov.au)

References cited

[1] Understanding the process to develop a model of care. An ACI Framework. NSW ACI HS13-034_Framework-DevelopMoC_D7.pdf (act.gov.au)

[2] World Health Organisation, *Mental health of older adults*, viewed 26 Feb 2021, https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

[3] AIHW Mental Health Snapshot released 23 Jul 2020 https://www.aihw.gov.au/reports/australias-health/mental-health

[4] Kasplew R, Carson R, Rhoades H. Elder abuse: Understanding issues, frameworks, and responses. Research report Feb 2016 Australian Institute of Family Studies, Australian Government https://aifs.gov.au/publications/elder-abuse

[5] AIHW Older Australians as a glance, web report updated 10 Sept 2018. Cat no AGE 87, Canberra, AIHW https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance

[6] The National Ageing Research Institute. Depression in older age: A scoping study. Final Report. Melbourne: beyondblue, 2009

[7] Australian Government dept of Health, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, published 2013 https://www.health.gov.au/sites/default/files/documents/2021/02/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf

[8] CMTEDD ACT population projections 2018 to 2058, https://apps.treasury.act.gov.au/__data/assets/pdf_file/0005/1305581/ACT-Population-Projections-Paper-FINAL.pdf

[9] PHN primary mental health care flexible funding pool programme guidance Stepped care 2019

Additional references, strategies and plans

- ACT Mental Health Act 2015
- Fifth National Mental Health and Suicide Prevention Plan 2017,
- National Framework for Recovery-Oriented Mental Health Services 2013,
- National Safety and Quality Health Service Standards,
- National Standards for Mental Health Services (NSMHS) 2010
- CHS Strategic Plan 2020-2023
- Territory wide Health Service Plan (in draft)
- ACT mental health and suicide prevention plan 2020-2025
- Older persons mental health and wellbeing strategy (in draft)
- ACT Aboriginal and Torres Strait Islander Agreement 2019-2028

CHS Operational guidelines referenced in this document:

- Providing physical health care across MHJHADS
- Recovery and Care planning for MHJHADS
- Use of mandatory national outcome measures in mental health service delivery
- Use of Psychological Interventions in MHJHADS
- Credentialing and Defining the Scope of Clinical Practice for Nurse Practitioners (NPs) and Endorsed Midwives (EMs)
- Clinical governance
- Clinical Supervision for Allied Health Staff in MHJHADS
- Credentialing and Defining the Scope of Clinical Practice for Allied Health

ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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