



Australian Government

Department of Health

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An Australian Government Initiative

Psychological Treatment Services for people with mental illness in Residential Aged Care Facilities

Acknowledgement

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Introduction

Primary Health Networks (PHNs) are required to commission psychological treatment services targeting the mental health needs of people living in residential aged care facilities (RACFs). These services are intended to enable residents of these facilities with mental illness to access mental health services similar to those available in the community through the Better Access to Psychologists, Psychiatrists and General Practice through the MBS Initiative (Better Access).

This activity is an extension of the role of PHNs in providing mental health services to underserved groups with particular needs. This guidance document should therefore be read in the context of other guidance provided to PHNs on commissioning services through the Flexible Mental Health Funding Pool.

(http://www.health.gov.au/internet/main/publishing.nsf/content/phn-mental_tools).

Psychological services for RACF residents will need to be adapted to the needs and environment of this group and commissioned in a way which complements personal care and accommodation services provided by RACFs, dementia services and broader physical health and social support.

- **In 2018-19** PHNs are expected to:
 - Commission new services for residents with mental illness commencing from 1 January 2019, which may trial new service models or build on existing arrangements for commissioning psychological services;
- **Over the longer** term PHNs are expected to:
 - Plan and implement services for residents in collaboration with RACFs, in a way which respects RACF roles, responsibilities and operational issues;
 - Develop appropriate referral and assessment processes to ensure services target residents with mental illness;
 - Commission evidence-based psychological services appropriate to the needs of older people within a broader stepped care framework;
 - Ensure services are efficient, sustainable and equitably distributed;
 - Ensure services increase capacity to identify and respond to residents at heightened risk of suicide, particularly older men;
 - Promote linkages and information exchange with broader support services for residents with complex needs, including dementia services and State or Territory Government funded Older Persons' Mental Health Services.

1 What are psychological therapies for people with mental illness in RACFs?

1.1 Essential Service Features

The services commissioned by PHNs through this initiative are expected to:

- Offer in-reach services, generally provided on location at RACFs;
- Target residents with a diagnosed mental illness or who are assessed as at risk of mental illness if they do not receive services;
- Provide evidence-based, time-limited psychological therapies which are adjusted to be responsive to the needs of older people;
- Be provided within a stepped care framework with a particular focus on meeting the needs of older people with mild to moderate mental illness;
- Be implemented collaboratively, in close communication with RACFs and other key stakeholders, including consumers and family members;
- Be subject to locally developed assessment and referral arrangements which ensure services are matched to need for mental health services; and
- Be equitable and efficient, to enable access to services to be offered across the region to RACF residents over time.

Services are expected to be implemented incrementally, reflecting the four year ramp up of funding for the initiative. In this respect:

- Initial services commissioned from 1 January 2019 may build on existing PHN arrangements for delivering psychological services to communities in need, or may trial new service models for residents of RACFs;
- Services provided over subsequent years will be informed by initial trials and will gradually seek to offer widespread, equitable access to services.

Unlike other services which PHNs commission, these new services may be the only source of psychological services for some RACF residents. Therefore, by the end of the ramp up period, services must be fairly distributed, well-targeted and provided through sustainable, cost-effective models.

1.2 What is not in scope?

The initiative is not intended to fund:

- RACF staff or services – including routine welfare or pastoral care services;
- Services that duplicate the role of State Government Older Persons' Mental Health Services in providing specialist care for residents with severe and complex mental illness;
- Services that duplicate the role of dementia support services or other aged care services such as the Community Visitors program;
- Services which are remunerable through Medicare such as psychiatry services or GP services;
- Services for family members or carers who are not residents (other than referral to other appropriate mental health services);
- Disability support services; or
- Social support or recreational services.

1.3 Why is this a priority for PHNs?

Mental health services are not routinely available to older people living in RACFs, and are not within scope of the personal care or accommodation services RACFs provide. On the other hand there is evidence that RACF residents have very high rates of common mental illness. It is estimated that approximately 39 per cent of all permanent aged care residents are living with mild to moderate depression¹. Experience with other initiatives such as Better Access suggests that up to half of this group of older people with mild to moderate depression may wish to receive mental health services if they were available to them. The funding provided to PHNs is intended to address this service gap.

PHNs will be able to use their established partnerships with local stakeholders, including GPs, specialist mental health services and RACFs, to target services to the needs and resources in the region. PHNs will also be well-placed to support local workforce capability to meet the distinct mental health needs of older people.

2 Client Eligibility - who should the services target?

The measure is intended to target people with a diagnosed mental illness who are residents of residential aged care. The new services are expected to primarily target residents with mild to moderate symptoms of common mental illness. However, residents with severe mental illness who are not more appropriately managed by a State or Territory Government Older Persons Mental Health Service, and who would benefit from psychological therapy are not excluded from the measure and may be a target group for some PHNs.

The services provided through the measure by PHNs may in some instances also target people who are assessed as at risk of mental illness. The 'at risk' group is defined for this measure as individuals who are experiencing early symptoms and are assessed as at risk of developing a diagnosable mental illness over the following 12 months if they do not receive appropriate and timely services. This flexibility is important as mental health needs can be highly changeable in vulnerable older adults and it may not always be possible to obtain an early diagnosis.

2.1 Definition of mental illness

For this initiative, the definition of mental illness is consistent with that applied to MBS Better Access items. This means that dementia and delirium are not regarded as mental illness. This is because these conditions require medical and/or other specialised support which is not within scope of this initiative. People with dementia are not excluded from treatment if they also have a comorbid mental illness such as anxiety or depression. Delirium may present with symptoms similar to those associated with a mental illness although it will not respond to psychological therapies and requires urgent medical assessment.

There are a number of sub-groups of residents who have particular needs which services are likely to encounter. This includes:

- Residents who are having significant transition issues and experiencing adjustment disorders or abnormal symptoms of grief and loss, for whom early treatment may avert descent into a more serious mood disorder. This group does need to be differentiated from residents who are exhibiting normal sadness and/or transition issues;
- Residents with mild to moderate anxiety and/or depression – as above, this is expected to be the largest group requiring services through the measure, given almost half of all residents are likely to experience depression;

¹ Australian Institute of Health and Welfare 2015. Australia's welfare 2015. Australia's welfare series no. 12. Cat. no. AUS 189. Canberra: AIHW.

- Residents with past history of mental illness for which they received services before being admitted which could not be continued – particular issues of continuity of care and understanding patient history apply; and
- Residents who, in addition to their mental illness, have a level of comorbid cognitive decline and/or dementia. The AIHW reported that 40% of residents with dementia were likely to have a mental health or behavioural problem².

Men over 85 have the highest suicide rates for all ages, at 39.3 deaths for 100,000³. Sensitivity to the risk of suicide among this group will be important.

2.2 Provision of mental health services to residents with comorbid dementia

A significant proportion of RACF residents will have some degree of cognitive decline or dementia. They should not be ruled out of receiving mental health services, particularly given many may have comorbid anxiety and depression which may respond to psychological therapies. It is also important that service providers providing psychological therapies in a RACF environment are broadly familiar with dementia, its signs and its management. Resources to support professional training on dementia are identified at the end of this guidance document.

However caution should be exercised in referring residents with dementia to psychological services without careful assessment for the following reasons:

- Psychological services will not be able to support management of the significant behavioural issues experienced by residents with dementia;
- People with significant cognitive decline associated with dementia may not respond to Cognitive Behaviour Therapy;
- Referral of individuals with needs relating to their dementia to a mental health service may simply delay them receiving more appropriate support which may help to alleviate their distress and support the RACF with the management of their behaviour.

Residents whose behavioural symptoms of dementia (BPSD) are affecting their wellbeing and care should continue to be referred to the Dementia Behaviour Management Advisory Service, delivered by Dementia Support Australia.

3 Referral and Assessment

Referral arrangements may need to be tailored to the local availability of key clinicians and to broader PHN referral and triage capacity.

In general, referral protocols established by PHNs should:

- Enable requests for services to come from a variety of sources including self-referral, family and friends, ACAT teams or RACF staff;
- Limit referrals to trigger service provision to clinicians who are able to confirm a diagnosis of mental illness or reliably identify individuals who would benefit from the service e.g. Registered Nurse, GP, psychiatrist or psychologist;
- Ensure that the patient's GP is advised that they have been referred to mental health services if the GP is not the referring agent;
- Require confirmation that the individual has been assessed for physical causes of symptoms, particularly if the onset of symptoms has been sudden (which could suggest delirium as opposed to mental illness);

² Australian Institute of Health and Welfare, Dementia in Australia, 2012.

³ Australian Bureau of Statistics 2017. 3303.0 - Causes of Death, Australia, 2017. Canberra: ABS.

- Provide advice on assessments undertaken for cognitive decline or dementia.

GPs will be expected to play a central role in diagnosing mental illness and referring residents for psychological services. This is appropriate in view of their broader role in coordinating physical and mental health needs of residents. Importantly, the MBS item for GP Mental Health Treatment Plans (GP MHTP) is not available in residential care facilities and, therefore, services cannot require a GP MHTP to trigger services. However within an RACF setting, GPs are generally required to contribute to, and coordinate, the broader care plan for each resident.

A medical diagnosis of mental illness by a GP or psychiatrist is important to ensure that symptoms of cognitive decline, dementia or delirium are not mistaken for mental illness, and to ensure that physical illness, and medication needs are considered in the overall care plan of the individual. However there may be some circumstances where it is not possible to get a timely medical diagnosis and provisional referrals to commence service provision in anticipation of a formal diagnosis, may be important to get timely care.

Individuals who may benefit from the service can be identified to the referring clinician by any concerned party, be that family members, visitors, personal care staff or through self-referral. Other services such as Aged Care Assessment Teams (ACAT) or dementia services may also identify individuals as potentially benefiting from the service. Mental health problems may also be identified as part of the assessment of the resident undertaken for the Aged Care Funding Instrument, although this is not likely to provide a detailed assessment or diagnosis.

3.1 Considerations in assessing residents for psychological services.

Assessment processes for services are important to tailor services to needs and to ensure key factors are considered. However they also need to be efficient and should not inappropriately subsume resources intended for delivering services to clients. For some patients, the referring clinician may have undertaken an assessment, or a brief assessment by the mental health professional at the first appointment may be sufficient. For patients who may have more intense needs, assessment may require liaison with the GP, with former service providers, or dementia services.

Assessment arrangements for residents formally referred to the service may consider the following in matching them to intensity and type of treatment:

- Risk of harm;
- Engagement, motivation – residents' expectations and preferences;
- Impact of symptoms and distress on functioning;
- The severity of symptoms and degree of distress;
- Presence of comorbid conditions that contribute to or are impacted by person's psychological state – chronic illness, significant pain;
- Cognitive capacity and presence of dementia;
- History of previous mental illness treatment and recovery;
- Environmental issues – transition issues, recent stress, trauma or bereavement. This may include consideration of signs or history of elder abuse, given this can be closely linked to, and an underlying cause of, mental health symptoms;
- Family support and background – including cultural and resident identity considerations.

Table 1. Referral and Assessment Pathways

Referral and assessment process	By whom	Description
Request for services	By self, relatives, RACF workers, former service providers, ACAT, dementia services or other service.	Resident identified to RN or GP as potentially being in need of low intensity services or assessment for mental health needs.
Formal referral to trigger the service	Local arrangements developed – may be a GP, psychiatrist, psychologist, RN or other provider who is able to reliably identify individuals who would benefit from the service.	Confirms diagnosis or identifies that person is at risk. Considers physical health needs relevant to mental health. Reviews likelihood of delirium. Identifies whether history of dementia exists.
Assessment/triage to identify level and type of service	By mental health professional (PHN commissioned service).	Assessment aims to identify which treatment is most suitable, and to inform individual approach to services.
Reassessment if necessary after mental health services provided	By mental health professional potentially in partnership with another provider.	If patient's mental health is deteriorating or they are not responding to treatment, they may have more complex needs for care which services can't meet and need referral.

4 What services should be provided?

The psychological services delivered to RACF residents will be consistent with other mental health services commissioned by PHNs in that they should be:

- Evidence based, or evidence-informed, short term therapies delivered by mental health professionals or other service providers with training in delivering these therapies;
- Equitably and efficiently provided in order to ensure optimal access is achieved within the available funding;
- Person-centred; and
- Delivered within a quality framework which ensures clear clinical governance, and compliance with national standards.

Some adjustment and tailoring of therapies will be required to meet the particular needs of RACF residents, including the following:

- It may take longer to engage with clients, because of hearing problems or a degree of cognitive decline;
- Cognitive behavior therapy may need to be adapted to the particular capabilities and needs of the individual and will not be appropriate for residents with significant cognitive decline;
- Particular types of therapies have proven to be effective with older people, including reminiscence therapies, validation therapy and adjusted cognitive behaviour therapy;
- Language used in talking to older people will need to respect the attitudes of older people towards mental illness. For example, use of the term 'mental wellbeing' may be better received than 'depression' or 'mental illness';
- Group sessions may be appropriate for some residents, particularly those with similar needs e.g. significant adjustment problems.

Digital mental health services may be less suitable for many older people, but should not be dismissed as a potential low intensity option. Telephone or videoconference based therapies, particularly for RACFs in rural and remote locations, could play a role in services. Computer-based therapies, including the use of iPads, may help to engage older people and provide a point of focus or to share photos or maps.

In addition, it will be important that PHNs require commissioned services to be inclusive, culturally safe and appropriate to the needs of people from diverse backgrounds including Aboriginal and Torres Strait Islander peoples, people who identify as LGBTIQ and people from CALD backgrounds. Partnerships, workforce considerations and cultural governance already established by PHNs for the culturally appropriate commissioning of other mental health services may help inform these approaches. However it will be important for commissioned services to note that the needs of older people for culturally appropriate care may be even greater than for younger people with mental illness, and that lack of such care could present a significant barrier to accessing services for these groups. There is a good evidence base to inform the choice of therapies for older people. beyondblue has provided a valuable guide to evidence-based therapies for older people which offers practical assistance matching services to needs.⁴ Other resources are listed at the end of this guidance.

⁴ beyondblue, What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings, 2014

4.1 A stepped care approach to delivering services to RACF residents

Consistent with other psychological services provided by PHNs, services for RACF residents should be commissioned in the context of a broader stepped care framework within which services are matched to need. However PHNs will not be expected to routinely cover the full spectrum of services for older people. Instead the focus for PHNs should be on addressing the gap in service associated with the lack of availability of Better Access services by providing services targeting residents with a diagnosis of mild to moderate mental illness.

The provision of low intensity services adjusted to this cohort may be an appropriate and sustainable option for delivery of services for people with mild to moderate needs. These services could be characterized by:

- Quick access to services whilst awaiting a formal diagnosis;
- Fewer and shorter sessions which are less resource intensive than standard psychological care required for this group;
- Provision of services through a broader workforce which includes mental health professionals but also other service providers with training in evidence-based therapies suitable for older people;
- Face to face and/or telephone based/digital mental health services;
- Use of group work where this is appropriate.

Medium to high intensity services are also in scope and may be the preferred option for some PHNs. These will be characterized by:

- Provision of services by mental health professionals;
- Inclusion of psychological services and behavioural therapies; and
- Provision for liaison with other service providers for those with comorbid physical health issues or dementia which impacts on their mental health.

PHNs are not precluded from provision of more intense services for individuals with severe illness where this illness is episodic and is likely to respond to psychological therapy. Some residents with severe mental illness may have received and responded to community based psychological services before admission to the RACF. However PHNs should ensure they do not duplicate the role of State Government Older Persons Mental Health Services in providing specialist services for older people with very intense and enduring mental health needs which are unlikely to respond to time-limited psychological services.

The below table provides a guide to how the services commissioned by PHNs may fit within a broader stepped care framework and which services are and are not in scope. The services PHNs commission will be informed by the particular needs of the community, the availability of other services and by considerations of supporting equitable access to services.

Table 2. A stepped care framework for meeting the needs of RACF residents

	Early intervention needs Within scope of PHN services	Mild to moderate needs Key focus of PHN services	Severe and episodic needs Within scope of PHN services	Severe and persistent or complex needs Out of scope for PHN services.
Care need	Low intensity services or routine social support	Primary care – low to medium intensity services	Primary care – high intensity services	Specialist mental health services and dementia services.
Target Groups	Residents who: Present as mildly depressed or anxious but do not have a diagnosis Or, are having trouble adjusting to changes or coping with loss	Residents who: Have a former or new diagnosis of mild to moderate mental illness.	Residents who: Have diagnosis of severe mental illness, which is episodic in nature. May include pre-existing conditions.	Have severe, long term mental illness May also have significant cognitive decline May have attempted suicide
Role of PHNs	Flexibility to provide low intensity services for people who do not yet have a diagnosis but are at risk of mental illness. Advisory role on resident mental health and wellbeing at facility level	Provision of evidence based psychological and behavioural therapy, including low intensity options if appropriate. Liaison with other service providers as appropriate eg GP pharmacist.	Flexibility to provide services where there is a service gap Services must not duplicate role of Older Persons Mental Health Service, but may liaise with them on assessment.	In general this group requires specialist care and won't respond to time limited psychological services.
Other services	RACF services, and welfare support Community visitors, and family and friends also offer social support	GPs, pharmacists, and RACF services form part of broader team. Dementia support services may also be appropriate	GP and/or psychiatrist diagnosis and medication management vital Private and public psychiatrists, Liaison with former mental health service providers may be appropriate.	Specialist services have lead role in care, supported by GPs and pharmacological management. Dementia Behaviour Management Advisory Service will support specific dementia related needs.

5 By whom should services be provided?

Services commissioned by PHNs are expected to be provided by the same types of trained mental health professionals who deliver other mental health treatment services in the community. This would include psychologists and other appropriately qualified allied mental health providers such as accredited mental health occupational therapists, accredited mental health social workers, and Aboriginal and Torres Strait Islander health workers and mental health nurses.

Low intensity services could be delivered by a broader range of professionals who have specific training in providing evidence based mental health services. PHNs will also have the flexibility to commission supplementary services from peer workers, to support a team approach to meeting the needs of older people. PHNs must be confident that the workforce involved is appropriate and competent to provide the level and type of service required by residents of RACFs. Clearance for working with vulnerable people will also be an imperative.

Specialised training credentials in relation to older person's mental health is not required of the workforce delivering services, particularly during the trial phase. However PHNs are expected to ensure that commissioned services are delivered by a workforce which is well-informed on and sensitive to the particular vulnerabilities of older people and on approaches to ensuring services meet their needs in a compassionate, supportive and evidence based way. Information on available on-line and other training resources is provided at the end of this guidance.

Professionals delivering these services should also be well briefed on the other services which may intersect with the provision of mental health care in the region. These services include personal care and leisure services provided by RACF staff.

Relevant national standards and frameworks should be applied to promote service quality and effectiveness, such as the National Standards for Mental Health Services 2010, the National Practice Standards for the Mental Health Workforce 2013 and the National Framework for Recovery Oriented Mental Health Services 2013.

6 Collaboration with RACFs

PHNs are likely to already have relationships with regional RACFs as part of their broader activities. RACFs have welcomed the new services given the role they will play in improving resident mental health and wellbeing.

Under the Quality of Care Principles 2014, RACF providers have a responsibility to ensure that residents with mental illness can access specialised services and treatment where needed and to assist with organisation of transport if required. Under the current Accreditation Standards, and from 1 July 2019 the Aged Care Quality Standards, RACFs are expected to promote the physical and mental health of care recipients in partnership with the health care team and refer care recipients to appropriate health specialists in accordance with their needs and preferences.⁵ RACFs are also expected to manage the needs of care recipients with challenging behaviours effectively. However they are not required to provide clinical mental health treatment services or to assist with out of pocket costs for residents associated with them.

In implementing new mental health services in RACFs, PHNs will need to be particularly mindful of the following key principles:

- The service should not be implemented in a way that results in additional demands on RACF staff beyond their responsibilities;
- Clear communication with RACFs about the overall role of the service and any issues arising with particular residents will be important;
- Up to date RACF resident data systems are important – therefore PHNs should assist RACFs by ensuring information on mental health service provision to residents is included with these records;
- Services need to be respectful of any particular procedures or protocols which RACFs may have for accessing the facility or residents.

The best results for both the resident and the RACF may result where collaborative arrangements between mental health service providers and RACF staff are established to support residents with mental illness. Efforts to increase RACF staff knowledge of mental illness also can be effective for residents⁶.

PHNs would need to discuss with individual RACFs the extent to which the RACF staff are able to participate in discussions about the progress of individual patients as part of the care team, and/or the extent to which they may wish to have visits from mental health professionals used to help raise the mental health competency of staff. RACF lifestyle directors may also be important points of contact for both identifying individuals at risk, and supporting the engagement of residents, including positive event scheduling.

In general it is reasonable to expect from RACFs:

- Assistance with ensuring residents attend appointments;
- Assistance organising transport to services if this is required, although the cost of transport would not be the responsibility of the RACF;
- Assistance in identifying residents who may benefit from mental health services;
- Access to information about patient history relevant to mental health treatment, (including status of medications), subject to clinical governance arrangements;
- Assistance promoting new services to clients and families;

⁵ Australian Aged Care Quality Agency, Accreditation Standards, Standard 2, 'Health and personal care'. Quality of Care Principles 2014.

⁶ Stargatt, J., Bhar, S., Davison, T. E., Pachana, N. A., Mitchell, L., Koder, D., Helmes, E. (2017). The Availability of Psychological Services for Aged Care Residents in Australia: A Survey of Facility Staff. *Australian Psychologist*, 52(6), 406-413. DOI: 10.1111/ap.12244

- The Aged Care Funding Instrument (ACFI) recognizes mental illness as a factor influencing the costs to RACFs of providing residential care and may be one way of identifying residents who may be in scope for the new services. However it does not offer funding for mental health therapies to RACFs.

6.1 Innovative collaboration with RACFs to promote mental health and wellbeing

PHNs may also wish to explore flexible and innovative approaches to working with some RACFs and their staff and with other service providers to promote better mental health outcomes of residents. This could include:

- Regular communication and/or knowledge sharing with RACF staff to raise their capacity to support residents who are receiving services;
- Advice on evidence-based activities that might raise the social and emotional wellbeing of all residents;
- Education and information sessions for residents on shared issues of concern such as coping with grief and loss;
- Collaboration with other providers at the RACF, including Dementia Support services and pharmacists involved in medication reviews.

6.2 Other important partnerships in designing and delivering services

Specialist Older Persons Mental Health Services provided by States and Territories, which target the needs of older people with severe and complex needs who require specialist care, will also be an important partner in delivery of services. Older Persons' Mental Health Services deliver services to a small number of older people within RACFs with high intensity or complex needs particularly where these individuals may have been receiving services in the community before their admission or where individuals may have displayed suicidal behaviour. These services may also be able to offer assistance in assessment of individuals with persistent and severe mental illness.

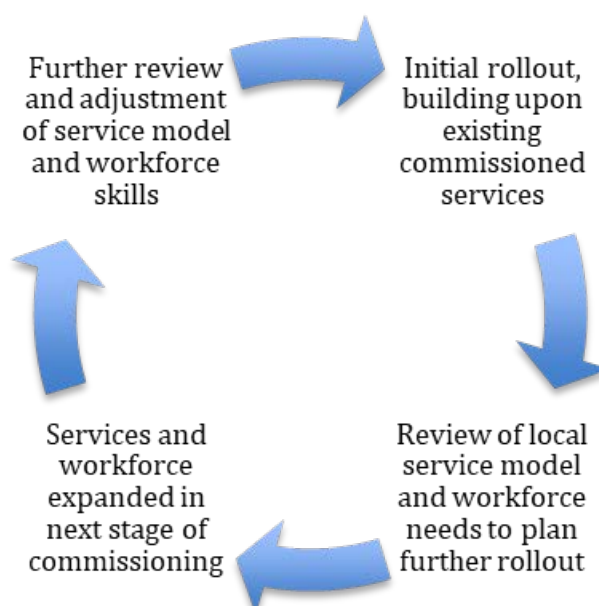
Dementia support services such as Dementia Behaviour Management Advisory Support Service (DBMas) and the Severe Behaviour Response Teams (SBRT), which are available in each state and territory, will be an important partner and may be the source of communication, advice and referrals to and from mental health services where patients have co-occurring needs. These services are funded through the Australian Government and provided by Dementia Support Australia and are available to provide support and advice to health professionals.

Community Visitors programs, which operate in many RACFs, may also be able to provide partnerships by way of ongoing contact and engagement with residents for whom isolation is a factor which contributes to their mental illness. Older persons' advocacy groups will also be valuable partners at a local level.

7 How should PHNs implement the new services?

Funding for the new initiative gradually increases over the next four years, commencing with modest part-year funding in 2018-19. This provides the opportunity for PHNs to incrementally roll out the measure and develop a stepped care model of service delivery that best meets the need of RACF residents in the region through a process of staged implementation and review. In some cases PHNs may wish to commence with pilots that target communities of need. In other cases PHNs could consider extending existing commissioned services through adjusting the service offer to meet RACF residents' needs. The staged approach provides opportunity to review and if necessary further upskill the workforce.

Figure 1. Staged implementation of the measure.



In general it is expected that PHNs will draw on the stepped care framework, knowledge base, workforce and service delivery models they have developed for commissioning psychological services. Other specific expectations of implementation are that PHNs should:

- Co-design services with RACFs, Local Hospital Networks (preferably with representation from specialist Older Persons Mental Health Services), consumers and carers and other local stakeholders;
- Communicate with regional RACFs about the initiative, its benefits, and issues associated with introducing services into RACFs in the region;
- Ensure clear understanding about the difference between the new service and existing dementia support services, specialist Older Persons Mental Health Services and broader supports for residents – it should be made clear that services are intended to increase access to mental health treatment services – not replace current services;
- Plan for the workforce needs associated with implementing services, including the upskilling of mental health professionals to support the needs of RACF residents;
- Ensure that funding is allocated primarily to service delivery, and that resources required for establishment and assessment are contained;

- Ensure clear instruction to service providers, to RACFs and to residents and carers on the PHN's policy in relation to co-contributions being charged for services as cost and payment processes can be a significant barrier to services for this group;
- Ensure a clear risk management and clinical governance structure is in place to support the quality of services and provide for clear roles and responsibilities;
- Facilitate the collection and reporting of data via the existing MDS arrangement, and appropriate data sharing with GPs, and RACFs to support service coordination, or evaluation activities and;
- Develop an equitable and sustainable service model which can be rolled out at full implementation to support access for RACF residents across the region.

Reporting requirements are to be established for the measure to ensure the number and type of services delivered to RACF residents is collected, including through the existing MDS arrangement.

As a new initiative, the Department will monitor uptake of services in partnership with PHNs in order to assess overall demand among the target group and to inform future program arrangements.

7.1 Flexibilities in implementing the measure

PHNs may explore a range of models of care for providing in-reach services. This might include team-based clinic arrangements which rotate across facilities, or commissioning services from private providers for individuals referred to the service.

7.1.1 Tips from the sector

- Ensure logistics such as arranging appointments are discussed in the context of commencing service delivery at RACFs;
- To support the mental health and wellbeing of residents from CALD backgrounds, links with local multicultural groups may be of assistance;
- Community Visitors may be a useful resource to support ongoing contact with residents who are isolated, and could be part of a team approach – local agencies train Community Visitors and they may be willing to partner in some way to improve capacity to support people with common mental illness;
- Ensure arrangements are in place to clearly delineate between dementia, delirium and mental illness, as the symptoms can present in similar ways;
- As a way of engaging RACFs, offer information sessions on coping with situational stress or loss – this can also raise the capacity of staff to support residents;
- Ensure professionals engaged to provide services have personal qualities which lend themselves to this particular environment – this may include patience, personal resilience, and an understanding of older people;
- Commence services with group based information sessions for residents and families – this may help to break down the stigma of mental illness for older people and encourage engagement with services.

Useful Resources

Key Reports, Standards and Guides

- What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care setting <http://resources.beyondblue.org.au/prism/file?token=BL/1263A>
- Position Statement 22 Psychiatry services for older people [https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-22-FPOA-Psychiatry-services-for-older-peopl-\(1\).aspx](https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-22-FPOA-Psychiatry-services-for-older-peopl-(1).aspx).
- Psychiatry services for older people: A report on current issues and evidence to inform the development of services and the revision of RANZCP Position Statement 22 https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/RPT-FPOA-Psychiatry-services-for-older-people-revi.aspx
- National Institute for Clinical Excellence, Mental wellbeing of older people in care homes, Quality standard [QS50] <https://www.nice.org.uk/guidance/QS50>
- Joint Commissioning Panel for Mental Health. Guidance for commissioners of older people's mental health services <https://www.icpmh.info/good-services/older-peoples-services/>

Training resources

- Swinburne University – The Wellbeing Clinic for Older Adults provides training programs for practitioners working with older adults. www.swinburne.edu.au/lss/psychology/pc/older-adults
- Health Education and Training Institute (HETI) - provides mental health education and training for the NSW Health mental health workforce and for the wider health workforce on mental health related matters, www.heti.nsw.gov.au/education-and-training/our-focus-areas/mental-health
- Australian Psychological Society - APS Institute - Practice Certificate In Services For Older Adults <https://www.psychology.org.au/Event/15429?view=true>
- *beyondblue* training resources for working with older people, www.beyondblue.org.au/about-us/about-our-work/older-adults-program

Dementia resources

- Dementia Behaviour Management Advisory Service, Dementia Support Australia. 1800 699 799, <https://www.dementia.com.au>
- The University of Tasmania's *Understanding Dementia* Massive Open Online Course (MOOC) Enrolment is via the [University of Tasmania website](#)
- The Dementia Training Program, delivered by Dementia Training Australia (DTA), provides accredited education and continuing professional development for the dementia care workforce in primary, acute and aged care. Further information is at: www.dementiatrainingaustralia.com.au.

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2. Australian Institute of Health and Welfare, Dementia in Australia, 2012
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5. Australian Aged Care Quality Agency, Accreditation Standards, Standard 2, 'Health and personal care'. Quality of Care Principles 2014.
6. Stargatt, J., Bhar, S., Davison, T. E., Pachana, N. A., Mitchell, L., Koder, D., Helmes, E. (2017). The Availability of Psychological Services for Aged Care Residents in Australia: A Survey of Facility Staff. *Australian Psychologist*, 52(6), 406-413. DOI: 10.1111/ap.12244.