Project commissioned by the NSW Ministry of Health

Evaluation of NSW Service Plan for Specialist Mental Health Services for Older People
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Evaluation of NSW Service Plan for Specialist Mental Health Services for Older People

Summary of findings

The NSW Ministry of Health engaged Health Policy Analysis to conduct a mid-term evaluation of the NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015 (referred to as the Service Plan for SMHSOP in this document). The purpose of the evaluation was to assess the progress of implementation of the plan, evaluate the outcomes from Phase 1, and review the strategies and service models outlined for development in Phase 2 to assess that they are still relevant and accord with current evidence.

This document is the final report of the evaluation. It builds on the draft report, which was considered by the reference group for the project and other key stakeholders. The reference group was comprised of the SMHSOP Advisory Group and the Older People’s Mental Health (OPMH) Working Group. Other key stakeholders included the NSW Mental Health Program Council and the Agency for Clinical Innovation (ACI) Aged Care Network.

The report is in three parts:

- Volume 1 (Summary report) provides an outline of the main findings from the evaluation, lists the recommendations, and summarises the progress of each of the Phase 1 strategies (based on the evaluation findings detailed in other parts of the report).

- Volume 2 (Main report) provides the overall findings of the evaluation, including results of analyses and investigations that led to these findings.

- Volume 3 (Appendices) provides the supporting information and analyses used for the evaluation, including a detailed review of the literature and of models used by other Australian states and territories, descriptions of selected initiatives under the plan, themes from stakeholder workshops, results of surveys, detailed data analyses, a listing of people/groups interviewed for the evaluation and copies of the surveys.

Overall, this evaluation finds that the Service Plan for SMHSOP provides clear strategies and support towards achieving its aims, which are to:

- Promote improved access to specialist services for older people with mental illness, including severe behavioural and psychological symptoms associated with dementia (BPSD) and for older people at risk of developing mental health problems.

- Contribute to improved health and mental health outcomes for older people in NSW.

However, although improving over time, access to SMHSOP is well below the level indicated by estimated need. Rates of access per head of population are also much lower compared with most other Australian states and territories. Access is particularly poor for priority groups, which include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) communities, rural residents and older people in custody.
Although SMHSOP have the potential to contribute to improved health and mental health outcomes for older people (as evidenced in the literature) coverage is currently insufficient to benefit the whole target population.

The next phase of implementation is crucial for the future of the program. This is due to the extensive reforms of the NSW health system, which provide challenges for SMHSOP due the small size and impact of the services currently. Also, demographic projections and projections of mental illness and dementia indicate that the target group will grow in the future, and the demand for these services will rapidly intensify. SMHSOP will need to be positioned to meet this increased demand.

**What are SMHSOP?**

There are various terms used in the literature to refer to services specialising in the care of older people (i.e. generally 65 years and over) with a diagnosable mental health disorder or problem. ‘SMHSOP’ is a NSW term, but others, such as ‘old age psychiatry’, ‘old-age mental health services’, ‘psychogeriatrics’ and ‘geriatric psychiatry’, have been used elsewhere. Key characteristics of the services are: targeted (broadly includes people as defined above, and also younger, ‘functionally old’ people with complex morbidity issues, including dementia, acquired cognitive impairment and poor health status), multidisciplinary (involving medical, nursing and allied health staff), comprehensive (including mental health promotion, prevention and early intervention, through to the management of severe psychological disturbances), and integrated (hospital and community care, and partnerships with primary service providers).

SMHSOP in NSW include the following service types:

- **SMHSOP community teams.** Provide specialist mental health assessment, community team care planning and case management for the target group. Also provide consultation/liaison to other key services, and conduct capacity building and other activities with a prevention and early intervention focus.

SMHSOP community teams include the following staff/teams with additional specialist roles:

- **Behavioural Assessment and Intervention Service (BASIS) teams.** Provide specialist, multidisciplinary mental health (and aged care) assessment, and some case management for older people with complex and severe BPSD in community settings.

- **Dementia Behaviour Management Advisory Service (DBMAS) teams.** Targeted at older people with complex and severe BPSD. Provide clinical support and advice; clinical supervision, mentoring and modelling behaviour management techniques; short-term case management/care planning and tailored information and education workshops. Also facilitate access to other services through referral pathways and collaborative arrangements.

In addition to DBMAS workers/teams operating within health services, the DBMAS service in NSW includes a ‘hub’ (or central) team. This team takes a lead role in
service establishment across NSW and provides state-wide operational coordination of the initiative. The hub also operates a telephone assistance line to assess clients and refer them appropriately to DBMAS staff within health services, SMHSOP staff or other services as appropriate.

- **Acute admission units.** Provide specialist mental health assessment and treatment for older people with acute mental illness in an inpatient setting.

- **Non-acute/extended care units.** Provide specialist mental health assessment and treatment for older people with mental health rehabilitation needs in an inpatient setting.

- **Transitional Behavioural Assessment and Intervention Service (T-BASIS) units.** Provides a non-acute assessment-treatment/management-discharge inpatient service for older people with severe BPSD, including both a ‘step down’ role from acute inpatient care and a ‘step-up’ role from community care (including residential aged care), as well as an outreach role.

- **Community residential.** Provide extended specialist mental health care (assessment and treatment) for older people with complex and persistent BPSD in a residential setting. These services may be delivered in partnership with non-government residential aged care providers.

### The Service Plan for SMHSOP 2005-2015

The Service Plan for SMHSOP was developed to support the significant changes occurring in demography and morbidity in NSW. These include the ageing of the population, increasing rates of morbidity associated with older age (including physical illness and associated anxiety and depression, as well as degenerative diseases), and increased longevity of people with lifelong mental illness.

It was developed to co-ordinate service planning and delivery of services to older people with mental health issues, to achieve better health and mental health outcomes for these people, and to strengthen support for families and carers.

The Service Plan for SMHSOP is being implemented in two phases:

- **Phase 1 (2005-2010)** – emphasis on community SMHSOP teams and community-based initiatives.

- **Phase 2 (2011-2015)** – emphasis on new service developments for inpatient care, including rehabilitation and recovery programs, and statewide services development and quality improvements.

The implementation of the plan is being managed by the Ministry (previously the Department) of Health’s Mental Health and Drug and Alcohol Office (MHDAO). MHDAO has the overall responsibility for managing and co-ordinating all mental health policies, strategies and funding for mental health across NSW. The MHDAO’s OPMH Policy Unit provides statewide
leadership in policy, planning and service developments across the older people’s mental health program. In addition, MHDAO and the OPMH Policy Unit receive advice on issues for older people with mental illness from various committees, as follows:

- NSW Mental Health Program Council
- SMHSOP Advisory Group
- Older People’s Mental Health (OPMH) Working Group
- Aboriginal Older People’s Mental Health Working Group
- Culturally and Linguistically Diverse (CALD) Older People’s Mental Health Working Group.

At a health service level, SMHSOP sit within mental health services, and are generally represented on local mental health executive committees. SMHSOP Clinical Co-ordinators have overseen implementation of the Service Plan for SMHSOP and the development of services locally (including staff development and resource management), and have also provided leadership and direction for clinical standards and quality improvement. SMHSOP Clinical Directors have provided clinical leadership and governance for SMHSOP.

**Policy context**

The evaluation is being undertaken at a time when the NSW and national health care systems are undergoing major reform. In NSW, the Ministry of Health has replaced the Department of Health, a NSW Mental Health Commission is being established and Local Health Districts (LHDs) and Speciality Health Networks (SHNs) have been created, with new roles and responsibilities (including new geographic boundaries for the LHDs). Nationally, a National Health Reform Agreement (COAG 2011) has been signed by all states and territories, which includes the implementation of the new service structures within states and territories aimed at increasing local accountability, and new funding arrangements. A National Mental Health Commission is also being established.

The reforms present risks and opportunities for SMHSOP. The risks are in the ability of the Ministry to provide support and targeted enhancement funding for the program until it reaches a level of maturity where it is able to be sustained into the future and is sufficiently embedded and recognised with mainstream care, particularly mental health services. This includes the continuation of OPMH Policy Unit, and the SMHSOP Clinical Co-ordinator and Clinical Director positions in the LHDs. The opportunities are in the potential recognition of the importance of SMHSOP, particularly given the ageing of the population and projections for mental illness and dementia, and SMHSOP being able to receive funding on a fair and equitable basis for the complexity of clients managed (i.e. through activity based funding), and the potential for targeted funding as part of the aged care reforms.
Evaluation plan and method

A framework for the evaluation was developed early in the project based on input from key stakeholders. Its function was to focus the evaluation on issues identified by stakeholders as being important for the task, which included issues along the spectrum from the establishment of the program (objectives, supporting structures, service models etc.) to implementation, and then resulting outputs and outcomes. This is shown in Figure 1 below.

![Evaluation framework](image)

**Figure 1 – Evaluation framework**

Twin objectives were established for the evaluation. One was to assess the overall progress and impacts of the Service Plan for SMHSOP to date (i.e. Phase 1). The other was to provide advice on how the plan might be adjusted, refined and improved going forward (i.e. Phase 2).

Information for the evaluation was obtained through four approaches:

- analysis of relevant documents and literature
- interviews with key stakeholders
- surveys of SMHSOP Clinical Co-ordinators and SMHSOP clinicians
- analysis of data.

In addition, a workshop was held with the reference group for the project as a means of validating the preliminary evaluation findings and obtaining further input.

Literature review

A comprehensive literature review was undertaken to ascertain the evidence base for the Service Plan for SMHSOP and identify any new models that may be considered for Phase 2. In addition to peer reviewed literature, the review examined service models described in other Australian states and territories.

The last comprehensive review of the evidence base for varying service models for older people with mental illness was published in 2005 (Draper & Low), and examined literature published up to 2003. A further search was undertaken for this project, for studies published between 2003 to 2011, using the same search terms as the earlier review. The 2005 review found evidence for:

- case management styles in the community
• liaison styles in long term residential care
• integration of hospital and community care to improve outcomes following hospital discharge
• psychogeriatric services for the provision of effective mental health service delivery to older people over geriatric services
• acute inpatient care in psychogeriatric units (recognising that the level of quality of studies is low, but that the results are consistently positive).

The review conducted for this evaluation found further support for these models of care in more recent studies. It also expanded the evidence for collaborations between primary health care and specialist services in identifying late life depression (i.e. to include cost effectiveness in addition to overall effectiveness) (Unutzer et al. 2008; Wolfs et al. 2009), for combined psychogeriatric and geriatric medical wards for improving some aspects of mental health outcomes of patients (Chiu et al. 2009), and for combined management of patients by a psychiatrist and gerontologist/geriatrician in reducing patients length of stay (Maier et al. 2007). New evidence was also found for intensive community teams for the management of older people with mental illness (George & Giri 2011).

Apart from Victoria, little other documentation was available from other jurisdictions specifically relating to models of care for older people with mental illness. Victoria has similar service models to NSW, and in addition has implemented an Intensive Community Treatment (ICT) program designed to provide an alternative to hospitalisation for the treatment of the acute phase of mental illness (Dieterich et al. 2010). The service is provided in the homes of consumers and is intended to minimise the amount of time spent in inpatient units. The literature review identified a study that evaluated one of these services (George & Giri 2011). It found that most patients were able to be managed in their homes for a longer period than would have been the case without the service. Therefore, although it did not replace the need for acute inpatient beds, the length of stay of patients and costs associated with admission were reduced.

Estimates of demand for SMHSOP

Two sets of estimates of the demand for SMHSOP were examined: those for dementia with BPSD, and those for other mental illnesses affecting older people (Brodaty et al. 2003; Draper et al. 2006).

The analysis in relation to dementia showed that the numbers of people with dementia are projected to grow, from just under 80,000 in 2006 to over 103,000 in 2016 (an annual rate of growth 3.0% per year), and then to around 193,000 by 2036 (an annual rate of growth 3.2% per year). People with dementia and BPSD are projected to increase at the same rate, that is, from 46,150 in 2005-06 to 62,044 in 2015-16 and 115,632 in 2035-36.

In applying these methods to LHDs, it was found that there are significant differences in the age structure between LHDs for people aged 65 years and older. LHDs with high projected rates of people with dementia and BPSD per population aged 65 years and over that are higher than the NSW level include South Eastern Sydney (around 8% higher), Northern Sydney (12% higher)
and Central Coast (4% higher). LHDs with lower projected rates include South Western Sydney (5% lower), Western Sydney (6% lower), Southern NSW (9% lower), and Western NSW (5% lower). Over the projection period (i.e. to 2035-36), most LHDs are projected to move closer to the state average, but differences will persist due to different age structures in the over 65 years population. In addition to the demographic structure of the population, other factors will impact the relative need for SMHSOP, a major one being the supply of residential care places in each LHD.

For other mental health disorders, people with mild mental disorders generally manageable by carers and primary care (e.g. mild depression and anxiety) are projected to increase from 138,092 in 2005-06 to 182,874 in 2015-16 and 292,696 in 2035-36. People with moderate to extreme mental disorders in some instances requiring management by multidisciplinary teams and at times institutional care (such as major depression and late life psychosis) are projected to increase from 42,440 in 2005-06 to 56,203 in 2015-16 and 89,955 in 2035-36. However, these projections are limited by the underlying estimates of prevalence, which are expressed in terms of rates per person aged 65 years and older. As discussed above, there are significant differences between LHDs in the age structure of people in the 65 years and over age group.

Estimates of prevalence of need have also been developed by the Mental Health Clinical Care and Prevention model (MH-CCP) developed previously by the NSW Department of Health. This model is a population-based mental health planning model that provides the clinical and epidemiological evidence base to estimate the need for mental health services in NSW across the spectrum of care (i.e. including mental health promotion, illness prevention and early intervention, through to services for people with severe episodes of mental illness). Many of the components of this model were directly derived from the prevalence estimates used in the projections outlined above.

Applied to the NSW population, MH-CCP predicts that for June 2011, 64,822 individuals would require specialised mental health services (including SMHSOP and adult mental health), of whom 8,068 would require a hospital admission (SMHSOP, adult mental health or other services).

For 2010-11, it is also estimated that 738,000 ambulatory occasions of service provided by specialist mental health services would be needed, and a further 86,000 provided by non-specialist services. For the latest complete year of data available (2009-10), there were just over 205,000 community contacts in total (i.e. including contacts with SMHSOP and adult mental health community teams). Applying the average rate of growth across the last five years, the estimate for 2010-11 would be approximately 250,000 contacts. Therefore, only about a third of the need implied is being met.

MH-CCP also predicts a need for 4,337 admitted patient episodes and 194,000 bed days in specialised mental health facilities for people aged 65 years and older in 2010-11. There were an estimated 2,886 admitted patient episodes and 107,335 bed days actually reported for 2009-10 for the target group across acute SMHSOP and acute adult mental health (overnight episodes only, as same day are regarded as ambulatory). Given that the trend over the last few years has been for a decline in separations, the 2010-11 actual figures are not expected to be above those
for 2009-10. As expected, the MH-CCP estimates of need for 2010-11 exceed current rates of utilisation of admitted care by the SMHSOP target group. Therefore, only about two-thirds of the need implied by MH-CCP for admitted services for the target group is being met.

The MH-CCP model also predicts a need for 567 ambulatory clinical FTE. The current ambulatory clinical FTE is estimated to be around 387, which is two thirds of the level implied by the model.

For bed-based services, including both SMHSOP and adult mental health services, the model predicts 971 clinical FTE for 2010-11. Currently these services are estimated to have 429 FTE. These represent less than half of the need implied by MH-CCP. Specifically for SMHSOP, MH-CCP predicts 785 bed-based FTE (excluding community residential). The current staffing level for SMHSOP is estimated to be 413 FTE, which represents just over half of the requirement implied by MH-CCP.

For ambulatory services, the gap between the need implied by MH-CCP is greater for contacts than staffing (i.e. about one-third of the contacts required are being provided, and about two-thirds of the staffing required is in place). However, for admitted patient services, the gap between the need implied by MH-CCP is greater for staffing than for episodes provided (i.e. where about two-thirds of the episodes needed are delivered and about half of the staff required are in place). Nevertheless, much greater levels of need than those currently being provided are implied overall. While some of these approaches may need refinement, there is no doubt that the need for SMHSOP will grow. Therefore, service expansion should be one of the key priorities for the future.

Overview of SMHSOP in NSW

There are different ways in which services deemed as ‘SMHSOP’ are identified. For this evaluation, we initially obtained a list from InforMH, which is the group within MHDAO responsible for collecting, analysing and reporting information about mental health services in NSW. For admitted units, this listing reflects the units identified as SMHSOP in the benchmarking initiative. We also asked SMHSOP Clinical Co-ordinators to identify both ambulatory and admitted SMHSOP that they co-ordinate within their former Area Health Service through the survey undertaken. We reconciled the services reported through both of the above sources, and resolved discrepancies.

Our ‘final’ list of SMHSOP units/teams was the InforMH listing with the addition of two other admitted units, as advised by stakeholders. For the most recent year for which activity data are available, 48 SMHSOP community teams were identified (including DBMAS and BASIS teams), 15 acute inpatient units, three non-acute/extended care, and five T-BASIS units. This still underrepresents SMHSOP, mainly due to individual SMHSOP workers embedded in adult mental health units/teams not being counted as separate ‘entities’, and units delivering services to the SMHSOP target group that are under the management of aged care rather than mental health within health services. There have been changes to SMHSOP units/teams over time. Some have closed, new ones have been added, and some have changed function (i.e. from acute to non-acute/extended care or vice versa).
Table 1 summarises some of the key features of services provided for the SMHSOP target group in 2009-10 by SMHSOP units, other mental health units and, for acute inpatient services, non-mental health services. In 2009-10, there were more than 141,000 contacts provided by community SMHSOP teams to close to 11,000 individuals. The contacts provided by these teams have increased by more than 200% since 2004-05, and they have increased as a proportion of total services provided to the target group (i.e. with services also provided to this group by adult mental health teams), from 52% in 2004-05 to 69% in 2009-10. The number of contacts per person provided by SMHSOP community teams has increased over time, from nine in 2004-05 to 13 in 2009-10. Adult mental health teams were providing an average of nine and eleven contacts per person in the corresponding period. SMHSOP clients are generally older than clients in the target group managed by adult mental health teams (median age of 74 and 70 respectively in 2009-10) (although a fair proportion, 27%, are younger than 65 years), and tend to have slightly shorter contacts on average (median contact duration was 30 and 50 minutes respectively in 2009-10).

SMHSOP acute admission units provided just over 2,000 episodes of care in 2009-10, which was around 18% of all mental health related admissions for the target group (31% of overnight admissions only). Note that the broadest definition of the SMHSOP target group is being used here; it should be noted that SMHSOP and adult mental health units tend to focus on the more severe and complex clients within this group. Other episodes to the target group were provided by adult mental health units (44% of total, 16% of overnight) and other admitted units such as aged care and general medical wards (38% of total, 52% of overnight). The median length of stay for SMHSOP units was 23 days, with a small increase since 2004-05. This is much higher than for other mental health units (14 days) and non-mental health units (six days). The median age of patients for SMHSOP units is around 77 years, which is slightly younger than the median ages for those admitted to other mental health units and non-mental health units (84 and 80 years respectively).

Clients admitted to SMHSOP acute units tend to be admitted for affective disorders as a primary diagnosis at a higher rate than clients admitted to adult mental health and other admitted units, and similar to these other units, tend to have an organic disorder as the leading secondary diagnosis. However, clients admitted for a particular condition, such as psychosis, may also have reported additional diagnoses, such as dementia. To analyse both the principal and additional diagnoses for acute admitted clients, all diagnoses reported for each episode were analysed to determine combinations of diagnoses of the SMHSOP target group. The finding from this analysis was that SMHSOP units tend to focus on clients with dementia (with other conditions), psychosis and affective disorders. Adult mental health units see a much smaller proportion of clients with dementia, and have a focus on psychosis and affective disorders. Other acute units treating clients within the target group are principally focussed on clients with dementia (without other mental health conditions), and affective and anxiety disorders.
Table 1 – Summary of services provided to SMHSOP target group, 2009-10

<table>
<thead>
<tr>
<th></th>
<th>SMHSOP</th>
<th>Adult mental health</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts:</td>
<td>141,404</td>
<td>63,710</td>
<td></td>
</tr>
<tr>
<td>Change in contacts since 2004-05:</td>
<td>206%</td>
<td>52%</td>
<td>Not available</td>
</tr>
<tr>
<td>Unique persons:</td>
<td>10,925</td>
<td>5,677</td>
<td></td>
</tr>
<tr>
<td>Change in unique persons since 2004-05:</td>
<td>120%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Contacts per person:</td>
<td>12.9</td>
<td>11.2</td>
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**Acute admitted**

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<tr>
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<tbody>
<tr>
<td>Separations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,007</td>
<td>4,808</td>
<td>4,137</td>
</tr>
<tr>
<td>Same day</td>
<td>118</td>
<td>3,811</td>
<td>960</td>
</tr>
<tr>
<td>Overnight</td>
<td>1,889</td>
<td>997</td>
<td>3,177</td>
</tr>
<tr>
<td>Change in separations since 2004-05:</td>
<td>-9%</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Unique persons:</td>
<td>1,595</td>
<td>945</td>
<td>3,379</td>
</tr>
<tr>
<td>Change in unique persons since 2004-05:</td>
<td>-6%</td>
<td>-4%</td>
<td>0%</td>
</tr>
<tr>
<td>Median length of stay (days):</td>
<td>23</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Median age (years):</td>
<td>77</td>
<td>84</td>
<td>80</td>
</tr>
</tbody>
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**Non-acute/extended care admitted**

<p>| | | | |</p>
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<tr>
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<tbody>
<tr>
<td>Separations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in separations since 2004-05:</td>
<td>-58%</td>
<td>-32%</td>
<td>10%</td>
</tr>
<tr>
<td>Unique persons:</td>
<td>27</td>
<td>10</td>
<td>407</td>
</tr>
<tr>
<td>Change in unique persons since 2004-05:</td>
<td>-52%</td>
<td>-33%</td>
<td>7%</td>
</tr>
<tr>
<td>Median length of stay (days):</td>
<td>298</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Median age (years):</td>
<td>75</td>
<td>71</td>
<td>83</td>
</tr>
</tbody>
</table>

**T-BASIS**

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<tbody>
<tr>
<td>Separations:</td>
<td>198</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in separations since 2004-05:</td>
<td>321%</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Unique persons:</td>
<td>142</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in unique persons since 2004-05:</td>
<td>264%</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Median length of stay (days):</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median age (years):</td>
<td>78</td>
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Lengths of stay for clients with dementia only are similar in acute SMHSOP (13 days) and adult mental health units (12 days), and higher than other acute units (seven days). The presence of dementia with other mental health conditions tends to result in longer lengths of stay for psychosis and affective disorders in both SMHSOP units and adult mental health units. However, lengths of stay for these conditions tend to be higher in SMHSOP units.

SMHSOP non-acute/extended care units provided 27 episodes to 27 individuals in 2009-10. In addition, T-BASIS units provided 198 episodes of care to 142 people. Together, these represented 34% of episodes to clients in the target group requiring non-acute/extended care in that year.

The number of episodes provided by SMHSOP non-acute/extended care units has decreased by 58% since 2004-05. However, the number of episodes provided by T-BASIS units has increased three-fold.
The majority of non-acute/extended care provided to the target group was provided by other admitted units other than mental health (i.e. aged care and general medical wards). However, the services provided by these units are very different to the ones provided by SMHSOP non-acute/extended care and by T-BASIS units. The median length of stay in 2009-10 for non-acute/extended care SMHSOP was 298 days, for T-BASIS it was 53 days, for mental health units providing non-acute/extended care it was 11 days and for other units it was nine days.

The analysis discussed above is based on the major team or admitted unit in which a client was managed within any one contact/admission. However, clients may receive community services as well as admitted services within any one year and over time, and also be managed by SMHSOP or other units/teams at different times. To better understand these patterns, an analysis was performed on individuals longitudinally to the extent possible given identification of unique individuals. The quality of this identification is high (i.e. approximately 88% of admitted episodes have a unique identifier assigned), but the results should still be treated with caution as there may be particular characteristics/patterns associated with the individuals that are not uniquely identified.

This analysis showed that ambulatory services alone make up the most common pattern of service use by the target group. Within any one year, an average of 72% of individuals was managed solely in community settings, and across the six and a half year period analysed (Jul 2004 to Dec 2010), 64% were managed in this way. SMHSOP provide the majority of services to individuals (i.e. 40% of all individuals accessed only SMHSOP in any one financial year on average). The analysis also showed that on an admitted basis, the target group for SMHSOP tend to use either SMHSOP, adult mental health or other admitted patient services. Overlap in the use of these services is low (only 12% of individuals used more than one of these types of admitted services on average across the period examined).

Presentation of the SMHSOP target group to emergency departments is currently (2009-10) at around 5,672 presentations (by 4,977 individuals), and has increased by just over 3% since 2004-05.

In summary, the SMHSOP target group, defined by age (i.e. 65 years and over) and diagnosis (i.e. a set of diagnoses deemed to be responsive to services provided by SMHSOP), is also managed by other community teams (adult mental health) and admitted units (adult mental health, aged care and general medical wards). Adult mental health services provide about one-third of the total community contacts to the target group. Adult mental health services also provide around 16% of the overnight acute episodes for this group, with a further 52% provided by other admitted units. Although it is acknowledged that the clients managed by SMHSOP have conditions and circumstances requiring specialist care that are not picked up by routine data collections, SMHSOP are still far from achieving the levels of service implied by current utilisation by the target group, in addition to that implied by population needs-based models (e.g. MH-CCP). Apart from the need to expand these services, especially given the ageing of the population and the rates of psychiatric illness, it is also concluded that there is a need to better identify, in routine data collections, the conditions and characteristics that require attention by SMHSOP, to differentiate the group for which these services are targeted.
Key indicators (SMHSOP acute admission units)

Table 2 shows a summary of the results of key indicators for SMHSOP acute admission units, comparing 2004-05 and 2009-10 results. The indicators have been selected from ones used in the benchmarking initiative, where data are available and where they are meaningful for comparing the services and/or characteristics of the clients managed over time. Indicators on services structures and resources are not included here as they have been reported in other parts of this report.

Data relating to each of the indicators, including data for individual acute units and for other units, are in Volume 3, Appendix 9.

Key observations are:

- Improved processes of care:
  - There has been a slight reduction in 28-day readmission of clients over time.
  - There has been an improvement in follow up of clients 7 days and 90 days post discharge. However, this is still below the targets set for these within NSW and nationally.

- Increased complexity of clients:
  - An increasing proportion of clients admitted to acute clinics are admitted from emergency departments. This means that potentially, acute clinics are increasingly required to provide specific type of care to clients with complex behavioural and symptoms of mental health.
  - A lower proportion of clients are discharged home. This potentially means that clients are more complex at discharge and need to be continued to be cared for by other services.
  - Patients are getting older (e.g. increased proportion in the 85+ age group).

In addition, analyses of these indicators showed low data quality in some areas. A key one is matched HoNOS at admission and discharge for individuals, which makes it difficult to draw conclusion about the effect of the services on outcomes. This is discussed further below. Also, although unique identification of individuals was excellent for some units, it was very poor for others, thereby limiting opportunities for longitudinal analyses of the effectiveness of services for individuals. Therefore, data quality is an area that needs work.

Furthermore, these indicators have only been currently developed for admitted units, which only represent one component of SMHSOP. They would be particularly useful for ambulatory services given the high volumes of clients managed by these services. This is planned as part of the benchmarking initiative.
### Table 2 – Indicator results summary

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Summary of results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key indicators</strong></td>
<td></td>
</tr>
<tr>
<td>28 day readmission</td>
<td>• Readmissions (within 28 days) for clients discharged from acute units have decreased over time (9.1% in 2004-05 down to 6.0% in 2009-10).</td>
</tr>
<tr>
<td>Follow up</td>
<td>• The proportion of clients followed up by community teams within 7 days of discharge from an acute unit has almost doubled between 2004-05 and 2009-10 (18% to 34%), and the proportion seen within 90 days has also improved substantially (29% to 47%). • However, these figures are still below the NSW target and the target set by the National Mental Health Benchmarking Forum 2009 for this indicator (which are 70% and 90% respectively).</td>
</tr>
<tr>
<td>HoNOS change groups</td>
<td>• Difficult to ascertain due to low proportion of records with a valid state unique patient identifier in both inpatient and outcome measures collections and a valid HoNOS at admission &amp; discharge. • Latest data (2009-10) are showing improved outcomes for 46% of clients, unchanged status for 43%, and deterioration for 11%. However, unable to compare to 2004-05 due to very low matches of admission and discharge HoNOS scores for individual client episodes obtained (i.e. 15%).</td>
</tr>
<tr>
<td><strong>Processes of care</strong></td>
<td></td>
</tr>
<tr>
<td>Admission pathways</td>
<td>• An increasing proportion of admissions to SMHSOP acute units are from emergency departments (25% in 2004-05 to 31% in 2009-10). • There is also a decreasing proportion of clients being admitted directly to these units; a larger proportion are being admitted via other pathways (e.g. transfer from other admitted units) (67% in 2004-05 to 55% in 2009-10).</td>
</tr>
<tr>
<td>Length of stay</td>
<td>• In 2004-05, clients in admitted acute SMHSOP units stayed an average of 35.8 days. In 2009-10, they stayed an average of 36.9 days. Therefore, the average length of stay is almost unchanged over the period.</td>
</tr>
<tr>
<td>Length of stay profile</td>
<td>• The distribution of length of stay for acute SMHSOP units has changed slightly for the 1-3 day band, where fewer clients are being admitted within this time frame in 2009-10 compared with 2004-05. There are also small differences in the 7-12 week and 4-6 month bands, where there is a slightly larger proportion of clients staying these longer periods in 2009-10.</td>
</tr>
<tr>
<td>Length of stay by primary diagnosis</td>
<td>• Between 2004-05 and 2009-10, average length of stay has increased substantially for clients with psychosis (from 60 to 80 days), affective disorders (from 33 to 46 days) and anxiety (from 16 to 26 days) as a primary diagnosis. It has decreased for substance disorders (from 21 to 8 days) and all other diagnoses as a group (from 43 to 28 days).</td>
</tr>
<tr>
<td>Discharge pathways (mode of separation)</td>
<td>• A lower proportion of clients admitted to acute units are discharged home (64% in 2004-05 to 58% in 2009-10). • A higher proportion are transferred elsewhere (25% in 2004-05 to 33% in 2009-10).</td>
</tr>
<tr>
<td>Legal status</td>
<td>• There were a slightly smaller proportion of clients with involuntary legal status on admission in 2009-10 compared with 2004-05 (30% compared with 27%), and a slightly small proportion of separations with any involuntary days during their period of stay (39% compared with 35%).</td>
</tr>
<tr>
<td><strong>Consumer</strong></td>
<td></td>
</tr>
<tr>
<td>Age profile</td>
<td>• There is a larger proportion of clients in the 65-74 year age band in 2009-10 compared with 2004-05 (28% in 2004-05 to 37% in 2009-10). • There is a larger proportion of clients in the 85 plus age band in 2009-10 compared with 2004-05 (11% in 2004-05 to 17% in 2009-10).</td>
</tr>
<tr>
<td>Cultural background</td>
<td>• The numbers of Aboriginal and Torres Strait Islander people being managed by all SMHSOP units is extremely low, and has remained so over the period examined (i.e. 6 clients in 2004-05 and 11 in 2009-10 in all units) • People born in countries other than Australia make up slightly more than one third of all clients in acute units, and this has remained consistent over time.</td>
</tr>
<tr>
<td>Residence</td>
<td>• The proportion of people managed outside of the LHD boundaries has remained similar between 2004-05 and 2009-10 for acute units.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Summary of results</td>
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</tr>
<tr>
<td>Primary diagnosis</td>
<td>• Affective disorders (F30-39) make up the largest proportion for acute units (about one-third), followed by psychosis (F20-29) (about one-fifth) and organic disorders (F00-09) (14%). The proportions have remained similar over the two time periods.</td>
</tr>
</tbody>
</table>
| Comorbid diagnoses | • The most common comorbid diagnosis for clients managed in SMHSOP acute units is dementia (organic disorders F00-09), followed by substance disorders (F10-19).  
• However, the proportion of clients with organic disorders as a comorbidity has increased in the most recent year, while the proportion of clients with substance disorders has decreased. |
| Data quality | • Between 46% and 100% of records have a SUPI for any one acute unit.  
• SUPI coverage has remained similar over the periods examined. |

**Funding and staffing**

Since the establishment of the *Service Plan for SMHSOP*, the NSW Department of Health had made a number of funding enhancements under the program. These enhancements have been sourced from both the NSW Government and the Australian Government (through the National Mental Health Program and the DBMAS initiatives). By 2009-10, additional funding of just over $29.6 million per year was allocated to the program. Just over 45% of the new funding related to community services and BASIS, 6% related to SMHSOP Clinical Co-ordinators (as well as part coverage of Clinical Director/Advisor position and administrative support), and 13% to DBMAS. T-BASIS accounted for about 8% of new funding. In addition, funding was also provided to South Eastern Sydney/Illawarra for the Wollongong unit ($6.2 million), and to Hammond Care for the MHACPI model ($1 million), which included funding to Sydney South West specialist clinical support ($100,000). Small amounts of funding were allocated for benchmarking, workforce development and purchase of videoconferencing equipment. The OPMH Policy Unit accounted for 3% of recurrent allocations.

Actual expenditures under SMHSOP are not directly reported through routine data sources, but they are reported indirectly through the Mental Health Establishments (MHE) data collection. The latest year for which these data are available for this collection is 2008-09. There are several factors that impact the way in which mental health services for older people are identified within these data. Several SMHSOP are not reported through the MHE collection, principally where a key worker is embedded in a general or adult community mental health team. The collection also reports on several services where the target group is ‘older persons’, although the service does not have a formal relationship with SMHSOP. That is, it is managed under a different organisational structure or even outside the mental health program. Finally, the MHE collection does not take into account expenditures on mental health for older people provided by adult mental health service teams.

In 2008-09, health services reported through the MHE that expenditures on mental health services for older people were $97.7 million. For reasons described above, this is an underestimate. Over the period 2004-05 to 2008-09, reported expenditures on mental health services for older people increased by 19%. Of the $97.7 million, $69.4 million was related to admitted care and $28.3 million to ambulatory. Between 2004-05 and 2008-09, admitted patient...
expenditures increased by 10% and ambulatory expenditures increased by 122%. In 2004-05, ambulatory expenditures made up 17% of total expenditures, and in 2009-10 they made up 29%.

Reliable estimates of SMHSOP clinical staffing are also not directly available. Staffing is reported through the MHE, as discussed above, this is dated and incomplete. For the current evaluation, SMHSOP Clinical Coordinators were surveyed on the number of FTE clinical positions in SMHSOP. They identified a total of 549 FTE positions covering admitted and ambulatory care. However, a staffing return was not received from one coordinator. In addition, data on several units (mainly admitted patient services) were not provided, as SMHSOP Clinical Coordinators did not have a direct relationship with these units. Data from the MHE and the SMHSOP coordinators was reconciled to estimate total SMHSOP related staff over the period 2004-05 to 2010-11. We estimated there were 284 clinical FTE for ambulatory SMHSOP in 2010-11. For bed-based SMHSOP (excluding community residential) for 2010, we estimated there were 381 clinical FTE.

According to the benchmarks for FTEs used by MHDAO as the basis for funding enhancements, the enhancements for community services (including BASIS and DBMAS) should have been able to ‘buy’ approximately 175 staffing positions over 2004-05 FTE levels.

**Initiatives under the Service Plan for SMHSOP**

MHDAO has undertaken a broad range of initiatives to progress strategies from the *NSW Service Plan for SMHSOP 2005-2015*. These have included initiatives around clinical services, access for priority groups, SMHSOP workforce recruitment and development, planning, resource allocation and accountability, and clinical quality and safety (e.g. benchmarking). These initiatives have contributed to achieving many of the strategies outlined for Phase 1 of the *Service Plan for SMHSOP*, and have also demonstrated the evolution of the program over the six years that it has operated as a statewide program. That is, issues are being tackled progressively over this time at greater levels of depth. Examples of this are the forging of stronger partnerships with the aged care sector (e.g. MHACPI, PLAC awards), the development of the acute inpatient model of care, as well as establishing and developing relationships with Aboriginal stakeholders and CALD stakeholders (through both the Aboriginal Older People’s Mental Health Working Group and the CALD Older People’s Mental Health Working Groups).

Initiatives have included:

- **SMHSOP clinical services:**
  - *Behavioural Assessment and Intervention Services (BASIS) and NSW Dementia Behaviour Management Advisory Service (DBMAS):* BASIS is a model for older people with severe and complex behavioural and psychological symptoms and/or unclear aetiology. The BASIS model was already in place at the commencement of the *Service Plan for SMHSOP*, and through the program, additional funding was able to be targeted for its further expansion and availability across all the Area Health Services.

  DBMAS is a model for older people with behavioural disturbance specifically related to dementia, funded by the Australian Government Department of Health and
Ageing. NSW Health was the successful tenderer to provide DBMAS across NSW. The service was established as a ‘hub and spoke’ model.

- **T-BASIS units:** T-BASIS units arose out of a clinical service redesign of Confused and Disturbed Elderly (CADE) units. They provide non-acute care to older people with severe levels of BPSD. An evaluation of the model and initiative completed in 2010 found that it can be both clinically and cost effective, with few readmissions and high family and carer satisfaction.

- **NSW Mental Health Aged Care Partnership Initiative (MHACPI):** This initiative involved piloting, within two residential aged care facilities, purpose-designed special care units with specialist consultation-liaison and case management from SMHSOP (or aged care services, as appropriate) and supported transition to mainstream residential aged care. An evaluation of the initiative demonstrated that the model can successfully deliver quality care for older people with severe BPSD and/or mental illness in mainstream residential aged care facilities, improving quality of life, and access to long-term, community-based care.

- **Positive Living in Aged Care (PLAC) awards:** The PLAC awards have been designed to develop innovative approaches to promoting better mental health and well-being for residents of residential aged care facilities and the broader residential aged care community.

- **NSW Elderly Suicide Prevention Network (ESPN):** NSW ESPN was established to provide support and reduce isolation for specialist staff working on preventing suicide and depression in older people. It now also provides a forum to support a coordinated approach for preventing suicide among older people.

- **Consumer and carer engagement:** In 2008 a scoping paper was developed which found that the overall capacity of consumer and carer organisations needed further development, including engagement, partnerships and consultation with OPMH.

- **Clinical quality and safety:** The SMHSOP Benchmarking project aims to improve the quality of SMHSOP acute inpatient and community services through the use of data to assess current practice.

- **Priority groups:** A report was developed in 2010 to increase understanding of the mental health needs of Aboriginal and Torres Strait Islander people. Recommendations were in the areas of principles of care, partnerships and collaboration, and program advisory. The Transcultural Mental Health Centre of NSW released a project report to address the needs of older people from CALD communities, finding the need for improved quality and safety measures, such as culturally relevant assessment tools, and additional partnerships with relevant organisations.

- **Workforce:** Initiatives around workforce have included a SMHSOP orientation program and brief clinical induction course developed for all new staff, recruitment and retention focus groups, a workforce survey, a BPSD Training Project held at 19 sites, development of core
competencies for SMHSOP staff through a survey and workshop, and a review of NSW Institute of Psychiatry OPMH programs.

- **Planning**: Each former Area Health Service had developed strategic plans for SMHSOP, which included information on local need, service structures and strategies. The SMHSOP Acute Inpatient Unit Model of Care was developed to promote effective inpatient care and good practice in these units.

### SMHSOP objectives and governance

The NSW Service Plan for SMHSOP promotes a population-based approach, which is in line with broader mental health and health service strategies and international best practice. The aims, principles and outcomes advocated were considered to be sound by stakeholders, and were supported by evidence reviewed through the literature.

There is a high level of ownership of the Service Plan for SMHSOP amongst people working in the services, but it tends not to be one of the higher priorities for people working in wider mental health. Also, ownership of the management of clients with dementia is still an issue for some clinicians working in SMHSOP, despite the policy directions articulated in the plan. That is, they perceive these clients as being clients of geriatric medicine rather than mental health.

The governance at the State level was found to be sound, and has contributed to the program being recognised as a distinct program within mental health, and to its growth and development over time. Of note are the roles of the OPMH Policy Unit, SMHSOP Advisory Group, the OPMH Working Group, the Aboriginal Older People’s Mental Health Working Group, and the CALD Older People’s Mental Health Working Group. There were some small gaps identified in the governance structure, specifically achieving consistent representation on the Advisory Group from Clinical Directors from mental health services (as distinct from SMHSOP Clinical Directors), and on the OPMH Working Group from consumer and carer organisations, General Practitioners(GPs), and Ageing, Disability and Home Care. In addition, there is a need for ongoing clarification of the roles of all governance groups at different stages of their work, as some stakeholders reported that at times these groups struggled to define their respective roles. This was reported to be particularly the case with the CALD Older People’s Mental Health Working Groups.

Governance of SMHSOP is also strong at a health service level, but is reported to sometimes get a lower priority compared with other streams within mental health.

SMHSOP Clinical Co-ordinator and Clinical Director roles have been pivotal in establishing and/or developing SMHSOP in NSW health services, including providing leadership and direction for clinical standards and quality improvement, developing SMHSOP staff, and managing resources for SMHSOP (particularly enhancement funding). These roles are crucial to the continuity of the program.
SMHSOP structure

SMHSOP have been established as community teams (including BASIS and DBMAS), acute admission units, non-acute/extended care units, non-acute T-BASIS units and community residential services. These services are in-line with those advocated by evidence (i.e. as documented in the literature).

The configuration of services has varied across different regions within NSW. Some services were established prior to the Service Plan for SMHSOP and associated funding enhancements. The funding enhancements were then used to ‘even out’ differences amongst some services, that is, starting with the existing levels of staffing as a base, and supplementing these, also taking population needs into consideration. This had an effect of decreasing some of the disparity between metropolitan and rural areas. Also, the funding enhancements were mainly aimed at ‘evening out’ the situation with respect to community services; large disparities in admitted services remain amongst the geographic regions.

Despite growth of the services and increasing maturity of the program, SMHSOP are not at the level where they can be sustained without continued leadership at levels of the past six years. This means that the services are vulnerable in the face of extensive State and national health care reforms.

Strategies for Phase 1 in the Service Plan for SMHSOP were reported as being highly ambitious, and all have not been able to be achieved to the level planned during Phase 1.

Program inputs

The main input to the program was the funding enhancements provided from the State to health services as discussed earlier. Other inputs explored through the evaluation were staffing and input by consumers, families and carers into the program.

Through the surveys, SMHSOP clinicians reported that they are enthusiastic about working in the service, and retention was reported to be good. However, there are still issues in the availability of skilled staff, particularly in rural areas, and other challenges to recruitment, such as staff freezes.

The input of consumers, families and carers into the program and into services still needs work.

Program reach

As a result of investments, community-based services for the target group have increased since 2004-05. However, there has been little change in admitted patient services. Currently clients within the target group are managed by SMHSOP, adult mental health and other (non-mental health) services.

The program has been instrumental in building up SMHSOP across the State. However, these services are still struggling to meet the demands, particularly in some parts of the State.
In addition, national comparisons show that compared with other Australian states, NSW has one of the lowest rates of community contacts for older people with mental health illness.

There have been many efforts across the State to build culturally appropriate resources and/or services to meet the needs of priority population groups. However, there is still significant work to do to improve access for these groups.

Aboriginal and Torres Strait Islander people account for only a small proportion of total contacts and unique people seen by SMHSOP community teams; they are more likely to be seen by adult mental health teams. In 2009-10, 302 Aboriginal and Torres Strait Islander older people were seen by SMHSOP community teams, being provided 1,885 contacts (around 1% of community contacts provided by SMHSOP teams). There were a further 616 people seen by adult mental health teams, being provided 15,565 contacts (approximately 20% of community contacts provided to the SMHSOP target group by these teams).

There were only 10 people identified as Aboriginal and Torres Strait Islander admitted to SMHSOP acute units in 2009-10, resulting in 12 episodes of care. In adult mental health units and other admitted units, there were 171 people identified as Aboriginal and Torres Strait Islander admitted, resulting in 305 episodes of care.

There were very few Aboriginal and Torres Strait Islander people admitted to non-acute/extended care or T-BASIS units.

There were just over 250 older people from CALD communities (with 3,000 contacts) seen by SMHSOP community teams in 2004-05, and just over 700 patients (with 8,000 contacts) in 2009-10. Although the overall number has increased, the representation of this group amongst overall contacts and clients has not changed much over time (i.e. approximately 6% of contacts).

During the same period, there were close to 300 older people (2,500 contacts) from CALD communities seen by adult mental health community teams in 2004-05, and close to 600 (6,000 contacts) in 2009-10. They have been increasing as a proportion of total contacts and clients managed by these teams (i.e. from about 6% for both contacts and clients in 2004-05, to 9% as a proportion of total contacts and 10% as a proportion of total clients in 2009-10).

SMHSOP have generally provided more contacts per person for this group than adult mental health teams (11 versus 10 in the most recent complete year – 2009-10), and the people seen by the SMHSOP community teams tend to be slightly older. The contact duration tends to be slightly higher for clients seen by adult mental health than SMHSOP community teams, and has increased for the former group over time more so than for the latter group.

There were close to 200 older people from CALD communities admitted to acute SMHSOP units in 2004-05, and just over 250 in 2009-10. These clients accounted for 250 separations from SMHSOP acute units in 2004-05, and just over 300 in 2009-10. They have increased as a proportion of all admissions to SMHSOP acute units since 2004-05, but this proportion has remained steady in more recent years.

SMHSOP are less likely to admit clients from this group on a same day basis compared with acute clients in the target group admitted to other units. Although the age profiles are similar for
both unit types, average length of stay is much higher for clients admitted to SMHSOP acute units.

There were a very small number of older people from CALD communities admitted to non-acute/extended care SMHSOP and T-BASIS units.

**Impact on processes of care and program outputs**

The evaluation found that the program has been able to achieve strong partnerships at the State and health service levels. However, some require more work, such as those with aged care assessment teams (ACATs) and families and carers at the health service level.

A lack of visibility of SMHSOP amongst public sector aged care services and private organisations and non-government organisations (NGOs) (particularly those providing mental health services), was reported. Also, although the program has concentrated on strategies to forge and maintain partnerships with the aged care sector, awareness of and collaborative partnerships with these services and SMHSOP are still identified as being problematic within local services.

The perception from stakeholders is that SMHSOP has been able to maintain people in the community, which was in line with Phase 1 priorities. This is also evidenced by the increase, from 2004-05 to 2009-10, of clients being managed by community SMSHOP teams and the relative decrease of clients managed by other MH community teams. Also, on average each year, 72% of clients from the target group were managed solely in community settings and there is minimal overlap/duplication between SMHSOP services (i.e. a majority of clients are only managed by one type of service). However, as pointed out elsewhere, the demand implied by MH-CCP is greater than current service provision (and the gap is much higher than for inpatient care). An important barrier to maintaining clients in the community identified was the availability of psychogeriatricians and psychogeriatric services (e.g. nurses, allied health practitioners) and geriatricians in the community, including those working in a private capacity.

Continuity of care for clients was also explored, and found to have some challenges at a system level (mainly to do with lack of technology to support sharing of clients’ information/care plans) and at a local level (e.g. relationships between public sector and other providers).

Capacity building was another element explored, and examples of this were cited in relation to training and workforce development, building partnerships with key groups, and in strengthening mental health promotion, prevention and early intervention.

In terms of quality and safety processes, the OPMH Policy Unit has been able to contribute to some significant State level initiatives in this area that have relevance for older people with mental illness. In addition, the benchmarking initiative was found to be highly valuable in also supporting this, although in more recent forums, evaluations identified that participants were less confident of the impact of the forums on effecting local service improvement. This was also fed-back through the interviews with stakeholders.
An issue raised by stakeholders was the need for consistent, high quality care of the older people with mental illness, regardless of the sector (i.e. public or private), and regardless of the service (e.g. SMHSOP, adult mental health, aged care). This is particularly important given the high proportions of the SMHSOP target group managed by these other sectors. The analysis in this report refers to public sector based services, but it is known that a large proportion is also managed by the private sector (particularly by residential aged care facilities).

Clinicians reported positive experiences working in SMHSOP, including useful orientation and induction, opportunities for training, the availability of local clinical guidelines and support from other team members.

**Impact on outcomes**

Outcomes for clients and carers were only examined indirectly in this evaluation. Two ways in which they were examined were through seeking the opinions of SMHSOP Clinical Co-ordinators and clinicians on this issue and through routinely available data.

Although asking Co-ordinators and clinicians about client and carer outcomes is not a valid way of ascertaining these, their perceptions are important given that this is the main goal of their roles.

Clinical Co-ordinators reported moderate to high impact of SMHSOP on the mental health care of clients that were reached. Three quarters of clinicians surveyed also reported a high or extremely high impact. Only 3% felt that the impact was lower than moderate. It was also felt that SMHSOP had good outcomes for families and carers, with close to three quarters of the clinicians surveyed responding as such. These results indicate a high level of confidence of Co-ordinators and clinicians in the services’ impact.

The routinely available data used to analyse outcomes for SMHSOP clients was the Mental Health Outcomes and Assessment Tools (MH-OAT) data collection. The Health of the Nation Outcome Scales for Elderly People (HoNOS) is the tool used by mental health teams to measure health and social functioning of people with severe mental illness, and HoNOS scores are recorded in MH-OAT.

Initially, matched admission and discharge HoNOS scores were analysed for admitted clients to show the change in score from admission to discharge, as evidence of the effectiveness of the service in improving their mental health functioning. Improvement is indicated by a HoNOS total score at discharge of four or more points lower than the score at admission. A deterioration is indicated by a HoNOS total score at discharge of four or more points higher than at admission. Unchanged is indicated by a score within four points less than or higher than the score at admission.

The indicator requires a valid state unique patient identifier in both inpatient and outcome measure collections and a valid HoNOS at admission and discharge. The analysis found that this was only available for a small number of episodes. That is, for acute units, less than one-third of the separations met these conditions in 2009-10. Within these, approximately 46% improved during the stay, 43% remained unchanged, and 11% deteriorated. The aim of this analysis was to
compare whether units achieved better outcomes since the establishment of the program. However, there were less than 15% of separations with matching admission and discharge scores, therefore, this comparison could not be made. Without a comparator, it is hard to conclude whether SMHSOP in fact results in better outcomes for clients.

Therefore, further analysis was undertaken comparing SMHSOP units with adult mental health units managing the target group. This time admission and discharge scores were not matched, but examined overall for admissions and discharges for the two groups. However, the comparisons were still flawed due to very small proportion of separations with a matched HoNOS record in the admitted patient and MH-OAT data sets and a valid admission or discharge score. Although inconclusive, it was found that clients admitted to SMHSOP units tend to have higher (more severe HoNOS scores) than clients admitted to adult mental health units. Both groups discharge clients with a lower (i.e. less severe score) than at admission on average. However, the discharge scores for SMHSOP acute clients tended to be higher than for acute clients discharged from adult mental health units. Therefore, this seems to indicate that SMHSOP admit clients at a higher level of severity, and although severity is reduced, it remains higher than the severity of clients in the target group managed by adult mental health services.

The overall conclusion on client outcomes is that although attempts were made to explore them, they could not be ascertained through this project. Therefore, a specifically designed study is needed to draw conclusions on outcomes.

Phase 2

Priorities identified for Phase 2 include those flagged for Phase 1 that have not been achieved to the levels planned (such as the further development of community teams) and those already identified for Phase 2, as documented in the Service Plan for SMHSOP (which were supported).

In Phase 2, SMHSOP will be impacted by the implementation of activity based funding. This presents risks and opportunities. It is important that the program has input into the funding model design.

There are also structural issues for SMHSOP resulting from the health reforms which need to be resolved. Specifically, these relate to how services and SMHSOP Clinical Co-ordinator and Clinical Director roles and funding will be split amongst the new LHDs.
Recommendations

**Phase 2 of the Service Plan for SMHSOP**

1. Given the projections showing growing need for SMHSOP, and the lower rate of access to these services for NSW residents compared with other jurisdictions, that the NSW Ministry of Health reiterate its commitment for Phase 2 of the *Service Plan for SMHSOP*, with modifications as recommended below.

2. That under Phase 2, the Ministry of Health provide enhancement funding to address firstly the gaps in availability of services across LHDs, and secondly, to manage projected growth in demand for SMHSOP. Rather than emphasising admitted patient services generally, enhancement funding under Phase 2 should be targeted to address the specific circumstances and needs of each LHD, in addition to overall statewide priorities that align with statewide need and NSW Government priorities.

3. That the NSW Ministry of Health maintain and pursue strategies identified in Phase 2 of the *Service Plan for SMHSOP*, including:
   - Consolidation of planning and service developments in Phase 1 (e.g. including further enhancement of community teams and community residential care, implementation phase of policy development work regarding SMHSOP acute inpatient unit model of care, initiatives around older Aboriginal and Torres Strait Islander People and people from CALD communities).
   - New policy and service development initiatives, which will depend on the circumstances of the LHDs. They may include: further enhancement of community teams, acute and non-acute inpatient care, rehabilitation and recovery programs for older people.
   - Statewide service development and quality improvement initiatives.

4. That the NSW Ministry of Health continue to work on strategies that were not achieved to the level planned during Phase 1:
   - initiatives targeting priority groups, such as Aboriginal and CALD older people with mental health problems (although initiatives were implemented during Phase 1, further work continues to be required to improve the level of access for priority groups).
   - further partnerships with aged health and aged care services, private psychiatry and other groups
   - training and support to ED staff, acute hospital and mental health inpatient facility staff and mental health crisis teams
   - continuity of care
   - mental health promotion, prevention and early intervention
   - improved accountability.
That the above are aligned with broader policies and frameworks developed for mental health as a whole, particularly those arising out of the NSW Mental Health Commission when it is established.

5. That as a component of Phase 2 of the Service Plan for SMHSOP, the NSW Ministry of Health develop and trial intensive community care models designed to provide an alternative to hospitalisation for the treatment of the acute phase of mental illness, as a supplement to the functions of existing SMHSOP community and inpatient teams (drawing on the Victorian and other relevant models). The trial should assess the benefits, costs, and cost effectiveness of the model, compared with the existing SMHSOP community and inpatient team models and community care options.

6. That the Ministry of Health takes steps towards planning for a tertiary intensive care behavioural unit, as flagged in the Service Plan for SMHSOP for Phase 2 development. This will involve, as a starting point, reviewing current prevalence and projections of older people with extreme mental disorders and dementia with extreme BPSD (i.e. Tier 7 on the Draper et al. 2006 and Brodaty et al. 2003 seven tiered models), as well as current models for managing this group. Also, as flagged in the Service Plan for SMHSOP, that the benefits of a centralised, tertiary model, as distinct from a more localised model, for responding to the needs of people in with extreme behavioural issues be considered. That further consideration of this model be based on the suitability of current options for managing older people in this group, future needs and cost.

**Governance**

7. That the NSW Ministry of Health maintain the SMHSOP Advisory Group and the OPMH Working Group. That the membership of both these groups be expanded to include representatives from the proposed NSW Mental Health Commission. That the SMHSOP Advisory Group continue to report to the NSW Health Mental Health Program Council (or its equivalent under new Ministry arrangements), and potentially other agencies such as the Agency for Clinical Innovation (ACI), as relevant.

8. The OPMH Policy Unit, SMHSOP Advisory Group and OPMH Working Group continue to work and build partnerships with both the Aboriginal Older Peoples’ Mental Health Working Group and the CALD Older People’s Mental Health Working Group to meet the needs of these priority population groups.

9. That the NSW Ministry of Health continue to support the Aboriginal Older People’s Mental Health Working Group. That this working group continues developing linkages and collaborative partnerships with MHDAO’s Aboriginal Mental Health and Wellbeing Reference Group.

10. That the NSW Ministry of Health continue to support the CALD Older People’s Mental Health Working Group. That this group continues developing close working relationship with the NSW Multicultural Mental Health Plan Implementation Committee.

11. That the NSW Ministry of Health maintain the OPMH Policy Unit. The Unit’s role is
particularly important given the significant growth in demand for mental health services for older people, the stage of development of the SMHSOP program as a whole, and the need for ongoing leadership in policy, planning and service development in this area.
SMHSOP Clinical Co-ordinators and Clinical Directors

12. That LHDs ensure that the SMHSOP Clinical Co-ordinator and SMHSOP Clinical Director roles are continued. That each LHD have a designated SMHSOP Clinical Co-ordinator (except for rural LHDs, where alternative arrangements may need to be considered but key functions retained), and appoint a Clinical Director (who may be on a visiting basis for rural areas). It is also recommended that the Ministry of Health allocate some enhancement funds through Stage 2 of the program for this purpose. Designated Clinical Co-ordinator roles are required within each LHD as: there is significant growth in demand occurring within the target group; there will be growth in services over the next few years to meet this demand; services and the program have not yet fully matured; and there are complex relationships with other services to be developed and maintained. SMHSOP Clinical Co-ordinators also provide clinical and strategic leadership and clinical governance, and quality and safety for SMHSOP in health services. Therefore, there are important tasks required in all LHDs to progress SMHSOP to the next stage of development.

Planning

13. To improve the basis for planning SMHSOP services, that the NSW Ministry of Health adopt the methods for estimating the incidence and prevalence of people with dementia with BPSD and other mental illness presented in this report, and use these for projecting levels of service need for the target group for NSW as a whole and for individual LHDs. That the method take into account different levels of prevalence and incidence across five year age groups in the 65 years and older population. That the Ministry of Health initiate a process to identify additional factors impacting on the relative need for services, in particular, the relative supply of residential aged care services across NSW, and incorporate these into the projections methodology.

14. That the NSW Ministry of Health update the Mental Health Clinical Care and Prevention model (MH-CCP) to reflect the relative impact of different levels of prevalence and incidence across five year age groups in the 65 years and over population. This is important for the model to more accurately reflect the needs of the target population.

Information on SMHSOP services

15. That InforMH, supported by the OPMH Policy Unit and other MHDAO staff, and SMHSOP Clinical Co-ordinators, review the capture of activity, outcomes, staffing and expenditure data related to SMHSOP, to ensure data related to these services can be identified in all relevant data collections, that SMHSOP key workers embedded in adult mental health units can be identified, and all relevant service names are aligned and are current. That a business process to ensure that changes in services (e.g. changes in names, opening, closing, merging, splitting of SMHSOP teams/units) can be tracked over time also be established.

16. That InforMH, supported by the OPMH Policy Unit and relevant experts and advisory
groups, identify how existing data items in the various current data collections capture the nature of the client group managed by SMHSOP, and encourage appropriate use of these variables by staff. The review should focus on data items that identify the level of BPSD or mental health disorder, as proposed by Brodaty et al. (2003) and Draper et al. (2006). This work should also advise the upcoming National Outcomes Strategic Directions 2014-2024 (AMHOCN 2011) project if there are additional outcome measures that should be captured that are more appropriate for the SMHSOP target group.

17. That SMHSOP Clinical Co-ordinators review the collection of ambulatory care encounters and health outcomes data by SMHSOP clinicians within their LHD/SHN, ascertain the completeness and quality of reporting and take steps to address gaps. That Co-ordinators provide regular updates to the SMHSOP Advisory Group on steps to achieve completeness and quality of reporting within their LHD/SHN. Discussion at the meeting should be informed by existing reports/tools on the quality of activity and outcomes for each LHD/SHN prepared by InforMH.

18. That InforMH and the OPMH Policy Unit continue with benchmarking initiatives around SMHSOP and implement further planned developments. Together with the SMHSOP Advisory Group, InforMH and the OPMH Policy Unit to continue to identify and work on opportunities to use the initiative to effect local service improvements.

**Improved awareness of SMHSOP**

19. That the OPMH Policy Unit, in conjunction with the SMHSOP Advisory Group and the OPMH Working Group, develop a strategy to communicate information about the mental health needs of older people, the nature of SMHSOP, eligibility criteria and processes for referral to the services in each LHD, to be targeted at:

- mental health clinicians
- aged health clinicians
- residential aged care providers
- mental health non-government organisations
- consumer and carer groups.

**More consistent, high quality care for older people with mental illness**

20. That the OPMH Policy Unit undertake joint initiatives to identify opportunities to develop evidence-based, consistent service models for the care for older people with mental illness, regardless of the service unit responsible for their care. That this be in conjunction with the SMHSOP Advisory Group, OPMH Working Group, ACI Aged Care Network and other relevant stakeholders.

21. That the OPMH Working Group and the Mental Health Clinical Advisory Council undertake joint initiatives to develop evidence-based, consistent service models for the care for older people with mental illness managed by adult mental health community or admitted teams.
22. That the OPMH Policy Unit and SMHSOP Advisory Group/Clinical Coordinators further identify strategies to prevent older people with mental illness presenting to emergency departments. With clients that do present to emergency departments, that these groups identify strategies to manage them more effectively. That this include the development of a policy (in conjunction with other relevant groups) on who is responsible for clients with BPSD presenting to emergency departments. That the groups also identify and implement evidence-based pathways for clients on discharge from emergency departments to prevent readmission.

23. That the OPMH Policy Unit, together with the SMHSOP Advisory Group and the OPMH Working Group, identify and develop policies and strategies to improve the quality and safety of the care of older people with mental illness. That these groups identify opportunities to provide input to policies and strategies to improve quality and safety developed for mental health services more widely and/or for the wider health system, specifically on issues affecting older people with mental illness.

**SMHSOP workforce**

24. That the OPMH Policy Unit continue working with the SMHSOP Advisory Group to address workforce issues at a State level, such as through funding further training opportunities, reviewing and acting on workforce issues, and disseminating information about local strategies to recruit and train suitable staff (e.g. through discussions at SMHSOP Advisory group meetings). That the OPMH Policy Unit continue and further develop work with relevant groups (including the NSW Branch of the Faculty of Old Age Psychiatry, Royal Australian and New Zealand College of Psychiatrists (RANZCP), and NSW Institute of Psychiatry) to further develop appropriate training, such as training for more experienced clinicians and around BPSD. That this also include further training delivery strategies, such as online learning approaches (particularly for rural clinicians).

25. That the SMHSOP Advisory Group review the orientation and induction programs for new SMHSOP staff developed previously. SMHSOP Clinical Co-ordinators continue to implement these, and to provide feedback to the SMHSOP Advisory Committee on an ongoing basis on their usefulness to ensure their continued improvement and currency.

26. That LHDs develop strategies to address barriers to ongoing training for SMHSOP clinicians, including availability of appropriate training, backfill and funding.

27. That LHDs consider resources required by staff to effectively execute their roles. This includes the availability of a motor vehicle for staff having to undertake home visits as part of their role.

**SMHSOP consumers and carers**

28. That the OPMH Policy Unit, working with the SMHSOP Advisory Group and the OPMH Working Group, strengthen input into SMHSOP and further SMHSOP/OPMH program developments from consumers, families and carers. This can be achieved through: wider consultation with these groups on any upcoming policies/initiatives; strengthening the input of organisations representing these groups; identifying best practice initiatives/programs and...
creating mechanisms to disseminate information about them (similar to the PLAC awards) and for the adoption of the ideas of other organisations/groups; and identifying and working more closely with ‘champions’ advocating for consumers, carers and families.

**Priority groups**

29. That for all priority population groups, the Ministry of Health/MHDAO seek input from relevant representatives of these groups at all stages of the development of new policies/initiatives, from initial consultation through to policy/initiative development and implementation.

30. That the OPMH Policy Unit and the SMHSOP Advisory Group, in partnership with the Aboriginal Older Peoples’ Mental Health Working Group, implements the recommendations from the *Aboriginal Older Peoples’ Mental Health Project Report* and other strategies to facilitate improved access to and appropriateness of SMHSOP services for Aboriginal people. That any additional specific issues required for improving access specifically for Torres Strait Islander people (i.e. given the focus of the current strategies on Aboriginal people) be identified.

31. That the OPMH Policy Unit and the SMHSOP Advisory Group, in partnership with the CALD Older People’s Mental Health Working Group, continues to support the implementation of the strategies identified by the CALD Older People’s Mental Health Working Group. That in particular, the work focus on the development of additional partnerships with organisations that work with older people from CALD communities.

32. That the Ministry of Health provide funding for specific strategic planning regarding the needs of older people with mental illness while in custody, and the development of effective models to meet these needs. That the Ministry then review the funding for SMHSOP for Justice Health for Phase 2 to ensure its adequacy in meeting the needs of older people with mental illness while in custody, and in supporting appropriate placements for them in this context.

33. That the OPMH Policy Unit, working with the SMHSOP Advisory Group and other relevant groups, further pursue the incomplete Phase 1 strategy to develop operational models for the effective use of telepsychiatry and other relevant service delivery models in Phase 2, to assist with access issues for rural communities.

**Activity based funding**

34. That MHDAO and OPMH Policy Unit, working with the SMHSOP Advisory Group, review the implications for SMHSOP of the move towards activity based funding for health services generally. That steps be taken to address issues immediately to ensure readiness for the planned 2013 implementation of activity based funding for mental health and position SMHSOP to minimise risks and maximise opportunities from this.
Progress of Phase 1 strategies

In this section, Table 3 (see next page) presents a summary of the progress of each of the Phase 1 strategies (based on the evaluation findings detailed in other parts of this report) and provides comments on areas needing further work.
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<th>Strategies</th>
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<th>Overall evaluation of achievement</th>
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<tr>
<td><strong>1. SMHSOP clinical services</strong></td>
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| 1.1 Develop SMHSOP **community teams** across NSW to address access and equity issues | SMHSOP resource allocation, utilisation and staffing (against MH-CCP benchmarks); Community team activity; Client outcomes | • SMHSOP community teams developed across all health services.  
• Development/growth in these has been as a direct result of the program (e.g. through enhancement funding and efforts of SMHSOP Clinical Co-ordinators and Clinical Directors).  
• However, SMHSOP community teams have not achieved:  
  • Equitable access across geographic regions  
  • Equitable coverage for priority groups (i.e. Aboriginal and Torres Strait Islander, CALD, rural residents, older people in custody). | Substantial progress, with further work required |
| 1.2 Develop and support **partnership arrangements** to improve access to private psychiatric services for older people with mental health problems | Arrangements in place; Access to private psychiatric services by older people | • At the State level, private psychiatry has been represented on the OPMH Working Group, but membership has been intermittent. At health service levels, there are instances of partnership arrangements with private psychiatrists, but these are not widespread.  
• Nevertheless, comparisons with other jurisdictions show that NSW has better use of private psychiatric services for the 65 plus age group (and for all age groups combined) than many of the other Australian jurisdictions (use is about the same as the average for all of Australia). | Some progress, with further work required |
| 1.3 Develop service agreements or protocols in all AHSs for **collaboration between the NSW Health mental health and aged care services in the care of older people with severe BPSD** | Formal agreements or protocols in place | • Many examples of service agreements cited. Some working extremely well, while tensions noted for others. | Substantial progress, with a small amount of further work required |
| 1.4 Develop **BASIS function** in all AHSs for older people with severe and complex behavioural disturbance | BASIS staff and service arrangements in place; Client contacts with people with dementia; Assessment, care planning and care conference activity; Partnership and training activity | • Funding enhancements particularly targeted towards development of BASIS function.  
• Function established in all health services.  
• However, as with community teams generally, geographic coverage and coverage for priority groups is an issue. | Substantial progress, with a small amount of further work required |
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| 1.5 Develop and support arrangements for older people with acute psychiatric symptoms to access acute inpatient care, including training and support to ED staff, acute hospital and mental health inpatient facility staff and mental health crisis teams | Local access to inpatient care for SMHSOP clients; SMHSOP activity in acute inpatient settings | • At a state level, the SMHSOP benchmarking self-audit tool and recommendations to LHDs (as endorsed by NSW Mental Health Program Council) regarding SMHSOP consultation liaison support this strategy.  
• Development and re-development of SMHSOP acute units at Wollongong, Orange and Newcastle also address this.  
• SMHSOP acute inpatient unit model of care project report and MH-CCP also address/support this.  
• Some local examples cited of training and support by SMHSOP staff to other hospital staff, but not widespread. | Some progress with further work required |
| 1.6 Develop and support arrangements that promote continuity of care between inpatient and community settings for the SMHSOP target group, including clinical pathways | Cross-setting continuity | • The proportion of clients being followed up by community teams within 7 days of discharge from an acute unit have almost doubled between 2004-05 and 2009-10, and the proportion followed up within 90 days has also improved substantially over this time frame, indicating increased continuity of care over time.  
• Various initiatives towards continuity of care were also cited at the State and health service level. For example, the benchmarking workshops have focused on building stronger relationships between community and inpatient teams in health services to support continuity of care.  
• Nevertheless, stakeholders identified this as one of the areas where further efforts are required. | Some progress with further work required |
| 1.7 Develop service models and arrangements to support improved access to long-term care options for the SMHSOP target group | Pilot models established; consultation liaison and training activity; Service models and arrangements in place | • Pilot models were established in two sites under the NSW Mental Health Aged Care Partnership Initiative (MHACPI): Catholic Health Care and Hammond Care.  
• An evaluation was undertaken, which concluded that the MHACPI model can successfully deliver quality care for older people with BPSD and/or mental illness within a mainstream residential aged care setting, improving their quality of life, and their access to long-term, community-based care.  
• High level of family, carer and staff satisfaction was demonstrated, and the potential of this model to relieve pressure on NSW Ministry of Health acute hospitals and mental health inpatient services and transition SMHSOP clients into mainstream residential aged care places, with few readmissions.  
• The NSW Ministry of Health will conduct further analysis of the cost-effectiveness and funding model of the MHACPI model and further monitoring and evaluation (including assessment of client clinical outcomes) to inform the expansion of the MHACPI across NSW, in consultation with the Australian Government Department of Health and Ageing.  
• Consultation liaison and training activities to residential aged care facilities increased significantly through BASIS/DBMAS and T-BASIS initiatives. | Achieved |
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| 1.8 Implement strategies to improve access to non-acute inpatient or rehabilitation services for the SMHSOP target group (and investigate community mental health rehabilitation models) through: Clinical service redesign of CADE Units; development of SMHSOP sub-units, or appropriately supported and designed care environments within mental health non-acute facilities; and arrangements with aged care services (including transitional aged care service models and flexible care service models) | Implementation of CADE review recommendations; Arrangements with CADE Units and aged care services in place; Access to CADE Units and rehabilitation services for SMHSOP clients; SMHSOP activity in CADE Units; Service redesign of mental health non-acute inpatient units; New SMHSOP clients to mental health non-acute inpatient units and length of stay | • Transition of CADE units to T-BASIS has been achieved, in line with the CADE review recommendations. An evaluation of the T-BASIS units found that the five remaining units have moved substantially towards the T-BASIS model of care, a non-acute assessment-treatment/management-discharge inpatient service for older people with severe BPSD.  
• The evaluation noted an increase in the severity and complexity of patients admitted to the T-BASIS units, an increase in the number of patients treated annually, and a decrease in average length of stay. The evaluation also found that where the T-BASIS model is more fully implemented, it can be both clinically effective and cost effective, with few readmissions and high family and carer satisfaction.  
• The evaluation highlights that the need for appropriate services across the spectrum of care for people with BPSD will continue to be an issue.  
• Benchmarking in mental health more generally has also facilitated service improvement and reform in non-acute units, with some input and focus on older people’s mental health.  
• There are still only a very small number of SMHSOP non-acute inpatient beds throughout the State for the level of existing demand and estimated need. This is targeted to be addressed Phase 2. | Substantial progress during Phase 1. Further work identified for Phase 2 |
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| 1.9 Conduct education and training activities regarding older people’s mental health issues with primary health, aged care, community care and residential aged care staff to enhance capacity for prevention and early intervention and appropriate referral. (Training to cover depression, suicide risk assessment and suicide prevention as priority issues.) | Education and skills training activity                                                            | • OPMH/SMHSOP promotion, prevention and early intervention staff and community teams have conducted significant education and training and capacity work in some of the former Area Health Services with a range of key services. However, coverage has not been comprehensive on a statewide basis.  
• Positive living in Aged Care (PLAC) awards also promoting innovative practices in residential aged care facilities to improve the mental health and wellbeing of residents. The initiative has also involved compiling and disseminating, within the residential aged care sector, information about innovative approaches to improving the mental health and wellbeing of residents.  
• The NSW Elderly Suicide Prevention Network (ESPN) also provides information sharing and advocacy for staff working in specialist positions focused on preventing suicide and depression in older people, through state-wide conferences and resource development and dissemination as well as other avenues.  
• Other examples cited within health services of DBMAS/BASIS staff across NSW providing education and training activities to other staff, but mostly with residential aged care staff.  
• Needs further expansion, particularly with primary and community care.                                                                 | Substantial progress in relation to residential aged care facilities, but some progress overall with primary health and community care in particular (significant in some LHDs/former Area Health Services). Further work required, particularly for primary and community care. |
| 1.10 Conduct community development activities with health promotion, prevention and early intervention goals | Community development activities conducted                                                      | • On a statewide basis, PLAC project has been conducted as a statewide mental health promotion project.  
• Examples of activities also cited within LHDs (see notes in relation to 1.9).  
• However, stakeholders pointed out that resourcing in relation to health promotion, prevention and early intervention is still limited.                                                                                                                                                                                                                                                   | Some progress, with further work required                                                                                                     |
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| 1.11 Provide information and support to carers of older people with mental illness | Carer information and support activity                                  | - Scoping paper developed for the OPMH Working Group to support consultation and capacity building with consumer and carer organisations in older people’s mental health to increase their advocacy and advisory roles and input into processes, indicatives and policy development in older people’s mental health services within NSW.  
- Audit of carer, consumer and community-focused programs/projects also undertaken as part of the above initiatives. Information about statewide and local programs/services circulated to carer and consumer organisations and other stakeholders (including NSW Family and Carer Mental Health Program Network).  
- Local health service initiatives in relation to families and carers also cited. However, one of the issues identified by clinicians is that they do not have adequate time to provide information and support to carers to the level that they perceive is required. | Some progress, with further work required                              |
| 1.12 Develop collaborative strategies with GPs to promote early intervention and referral, and effective primary health care for older people with mental health problems, including: Training activities; provision of information and development of protocols to promote appropriate referral; and shared care approaches | Training activity; Referrals from GPs; Care conference and care planning activity | - Almost all health services cited formal or informal collaborative strategies with GPs, such as training or shared care.  
- However the extent to which these have been able to be developed with all GPs/primary care providers is variable.  
- At a statewide level, the SMHSOP benchmarking project and self-audit tool have promoted strategies regarding referral and follow up process between SMHSOP and GPs.  
- As part of OPMH Working Group activities, links between HealthOne services and SMHSOP have been promoted.  
- Specific content developed regarding older people’s mental health (with input from MHDAO) for statewide MHDAO-funded GP initiative relating to mental health professional development and collaborative care between mental health services and GPs. | Some progress, with further work required                              |
| 2. Priority groups                                                        |                                                                        |                                                                                                                                                                                                                      |                                           |
| 2.1 Develop and implement strategies to improve responses by mental health services to older Aboriginal people with mental health problems, including opportunistic mental health promotion, training with mental health staff regarding culturally appropriate assessment and treatment, capacity building with primary health care workers and establishment of professional development and support structures (including specialist back up) | Strategies implemented; Training activity; Access to SMHSOP by Aboriginal people | - Development of an Aboriginal Older People’s Mental Health Project Report focused on the mental health and social and emotional wellbeing needs of older Aboriginal people on issues regarding access and appropriateness of SMHSOP for this group.  
- Establishment of Aboriginal Older People’s Mental Health Working Group (expansion of Aboriginal Older People’s Mental Health Project Reference Group) to advise on strategies to support implementation of Project Report recommendations and other work, particularly in the areas of partnerships. This working group is also designed to provide input and advice on older people’s mental health policy and initiatives, as well as broader policies impacting on Aboriginal older peoples’ mental health.  
- Access to services for Aboriginal and Torres Strait Islander people continues to be an issue. | Some progress, with further work required                              |
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| 2.2 Develop and implement strategies to improve responses by mental health services to older people from culturally and linguistically diverse backgrounds with mental health problems, including consulting with CALD organisations and communities, developing culturally competent assessment and care, disseminating appropriate information resources and developing partnerships with multicultural organisations and bilingual workers | Strategies implemented; Relevant activity; Access to SMHSOP by people from CALD communities       | • Transcultural Mental Health Centre undertook the CALD Community Mental Health Project with MHDAO funding, with a number of objectives: building capacity of CALD communities in NSW to increase mental health literacy, access, and equity to mental health services; and examining and improving accessibility and appropriateness of SMHSOP to older people from CALD communities.  
• Developed a multimedia community awareness campaign on mental health for older people in 11 different languages as part of the above initiative.  
• Establishment of the CALD Older People’s Mental Health Working Group to advise on strategies to support implementation of report recommendations and other work.  
• Many examples of initiatives to improve access at local health service levels also cited.  
• However, access for this group continues to be an issue. | Some progress, with further work required |
| 2.3 Examine and develop operational models for the effective use of telepsychiatry for SMHSOP to support improved access to specialist consultation/ liaison for older people in rural and remote areas and other appropriate service delivery models | Model developed; Use of telepsychiatry by SMHSOP                                                 | • SMHSOP engaged in telepsychiatry services development in rural areas and these practices considered in SMHSOP benchmarking. However, no statewide operational model developed during Phase 1.  
• Small number of examples of telepsychiatry (including videoconferencing for clinical review of clients) cited. | Some progress, with further work required |
| 2.4 Implement strategies to address the needs of older people with complex mental health problems in the criminal justice system, including: Developing tertiary referral clinics and clinical pathways; Establishing an aged care and rehabilitation unit within the new Long Bay Prison Hospital; Piloting a joint Department Corrective Services/Justice Health supported accommodation model; and Improving pre-release risk assessment and other discharge planning processes | Clinics and clinical pathways established; Hospital aged care and rehabilitation unit established; Supported accommodation model established; Assessment, care planning and discharge activity; Client outcomes | • Most of the initiatives achieved except supported accommodation model.  
• However, post custody options for management within the community are still limited.  
• Resourcing for the service within Justice Health is also very limited.  
• Further work required with Department Corrective Services/Justice Health supported accommodation model, discharge planning, community and residential care and post-acute care options. | Some progress, with further work required |
### 3. Workforce

#### 3.1 Develop and implement a SMHSOP training package and orientation program and core competencies (including cultural competency) for new SMHSOP staff to support recruitment and quality of care (to be mandatory)

<table>
<thead>
<tr>
<th>Training package and orientation program developed; Core competencies developed; Participation in training activity; Core competencies met by SMHSOP staff; SMHSOP staffing against resources allocated</th>
</tr>
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</table>
| • Orientation program guide developed, and mandated for all new SMHSOP staff. Implemented in most instances, although reporting by SMHSOP clinicians that some have not participated in this.  
• SMHSOP brief clinical induction resource also developed and disseminated/ implemented statewide.  
• SMHSOP core competencies developed, endorsed by the NSW Mental Health Program Council, and disseminated across NSW.  
• More recently MHDAO funded the NSW Institute of Psychiatry to conduct training across NSW to support the implementation of the SMHSOP core competencies for beginning community clinicians.  
• Cultural competencies developed nationally and have informed revision of the SMHSOP core competencies in consultation with the Aboriginal and CALD Older People’s Mental Health Working Groups.  
• OPMH Policy Unit worked with the NSW Institute of Psychiatry and other training providers to review the current content of post-graduate training in SMHSOP to ensure applicability to the current and future needs of the SMHSOP workforce, and address feedback on survey findings regarding educational priorities.  
• Scholarships offered to SMHSOP clinicians to undertake postgraduate training  
• Through the survey undertaken for this evaluation, the majority of clinicians (51%) reported that they had received a ‘fair amount’ of training.  
• Other training opportunities also available within local health services, such as ‘in-service’ sessions and upskilling. |

#### 3.2 Conduct training with adult mental health teams and SMHSOP key workers to improve knowledge of and responses to older people’s mental health clinical issues

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<tr>
<th>Training activity</th>
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<tr>
<td>• Some local examples of training of adult mental health teams and/or SMHSOP key workers cited, but generally very little progress in this area.</td>
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#### 3.3 Develop and implement clinical guidelines to support SMHSOP staff in clinical care

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| • At a statewide level, guidelines developed for SMHSOP or inclusion of SMHSOP/older people’s mental health content in guidelines for mental health generally. The latter includes the following guidelines:  
  • Physical Health Care of Mental Health Consumers  
  • Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW (yet to be endorsed).  
  • Clinical guidelines also developed by most health services. Through the survey undertaken for this evaluation, clinicians reported that clinical guidelines were available to them in most instances, and that they were very helpful in their work. |

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**Overall evaluation of achievement**

- Substantial progress, with a small amount of further work required
- Limited progress, with substantial further work required
- Substantial progress
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<td>3.4 Develop and support workforce training and recruitment programs to increase the supply of appropriately qualified medical, nursing and allied health staff for SMHSOP, in partnership with peak professional bodies and education and training organisations</td>
<td>Workforce training and recruitment initiatives conducted; Training activity; SMHSOP staffing against resources</td>
<td>• A statewide SMHSOP survey was conducted focused on workforce profile (mix of disciplines, background, training and experience), skills and proficiency in various key areas of clinical practice, and training priorities. The results were used to further inform the SMHSOP workforce development project.</td>
<td>Substantial progress, with a small amount of further work required</td>
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<td>4. Planning</td>
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<td>4.1 Develop Area Health Services (AHS) SMHSOP Strategic Plans for 2005–2010 to guide the implementation of the Service Plan for SMHSOP in AHSs, in line with AHS service gaps, priorities and population needs</td>
<td>Area SMHSOP Strategic Plans produced and disseminated to key stakeholders</td>
<td>• All former AHs developed these plans addressing appropriate issues.</td>
<td>Achieved. However, time frame for plans has elapsed and new plans are required for Phase 2</td>
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<td>4.2 Establish consultation and planning processes at the state level and AHS level to facilitate stakeholder input to and partnerships in SMHSOP service development</td>
<td>Consultative processes in place; Consultation and joint planning activity</td>
<td>• Evidence of substantial work to build partnerships, particularly at the State level and also at a health service level.</td>
<td>Substantial progress, with a small amount of further work required</td>
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<td>4.3 Review current inpatient care services, including clinical quality and safety, effectiveness, appropriateness and efficiency, and develop appropriate inpatient care models for the SMHSOP target group</td>
<td>SMHSOP inpatient care model developed</td>
<td>• SMHSOP inpatient model of care developed, covering the following components of care: philosophy of care; functions and target population; comorbid disorders and problems; functional relationships; key processes; clinical interventions; the use of seclusion and restraint; facility design issues relevant to the model of care; staffing; and performance.</td>
<td>Achieved</td>
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<tr>
<td>Strategies</td>
<td>Performance or process indicators</td>
<td>Summary of progress</td>
<td>Overall evaluation of achievement</td>
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| 4.4 **Influence and advise on capital planning processes** at the state and AHS level to promote development of SMHSOP acute and non-acute inpatient services in Phase 2 of the SMHSOP implementation plan (based on effective inpatient care models and in line with MH-CCP benchmarks) and appropriate environments for the SMHSOP target group in existing and new inpatient facilities catering to older people | New SMHSOP acute and non-acute inpatient beds on NSW Health capital plans; Environmental modifications (including capital works) to existing inpatient facilities; Utilisation of and compliance with relevant guidelines from the NSW Department of Health | • Limited input into capital planning at a State level.  
• Plans developed at a local level for the development of new services.  
• Suitability of physical facilities is still an issue for some services.  
• NSW Health (particularly the OPMH Policy Unit), led the development of the first (forthcoming) Australasian Health Facility Guidelines for Older Person’s Acute Mental Health Inpatient Units to promote appropriate design of these units.  
• Facility design issues relevant to SMHSOP addressed in the Review of Admitted Model of Care project. | Some progress, with further work required                                                                                                                                                                                                                                                                                                                                                          |
| 4.5 **Participate in planning with aged care services and other relevant services** to develop joint initiatives and coordinated responses to the needs of older people with mental health problems | Mental health partnership activity                                                                                                                                                                                                                                                        | • Many examples of joint planning initiatives with aged care at a state and local levels, such as the **NSW Integrated Services Framework for Specialist Care for Older People**. | Substantial progress, with a small amount of further work required                                                                                                                                                                                                                                                                                      |
| 5. **Resource allocation**                                                                                                     |                                                                                           |                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |
| 5.1 **Increase resource allocation to support the development of SMHSOP** and improve responses to needs of older people with mental health problems | NSW Department of Health funding for SMHSOP; Funding for SMHSOP partnership activities and other programs targeting older people mental health by other agencies | • Funding enhancements for the development of services provided, and evidence of service expansion as a result.  
• Funding for special projects identified and provided as work undertaken. | Achieved                                                                                                                                                                                                                                                                                                                                         |
| 6. **Accountability**                                                                                                          |                                                                                           |                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           |
| 6.1 Implement strategies to increase MH-OAT standard outcome measure reporting by SMHSOP clinicians, maintain reporting quality and provide feedback on reports to SMHSOP | MH-OAT reporting by SMHSOP against CMH targets; Feedback provided to SMHSOP staff | • Addressed through benchmarking initiative.  
• Capture of information has improved over time, but remains an issue. | Some progress, with further work required                                                                                                                                                                                                                                                                                                                                                          |
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| 6.2 Implement strategies to facilitate streaming of SMHSOP activity reporting (through data linkages between mental health, aged care and community health data collection systems), increase activity reporting by SMHSOP clinicians, facilitate reporting quality and consistency, and provide feedback on reports to SMHSOP staff | MH-AMB reporting by SMHSOP against CMH targets; Feedback provided to SMHSOP staff | • SMHSOP benchmarking initiative has aimed at increasing activity reporting by SMHSOP clinicians, facilitating reporting quality and consistency, and providing feedback on reports to SMHSOP staff. Generally good impacts on these areas.  
• Further streamlining required, particularly regarding data linkages. | Some progress, with further work required |
| 6.3 Implement Mental Health Unique Patient Identifier (MH-UPI) in SMHSOP, in line with the NSW Department of Health UPI development and implementation process | MH-UPI completion | • Implemented, and some units achieving 100% separations with a SUPI assigned.  
However, others still less than 50%.  
• Overall, SUPI assignment is good (around 88% of separations have a SUPI assigned on average), but has not improved over the last five years for SMHSOP a whole. | Some progress, with further work required |
| 6.4 Develop and support effective clinical governance arrangements and quality improvements to promote quality and safety in clinical care | Clinical governance arrangements in place; Reportable incidents | • SMHSOP Clinical Co-ordinators and Clinical Directors provide effective clinical governance. Clinical Co-ordinators provide leadership and direction for clinical standards and quality improvement, and Clinical Directors provide clinical leadership and governance.  
• Reportable incidents were not able to be analysed for this project. | Some progress, with further work required |
| 6.5 Implement benchmarking initiatives involving like services within and across AHSs and participate in state and national benchmarking processes to inform data collection developments, performance monitoring and evaluation, clinical service development and quality improvement | Benchmarking conducted; SMHSOP participation in state and national benchmarking | • Various initiatives implemented as part of SMHSOP benchmarking project, including: six-monthly statewide benchmarking forums; annual completion of self-audit tool; six-monthly clinical information reports; site visits conducted by InforMH throughout the year.  
• A recent review of the forums showed an increase in the number of participants over time.  
• Feedback on the forums has consistently been positive regarding participants’ understanding of data and consequently a better understanding of their services.  
• However, less confidence has been expressed in more recent evaluations about the forums effecting local clinical practice.  
• Extremely good feedback about the forums provided through stakeholder interviews undertaken as part of the current evaluation.  
• NSW SMHSOP units/teams also participated in national mental health benchmarking, with strong linkages made between national and NSW benchmarking processes. | Substantial progress, with a small amount of further work required |
References


Council of Australian Governments 2011, National Health Reform Agreement, COAG, Canberra.


