Older People's Mental Health Community Services Model of Care

Evidence Report

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

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Foreword

The ultimate goal of this model of care is to improve the care, and outcomes, of people requiring assistance from older people's community mental health services. The model of care provides guidance for policy makers, service planners, service managers and mental health professionals in providing and improving OPMH community services. These diverse groups of people will vary in which aspects of the guidance are most relevant to them, and what forms of evidence are most important to them.

This Evidence Report provides access to the broad range of evidence synthesised to support the updated model of care. The length reflects the increasing breadth of what is recognised as evidence. That breadth includes not only considering published literature; but evaluations relevant to the use and implementation of the preceding model of care, changes in policy and roles of other services, and the experiences and values of those using and providing services, as well as the outcomes of care. The implications of different forms of evidence have been explored in statewide benchmarking activities with stakeholders in developing the predecessor to this model of care, supporting its implementation, and informing this revision. Giving a voice through benchmarking to those directly providing services, and those receiving services, has been fundamental to the model's development and I hope it will drive the success of the model, as measured by ongoing improvement in mental health care for older people in NSW.

It has been a privilege to work with so many dedicated and passionate people in revising the Older People's Mental Health (OPMH) Community Services Model of Care, and in working in those services. It is an even greater privilege, and reward, to work with older people accessing those services. Older Australians have a lifetime of contributing to society before accessing mental healthcare; and their potential to continue contributing is too easily overlooked. I look forward to seeing the ongoing evolution and improvement of mental health services for those older Australians in New South Wales; and continue to take pleasure at seeing those Australians' resilience and ongoing contribution despite the trials bringing them to services.

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Section 1. Introduction

1.1 Purpose of the OPMH community services model of care

The Older People's Mental Health (OPMH) Community Services Model of Care (MoC) is about older people with, or at risk of, mental illness, their needs, and the needs of those who care for and support them. It also is about the role of mental health professionals within OPMH community services, and the way these mental health professionals work with a range of partners, including consumers, families, carers and relevant services and supports, to improve the lives of older people with mental illness and their carers.

Like people of any age, older people can be vulnerable to mental illness. Some older people develop a mental illness as they age, while others grow older with a continuing experience of a mental illness that developed earlier in their lives.[1,2] Such illnesses include depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, alcohol and substance misuse disorder and behavioural and psychological symptoms of dementia (BPSD).

Older people also experience responses to events and developmental stressors that may or may not have a diagnosis. This may be relevant to suicide prevention strategies and support provided in the mental health system, including acute hospital services and community-based services. In some circumstances, the presence of mental illness in older people is more common, including in those with chronic illnesses[3,4] and in residential aged care homes.[4,5] Men aged 85 and over persistently have one of the highest suicide rates in Australia and there is increasing evidence that rates of mental illness increase in very late life after lower levels in the sixth decade of life.[2] Mental illness and dementia, however, are not an inevitable part of ageing.[4]

Current Australian population projections identify an increase in New South Wales of people over the age of 65 with particularly high projected increases between 2026 and 2041 in the 80-84 years population (expected to increase by one third) and the 85 years+ population (expected to double).[6] As the NSW population ages, the number of older people with a diagnosable mental illness is projected to increase significantly, rising from approximately 338,000 in 2025-26 to approximately 404,000 in 2035-36 .[7]

This OPMH Community Services Model of Care (MoC) Evidence Report and the associated OPMH Community Services Model of Care (MoC) Guideline[8] are intended to guide policy makers, service planners, service managers and mental health professionals in providing and improving OPMH community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified from consumer, carer, mental health professional and stakeholder consultations.

The Guideline contains key information and guidance, in the form of good practice features, to support local implementation of the MoC (whilst recognising that there are variable starting points in terms of current care delivery across NSW OPMH community services, and local service context will also vary). The Report provides more detailed information about the consumer, carer, mental health professional and stakeholder advice, evidence and policies that support the model of care, as well as good practice features for OPMH community services.

[a] Source: National Mental Health Services Planning Framework (NMHSPF) V4.4, which uses NMHSPF-modified 2023 Global Burden of Disease (GBD) prevalence estimates for Australia. This figure indicates the 12 month prevalence of mental illness for people aged 65+ years in NSW across three levels of severity (mild, moderate and severe).

1.2 Scope of the model of care

OPMH services are a specialist clinical stream of public mental health services focussed on older people with mental illness, and include inpatient, community and community residential services (generally delivered in partnership with non-government residential aged care services). The OPMH Community Services MoC articulates how community mental health services for older people should be delivered, aiming for the right care to be provided to people at the right time, by the right team and in the right place, with care directed by the consumer and carer with expert mental health professionals alongside.

1.3 Updating the OPMH Community Services Model of Care

The OPMH Community Services MoC was first published in 2017. This report and the associated guideline contain updates to the MoC to reflect changes in policy, practice, evidence and the service context for OPMH community services. The updated MoC reflects input from consumers, carers, mental health professionals and stakeholders, and includes some new or revised guidance. It maintains a focus on recovery-oriented and person-centred care and recognises the importance of culturally safe, responsive and trauma-informed care. It supports a focus on the individual defining their own recovery goals and directing their own care. It recognises variations in practice and governance in OPMH community services across NSW and seeks to promote consistent good practice.

Building on the extensive consultation, policy and literature review undertaken to support the 2017 OPMH Community Services MoC, the updates have been informed by:

- Advice from an expert reference group (ERG), including consumer and carer representatives, representatives with expertise in working with Aboriginal consumers and communities, culturally and linguistically diverse (CALD) communities, LGBTIQ+ communities, OPMH clinical and strategic leaders, OPMH clinicians from various disciplines and services (including metropolitan and rural services), and community managed mental health sector representation. See Appendix A for ERG membership.
- A review of relevant and current policy and practice guidance and the international literature.
- Consumer and carer consultations via a focus group and a survey to review the main directions of the OPMH community services guideline and key areas of care provided by OPMH community services. See Consumer and Carer Consultation Summary Report attached as *Appendix B*.
- Consultation with the NSW Health OPMH Services Advisory Group and OPMH community services, OPMH Working Group, CALD OPMH Working Group, Aboriginal OPMH Working Group, Emergency Care Institute Clinical Advisory Committee (Agency for Clinical Innovation), General Practice Advisory Group (Agency for Clinical Innovation), and relevant NSW Ministry of Health branches.
- Feedback on the draft updated Community OPMH MoC guideline from NSW local heath districts (LHDs), relevant NSW Ministry of Health branches and other key stakeholders.
- Findings from the OPMH Mid Term Service Plan Evaluation Summary Report[9] and statewide OPMH benchmarking.

1.4 Themes from consumer and carer consultation

Themes from 2017 consultations

The development of the OPMH Community Services MoC (2017) included an extensive consultation process with consumers, carers and clinicians. This process included a series of workshops that helped define the primary vision and values for OPMH services, as well as the key principles and elements of the consumer journey.

The 2017 consultations revealed a strong desire for self-determination and recovery-oriented care, with consumers and carers advocating for meaningful involvement in decision-making and care planning, and effective communication. The importance of collaboration between different services was highlighted, along with support for developing a peer workforce in OPMH. Flexibility in service delivery across different settings including homes, residential aged care homes, and hospitals was highly valued. At this time, virtual care received mixed feedback, with its success largely dependent on preparation and user familiarity.

From a clinician perspective, stigma and low mental health literacy were identified as significant barriers to access. Centralised intake systems were often perceived as impersonal and inconsistent, especially for older people with hearing impairments. OPMH services were recognised as specialist services requiring staff with expertise in older people's mental health. Multidisciplinary teams were considered best practice for delivering comprehensive and coordinated care.

The following elements of care emerged from the 2017 consultations as priorities for consumers and carers, as well as OPMH clinicians and key stakeholders, and guided the model of care.

- Good communication and engagement with older people from initial contact.
- Easy and timely access to appropriate assessment.
- Recovery-oriented, consumer-led care, involving partnering with a consumer and their carer and GP and supporting consumers in their personal recovery journeys.
- Joint care planning and coordination with GPs and other key services and health care providers, with a focus on recovery.
- Support and good communication during transitions between inpatient and community services, and other transitions of care.
- Well-planned discharge processes that included relapse prevention and clear re-entry pathways.

Consumers and carers particularly valued the role of OPMH services in providing specialist mental health care/treatment for older people with acute, severe and/or complex mental illness (including moderate-severe behavioural and psychological symptoms of dementia or BPSD).

Themes from 2025 consultations

Many of the key themes identified in the 2017 consultations with consumers and carers have been reaffirmed in recent survey and focus group consultations, as documented throughout this report. Some new themes and priorities have emerged (See *Appendix B*). Key themes that have remained consistent over time include the importance to consumers and carers of:

- Connection, purpose and hope
- Recovery-oriented care
- Access to specialised staff
- Working in partnership
- Good communication
- Flexible services that provide individualised care

A number of clear priorities have emerged from consumer and carer consultation, and these priorities are reflected in the OPMH Community Services Model of Care. They include:

Personalised, specialist, and face-to-face care

Both consumers and carers strongly valued care delivered by specialist clinicians who understood their specific needs and provided support in a timely, collaborative manner. There was a clear preference for face-to-face care to be delivered at a person's residence or community health centre, with most respondents viewing videoconferencing as the least desirable mode of care due to difficulty using technology.

Communication, engagement, and continuity

Effective communication with health professionals was a top priority for both groups. Consumers and carers wanted to be listened to, involved in decision-making, and informed throughout the care journey. Continuity with the same mental health professional and clear discharge processes, including information about how to re-engage with service if needed, were also highly valued.

Access, navigation, and coordination

Initial access to services was typically through GPs or hospital referrals, but many carers reported difficulty in navigating the system and finding the right services. Care navigation and coordination support was identified as an important need to ensure smooth transitions and integrated care.

Treatment and support preferences

Consumers and carers both highlighted the importance of having access to psychological/talking therapies, as well as medication. They also desired greater access to psychologists and psychiatrists, and support during discharge and follow-up care planning.

Values, partnerships and system improvements

A shared vision for OPMH services includes creating connection, purpose, and hope, supported by warm, friendly staff. Stronger integration of physical and

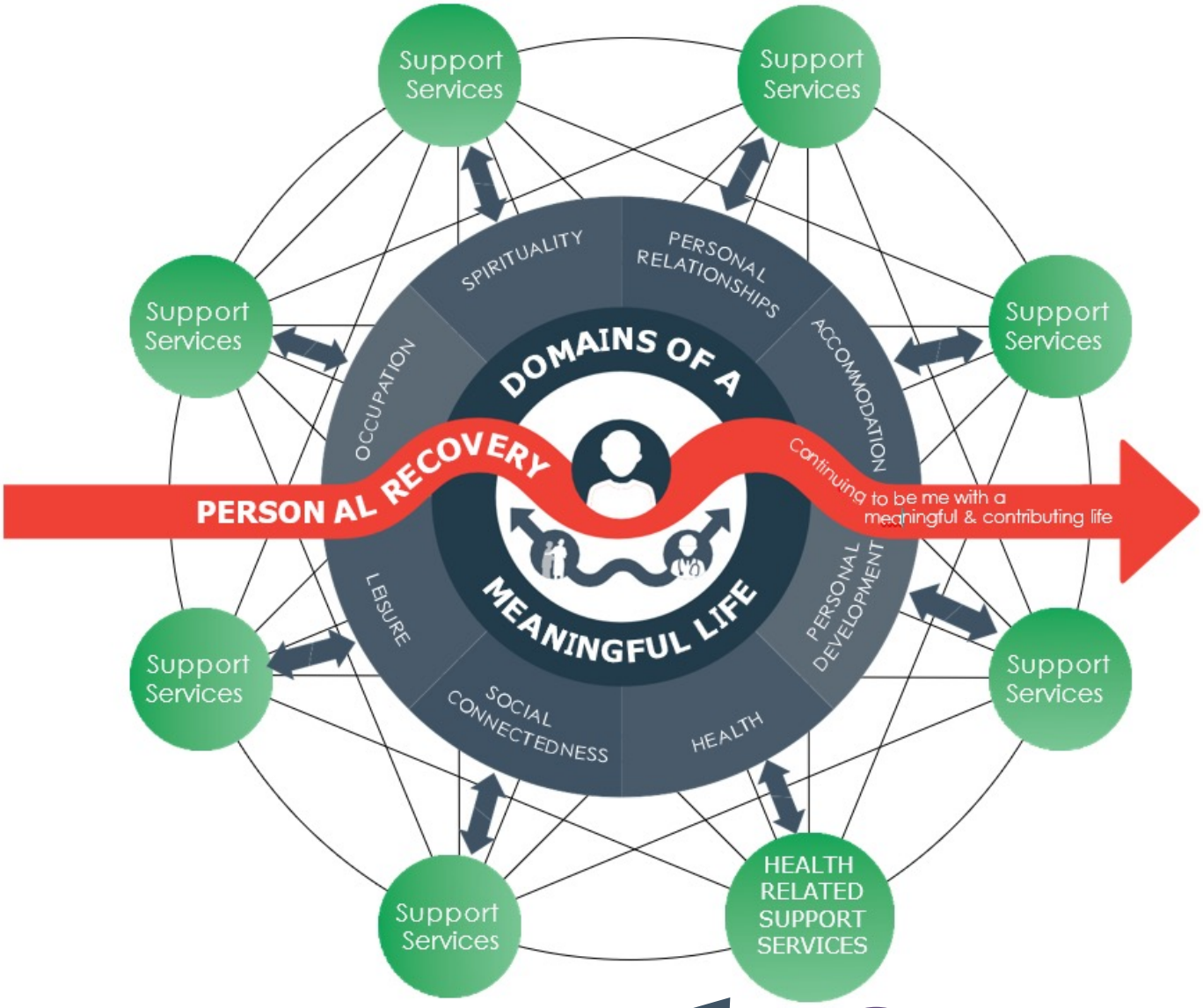
mental health care, greater carer involvement, improved service promotion, and collaboration with external services/agencies were recommended to enhance service delivery.

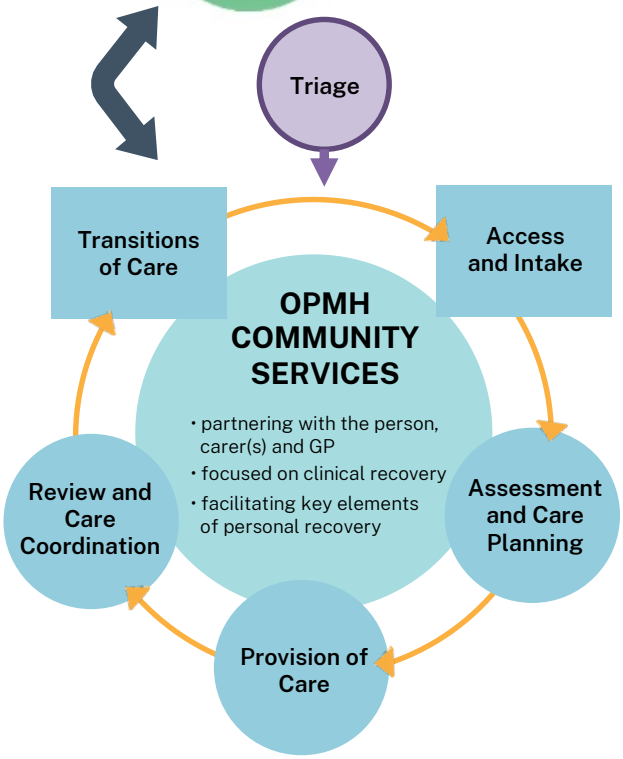
1.5 Principles underlying the OPMH Community Model of Care

Consumers have indicated that they see OPMH community services as one part of a complex system of care that supports their recovery journey. The OPMH Community Services MoC has been developed to match this consumer perspective, as shown in Figure 1.

The OPMH Community Services MoC is guided by the principles of recovery, consumer-led care and partnering with the consumer, carer, GP, and other key services and supports. This reflects the expressed desires of consumers, carers and mental health professionals in consultations, and the clear focus on recovery principles and recovery-oriented practice in mental health policy in Australia.[10–14]

Figure 1: The role of OPMH community services from the consumer's perspective: one of many supports in a personal journey of recovery





The National Framework for Recovery-oriented Mental Health Services: Policy and Theory defines recovery as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.[10] Research with older consumers has found that "continuing to be me" may capture the essence of what this means for older people.[13] Recovery is much broader than clinical recovery and the interconnectedness between 'personal' and clinical recovery is well recognised.[10,15] **Figure 1** shows the interface between clinical and personal recovery and the centrality of the consumer, their carer/s, family and supporters, and GP.

While recovery is unique to the individual, it is likely to involve some or all the 'domains of a meaningful life'. A range of health and community providers – of which community OPMH services are one - will be required to meet the complex physical, social, behavioural and psychological needs of the older person with mental illness. The exact supports offered will be driven by a person's unique values, goals and needs, thereby supporting that person's journey of recovery.

The statewide OPMH Recovery-oriented Practice Improvement Project[16] has promoted recovery-oriented practice in NSW OPMH community and inpatient services through local service improvement projects across NSW. Key messages from this project specific to older people's mental health recovery were:

1. The individual's personal recovery is unique and personal
2. Personal recovery has a complex relationship with clinical recovery
3. Recovery-oriented practice involves a set of capabilities which supports people to undertake their recovery journey.

Since the 2012 Substance Abuse and Mental Health Services Administration (SAMHSA) consensus statement on recovery, the importance of trauma-informed mental health care has been further recognised and the understanding of what recovery means for people living with mental health conditions has developed.[16–20]

While the established evidence base and expert consensus drive clinical practice of OPMH community services and are a key component of this project, each element of the OPMH Community Services MoC should be consistent with (or at least not impede) personal recovery. All elements of the OPMH Community Services MoC have been considered and developed with reference to the five personal recovery processes of Connectedness, Hope and optimism, Identity, Meaning in life, and Empowerment, commonly represented using the acronym CHIME.[21,22]

1.6 Key policies, evidence and practice guidance underpinning the OPMH Community Services Model of Care

The key themes identified through a review of the literature, including relevant state and national policies, and supported by expert consensus, are outlined below. Many of these are consistent with the priorities identified during MoC consultations and have further provided direction to the MoC.

- The importance of working in collaboration with GPs and family/carers as relationships with these support networks change across older age.
- The biopsychosocial approach to care is integral to the assessment, delivery of care and staffing of OPMH community services.
- The value of OPMH service outreach to residential aged care homes, and of collaborative, partnership models between mental health services and aged care services. These OPMH service functions and partnership models can support pathways from hospital to community care in residential aged care homes, and appropriate care, support and accommodation for older people with complex mental health and aged care needs.
- The importance of targeted, systemic approaches to suicide prevention adapted for older people and role of OPMH services in supporting older people in suicidal distress in line with NSW Health older people's suicide prevention initiatives.[23–26]
- The importance of consumer and carer perspectives in driving care, service design and service improvement in mental health services in line with the Agency for Clinical Innovation principles on co-design.
- Recovery-oriented care and practice. This is reflected in the development of the National Framework for Recovery-oriented Mental Health Services,[27] the National Lived Experience (peer) Workforce Development Guidelines,[28] NSW Health's resources on recovery-oriented approaches in mental health,[19] and the OPMH

Recovery-oriented Practice Improvement Project Report[16] which provides a good overview of the recovery literature and considers this in the OPMH context. Recovery-oriented care is discussed in detail in Living Well in Later Life: The Case for Change[29] and incorporated into the NSW Mental Health Act.[14]

- Promoting and supporting triage arrangements that facilitate access to appropriate mental health assessment and care including specialist OPMH assessment and care, in line with the NSW mental health triage services/NSW Mental Health Hub initiative and NSW Health Mental Health Triage Policy (PD2012_053).
- Multidisciplinary care of older people with mental illness. There is considerable evidence to support this as best practice to enable integration of different professional capabilities required for biopsychosocial assessment and care.[15,21,30–34]
- The importance of age-specific service partnerships and collaboration to support integrated care across settings and with service providers both within and external to NSW Health. This helps to ensure that the complex needs of older people with mental illness, and their clinical and personal recovery goals, are addressed, in line with the NSW Health document, NSW Health: Strategic Framework for Integrating Care,[35,36] Research from the UK highlights the importance of integrated care in bridging the gaps between physical and mental health care.[37]
- The importance of coordinated, well-planned transitions of care that prioritise consumer and carer choice, continuity of care, and both clinical and personal recovery needs and align with the NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services* (PD2019_045).
- The importance of attention to the physical health needs of OPMH consumers, noting the link between physical and mental health and the need for appropriate linkages between mental health services and other healthcare providers. The recently published Older People's Mental Health Physical Health Practice Improvement Project Report[38] and the Physical Health Care for Older People Living with Mental Health Issues (GL 2021_006)[39] provide guidance to OPMH community services.
- A stepped care approach to service provision, with the level of service provided matched to each consumer's needs, including 'wrap around' coordinated care for those with severe and complex mental illness.[40–44] This is a key focus of the national mental health reform agenda[45] and is relevant to OPMH community services in terms of prioritisation for OPMH care and key service partnerships. Intake, assessment and prioritisation systems need to balance maintaining a specialist role with the known low access rates of older people with mental illness to Medicare-funded mental health services and increasing rates of presentation to emergency departments.[46]

The OPMH Community Services MoC is informed by key state and national mental health and aged care drivers of policy and practice including NSW Mental Health Reform[47], national mental health reforms[45], and national aged care reforms.[48] The introduction of activity-based funding and activity based management into community mental health services from 1 July 2025 is significant. The National Mental Health and Suicide Prevention Agreement[45] is a key driver of priority work in mental health nationally.

The OPMH Community Services MoC aligns with key national and state standards and policy frameworks including the:

- NSW Older People's Mental Health (OPMH) Service Plan 2017-2027[41]
- Strategic Framework for Suicide Prevention in NSW 2022-2027[49]
- NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 and NSW Health Aboriginal Health Plan 2024-2034[50,51]
- Ageing Well in NSW: Seniors Strategy 2021–2031[52]
- Fifth National Mental Health and Suicide Prevention Plan[53]
- National Mental Health Workforce Strategy 2022-2023[54]

The NSW Older People's Mental Health Services Service Plan 2017-2027[41] is the current guiding document for OPMH services in NSW, and the key findings from the NSW Older People's Mental Health Service Plan Mid-Term Evaluation Summary Report 2023[9] have informed this updated OPMH Community Services MoC.

OPMH community services operate within a complex environment and network of key services that are relevant to older people with mental illness. There are many key partners for OPMH community services,

and developing and maintaining partnerships with key services is a vital component of the work of OPMH community services. This is both challenging and important in the context of ongoing changes in the service environment.

Key partners in the OPMH service network include: families, carers and supporters of older people with mental illness; general adult mental health services and OPMH inpatient services; primary care services including GPs, Medicare-funded primary mental health services and PHN-commissioned mental health services; crisis and suicide prevention services; virtual/online mental health services; dementia care and support services; community care and support services; residential aged care services; specialist private mental health practitioners and facilities; geriatric and aged health services; and community managed / non-government organisations.

The OPMH Service Plan Mid-Term Evaluation[9] highlights a number of key priorities for OPMH community services:

- Adapting service delivery to the needs of the OPMH services target population in the context of an ageing population and pressure on OPMH services, the complexity of older consumers accessing public mental health services, and the ongoing role of general adult mental health services in providing care for some older people.
- Navigating ongoing changes in key partner services (including primary mental health care and Medicare-funded mental health services, PHN-commissioned mental health services, aged care services, and Commonwealth-funded dementia services) and further developing and maximizing partnerships to support older people with mental illness.
- Building on the learnings from older people's suicide prevention initiatives and OPMH outreach and partnership work with residential aged care providers in OPMH community service developments and improvements.

The OPMH Community Services MoC seeks to guide OPMH services in addressing these priorities. It also aims to prepare OPMH community services to meet current key challenges including:

- The capacity of a range of service providers (public mental health, primary care and other providers) to respond to increasing demand generated by a growing older population that is distributed unevenly across NSW.
- Further reform of the mental health, aged care and disability systems that will result in continued evolution of OPMH services within the health system. Key findings of the OPMH Service Plan Mid Term Evaluation recognise that these systemic changes and the impact of the COVID pandemic have provided both opportunities and challenges for OPMH services.
- Economic and community demands for specialised mental health care that is readily available in the community, with hospital care reserved only for those whose needs cannot be met in the community.
- Continued variation in OPMH community services and practice across NSW.

1.7 Overview of the OPMH community services model of care guideline

The OPMH Community Services MoC places the consumer, their family, carers and supporters, and their GP at the centre of **recovery-oriented, person-centred, trauma-informed, biopsychosocial and culturally responsive** care.

There are eight key components in the OPMH Community Services MoC:

- Target population
- Principles and philosophies of care
- Working in partnership
- Adapting for the person's location and context
- Clinical processes
- Staffing
- Monitoring and improving performance.

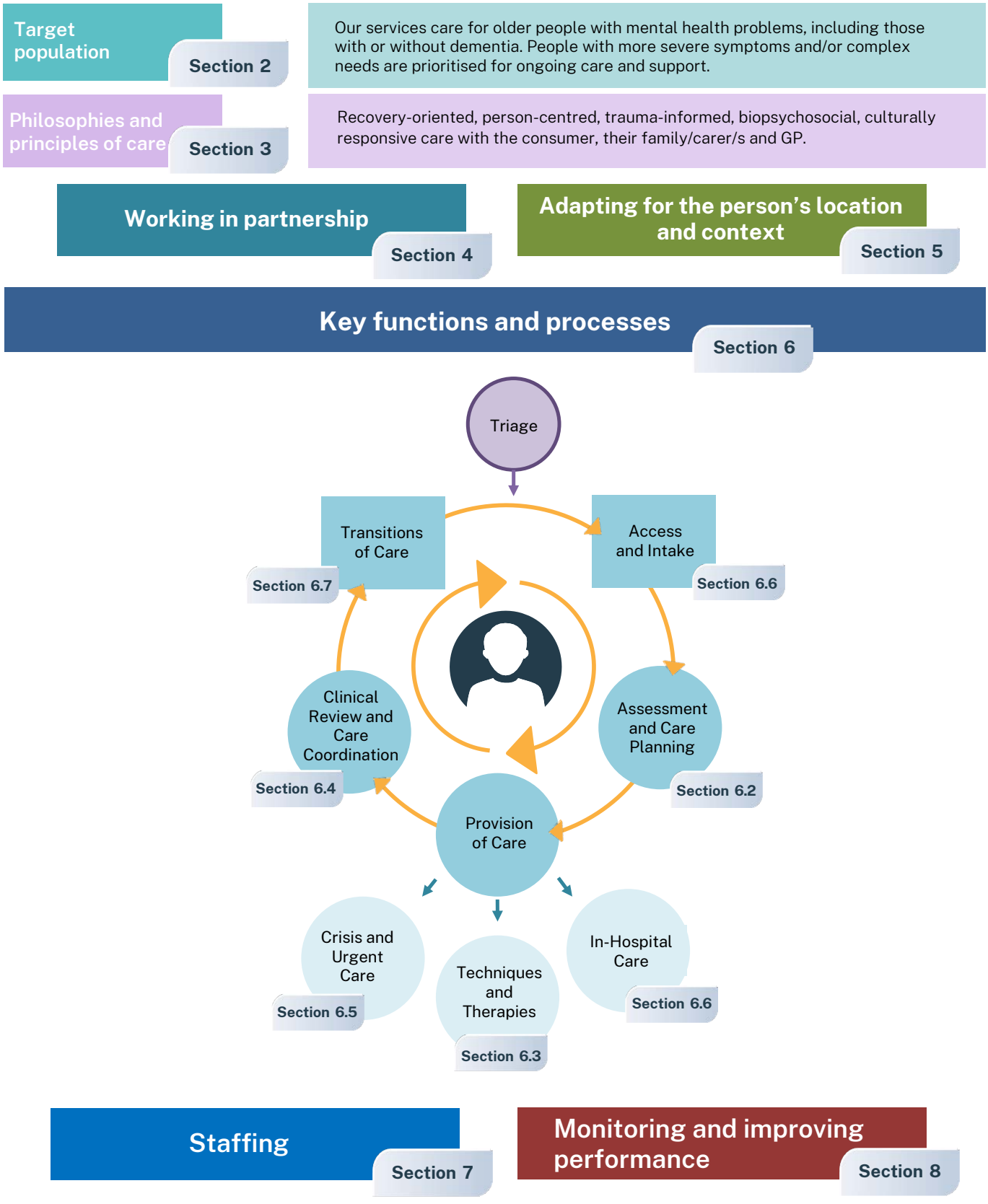
In each of these areas, 'good practice features' represent the core guidance in the OPMH Community Services MoC.

The relationships between key service model components are outlined **Figure 2**. The consumer is at the centre of the model, supported by their family, carers, and GP. There is a close relationship between the OPMH community service's principles and philosophies of care, techniques and therapies, and clinical processes. Underpinning the model are the

Figure 2: Overview: OPMH Community Services Model of Care Guideline

Model of care at a glance

All sections listed on this page refer to sections of the OPMH Community Services Model of Care Guideline (GL2026_014) as available on the NSW Health website



cornerstones of appropriate staffing and good performance.

The OPMH Community MoC is closely aligned to the NSW Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care Guideline[55] reflecting the importance of continuity of care and maximising integration between inpatient and community settings. The two models of care have consistent principles and philosophies of care. Ideally, OPMH acute inpatient units (AIU) and community teams are part of the one service. When governed separately, clear protocols are required to support integration between the two services. The OPMH Community Services MoC supports integration with OPMH AIUs, where present, by recommending OPMH community clinicians work in accordance with the AIU MoC and are involved in OPMH AIU intake processes, clinical review and transitions of care. The importance of applying promotion, prevention and early intervention throughout the process of clinical intervention is supported by guidance for teams in the Physical Health Care for People Living with Mental Health Issues (GL2021_006) and the enabling of functions is to be considered in each community setting.[39,56] Further, community mental health assessment should occur prior to inpatient admissions where possible.

Section 2. Target population

2.1 Who do OPMH community services see?

The target population for OPMH services, including community services, is defined in the NSW OPMH Service Plan[41] and/or its successor. This is currently defined as older people (65 years and over) who:

- Develop or are at high risk of developing a mental health disorder or symptoms in later life, including suicidality and self-harm
- Have significant difficulties associated with long-term mental illness and/or its treatment, and now experience ageing-related problems causing significant functional disability (i.e. frailty and/or progressive cognitive impairment) or
- Have a recurrence of an earlier mental health problem, have not seen a specialist mental health service for at least two years, and can be optimally managed by the OPMH service, with consideration to individual preference.

Given the ageing of the NSW population, and particularly the projected increases in the older old age groups, the OPMH services target group is likely to be more diverse with time, and services will need to plan for the evolving needs of the target population.

It is acknowledged that mental illness in the context of dementia may present differently and include what are sometimes called moderate-severe behavioural and psychological symptoms of dementia (BPSD). Older people with more severe symptoms and/or complex needs should be prioritised for ongoing care and support.

The OPMH Service Plan Mid-Term Evaluation identified that the development of stronger, purposeful collaboration with residential aged care and other community partners, including PHNs and Commonwealth-funded dementia services is likely to help with effectively addressing the needs of people with BPSD. Commonwealth-funded dementia services to support people with BPSD include the Specialist Dementia Care Program (SDCP), Dementia Behaviour Management Advisory Services (DBMAS) and Severe Behaviour Response Teams (SBRT), with Dementia Support Australia (DSA) providing DBMAS, SBRT and the initial assessment for the SDCP nationally. See Section 4 for further discussion on working in partnership including partnerships with dementia-specific support services.

The NSW OPMH Service Plan[41] also highlights a number of population groups that require specific attention including Aboriginal people, CALD communities, LGBTIQ+ people, people living in residential aged care homes, 'functionally old' younger people with mental health needs, people with recurrent or life-long mental illness who are ageing and older people with co-existing mental illness and intellectual disability. Other groups that may require special attention due to disadvantage and other factors include older people living in rural and remote areas, people living in squalor or who are homeless or at risk of homelessness,[57] and people in contact with the criminal justice system. Families and carers of older people with mental illness are also part of the broader target group for OPMH services. Drug and alcohol use among older people is linked to mental health comorbidities and requires services to offer age-specific, supportive, non-confrontational programs that focus on addressing both mental and physical comorbidities.[58–62]

A 'no wrong door' approach and prioritisation in access to OPMH community services

It is recognised that OPMH community services will need to prioritise access to services according to clinical need, risk and a range of other factors. The NSW OPMH Service Plan provides guidance regarding prioritising access to OPMH community services. As a 'no wrong door' approach is

recommended, prioritisation of who receives what ongoing care from OPMH services will need to be applied after initial assessment and at key progress reviews. The concept of a 'no wrong door' approach expresses the aim that all presenting clients will be provided with appropriate treatment services or referral, consistent with their treatment needs, regardless of where they enter the treatment system.[62] The outcomes of prioritisation will vary between services and over time as it must incorporate knowledge of the current practice and capacity of other (including adult) mental health and related services; but the principles should be consistent with state guidance. Recent evidence indicates that the 'older old' face significant challenges in accessing clinical mental health care across primary and specialist mental health care settings,[46,63] and that as people age, their access to specialist mental health care decreases. Use of non-specialist services for mental health care (eg emergency departments) is much higher for the older people.[46] These issues should be considered in prioritisation. Older people with more severe symptoms and/or complex needs should be prioritised for ongoing care and support.

Physical health and mental illness

The impact of physical health conditions upon older people with mental illness, and the appropriate role of OPMH community services in ongoing physical health care, is complex. For older people in contact with mental health services, co-existing medical conditions are common and providing or facilitating physical health assessment and care is core business of all mental health services. Early identification and intervention are as important for the older person as anyone else, and access to services that meet older people's needs can help prevent unnecessary hospitalisation and premature entry to residential care.[46]

Physical 'frailty' is a key issue among OPMH consumers, including some people under 65 years with early ageing issues. The Australian consensus statement on frailty introduces an integrated, evidence-informed and consumer-focused framework to guide healthcare professionals in delivering personalised and effective care for community-dwelling older adults living with or at risk of frailty.[64,65] Factors to consider include the presence of frailty, multiple complex problems, complex disease, reduced mobility, continence problems, and/or cognitive impairment that appears related to an age-related neurocognitive disorder.

People under 65 years

As outlined in the NSW OPMH Service Plan,[41] OPMH community services should apply flexibility in seeing consumers who are under 65 years and have age-related problems causing significant functional disability. Key factors to consider include the presence of frailty, progressive cognitive impairment and/or contact with aged care services. Other considerations include overcoming potential barriers to care access, including finances, environment, and stigma.[46,63] Decisions about the which service is the primary care provider – adult mental health or OPMH - should be focussed upon the capacities of OPMH and adult mental health teams to meet the consumers' needs, consumer choice, and continuity of care.

It is recognised that some adult mental health clinicians may find it difficult to determine when or if a consumer should be transferred to the care of the OPMH community service and written or phone communication may not always be able to resolve this. This is a person-centred process that should be guided by the needs and desires of the consumer and carer. A collaborative approach based on joint respect and appreciation of the skills and expertise of both the adult mental health and OPMH service clinicians has been successful in reducing the number of inappropriate referrals, improving communication between the two services, and better meeting the needs of the individual consumer.

Consultation findings

Consultations to inform the OPMH community services model of care revealed a lack of awareness and understanding within primary health, aged care services and the general community about the existence, functions and target population of OPMH community services, resulting in lack of and/or delayed referral and impacting on access to services. OPMH community services should clearly define and communication their role and target population to key local service partners and referral services.

In consultations, some consumers and carers indicated that they had experienced barriers in trying to find support and access the appropriate mental health service within the NSW health system. It was strongly communicated in consultations that no matter which NSW mental health team people present (or are referred) to, they want this service to assess their needs and then provide care and/or facilitate access to other services as required, to address their range of mental health and other

clinical and social needs. Developments in NSW mental health triage services and the NSW Mental Health Hub initiative are designed to help address this.

Consumers and carers want easy access to the mental health services they need, and OPMH community services should support this by accepting any person referred to them following triage for initial assessment, thereby translating the principles of the 'no wrong door' approach into practice. Following initial assessment, OPMH services should support consumers to access the most appropriate services, including OPMH services, for ongoing care and other clinical and community supports, to address their particular needs in a timely manner.[66]

2.2 Potential exclusion criteria for primary OPMH community service response

OPMH community services should exercise appropriate flexibility in providing assessment for older people with complex and unclear aetiology and, where possible and appropriate, should provide care for consumers who are under 65 years old with age-related problems causing significant functional disability. While the 'typical' OPMH consumer is aged 65+, age should not be considered a unique exclusion or inclusion criterion for accessing OPMH services.

Providing advice on the services not provided by OPMH community services (exclusion criteria) assists older people, carers and GPs to more easily access appropriate services and care. Easy access can be promoted if clear exclusion criteria are distributed to key service partners and referral services. Applying a trauma-informed approach to providing this information can be helpful to ensure a clear, open, collaborative and safe method of guiding the consumer to the services they most require.

OPMH services,[8] including community services, will not generally provide services for:

- Older people with a primary diagnosis of alcohol and/or other drug (AoD) disorder
- Older people with a presenting diagnosis of delirium
- Young people with a static cognitive impairment (ie not suffering from a progressive, neurogenerative condition).

If an older person with delirium or drug and alcohol disorder presents to or is referred to a OPMH community service following triage the OPMH clinician should, following an initial assessment, refer and/or assist the person to obtain assessment and management of these issues from a different service provider. This might include directly arranging for the consumer to be assessed by that service or ensuring that the consumer has achieved access to the service to which they were referred. This should be

Good practice features – Target population – Who do OPMH services see?

1. OPMH community services have clearly defined target populations that support access to mental health care consistent with a 'no wrong door' approach and *NSW Older People's Mental Health Services SERVICE PLAN 2017-2027* (GL2017_022) [NSW OPMH Service Plan] and/or its successor. Practices consistent with this include:
    a. OPMH community services have a publicly available, clearly defined, target population inclusive of people with potential mental illness with and without dementia.
    b. OPMH community services recognise that NSW mental health triage services and the NSW Mental Health Hub initiative may have a low threshold for referring older people to OPMH services.
    c. The target population for initial assessment includes older people with complex and unclear aetiology potentially suggestive of mental illness, with progressive prioritisation of the target population for initial then ongoing care.
    d. Exercising appropriate flexibility regarding people who are under 65 years with age-related problems causing significant functional disability.
    e. An agreed approach to the inclusion of older people with severe behavioural and psychological symptoms of dementia (BPSD) for assessment and/or further care, considering the role of other service providers who have remit to provide BPSD support such as Dementia Support Australia services.

accompanied by clear information regarding how to re-contact the OPMH community service if this still appears indicated after management of delirium/ acute medical illness. OPMH community services should aim to have capacity to provide assessment and clinical care for older consumers with co-existing alcohol and other drug (AoD) and mental illness, working in collaboration with specialist AoD services. There is a general need for more collaborative arrangements with drug and alcohol services. The Older People's Drug and Alcohol Project Report provides some guidance for mental health services and OPMH services.[7,8]

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

Further details about the intake of older people with delirium or AoD disorder are in Section 6.1 Access and Intake.

Good practice features – Potential exclusion criteria for primary OPMH community services response

1. OPMH community services have clearly defined criteria that may lead to the service not providing assessment and/or care, consistent with the *NSW Older People's Mental Health Services SERVICE PLAN 2017-2027* (GL2017_022), and/or its successor, and informed by the local needs of the target population. Practices consistent with this include:
    a. OPMH community services have publicly available information regarding criteria that may lead to the service not providing assessment and/or care.
    b. Potential exclusion criteria are developed with other relevant services in the local health district (LHD) and specialty health network (SHN) to optimise continuity of response to older people, consistent with the NSW OPMH Service Plan.
    c. Where a referral is received through channels other than from NSW mental health triage services and the NSW Mental Helath Hub initiative, and the information provided is suggestive of delirium, acute medical illness or other exclusion criteria, the person is referred for, and/or assisted to seek assessment and management of these issues.
    d. If a person is considered to have exclusion criteria at point of referral, they should be provided with clear information regarding how to re-contact the OPMH community service if this is still indicated after management of these issues.
    e. There are clearly documented pathways to alternate care providers where local prioritisation results in OPMH community services not providing ongoing care to a subset of older consumers in the NSW OPMH Service Plan target group.

Section 3. Principles and philosophies of care: What do we value?

The philosophy of care of OPMH community services should articulate key principles and ways of working that reflect good practice. Most importantly, the philosophy of care underpinning OPMH community services should help to ensure that care is delivered in ways that consumers say they need and want.

In 2017 and 2025 consultations to inform the OPMH Community Services MoC, consumers and carers highlighted that they wanted care that:

- Is **recovery-oriented**, strengths-based and consumer-led, involving partnering with the consumer and their carers/supporters and GP, and supporting the consumer in their personal recovery journey.
- Is **person-centred**, and fosters connection, purpose and hope
- Gives consumers and carers **meaningful involvement in decision-making and care planning**
- Takes a holistic approach that considers the range of the person's needs and provides tailored interventions in response – **biopsychosocial** care.

Consultations with stakeholders representing specific population groups including Aboriginal, CALD and LGBTIQ+ communities highlighted the importance of practice that:

- Is **culturally responsive**, seeking to understand, respect and tailor care to a person's background, beliefs, values, customs, knowledge, lifestyle, and social and cultural context.
- Is **trauma-informed**, reflecting an understanding of the ways trauma may have affected the person's life, their engagement with the service, their needs and their care preferences.

Reflecting the importance of continuity of care across OPMH service elements, the OPMH Community Services MoC adopts a similar philosophy of care to that in the OPMH Acute Inpatient Unit Model of Care Guideline.[55]

Person-centred and individual-based models of care are common modes of service provision considered central to the concept of recovery in older people's mental health. Key national and state policies and standards, including the National Safety and Quality Health Service Standards (2nd Edition)[67] the 'User guide for health services providing care for people with mental health issues',[68] and the National Mental Health Workforce Strategy[54] recommend mental health services incorporate recovery principles into service delivery, culture and practice. The Royal Australian and New Zealand College of Psychiatrists' (RANZCP) *Position Statement #37: Principles for mental health systems* advocates for an equitable, culturally-safe, and person-centred approach to addressing mental illness in older people, informed by lived experience and a comprehensive evidence base.[69]

Some consumer and carer perspectives about expectations of OPMH community services are highlighted below:

> "I should always be consulted prior to making decisions and planning my care"

> I should be "...included and asked about what I think about everything"

> "It is important to be treated as an individual, not as an age-specific condition"

> "Never underestimate the power of listening"
>
> **Consumer and carer consultations, 2017 & 2025**

Recovery-oriented, person-centred, trauma-informed and biopsychosocial care

Project consultations consistently highlighted the value that older consumers place on being treated as an individual and having control over their own care. This requires mental health professionals to be able to listen effectively and to spend time with consumers and carers to get to know the person and their situation. Understanding an older consumer's background, considering their needs and preferences from a holistic perspective (including any physical health issues and psychosocial needs), recognising their individual strengths and abilities, sharing decision making, and delivering services in collaboration with consumers and carers are all important within a person-centred[70–72] and recovery-oriented philosophy of care.

Consumers should be recognised as partners in the management of all aspects of their treatment, care and recovery planning.[11,29,43,73,74] A partnership with a consumer involves providing care that is respectful, sharing information in an ongoing manner, and supporting and encouraging the consumer's roles in their own care. This includes involving the consumer in identifying their care goals, planning their care, and reviewing their progress, thereby supporting personal recovery.

Using a recovery-oriented approach to care recognises the uniqueness of the individual, provides real choices to consumers, and supports consumers to undertake the journey of individual recovery. It focuses on the rights of consumers and carers including self-determination, promotes dignity and respect, and recognises the importance of partnerships (with consumers, carers, GPs, other service providers) and communication.[27] Wellness planning, collaborative consumer care planning, life stories work, and shared decision making are all well-recognised recovery-oriented practices.[16] The NSW OPMH Recovery-oriented Practice Improvement Project[16] report indicates that consumer and carer involvement is highly valued in project design and planning, delivery and evaluation in implementing recovery-oriented practice, and fostering a shift in service approach and culture.

OPMH community service clinicians often work with older people who experience co-occurring physical health and psychological conditions, intellectual/developmental impairments, and co-occurring substance misuse issues. People experiencing co-existing conditions frequently live with multiple and complex needs, experienced in an entirely individual way[75] and have higher rates of morbidity and mortality than the general population.[76] A recovery-oriented approach remains relevant, and mental health professionals should support consumers to determine their own recovery journey, which will be influenced by their particular circumstances and the impact of their co-existing conditions on their lives.[63] Older people with BPSD and co-existing conditions require a range of expert input and care should be collaborative and focused on the person's goals. Aligning care goals with the individual's strengths and interests, working with family/carers, and recognising the need for trauma-informed care provides structure for individualised care goals when recovery is experienced differently by people in advanced/different stages of their illness.

In addition to the growing focus on recovery-oriented care, current research and practice guidance supports an emphasis on trauma-informed care and practice (TICP), positive ageing and enablement, consumer-directed care, and the involvement of people with lived experience of mental illness in guiding service design, development, evaluation and improvement. TICP is an 'approach to healthcare service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage'. It is a strengths-based framework that is responsive to the impacts of trauma, incorporating safety, choice, empowerment, trust and collaboration.[75] Research has indicated that trauma-informed care is associated with less seclusion and restraint, better outcomes, fewer staff injuries and less over-utilisation of health care services.[18,77]

OPMH community services have traditionally held a person-centred, biopsychosocial approach to care. The biopsychosocial approach systematically considers biological, psychological and social factors and their complex interactions in understanding

health, illness, and health care delivery.[78] This approach is integral to assessment and formulation, delivery of care and staffing of OPMH community services and can be applied in a holistic way with recovery-oriented care.[79] Effective delivery of biopsychosocial interventions can enhance daily functioning, social connectedness and quality of life. Mental health promotion and prevention across biopsychosocial factors is of particular importance for older adults due to the frequent under-recognition and misattribution of mental illness as part of normal ageing.[80]

Statewide OPMH benchmarking data, consumer and carer experience survey results[81,82] and the OPMH Service Plan Mid-Term Evaluation[9] have shown that recovery-oriented practice has become embedded in OPMH community services and remain a focus of practice. This has been supported by the National Recovery Framework 10 and NSW OPMH Recovery-oriented Practice Improvement Project.[16] However, it should be noted that carer experience survey findings indicate that carers are seeking more contact from OPMH services and more involvement with the healthcare team and their loved ones during care.[82] TICP principles need continued focus across services.[18]

Involvement in decision-making and the role of carers

The starting presumption for all people is that they have capacity to consent to treatment. Any concern about an individual's capacity to understand or participate in health-related decision making must be assessed on an individual basis. A lack of capacity cannot be assumed based on the person having a mental illness. Assessments relating to capacity should be repeated at different times and a person may have capacity in respect of one decision, but not another.[73,74] See the Guardianship Act 1987 (NSW)[83] for further information on substitute consent provisions when a person loses or lacks the capacity to make decisions about their medical treatment. NSW Health provides guidance in the Consent to Medical and Healthcare Treatment Manual[84] for consent for patients being treated under the Mental Health Act 2007.[85] The Mental Health Act[14] and good clinical practice, require that consumers are involved in their care and recovery and that their views are considered in the development of treatment plans.

The Mental Health Act also recognises the role of carers and the importance of involving them in the care and recovery of mental health consumers and providing them with key information about a consumer's treatment. The Mental Health Act and Mental Health Carers NSW brochures[86] provide further information on carers, including types of carers (designated carers and principal care providers), nominating carers including during times of incapacity, and excluding people from being provided with information and/or consulted about a consumer's treatment. NSW Health clinicians can access learning pathways about the Mental Health Act, working with consumers and carers, and many more topics through the My Health Learning: Mental Health Pathways in Practice series. It should be noted that consultations for this model of care highlighted the importance of considering the consumer's key 'supporters' in providing care, who may not identify or be formally recognised as 'carers'.

The value of carer engagement is underpinned in both legislation and policy, including the NSW Carers (Recognition) Act 2010[87] and the NSW Carers Strategy: Caring in NSW 2020-2030.[88] Mental health services should implement and maintain 'ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care'.[89] However, it must be acknowledged that a consumer may not always have a carer(s), or the carer(s) may be ageing, and this may affect their capacity to provide support and advocacy. Some consumers are reluctant or unwilling to nominate a carer or are socially isolated. In some cases, health providers such as mental health workers or GPs are the main contact, especially if the person is isolated. Working with a consumer early, including through provision of in-reach services, may help those without a carer/advocate to access care as early as possible. This may help prevent the need to substitute consent later due to deterioration. Further information on substitute consent, include a definition of 'person responsible' and appointment of guardians, can be obtained from the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT).

The concepts of consumer self-determination, personal responsibility, self-management and reclaiming control and choice are pivotal to recovery-oriented practice regardless of a person's legal status.[27] Mental health professionals can work in a recovery-oriented way with involuntary consumers by maximising their opportunities for sustaining hope, promoting agency for recovery, supporting relationships and redefining self.[90] Providing consumers with access to information on their consumer rights under the Mental Health Act is an essential part of informing consumers and further enabling their engagement in their care.

Promoting and supporting positive perspectives on ageing

The needs of older people change across older age, in the community and in accessing mental health services.[46] Older people who access mental health services are impacted by both their mental ill health and associated stigma; and also the stigma and self-stigma associated with ageing. Most developed countries, including Australia, have very high rates of ageism.[91] That is "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people on the basis of their age".[92] This may be self-directed (also referred to as self-stigma), between people (or interpersonal), or institutional.[91,92] Ageism in the community is associated with multiple adverse outcomes for older people including reduced quality of life, poorer physical and psychological health, and reduced autonomy.[91–93] Ageism is also prevalent in aged care[94] and mental health services.[95] This is associated with reduced involvement in decision-making , therapeutic nihilism,[94] and poorer access, experience, quality and outcomes of care.[91,92,94,96]

Self-stigma related to age can reduce internal expectations, preventative health activities, hope and help seeking.[91,92] The combined impacts of stigma and self-stigma have been described as facilitating factors in the pathways to death by suicide in older people.[97]

There is increasing international recognition that mental health professionals working with older people must reflect on their own attitudes to ageing to counter the impact of ageism in their own practice to support the dignity of older people.[98] They should reframe care practices to combat the impacts of ageism such as focusing on supporting hope[99] through 'positive psychiatry' and 'successful ageing'.[100]

Culturally responsive practice

Current practice guidance highlights the importance of culturally responsive practice. Culturally responsive practice means being respectful of everyone's backgrounds, beliefs, values, customs, knowledge, lifestyle and social behaviours. It is important for all social and cultural groups including Aboriginal people, people from culturally and linguistically diverse (CALD) background, refugees or displaced migrants, people at all life stages, people with different abilities including intellectual and cognitive disability, LGBTIQ+ people, and people from priority populations and sub-cultures such as the hearing and vision-impaired community. Cultural responsiveness involves continuous learning, self-exploration and reflection, and draws on cultural awareness, sensitivity, safety and competence.[101–103]

NSW Health evidence-based practice guidance highlights that becoming culturally responsive is an ongoing reflective practice that should continue throughout a person's professional life. It includes: developing awareness and understanding of different cultures and migration experiences; ability to identify risks and vulnerabilities in specific groups and respond appropriately; ability to work with people of different cultures in safe and supportive ways; responding to attitudes, feelings and circumstances of different people, and understanding structures and services necessary to deliver cultural support and system change. It recognises the importance of

Good practice features – Principles and philosophies of care

1. OPMH community services use a biopsychosocial understanding of mental health and ill-health, inclusive of cognitive and comorbidity complexities.
2. OPMH community services use approaches that are recovery-oriented, person-centred and trauma-informed.
3. Consumer involvement in all planning of care in a manner that maximises their empowerment in decision-making.
4. OPMH community services promote and support positive perspectives of ageing and older people.
5. OPMH community services promote and support culturally responsive practice.
6. OPMH community services have specific strategies to promote and support culturally responsive practice with Aboriginal, culturally and linguistically diverse (CALD) and LGBTIQ+ older people.

3.1 Specific population groups and culturally responsive practice

The content and guidance below aims to assist OPMH community services in culturally responsive practice with older Aboriginal people, older people from CALD backgrounds, and LGBTIQ+ people. It reflects published evidence, policy and practice guidance, input to the OPMH community services model of care from key stakeholders including the NSW Ministry of Health's Aboriginal OPMH Working Group and CALD OPMH Working Group, and feedback from local consultations with Aboriginal elders and stakeholders by LHD OPMH services.

3.1.1 Aboriginal older people

Aboriginal people belong to a strong living culture that has continued to thrive for thousands of years. Along with a history of survival, healing and resilience, Aboriginal people have a proud heritage of commitment to family and community, spirituality, and have strong connections to culture and Country. In NSW, Aboriginal people fare significantly worse than non-Aboriginal people on every indicator of economic and social disadvantage, and experience multiple stressors that are pre-determinants of mental health problems and substance use.[50]

Given this, and the earlier onset of illnesses and conditions usually associated with ageing in this population,[104] OPMH services should be able to provide care to Aboriginal people from the age of 50 years if they identify as older people and/or with the specific needs of older consumers, and if this is their preference. Aboriginal people with a mental health issue who are aged 50-64 years may choose to be seen in adult mental health or OPMH services.

Aboriginal and Torres Strait Islander health is viewed in a holistic way that encompasses mental health and physical, cultural and spiritual health. Land and sea are central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill-health will persist. All parts of the Australian mental health system should be guided by Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in combination with clinical approaches when working to heal and restore the wellbeing and mental health of Aboriginal and Torres Strait Islander people.[105]

Identity, cultural practices, lore, social systems, traditions and concepts of spirituality are all drawn from, and depend upon, connection to Country. Research shows that this is a powerful determinant of health and is foundational to older Aboriginal and Torres Strait Islander peoples' ability to live, die and age well.[106]

To be culturally safe and responsive, OPMH clinicians require an understanding of older Aboriginal peoples' connectedness to family, community and Country; their role within family and community, particularly the significant and special place an older Aboriginal person or Elder may have within one or many communities, and the burden of grief, loss and trauma experienced by many Aboriginal people.[50,51,107–111] Aboriginal people are also adversely affected by multilayered discrimination, marginalisation, and stigma in ways that are relevant to recovery and need to be considered in recovery-oriented practice.[27]

OPMH services should also understand the strengths of Aboriginal Elders and older people. Elders and older community members are essential in transmitting knowledge to younger generations. They hold cultural responsibilities to support families and community to cope with experiences of loss, grief and trauma, which may teach coping strategies and/or demonstrate them within family/community.[112]

A full appreciation of the holistic notion of health and mental health (and the language used to express this) is important in working with older Aboriginal people with mental health issues, and may be particularly relevant to assessment, therapy and family/carer education. Acknowledging an older Aboriginal person's contribution to, and inclusion within, culture, family and community is also important. Mental health professionals need to have an understanding that older Aboriginal people may experience mental health not only at an individual level but at the community level and should appreciate the impact of transgenerational traumatisation for both the older Aboriginal person and their family/community.

The Aboriginal social and emotional wellbeing model outlined in the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 is a strengths-based approach to working with mental health and wellbeing. It recognises the influence of social, political, historical and cultural factors and can be applied across the continuum of mental health care. If connections are disrupted, and for many Aboriginal people and families some of these connections have been significantly disrupted from colonisation, it can

lead to ill-health.[50] This model should guide the delivery of OPMH community services.

There are a number of factors to consider when implementing standardised assessments with Aboriginal people.[107,110] These include any cultural views and taboos regarding signs and symptoms being assessed, the cultural and political context of the assessment and setting, and inherent cultural factors of the assessment tool itself (e.g. language, terminology). A number of mental health assessment tools have been developed or adapted that are culturally appropriate and validated for use with Aboriginal people.[107]

Recent aged care reports have highlighted the unique and complex needs of Stolen Generations survivors, many of whom face significant challenges in accessing care. The trauma experienced by this group has had lasting effects which require services to provide trauma-aware, healing-informed care. Stolen Generations survivors often avoid mainstream services, due to insensitive assessments and care environments that resemble institutions they were placed in as children. Many survivors have expressed a strong preference for home or community-based care, avoiding institutionalised settings wherever possible.[106,109,111] The Stolen Generations Survivors Action Plan 2025-2030: Towards Health and Healing aims to guide a response in NSW to the urgent health, aged care, healing and wellbeing needs of Survivors and their descendants.

Mental health services should ensure the cultural safety and responsiveness of Aboriginal people throughout all stages of care,[50,51,113,114] including facilitating access to an Aboriginal mental health clinician and/or health worker. Aboriginal community organisations and Aboriginal Community Controlled Health Organisations (ACCHOs) including Aboriginal Medical Services are well placed to develop innovative forms of service delivery and may act as advocates for older Aboriginal people with mental health issues, carers and families. OPMH services should seek to develop effective partnerships with ACCHOs to facilitate culturally competent assessments, treatment and care planning.[114,115]

Treatments and therapies should be culturally appropriate.[69,105,109,112,116] The Guidelines for Diagnosis and Care of People with Dementia in Remote Communities117 provide suggested culturally appropriate activities for Aboriginal people with dementia, and Behaviour Management - A Guide to Good Practice[118] provides further information on cultural considerations for service provision to Aboriginal people with dementia.

Formal service level agreements and Memoranda of Understanding (MoUs) between key services are considered an extremely effective way to support Aboriginal consumers and enhance service delivery and treatment outcomes. The NSW Aboriginal Health Partnership Agreement 2015-2025[119] and the NSW Aboriginal Health Plan 2024-2034[51] recognise the importance of working in collaboration with, and developing strong partnerships between, LHDs and Aboriginal communities including ACCHOs and Aboriginal health/mental health workers, and requires LHDs to have local partnerships with ACCHOs. At the local level, some OPMH services have developed informal connections with local ACCHOs/regional ACCHOs consortia where available and the ability to access Aboriginal health workers if requested. Flourishing in Later Life: promoting older Aboriginal and Torres Strait Islander peoples' mental health and suicide prevention,[109] Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice,[107] Aboriginal Older People's Mental Health Project Report[120] and Aboriginal Older People's Mental Health: Resources for LHD SMHSOP Services[108] provide information to assist mental health services to improve collaboration and partnerships with ACCHOs.

Good practice features – Aboriginal older people

1. Considers the choices and preferences of Aboriginal people aged 50 years or older, whether they identify as older people and their specific age-related needs, when determining whether OPMH services or adult mental health services are the most appropriate to meet their needs.
2. Care is culturally safe and trauma-aware, providing connection with community, and flexible service options that avoid institutionalised settings wherever possible.
3. Demonstrates the following in key clinical processes:
   a All consumers are asked if they identify as Aboriginal (recognising that it is the person's choice if they choose to identify or not).
   b Staff support the consumer's access to Aboriginal liaison/health workers and cultural consultants as appropriate.
   c Staff actively seek involvement of Aboriginal health/mental health workers in preadmission processes, during assessment and during treatment as appropriate.
   d Assessment processes for Aboriginal older people are trauma-informed and culturally safe and consider the potential for complex family and community relationships.
   e Carer(s), other health care providers and community support services participate in the process of planning for transition of care/discharge as appropriate.
4. At a service level, culturally responsive OPMH community services will:
   a Support staff to build and maintain cultural knowledge, be knowledgeable about local services for Aboriginal older people, and participate in community and cultural events (e.g., Sorry Day, NAIDOC Week, local gatherings).
   b Draw on partnership arrangements in place between the LHD Mental Health Service and Aboriginal service providers including ACCHOs and/or communities to support older Aboriginal people.
   c Support OPMH clinicians to work in a range of settings including Aboriginal health services, based on consumer preference

3.1.2 Culturally and linguistically diverse (CALD) older people

An older person from a CALD background is likely to have specific needs depending on individual experiences/factors, language and cultural barriers, and migration circumstances, and the extent to which cultural traditions have been maintained.[103,121] Older people from refugee backgrounds are particularly vulnerable to mental health issues. Psychological health concerns of older refugees include isolation, depression and cognitive decline.[102] Evidence suggests that the multiple impacts of severe traumatisation can persist for many years after the traumatic events took place.[122] Mental health professionals must recognise the high degree of intra-cultural diversity and avoid assuming shared cultural backgrounds equate to similar individual experiences.[102] A person's culture is influenced by many factors, such as upbringing, education, migration experience, reason for and time of migration and interactions with people from other cultures. Having access to services relevant to the local demography is particularly important for CALD communities. These services may include transcultural mental health and/or multicultural services and other agencies where relevant.

Person-centred care approaches for CALD consumers may emphasise the role of family and cultural belonging. Alternative approaches may be required for older people from CALD communities experiencing isolation and/or loneliness and for those who do not have extended family/community networks for support.[103] This is also true for people who are ageing in an unfamiliar cultural environment, and/or are experiencing grief, loss, shame, stigma and discrimination associated with migration or displacement. Local partnerships and strategies are essential for culturally specific services for older people from different CALD backgrounds and OPMH community services have a role in ensuring

partnerships and connections are made with key services such as the Transcultural Mental Health Centre and interpreter services to enable further local networking.

Community and cultural traditions, beliefs and values play a significant role in and have a significant influence on a person's experience of recovery. Cultures vary in their emphasis on individuality, personhood, gender, kinship and family ties. Deference to community leaders—traditional healers, priests, elders and community leaders— and family members regarding personal decision making is a strong tradition in some communities.[27] For some people spiritualty is defined by formal religion, while for others spiritualty is a more individual construct.

The concept that cultural beliefs and practices flow through generations should be acknowledged in the same way that generational influence is accepted in Aboriginal culture. At the same time, individuals and families bring with them (into clinical and related settings) a range of varying and shared perspectives. Key processes, techniques and therapies then provide tools for exploring individual perspectives. Staff are likely to benefit from regular education in cultural awareness and cultural responsivity, as well as working with interpreters,[103] supported by education opportunities in My Health Learning for NSW Health workers.

The Multilingual Mental Health Assessment Tools were developed to support mental health clinicians to conduct culturally appropriate clinical and psychosocial assessments for consumers from CALD communities.[123] The Multicultural MH-OAT tool[124] assists in addressing the cultural implications arising in the care of people of CALD background. Validated translated assessment tools are also available in some languages and should be accessed where appropriate. Where translated assessment tools are not available, clinicians should consider the application of assessment tools in the cultural context in completing the assessment. Mental health services should ensure the cultural safety of consumers through the assessment process.[113] The Transcultural Assessment Checklist[123] can be used to support culturally appropriate and responsive assessments.

Cultural differences in verbal and non-verbal communication will have implications for practice and service delivery.[27,102,103] This includes provision of culturally responsive written mental health information and the use of direct or indirect questioning styles as appropriate. Service providers will also need to have specific skills in working with interpreters and cultural advisers and seek collaboration with transcultural mental health and/or multicultural health services when required.[102] Concepts of confidentiality are understood differently in many communities and across generations. Signs and symptoms may be expressed in spiritual or behavioural ways and by other symbolic and somatic references by some CALD consumers.[125] See Behaviour Management - A Guide to Good Practice[118] for further information on cultural considerations for service provision to CALD people living with dementia.

The most effective strategy in meeting the needs of diverse CALD communities is to have partnerships with different types of organisations that provide services to CALD communities,[103,126] including trained bilingual workers, specialist transcultural mental health services (such as the Transcultural Mental Health Centre's specialist clinical consultation service and Transcultural Mental Health Line, and the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors), Community Managed Organisations/NGOs and multicultural agencies. Constructive partnerships with CALD communities, health practitioners and organisations may generate referrals to OPMH services and/or support OPMH services in assessment and management of older people with mental health issues from CALD backgrounds. Given the variation across NSW in the composition of the local CALD population, OPMH services need to be cognizant of the specific needs of the local CALD population and any local non-health services that may provide support, such as Migrant Support Services offered by local Councils.

Research and policy reform initiatives clearly articulate the importance of, and expectations for, delivering culturally safe mental health services. The Introductory Guide: MHIMA Framework For Mental Health In Multicultural Australia: Towards culturally inclusive service delivery[125] assists mental health services to evaluate their cultural responsiveness and enhance their delivery of services for CALD communities.

Good practice features – CALD older people

1. For older people from CALD backgrounds, culturally responsive practice has the following features:
   a Staff access interpreters and cultural consultants where required.
   b Staff actively seek involvement of bilingual counsellors, cultural consultants and other cultural brokers in preadmission, assessment, care planning and treatment processes, where required.
   c Staff access and appropriately use validated culturally sensitive assessment tools and resources with CALD consumers.
   d The specific cultural customs and values, religious beliefs, and other beliefs and practices of a consumer are considered as part of the consumer's assessment, care and discharge/transition planning, with the Transcultural Assessment Checklist used to support culturally appropriate assessments where relevant.
2. At a service level, culturally responsive OPMH community services will engage in relevant partnerships to address local demography, needs and supports for CALD communities, and identify community supports, which may include transcultural mental health and/or multicultural services and other agencies where relevant.

3.1.3 LGBTIQ+ older people

LGBTIQ+ and gender diverse populations may experience differences socially, emotionally and physically as ageing progresses, and have specific concerns that need to be understood to ensure care is offered and received without creating further trauma and stress. A history of trauma relating to treatment of LGBTIQ+ and gender diverse populations in the past including criminalisation, contributes to apprehension towards services providing mental health and aged care services. Applying a trauma-informed approach and acknowledging identity and history early in the process provides sound background information to help the consumer, their key supporters, and mental health professionals safely navigate mental health services.[18,127]

LGBTIQ+ and gender diverse older people require safe, trusted, trauma-informed and respectful pathways for making contacting OPMH services, as identified in consultations to support this model of care. Acknowledging a person's lived experience is essential to guiding the person through the most appropriate pathway of care. This lived experience may include a history of trauma, hidden gender identity, stigma and barriers to accessing care.

An increasing number of resources are available for working with people from the LGBTIQ+ population including NSW Health's LGBTIQ+ Health page, LGBTQ+ Inclusive and Affirming Practice Guidelines for alcohol, substance use, and mental health services, support, and treatment providers,[127] NSW LGBTIQ+ Health Strategy 2021-2026,[128] and for carers: LGBTQIA+ Carers - Mental Health Carers NSW.[129]

Good practice features – LGBTIQ+ older people

1. OPMH community services demonstrate awareness that LGBTIQ+ older people may have specific needs and develop their understanding and capacity to respond appropriately.

Section 4. Working in partnership: How do we work with others?

In consumer and carer consultation, consumers indicated that it is very important for their OPMH care to include connection to other health services that they may require. Partnerships and care coordination with GPs were seen as particularly important. Many carers reported difficulty in navigating the system and finding the right services. Carers identified the importance of support in care coordination to ensure integrated care and smooth transitions of care for consumers.

These findings build on previous consumer feedback that OPMH community services are one partner in a range of services that support an older person's clinical and personal recovery. OPMH services need to work in partnership with a range of health and community providers to address the complex physical, social, behavioural and psychological needs of the older person. OPMH services play a key role in coordinating between mental health services and services outside of mental health, ensuring the provision of integrated care.

The importance of partnerships, collaboration and integrated care is also emphasised in NSW Health policy. NSW Health Strategic Framework for Integrating Care[36] outlines a number of system design principles which support integrated healthcare across settings. Having agreed goals and a clear vision, confidence in other service providers, clear roles and responsibilities, joint care planning, clarification and agreement in relation to expectations around communication, opportunities for information sharing, and shared or mutual access to documentation are considered key for successful collaboration with other service providers.[33,35,36]

Key OPMH service partners continue to evolve, particularly in community settings, reflecting the complex adaptive nature of the health system. This requires OPMH community services to continue efforts to identify, develop and maintain partnerships with key services to support OPMH consumers.

The OPMH Service Plan Mid-Term Evaluation[9] highlighted developments in key partner services such as aged care services, Medicare-funded mental health services, PHN-commissioned mental health services, Commonwealth-funded mental health services and dementia services, and NDIS services. The evaluation noted that anticipating and responding to ongoing changes in key partner services will be important in improving care pathways for older people with mental illness.

However, the evaluation also highlighted the challenges for OPMH community services, as relatively small specialist clinical services, in effective partnership effort given the range of partnerships required to support OPMH consumers and appropriate pathways to care for older people with mental illness, including mental health needs in the context of dementia. This finding echoes the evaluation of the early implementation of the OPMH Community Services Model of Care[130–132] and OPMH benchmarking findings. It is therefore recognised that OPMH community services will need to prioritise some key services in OPMH-specific partnership work and leverage broader mental health service or local health district partnerships with a range of other services as required.

OPMH community services should ensure clinical practices, service structures and service partnerships facilitate integrated and coordinated care that will meet the particular needs of the individual older

person. Services that provide care to older people are distinct from those relevant to younger people, and OPMH clinicians need to be aware of the range of these services.[130–132]

At a service level, OPMH community services should develop partnerships, service linkages and referral pathways that support older people who most need specialist OPMH assessment and/or care to access OPMH community services. They should provide specialist advice to other key services to provide appropriate care to older people with complex mental health needs who are not prioritised for specialist OPMH care. They should promote pathways to alternative care for older people who are not within the OPMH target population or do not meet local prioritisation criteria.

Current published evidence, the OPMH Service Plan mid-term evaluation, OPMH benchmarking data, and consumer, carer and stakeholder consultation to support this model of care highlight the following as key service partners for specific OPMH service partnerships: GPs; adult mental health services (including acute care teams, Pathways to Community Living Initiative (PCLI) teams, and rehabilitation teams); OPMH inpatient services; dementia services, aged care services, geriatric services and NDIS services. OPMH services will need to lead partnership work with these services, given that they are key to coordinated, integrated care for a large proportion of OPMH consumers.

Table 1: Key partners and partnership guidance:

Key partners	Partnership guidance
GPs	Consumers and carers consistently highlight the importance of GPs in their ongoing mental health care, and the importance of good collaboration and communication with their GP from OPMH services. GP consultation supports this. Working in partnership with GPs is central to the way in which OPMH community services operate,[9] and GP involvement is recommended in various key process of OPMH care processes. Good communication and collaboration with GPs is particularly important in intake and admission, assessment (including physical examinations), care planning, clinical review and transition of care (where clear, timely communication of discharge plans and ongoing care and medication management plans is required).[41]
Adult mental health services	Adult mental health services play a significant role in triage, crisis and acute care, and provide mental health care (including rehabilitation) to older people. OPMH community services need to work collaboratively with adult mental health services to: • Facilitate a low threshold for referral of older people from triage/initial contact to specialist OPMH assessment, particularly for new clients. • Promote early involvement of OPMH services in the assessment of older people in suicidal distress, and in follow-up care as appropriate. • Enable the provision of the most appropriate ongoing care for older consumers, based on clinical need, complexity, service capacity and consumer preference.
OPMH inpatient services	OPMH inpatient services play a key role in providing care to older people with acute, severe and/or complex mental health problems, and in supporting coordinated, effective transitions of care to OPMH community services. OPMH community services should work closely with local OPMH inpatient services to support integrated, coordinated care for OPMH consumers. Ideally, OPMH acute inpatient units (AIU) and community teams are part of the one service. If managed differently, clear protocols are required to support integration between the two services. Where relevant, OPMH community clinicians should be involved in OPMH AIU intake processes and in multidisciplinary reviews of AIU consumers and community mental health assessment should occur prior to inpatient admission where possible.[42]

Key partners	Partnership guidance
Dementia services	Dementia services, including services funded by the Commonwealth to support people with behavioural and psychological symptoms of dementia (BPSD), are key partners for OPMH community services and can play a role in supporting older people with moderate-severe BPSD. OPMH community services should develop and maintain partnerships with local dementia services to promote pathways to alternative care for older people with dementia who are not within the OPMH target population or do not meet local prioritisation criteria. These partnerships should aim to promote a coordinated local response to meet the needs of older people with moderate-severe BPSD, while facilitating timely access to OPMH assessment and/or care for those who most need a specialist OPMH response.
Aged care services	There is substantial evidence and policy support for the role of OPMH community services in working with aged care services, particularly residential aged care services, to effectively support older people with more severe and complex mental health needs.[9,41,133–135] OPMH services should develop and maintain partnerships with local residential aged care providers, including specialist mental health-residential aged care service providers, specialist dementia care unit providers and aged care providers that support people with more complex mental health needs, including severe BPSD. This includes partnerships that promote pathways to community care for older people who are experiencing, or are at risk of, long hospital stays, or potentially preventable hospital admission, and to that support effective transitions of care.[136]
Geriatric medical services	OPMH services and geriatric medical services should cooperate to ensure the best treatment and care of older people, many of whom have complex combinations of mental and physical ill health. Older people and their carers should have access to high quality, well-integrated community, residential and hospital services which include access to old age psychiatry and geriatric medicine specialists either in person or via telehealth. It is important that health services ensure appropriate settings are available for people with both behavioural and acute medical needs.[137]
National Disability Insurance Scheme (NDIS) services	OPMH services should develop capacity to work in partnership with NDIS providers in collaboration with whole of mental health service initiatives to effectively and appropriately support older people with more severe and or complex mental health needs that emerged while they were eligible for NDIS services.

OPMH community services will need to leverage broader mental health services or local health district partnerships with a range of key clinical and community service partners as required to support older people with mental illness and pathways to specialist OPMH community care. This does not diminish the importance of these partnerships but indicates where OPMH community services should prioritise their primary partnership work. These other key service partners include Emergency Departments and other hospital services, pharmacy services, private mental health professionals/services, Medicare Mental Health Centres, community managed mental health services, drug and alcohol services, ACCHOs, multicultural/transcultural health and mental health services, and Primary Health Networks. Key partners for OPMH community services considered critical in facilitating personal recovery include the consumer, their carer/supporter(s) and/or family and their social and community networks.

Good practice features – Working in partnership

1. OPMH community services have mechanisms in place to support effective partnerships at the service level and collaborative, coordinated care for individual consumers. This includes:
    a At the service level - workforce development in partnership skills and inter-professional practice, clear governance arrangements, consultation-liaison services, joint involvement in planning of services and/or review of processes, and formal agreements outlining service roles and responsibilities.
    b In care processes - clear expectations around communication and information sharing, joint case conferences/case sharing, joint assessments, shared care arrangements, and shared or mutual access to documentation.
2. OPMH community services prioritise some key partners and continue to review and adapt work with partners as the service context changes. Key considerations in prioritising partners include:
    a Partnerships supporting older people who most need specialist OPMH assessment and/or care to access OPMH community services.
    b Partnerships supporting provision of specialist advice to other key services to enable appropriate care for older people with complex mental health needs who are not prioritised for specialist OPMH care.
    c Partnerships promoting pathways to alternative care for older people who do not meet local prioritisation criteria.
3. OPMH community services have clear processes to facilitate integrated care with GPs.
4. OPMH community services work collaboratively with adult mental health services, including acute care teams, PCLI and rehabilitation teams.
5. OPMH community services maximise integration with OPMH Acute Inpatient Units (AIUs) and other OPMH inpatient services, where present, by working in accordance with the NSW Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care (GL2022_003) particularly regarding admission, clinical review and transitions of care.
6. OPMH community services develop partnerships with local geriatric services, dementia services and aged care services, particularly residential aged care services, to effectively support older people with more severe and/or complex mental health needs (including in the context of dementia) in community settings.
7. OPMH community services develop their capacity to work in partnership with NDIS providers, in collaboration with whole of-mental health service initiatives, to effectively and appropriately support older people who remain supported by NDIS services.

Section 5. Adapting for the person's location and context

The consumer's preferences should be considered when determining where and how to deliver services.[130,138] A consumer may prefer to receive care in their normal place of residence (private residence, residential aged care facility or supported accommodation), in a clinic, in a primary care setting, other safe location nominated by person, or through virtual care such as a videocall or phone call, and this choice should be supported as much as possible.[41]

> "OPMH services need to be willing to go where older people are"
>
> **Consumer and carer consultations, 2017**

Consumer and carer consultation informing this model of care indicates that consumers prefer receiving care in their home or residential aged care home, with some consumers preferring a community health centre. Carers expressed an even greater preference for care to be provided in the person's home or residential aged care home. A smaller proportion of consumers and a majority of carers indicated that it was important they could also access care via telehealth, particularly via phone (see *Appendix B*).

For some consumers, their particular circumstances will dictate where they are seen by OPMH community clinicians. Although there is significant evidence to support a person's home as the optimal service delivery setting in terms of effectiveness and healthcare costs,[21,139–142] not all consumers and/or carers welcome services provided in their home, preferring to keep home separate from the care and services environment, and some may be residing in unstable accommodation or are experiencing homelessness. With the evolution of virtual care, especially during the COVID-19 pandemic, this can be an important way for older people to access OPMH services in different care settings, particularly are in locations where there are barriers to regular in-person service provision.[138]

Rural older people experience challenges in accessing care including difficulties in timely access to specialists, social isolation, socio-economic deprivation, and in communicating with and navigating mental health services.[143] These challenges highlight the importance of the 'no wrong door' approach, flexibility in service delivery modality (eg use of virtual health care), and OPMH community services working in partnership with other key local services. Consumers and carers located in regional and rural areas may face more complex systems to navigate for access to mental health services, especially as distance to major regional centres increases.[144–146] Rural residents are more likely to present to emergency departments, and older rural residents have more chronic conditions in concurrence with mental illness and are more likely to experience issues with mobility and social isolation.[143]

Older people who are detained in forensic and corrections services are disadvantaged by settings that are typically designed for violent younger people.[147] With the doubling of inmates over 60 years of age in Australia since 2014, to 2560 inmates in 2024,[147] the burden of health needs of older people in justice health services is significant. Further work to develop suitable pathways, partnerships, and access to specialised clinical support is required to enable access for older people from justice health services to residential care, secure post-release containment, and rehabilitation.[147,148]

Care settings

OPMH community services must be willing and able to work in a range of service settings. However, it is noted that the availability of resources, including staffing, and partners in care will impact this.[149] All OPMH community services provide home visits to some extent, and outpatient clinics are offered in all LHDs, but with variable integration into community teams. All OPMH community services provide some in-reach to residential aged care homes, including dedicated specialist clinical in-reach to mental health-residential aged care services and specialist dementia care units in some districts. OPMH community services would rarely provide services in general practice or primary care centres.

OPMH community teams should provide in-reach to OPMH inpatient units as part of integrated care and supporting consumers to transition to community settings, including residential aged care. The provision of specialist OPMH consultation-liaison services to other mental health or geriatric units may be increasingly important. OPMH benchmarking and evaluation data indicate that a significant number of older people with complex mental health needs are cared for in general adult mental health units and some, particularly older people with severe BPSD, in geriatric units. OPMH community clinicians will be required to work closely with other service providers, providing consultation-liaison services that aim to facilitate person-centred, collaborative and integrated care.

The 2021 Aged Care Royal Commission (ACRC)[133] report highlighted the importance of OPMH service provision to people with complex mental health needs, including severe BPSD, who are receiving aged care services, particularly in residential aged care settings. The Commission recommended expansion of and more consistent access to OPMH 'outreach' services, with a focus on people living in residential aged care.[133] OPMH service outreach to residential aged care settings is a core function of OPMH community services in NSW.

Whatever service setting is decided on, OPMH clinicians should promote the optimal safety and wellbeing of the consumer, carer(s), families, visitors and staff.[68] Staff should be supported to provide appropriate and flexible care throughout the course of the consumer's admission through any combination of virtual care, at clinic settings, at home and residential visits, with provision of adequate transport for staff.[130]

Virtual care

Evidence and experience regarding the use of virtual care (provided by phone or video) for the provision of health services has developed significantly over the last 5 years. The preferences of consumers and carers regarding in-person care and virtual care should be supported where possible. Consumer and carer consultation informing this model of care indicates a general preference for in-person contact over virtual care, with some variation. Only 26% of respondents to the OPMH community consumer survey (2025) reported that they would use a telehealth appointment instead of a face-to-face appointment. Approx. 62% respondents reported they would prefer to use a telehealth service only if they couldn't get a face-to-face appointment, 19% only after a face-to-face appointment, and 19% for all appointments. Carer survey respondents also reported a preference for in-person care, with 70% reporting that the consumer would prefer to use telehealth only if the consumer couldn't get a face-to-face appointment and 22% preferring not to use telehealth at all. However, 50% of carers surveyed also reported that it was very important or somewhat important that the consumer could access OPMH community services via telehealth where needed (see *Appendix B*).

While in-person contact is desirable in terms of relationship building and reducing social isolation, more equitable access to services may be facilitated by the effective use of technology and virtual care is preferred by some consumers. Virtual care can improve access to healthcare for older adults from CALD backgrounds, but challenges exist, particularly regarding digital equity, cultural safety and confidence.[150] For many mental illnesses, including depression and anxiety, the outcomes for older people who participate in online therapies are broadly comparable to those of face-to-face services using similar treatment techniques, noting that these trials only include those willing to consider online therapies.[106,151–153]

Virtual care should be used as an adjunct to in-person services but not a replacement of in-person care. OPMH services are mostly provided in-person, with virtual care also used across NSW. Virtual care has developed further in recent years to ensure access to integrated healthcare enabled by technology as exemplified by NSW Health's myVirtualCare.[154] Virtual care can support access to specialist mental health care in circumstances where specialist services may be limited, such as in some rural and remote areas.

The Agency for Clinical Innovation (ACI) has developed Eight key principles of virtual care[155] to guide virtual care provision and complement existing models of care.

It is important to develop strategies that ensure culturally responsive and effective virtual care for diverse groups of older people. Privacy should be considered, depending when and where older people are accessing these services. For example, if a virtual community consultation is being conducted in a room with other people in the home or in residential aged care home there may be some barriers and/or withholding of information created because others (eg staff, family or other residents) are present. This would apply to both home and residential care settings.

State and national guidance on virtual care provision promotes a consistent and coordinated approach to the integrated use of digital health technologies.

Virtual care supports health system priorities such as person-centred care and inclusive, equitable access for consumers and carers.[156] Communications through virtual care can provide an alternative to in-person care throughout the healthcare journey, from first response to community care.[157] Technology must meet the needs of older people and also be accepted by them, and older people should be provided with time to establish confidence with the technology prior to undertaking computer-based online therapies. The NSW Virtual Care Hub[158] provides information about how to access virtual healthcare throughout NSW. The NSW Virtual Care Hub and ACI's Virtual Care website also provide resources for consumers, including a 'Virtual care suitability checklist'.[159] Clinician support resources are also available from ACI's Virtual Care[160] including a 'Virtual care implementation checklist', and 'Virtual care: embedding safety in practice'.

Good practice features – Adapting for the person's location and context

1. OPMH community services provide care in the location preferred by the consumer and carer wherever feasible, using their preferred modality. Where this is unknown, or unclear, care should occur in the person's normal place of residence unless there are specific reasons for it to occur elsewhere (such as consumers experiencing homelessness).
2. Where a consumer prefers to receive care in an outpatient clinic or other setting outside their normal place of residence, OPMH community clinicians support this preference and provide and/or arrange assistance as required, taking into account any mobility needs of the consumer and/or carer(s).
3. OPMH community clinicians are supported to work in a range of settings including a person's normal place of residence (which may be a residential aged care home or a private residence), outpatient settings, inpatient settings, primary health settings, Aboriginal health services, or other safe locations nominated by the consumer. To support service delivery across these settings, OPMH services are to provide clinicians with guidance on key arrangements, including:
    a The roles and responsibilities of the services involved in the provision of care.
    b Arrangements for the management of medical records.
    c The agreed expectations around communication (including handover of clinical details and discharge/transition of care information).
    d How to resolve any concerns related to partner agencies.
4. OPMH community services use in-person or virtual care to support consumers, their supporters and other involved health professionals.

Section 6. Clinical processes: What do we do?

Consumer, carer and health professional consultation findings

Consultation with consumers, carers and clinicians to inform the model of care identified key points that are relevant across all key OPMH clinical processes. Consumers reported that they valued staff taking the time to listen, establishing trust and rapport, having a person-centred, recovery-oriented focus, and working in close partnership with the consumer, carer/supporter and GP. Consumers, carers/supporters and health professionals, including GPs, emphasised the importance of communication with all parties that is timely, open, honest, transparent and collaborative, and timely provision of information, particularly within intake and transfer of care processes (2017 and 2025 consultations).

Consumer and carer consultation findings, and OPMH benchmarking data, suggest that most OPMH consumers are receiving mental health care from their GP prior to contact with OPMH services, and GPs and OPMH inpatient services are key referral sources to OPMH community services. Consumers indicated that they generally preferred to continue seeing the first clinician they had contact with, valuing the continuity of care this provided (see *Appendix B*).

Consumers indicated they had experienced a high level of involvement in planning and decision-making about their care in their contact with OPMH community services, with many highlighting that being included and informed was a high priority. Consumers and carers/supporters highlighted the importance of having a clear, well-communicated plan of care, both in their contact with OPMH services and as a longer-term care plan to support the older person's recovery journey (see *Appendix B*).

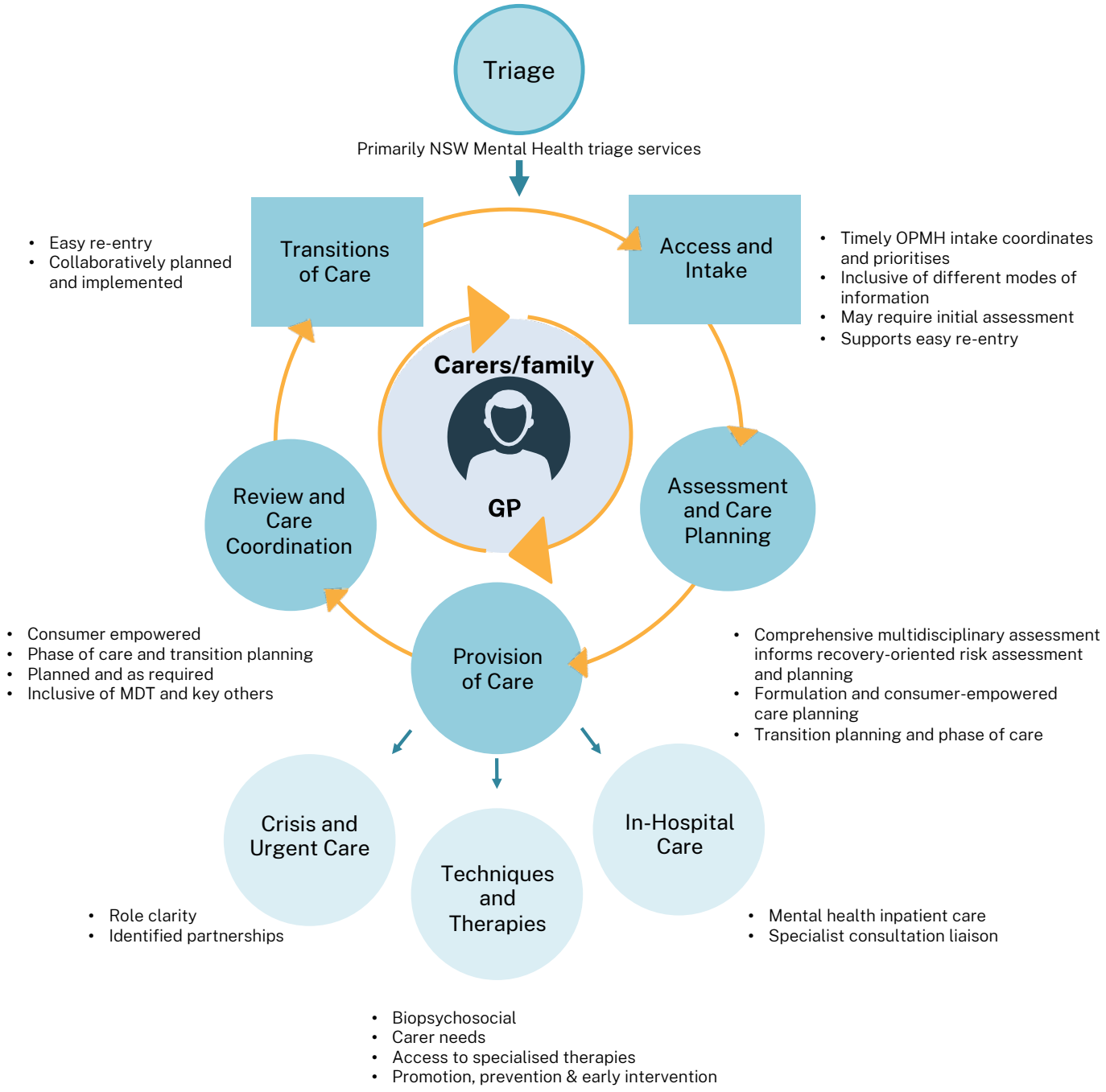
Carers highlighted that effective communication and involvement of carers is essential for service navigation and support. The role of OPMH community services in service navigation support was noted to be valuable in ensuring consumers were connected to the care and support they need, including other necessary health services. Regarding discharge planning, consumers and carers emphasized the need for clear information on what to do if problems arise, good communication with their GP, follow-up care planning, and re-entry pathways into the service if needed. Carers wished to be included in discharge planning where appropriate. Consumers, carers/supporters, and GPs all indicated that being able to connect directly and promptly with OPMH community services when needed was very important, particularly following discharge. (see *Appendix B*).

The OPMH Community Services Model of Care and OPMH benchmarking processes

The directions in this model of care are informed by statewide OPMH benchmarking data and processes. OPMH benchmarking processes are also used to support implementation of 'good practice features' in the model of care, particularly those relating to key clinical processes, and ongoing quality improvement in key processes within OPMH community services. The OPMH community services benchmarking self-audit tool (SAT) outlines a set of agreed standards to improve and maintain the various key processes of OPMH community services, including access and intake, assessment and care planning, clinical care, clinical review and care coordination, and community discharge/transfer of care. Findings to date have indicated good uptake of most features.[161]

The figure below provides an overview of key OPMH community service clinical processes, key features and flow.

Figure 3: Clinical processes and flow



6.1 Access and intake

Older people face multiple obstacles to accessing mental health care across all sectors of the mental health system.[4,46] In the context of developments in NSW mental health triage services, OPMH teams should rarely be directly involved in the primary triage of people seeking to access mental health care but must have clear processes to respond in a timely and appropriate manner to all people referred to the team, whether from NSW mental health triage services or other sources. These processes should be informed by state and local prioritisation guidance.[41,162]

6.1.1 Access

National standards[67,68] clearly identify that mental health services must support access and entry by providing information to the community, including GPs, regarding the availability and range of services they provide and how to establish contact. A lack of awareness of OPMH services and what they do is a key barrier to access. OPMH services should promote information about local OPMH services, including referral and prioritisation criteria, to key service partners and referral services.

> Consultation revealed that there is a general lack of knowledge and anxiety about mental health services among older people- 'like a black box, but one that is vaguely fearful'
>
> **Community consultations, 2017**

Stigma about ageing and/or mental illness and seeking help are barriers to accessing care. Negative beliefs about mental health professionals are also a barrier to help-seeking amongst older people.[163] One example of a strategy to address stigma in health services is targeted older people's suicide prevention training.[164]

Aboriginal and CALD people have additional barriers to access and care,[50,105,109,112,126,165,166] and enhancing their engagement in the mental health system requires a culturally safe and responsive approach and specific strategies.[111] This may include: collaboration with ACCHOs and/or Aboriginal health/mental health workers and multicultural mental health services; having clear and accessible contact pathways to facilitate access to services, and provision of culturally appropriate mental health information. Other groups that may face barriers to accessing care include LGBTIQ+ and gender diverse older people, older people living with mental illness and intellectual disability, and older people living in rural and remote areas.

LGBTIQ+ and gender diverse older people require safe, trusted, trauma-informed and respectful service contact pathways, as identified in consultations to inform the model of care. LGBTIQ+ and gender diverse populations may experience differences socially, emotionally and physically as ageing progresses, and have specific concerns that need to be understood to ensure care is offered and received without creating further trauma and stress. History of trauma relating to treatment of LGBTIQ+ and gender diverse populations in the past including criminalisation, contributes to apprehension towards services providing aged and mental health services. Applying a trauma-informed approach and acknowledging identity and history early in the process provides sound background information to help the consumer, their key supporters, and clinicians safely navigate mental health services.[127,167]

Older people living with mental illness and intellectual disability have unique barriers to accessing mental health services, and the document Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers,[168] National Centre of Excellence in Intellectual Disability Health,[169] and the Statewide Intellectual Disability Mental Health Hub provide advice on improving access.[170]

6.1.2 Intake

New referrals to OPMH community services will often occur through NSW mental health triage services but may occur through a number of pathways, including inpatient OPMH services, adult mental health services, and crisis or suicide prevention services. OPMH services should facilitate the 'no wrong door' approach to support easy and timely access to specialist mental health assessment and care for older people. A number of initiatives provide alternative options for people seeking mental health care, other than hospital Emergency Departments.[144,145,171] OPMH community services can enable smoother referral pathways through liaison with referring services and NSW mental health triage

services to support timely access to OPMH assessment and care.

The published literature supports a low threshold for referral of older people in suicidal distress into OPMH services and this is a key direction in targeted older people's suicide prevention pathways and aftercare initiatives.[172,173] Further information about NSW suicide prevention programs including for older people, Aboriginal people and people of diverse genders and sexualities is available through NSW Health's Towards Zero Suicides webpage.

Mental health triage in NSW is guided by the NSW Health Mental Health Triage Policy[162] and Call Handling Guidelines and NSW Health Mental Health Clinical Documentation.[174] However, mental health access and triage arrangements and associated guidelines are evolving in the context of the NSW Mental Health Hub initiative and national mental health Initial Assessment and Referral Decision Support Tool (IAR-DST).[175] OPMH community services will need to adapt their processes and communication with access/triage services to support appropriate access to OPMH services, particularly initial assessment.

A key difference between the triage of older people and that of younger age groups is the higher likelihood of co-existing medical conditions which may imitate, exacerbate or mask psychiatric symptoms[176] and physical (e.g. hearing) impairments. Screening for acute medical deterioration or delirium, including any potential underlying clinical cause of delirium, is essential for assessing risk in older people. Further details about the intake of older people with delirium or AoD disorder are available in Section 2.1 (Potential exclusion criteria for primary OPMH community services response).

Admission to an OPMH service commences from the point of initial assessment, which will determine if the team should continue the admission, or limit the admission to assessment, advice/ care planning and transition to a service better able to meet the person's needs. No referral from NSW mental health triage services/NSW Mental Health Hub or key partners should be redirected or declined without a documented assessment and clinical decision making.

As outlined in Section 1.4, consumers and carers want timely, easy access to care and services. To support this, OPMH community services should accept all people referred to the service following triage for initial assessment. This requires an acceptance of the role of the NSW mental health triage services/NSW Mental Health Hub in forwarding referrals of older people to OPMH services. The initial assessment undertaken by OPMH community services should consider a consumer's particular needs in order to support them to access the most appropriate services for ongoing care. This may include OPMH services and other clinical and community supports as required.

Mental health services have a responsibility to recognise and support the rights and needs of consumers, carers, and families throughout intake and admission processes (including language and cultural needs). They should also involve carers, families/supporters and/or GPs where possible and with appropriate consent.[15,41,45]

OPMH community services should support re-access, where possible, for consumers within 6 months post-discharge through direct contact with the previous clinicians involved. This process should be clearly documented and communicated to the consumer and, with consent, carers/supporters and GP. Consumer, carer and expert opinion informing this guideline supports OPMH community services having processes that promote easy re-access to services for OPMH consumers, carers, families/supporters, and clinicians including GPs following discharge, when required.

Good practice features – Access and intake

1. OPMH community teams have clear processes for reliably and confidentially receiving referrals from NSW mental health triage services and other referral pathways supported by their mental health service.
2. OPMH community teams have clear processes for making timely decisions and actions that support access to appropriate assessment and care for people referred.
3. OPMH community teams have processes that support easy re-contact and re-access to OPMH services by consumers who have been discharged in the previous 6 months.
4. OPMH community services regularly review and improve local access and intake pathways for older people. This may include the following actions:
    a Supporting the mental health service in collaborative processes with PHNs regarding access to mental health care for older people.
    b Collaborative processes to review data or experiences related to older people seen by other mental health services in the LHD prior to referral to OPMH community services.
    c OPMH services having inclusive and responsive processes for undertaking initial assessments to assist in appropriate responses to referrals. This may include:
        i Where review of referral information suggests delirium or acute mental illness is likely, this should be documented as part of an initial assessment and the consumer should be referred for and/or assisted to seek assessment and management of these issues.
        ii Involving carers and families in response to referrals, including initial assessments, with consumer consent.
        iii Staff actively contacting and seeking involvement of GPs in initial assessment processes, wherever possible.
        iv Older consumers and carers being informed of the nature of the OPMH community service and what to expect if accepted for treatment.

6.2 Assessment, formulation and care planning

Assessment

The triage and initial assessment process determines which service is most relevant to the consumer's needs and if further mental health assessment is required. Initial assessment of the mental health consumer making first contact or comprehensive assessment (as required) aims to identify and formulate the exact nature of the person's difficulties in order to 'plan and deliver appropriate prevention, intervention and management strategies'.[177] Older people require comprehensive assessment and management as each older person has 'a unique set of health problems and circumstances'.[178] Assessment and care planning should be recovery-focused, person-centred and consumer-led, with the consumer, carer and GP active participants in assessment and care planning processes.

Assessment should be comprehensive and multidimensional, considering a range of psychological, functional, physical and social attributes of the person in the context of their environment, as well as the risks and vulnerabilities for the person's family and/or carers. It should also consider what is important to the consumer (e.g. social activities, pets). A comprehensive assessment process should involve OPMH community clinicians, at admission and at other times where required, utilising the electronic medical record (eMR) system as per the Mental Health Clinical Documentation policy directive[174] with additional assessments used as required. People at risk of suicide should receive a comprehensive mental health assessment incorporating a psychiatric evaluation and a culturally safe and developmentally appropriate psychosocial assessment. Assessment should include current stressors and a detailed assessment of suicide risk, in accordance with the requirements of NSW Health

policy directive Clinical Care of People Who May be Suicidal.[178] The use of suicide risk measurement tools or checklists in isolation is not recommended.[178] There are a number of resources available for clinicians, consumers and carers on the NSW Health suicide prevention webpage,[179] with information about key services, programs and initiatives including the Older People's Suicide Prevention Pathway Project.[24]

> The essential tasks of establishing rapport, listening, and establishing trust were highly valued by consumers, carers and clinicians - 'forms and measures don't tell the whole story'
>
> **Consumer and carer consultations, 2025**

Assessment tools for older people recommended by NSW Health[180] include the Health of Nation Outcome Scale 65+ (HoNOS 65+), Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL), LSP-16 (an abbreviated version of the Life Skills Profile), and K10+-LM and K10-L3D (two versions of the Kessler-10). The 3MS and RUDAS are also supported in the NSW Health mental health documentation suite. There are currently no mandated or agreed instruments for assessing behaviour beyond sub-scale 1 included in HoNOS 65+. The Montreal Cognitive Assessment (MoCA)[181] is a state-supported tool for use in ECT pre-post assessment and in drug and alcohol services. The MoCA is a brief cognitive screening tool developed to detect mild cognitive impairment as a precursor to dementia but has also been validated with regards to frontal lobe (executive) impairment, including substance use disorders.[182] The MoCA has been validated for 55-85 year olds, is available in different languages and has variants for people who are blind or who have limited educational skills. The MoCA requires completion of an online training module prior to use.

There are many other tools available to assist with assessment of older people. The Dementia Outcomes Measurement Suite (DOMS) includes a range of annotated assessment measures and tools for the commonly rated constructs within dementia such as cognition, behaviour, function and quality of life.[183]

The NSW Agency for Clinical Information (ACI) has developed a resource: Screening and assessment tools for older people[180] and the Pathways to Community Living Initiative (PCLI) suite of assessments has been utilised with older people with mental illness in the PCLI program. Further information is available in the PCLI Planning, Assessment and Follow up Guide.[184]

Two key resources: *Assessment and Management of Behaviours and Psychological Symptoms associated with Dementia (BPSD): A Handbook for NSW Health Clinicians providing services for people experiencing BPSD185* and *A Clinician's BPSD Guide 2023: Understanding and helping people experiencing changed behaviours and psychological symptoms associated with dementia*[186] provide advice on assessment tools for use with people with dementia. An example of a broader tool looking at the functioning and needs of older people is the Camberwell Assessment of Need in the Elderly (CANE)187. Several mental health assessments tools have been developed / adapted that are culturally appropriate and validated for use with Aboriginal consumers. See *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*[107] for further information. RUDAS is recommended for use with people from CALD backgrounds.[180] While clinicians can make use of a wide range of assessment tools, these must supplement the use of recommended tools.

A number of projects utilising different approaches to promote recovery-oriented practice in OPMH services, including collaborative care planning, have been published as part of the NSW OPMH Mental Health Recovery-oriented Practice Improvement Project.[16] Projects targeted key elements of recovery including individualism, choice, attitudes and rights, dignity and respect, partnership and communication, and evaluation.

The NSW Health Physical Health Care for People Living with Mental Health Issues Guideline[39] and the Physical Health Care within Mental Health Services Policy Directive[188] outline the responsibilities of mental health services in relation to providing physical health care for people living with a mental illness. The Guideline outlines minimum standards for routine physical health screening and promotes the role of mental health services in facilitating access to comprehensive assessment and intervention for physical health issues. Assessment of older people should also consider drug (non-prescription and prescription) and alcohol use, falls risk,189 pain,

eating disorders[190–192], elder abuse/domestic violence[193,194] and suicide risk.[178] The NSW OPMH Physical Health Practice Improvement Project[38] has supported a range of strategies to improve physical health assessment and care in OPMH services.

Assessment of substance abuse

In NSW, people aged over 65 are most likely to drink daily, consume alcohol at risky levels, smoke tobacco more than young people, and to have an alcohol-attributable hospitalisation or death.[195,196] The NSW Health Older People's Drug and Alcohol Report[58] highlights that drug and alcohol misuse is a significant co-existing issue for some people with mental health problems, and provides guidance for mental health services in working with these issues. OPMH community services should provide routine screening and assessment of consumers with regards to substance use issues, including prescription drug misuse, utilising recommended screening tools. A screen for cognitive impairment should be undertaken if there is a positive screen for substance misuse/ alcohol misuse. Mental health services may also be requested to provide expertise and support to drug and alcohol services in cognitive screening and assessment. Canadian practice resources on working with older people with alcohol misuse and a range of other substance misuse issues provide further evidence-based guidance relevant to OPMH community services.[197]

Care planning

Based on the information gathered during the assessment, clinicians should complete the HoNOS65+ and other relevant outcome measures. HoNOS65+ is designed to be used by clinicians before and after interventions, so that changes attributable to interventions can be measured. Care planning templates are provided in electronic medical record (eMR) and should be used to summarise the goals and clinical issues that are the targets for the episode of care.[174]

Care plans should be recovery-focused, consider clinical and personal recovery, and be developed in partnership with the consumer and carer. Goals and plans should not be imposed on a consumer, but rather clinicians should support consumers to make decisions about their care and communicate their hopes and plans for recovery. Social needs are often key unmet needs[198] and should be considered by services as central in care planning and coordination.

The Consumer Wellness Plan facilitates a consumer's involvement in their own care, supports self-determination and serves as a recovery aid. Cultural and spiritual needs, as well as mental and physical health needs can be considered in the Wellness Plan. Clinicians should support consumers in completing their own Wellness Plan wherever and whenever possible and this may occur in concurrence with the care plan.

Advance care planning should be considered where appropriate. NSW Health guidance such as Dignity, Respect and Choice: Advance Care Planning for end of life for people with mental illness[199] and the Advance Care Planning[200] webpage provide information and resources.

Recovery-oriented approaches, and balancing risk and recovery

The development of a recovery-oriented approach to working with consumers and the successful management of risk may appear contradictory. Recovery-oriented care is associated with the development of hope, facilitation of self-determination and choice, and the provision of opportunities. Risk management in health services is traditionally a clinician-led activity that is focused on avoiding danger and reducing harm to the consumer and others and often includes implementing restrictions of some form.[201]

The NSW Mental Health Act both provides guidance, and highlights the tensions, in working in this area. The Act clearly promotes the provision of care that supports the recovery of people with mental illness, the involvement of those persons in treatment and recovery plans and maximising the involvement of people in consenting to such plans.[14] The Act also states '*any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances*'.[14]

However the Act also includes within its objects:

'while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others'.[14]

The objects of the Act also include that 'those who care for them' be involved in decisions involving appropriate care and treatment.[14]

These objectives capture the tension that is inherent in mental health care between maximising personal autonomy and at times restricting this autonomy to promote safety of the individual or others. All clinicians must work in a way that promotes the recovery of the person they are working with but cannot ignore the responsibilities inherent in being able to utilise the Mental Health Act to 'provide treatment' for the protection of the person or others from harm. In addition, clinicians have a responsibility to ensure that consumers are warned of risks to enable them to make an informed decision about treatment options.

This means that all clinicians must work in a manner that identifies and advises consumers of potential risks and ensures the response to such risks is clear; but does not assume all risks must, or can, be eliminated. There is increasing exploration in the literature regarding how to manage this tension, supporting a focus on recovery-oriented risk assessment and care planning based on shared decision making.[202–205] In this way, risks are assessed and managed in a way that is supportive of individual recovery. Within such approaches, consumers with capacity may choose to make decisions regarding their own treatment (or lack of). This could include choosing voluntarily to live with a level of risk, or, most commonly, involve decisions regarding which risks they prefer to live with. Of course, clinicians must advise consumers of the risks of treatment or not accepting treatment. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status (voluntary or involuntary, receiving treatment in hospital or in the community). The Mental Health Act, and this guideline, encourage the active involvement of others involved in the care of a consumer in collaborating to attain these goals.

A clinician needs to consider how best to support the consumer in their choice, which may involve implementing risk mitigation strategies, or engaging in positive risk taking.[27] 'Positive risk taking' refers to a way of working that enables clinicians to support people in taking risks as a route to positive outcomes. It may be defined as:

'weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes'.[206]

This approach links the risk assessment with the subsequent planning for safety, learning and personal growth, aligning closely with recovery-oriented practice. A consumer's confidence, capacity and resilience may be improved through carefully considered and appropriately supported engagement with risk. Clinicians must advise consumers of the risks and benefits of the options available to patients. An example of this in practice is shown in the following box.

CONSUMER STORY:
Balancing safety and positive risk taking

Joan is a 75 year-old woman with severe depression who is a consumer of her local OPMH community service. She is quite frail and has been assessed by her clinician as having a high falls risk. When depressed, she has taken large overdoses of medication but has not had any suicidal ideation for over two years. As part of her Wellness Plan, Joan has identified joining a local walking group as important for her personal recovery. However, Joan has been told that her medication increases her risk of falls, and she would like to reduce the dose slowly. Her clinician agrees that the medication has some impact upon Joan's risk of falling but is worried that Joan may have a deterioration in her depression with a change in medication and discusses this with her. Joan understands the risk but decides that she prefers to take this risk rather than the increased risk of falling, especially as she feels that joining the walking group will have such a positive impact on her recovery. Joan also agrees to develop a Safety Plan with her clinician to assist her if suicidal ideation returns. Joan has been assessed as having capacity and has a right to self-determination. The clinician and Joan together discuss what can be done to help her join the walking group and how best to monitor for any deterioration in her depression. They decide to involve her adult children in helping with this.

A collaborative, person-centred approach is fundamental to recovery-oriented risk assessment and planning.[202] Other important considerations include the following:[27,79,202,207–209]

- Joint or supported decision-making about the management of risk and promotion of safety, in the pursuit of the consumer's identified recovery and treatment goals.
- Recognition that the level and type of risks associated with a consumer can change over time. Each consumer requires a consistent and individualised approach that is clearly articulated within clinical reviews, management and recovery plans.
- Discussions with consumers regarding their treatment and recovery options, and the risks and benefits of the options, should be undertaken and appropriately documented. Further details can be found in the Consent to Medical and Healthcare Treatment Manual.[84]
- Decisions are based on evidence; knowledge of the consumer, their social context and the consumer's own experience; and clinical judgement.
- Inclusion of family and carer/s in opportunities for positive risk taking and learning.
- Assisting people to take responsibility for themselves and for ensuring their safety with appropriate supports.
- A focus on helping people to do the things they want to as safely as possible and supporting 'positive risk taking'.
- Knowledge and understanding of mental health legislation.

The use of recovery-oriented language, such as replacing the concept of 'managing risk' with 'promoting safety', can also often assist in maintaining a recovery-oriented approach in this difficult area of practice.

Good practice features – Assessment, formulation and care planning

1. All consumers seen by the service after referral should experience an assessment that is biopsychosocial, person-centred, recovery-oriented, trauma-informed and adapted for the individual's age and context.
2. Assessment informs a statement or statements of biopsychosocial understanding of the person's current situation and factors associated with this (formulation), including recovery-oriented use of diagnoses and identification of strengths.
3. All care planning is multidisciplinary, guided by assessment, and age appropriate.
4. All care planning aims to empower the consumer.
5. Assessment and care planning enable recovery-oriented approaches to working with risk.
6. The OPMH community service has clear governance expectations regarding the application of more general assessment guidelines to consumers of the OPMH community service. This may include:
    a The expected timing of relevant assessments.
    b The responsibilities and skill sets of staff who are conducting assessments.
7. Assessment and care planning utilises appropriate tools and instruments.
8. Mechanisms are in place for multidisciplinary care planning that seeks to empower the consumer, carers, and families/supporters. Such care plans should be reviewed at defined periods
9. Care planning and multidisciplinary reviews identify the appropriate Phase of Care for the next period of care; and result in completion of required documentation if the Phase of Care is changed.
10. Care planning and multidisciplinary reviews include planning for transition of care as early as is feasible, and consistent with the person's identified needs.
11. Care planning includes factors relevant to transitions of care such as post-discharge follow-up, review and support, and ongoing management.

6.3 Techniques and therapies

Consumer and carer consultation (2025) identified that consumers place importance on having access to a range of therapies, particularly psychological/talking therapies and medication. Consumers also value group sessions and support to access psychoeducation and social/activity groups, reflecting feedback about the importance of social connection for the older person. Feedback from carers was broadly consistent with this. Consumers and carers indicated a desire for increased access to a range of specific professionals, particularly psychologists, psychiatrists, and allied health professionals to enable access to the range of therapies (see *Appendix B*).

In line with the principles of recovery-oriented practice, an individualised plan should be tailored to the consumer's preferences. This plan should be developed with the consumer and carer to enable the consumer's unique values, goals, needs and preferences to drive the plan, whilst integrating this with clinical assessment findings, evidence-based practice and sound clinical reasoning.

There are many ways that mental health clinicians can support the empowerment of consumers. These may include: supporting consumers to choose from a range of options and to participate in all decisions; fostering exposure to people in recovery who can model empowerment and demonstrate experience in self-management; and supporting access to self-management resources including support groups.[210,211]

A variety of techniques and therapies are available to support the consumer on their recovery journey and help them achieve their treatment goals in collaboration with their carer, and families/supporters. OPMH community services have a primary responsibility for facilitating clinical recovery, while supporting consumers in other aspects of their recovery goals (e.g. by referrals to and partnerships with appropriate health and community care services, and psychosocial supports). Optimal 'clinical' interventions involve a biopsychosocial approach. This will often involve the OPMH community service integrating 'clinical interventions' with supporting the consumer to manage their self-care and daily functions, improve social and relationship skills, and achieve a broader quality of life (including in the areas of physical health, lifestyle therapies, social connectedness, housing, education and employment). Clinicians will utilise a variety of tools in undertaking therapies and to facilitate consumer and /or carer self-management, recovery, resilience and empowerment.[213] This includes age-appropriate use of processes and techniques supporting suicide prevention.[164,214]

CONSUMER STORY:

OPMH community services' influence on clinical and personal recovery

Steve is a 79 year-old man who became involved with OPMH services after an attempt to end his life. Whilst medication and cognitive behavioural therapy were important in resolving symptoms of Panic Disorder, re-engagement in volunteer activities was essential for Steve to regain a sense of purpose in his life. His OPMH clinician both responded to Steve's concerns about having lost his role in life and helped Steve plan steps to address this, but his family provided the main practical supports in achieving his goal.

Therapies may facilitate clinical and/or personal recovery and may be provided directly by OPMH services or by OPMH services partnering with, or linking to, other service providers. Local factors determine who should have primary responsibility for providing a particular therapy on a particular occasion. Many therapies, techniques and tools are supported by a good evidence base (particularly clinical therapies), while others (particularly in personal recovery domains) are newer or evolving approaches for which there is limited research conducted to date. These approaches may still provide good outcomes for individuals. OPMH community clinicians should support consumers to maximise their autonomy in directing care and accept the consumer's right to engage in therapies or supports without an evidence base, balanced by respectful discussions about limitations in evidence or any potential for harm associated with the consumer's decisions.

Many techniques and therapies used are more traditional in approach (clinician-led) and clinicians need to be mindful of this in practice and consider how adaptations in approach may be more consistent with supporting both clinical and personal recovery. Routine practice should include: fostering self-determination and personal responsibility; promoting

shared decision-making and working in partnership with the consumer, carer, and families/supporters, and GPs; supporting the development of consumer motivation, self-management and self-empowerment; providing dignity and respect including gaining appropriate consent; managing and sharing risk; ensuring adequate time for consultations, and utilising good communication.

> The focus within the consultations, as emphasised by consumers and carers, was very much on 'what I can do to improve and maintain my mental health' and what clinicians can do to facilitate and support this process.
>
> **Consumer and carer consultations, 2017**

Most therapies that are effective in younger people remain effective in older age, including medications and a range of psychotherapeutic approaches, even in the presence of cognitive impairment.[130,213,215] However specialised knowledge or skills may be required to adapt them appropriately to an older person or someone with cognitive impairment. Psychotherapy can be adapted to meet consumer needs. This may include increased number of sessions, slower presentation of material, increased use of behavioural activation and other similar techniques, use of memory aids and environmental cues, and including a role for the carer in therapy.[130] Psychotropic medication use in the older person may cause diverse outcomes including changes in sensitivity, benefits, and a variety of side effects.[130]

It is beyond the scope of this model of care to provide specific guidance regarding the management of particular conditions. However, the 2017 expert reference group for the development of the model of care and other experts consulted agreed that sufficient guidance should be provided to support LHDs and community OPMH services to develop the necessary clinical governance and organisational supports for their clinicians to use appropriate therapies, tools and techniques. Consultation participants expressed concern that some clinicians were unable to provide a range of biopsychosocial therapies, which placed too much focus on pharmacotherapy. Where consumers live in areas with small teams, or individual clinicians supported by general mental health services, there may be limited options for therapy, and sometimes a more biological-oriented approach from OPMH services, although sometimes complemented by other supports from other services. Decisions regarding the range of therapies offered are highly dependent upon clinical expertise, preferences, specific skills and/or availability of staff within each OPMH service. There is no one source of guidance available to OPMH community services regarding adaptation across therapies for age, or non-biological therapies; nor does the breadth of these therapies make this likely to be feasible in the foreseeable future.

The 2025 expert reference group and consultations to update the model of care highlighted similar considerations and supported the scope and direction of the existing good practice features in the model of care. LHD OPMH community staff feedback highlighted that the guidance in this section of the model, including the table below, was highly valued. Expert feedback also supported as a good practice feature that all OPMH community clinicians should provide some psychological strategies to consumers as part of care, in addition to coordinating and facilitating access to therapies and services.

OPMH community services should be familiar with how to utilise local suicide care pathways,[216] how these apply locally to older people; and how the interface between OPMH community teams and other services works. OPMH clinicians and peer workers should maintain currency with training related to their role in working with people who may be suicidal and associated brief interventions (for example via the HETI training pathway for suicide prevention).164

OPMH community services should have some capacity to provide clinical care for consumers with substance use issues, as outlined in the NSW Health Older People's Drug and Alcohol Report.[58] This may involve provision of brief interventions and education where appropriate and/or close collaboration and joint working with specialised drug and alcohol services.

Where consumers require access to highly specialised biological treatments such as clozapine, outpatient and maintenance ECT, or some depot antipsychotic medications, this often requires involvement of mental health services primarily focussed upon the needs of adults of younger ages.

Promotion, prevention and early intervention

The importance of promotion and prevention in mental health is recognised in a number of key policy documents.[11,29,53,217–219] Mental health promotion and prevention initiatives, across biopsychosocial factors, focused on older adults are particularly significant given that mental illness is often under-recognised, and is frequently misrepresented as a normal part of the ageing process.[220,221] Prevention of major depression in later life may be effectively achieved by targeting older people who experience risk factors, particularly functional limitations as a result of illness or medications prescribed, have a small social network, and/or have subthreshold (i.e. subsyndromal) symptoms.[219,222–224]

The NSW OPMH Service Plan indicates that prevention and early intervention strategies should be part of the OPMH community service's activity. This may include promoting self-care and peer support approaches, capacity building with families, carers and communities to recognise early warning signs and to support older people with mental health problems, and education and training with relevant services to promote early and effective response to mental health problems in older people. These would generally be progressed through a primary health care model, in partnership with primary health and aged care services, community support services and GPs. The extent of specific prevention and early intervention activities conducted by OPMH community services will be influenced by resource levels, the work of other organisations in this space, and national and NSW policy directions and initiatives regarding mental health promotion, prevention and early intervention,[43,219] and suicide prevention.[45,49,105,225,226] However, a focus on early intervention and relapse prevention is integral to OPMH clinical practice, and this should be done in a culturally relevant and safe way.

While there are currently no national clinical standards on the clinical care of older people with mental illness, there are a number of resources available to guide OPMH clinicians. Examples of these are included in the table below. International resources need to be considered and applied (if used) within the Australian context, especially in line with application to the Aboriginal population and CALD communities.

Table 2: Example resources to guide OPMH clinicians

Scope	Australian Guidance	International Guidance
Adaptation for older age		American Psychological Association (APA): Psychotherapy and Older Adults Resource Guide Age UK: NHS Talking Therapies Positive Practice Guide: Older People (2024) National Ageing Research Institute: Age-positive language guide
Anxiety	Royal Australian and New Zealand College of Psychiatrists (RANZCP): Clinical practice guideline: Panic disorder and agoraphobia Beyond Blue: What works to promote emotional wellbeing in older people	NICE: Generalised anxiety disorder and panic disorder in adults: management NICE: Post traumatic stress disorder
Bipolar disorder	RANZCP: Clinical practice guideline: Mood disorder	NICE: Bipolar disorder: assessment and management

Scope	Australian Guidance	International Guidance
Dementia and BPSD	NSW Health: Assessment and Management of Behaviours and Psychological Symptoms associated with Dementia (BPSD): A Handbook for NSW Health Clinicians providing services for people experiencing BPSD Cognitive Decline Partnership Centre (CDPC): Clinical Guidelines for Dementia Dementia Support Australia (DSA): Understanding behaviour changes Dementia Centre for Research Collaboration (DCRC): Behaviour Management: A Guide to good practice: Managing BPSD	International Psychogeriatric Association (IPA): The Complete Guides to Behavioural and Psychological Symptoms of Dementia (BPSD) – 3 volumes NICE: Dementia - quality standard
Depression	RANZCP: Clinical practice guideline: Mood disorder RANZCP: Position statement: Use of antidepressants to treat depression in dementia Beyond Blue: What works to promote emotional wellbeing in older people	UK National Institute for Clinical Excellence (NICE): Depression in adults: treatment and management NICE: Depression in adults with a chronic physical health problem: recognition and management
Intellectual Disability/ Mental Health	NSW Health: Statewide Intellectual Disability Mental Health Hubs Department of Developmental Disability Neuropsychiatry (3DN): Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers National Centre of Excellence in Intellectual Disability Health: Resources at NCEIDH	
Mental Health Act	Health Education and Training Institute (HETI): Mental Health Act 2007 - Guide Book	
Occupational therapy	Osborne Park Hospital, WA: Dementia: Osborne Hospital Guide for Occupational Therapists in Clinical Practice	NICE: Mental wellbeing in over 65s: occupational therapy and physical activity interventions
Physical health and lifestyle interventions	NSW Health: GL2021_006 Physical Health Care for People Living with Mental Health Issues Australasian Lifestyle Medicine Society: Clinical practice guidelines for lifestyle-based mental health care for major depressive disorder	NICE: Mental wellbeing in over 65s: occupational therapy and physical activity interventions

Scope	Australian Guidance	International Guidance
Promoting mental wellbeing	Everymind: Prevention First: A prevention and promotion framework for mental health NSW Health: Wellbeing in Later Life: Your Guide to Programs and Activities Beyond Blue: What works to promote emotional wellbeing in older people: *A guide for aged care staff working in community or residential aged care settings*	NICE: Older people: independence and mental wellbeing University of Toronto/Toronto Public Health, Canada: Best practice guidelines for mental health promotion programs: Older adults 55+ NICE: Mental wellbeing in older people in care homes
Psychosis and Schizophrenia	RANZCP: Clinical practice guideline: Schizophrenia and related disorders	NICE: Psychosis and schizophrenia in adults: prevention and management NICE: Overview | Rehabilitation for adults with complex psychosis | Guidance | NICE
Social interventions		NICE: Older people with social care needs and multiple long-term conditions Substance Abuse and Mental Health Services Administration (SAMHSA): Psychosocial Interventions for Older Adults With Serious Mental Illness Canadian Coalition for Seniors' Mental Health: Canadian Clinical Guidelines on Social Isolation and Loneliness in Older Adults
Substance use disorders	NSW Health: Older People's Drug and Alcohol Project – Full Report	NICE: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Canadian Coalition on Senior's Mental Health: Substance Use and Addiction - Alcohol, Benzodiazepines, Cannabis, Opioids Canadian Centre on Substance Use and Addiction: Care Pathway for Older Adults Experiencing Prescription Drug Harms
Suicide and self-harm	NSW Health: Clinical care of people who may be suicidal NSW Health: Suicide prevention: Workforce development, training and support RANZCP: Clinical practice guidelines for the management of adult deliberate self-harm	NICE: Self-harm: assessment, management and preventing recurrence

Note: Every effort has been made to ensure the accuracy and reliability of the information in the table above at the time of publication. Links to internet sites and resources are identified; however these represent only a selection of those available. Links to internet sites are provided for information purposes only. Due to the changing nature of internet content, it is the responsibility of users to make their own investigations, decisions and enquiries about any information retrieved from internet sites.

Good practice features – Techniques and therapies

1. OPMH community services enable access to coordinated biopsychosocial therapies by:
    a Actively working with consumers and carers to identify and prioritise desired therapies that are feasible to access and best align with the individual's personal and clinical recovery goals.
    b Having clear processes for working with clinicians and other providers delivering these therapies, both within and outside the team.
2. OPMH community services enable access to the following evidence-based therapies and expertise for personalised use consistent with each consumer's individual values, goals, circumstances, medical and age-related conditions
    a Biological therapies
    b Use of psychological strategies within care coordination
    c Strategies to support and promote physical health within scopes of practice
    d Formal psychological therapy, including through providers outside OPMH services
    e Social and lifestyle therapies and interventions, including through providers outside OPMH services
    f Self-directed therapies (e-therapies, bibliotherapy and emerging options)
3. OPMH community services ensure carers have access to a range of information, therapies and services that support their biopsychosocial needs and the consumer's recovery, either through direct service provision where appropriate or through facilitating access to other services
4. OPMH community services promote relationships and arrangements with mental health services providing highly specialised services (such as clozapine dosing, outpatient and maintenance electroconvulsive therapy (ECT) and depot antipsychotic medications) to ensure age is not a barrier to accessing appropriate care.
5. OPMH community services provide staff with easily accessible:
    a Guidance, tools and reference materials to support provision of relevant evidence-based therapies.
    b Information regarding the range of biopsychosocial therapies that may be provided by staff (including any therapies that are precluded).
    c Guidance on how staff will work with the consumer, carers and family/supporters and other providers when therapies not provided by staff are needed/wanted.
    d Guidance about how the team works with external providers of specific therapies or related clinical services (e.g. Medicare-funded psychology or psychiatry services)
    e Relevant professional and policy standards.
6. OPMH community services provide easily accessible information about the range of therapies they provide to key people. This should consider the needs of:
    a the consumer
    b carers and family
    c GPs
    d the community

Good practice features – Promotion, Prevention and Early Intervention

1. Functions which may be appropriate for some services include specific mental health promotion, prevention and early intervention activities and programs, including working in partnership with other service providers.

6.4 Clinical review and care coordination

'Clinical review' is undertaken by individual clinicians during regular consumer contacts, as well as through a formal structured process undertaken by the multidisciplinary OPMH community team and other clinicians as appropriate. The term 'care coordination' is broadly taken to include the range of activities involved in providing and/or organising clinical treatment and psychosocial interventions. This includes helping arrange access to a range of different services across the health and community care sectors to meet an individual's treatment and recovery goals. Care coordination may involve building therapeutic relationships, providing and/or facilitating access to a range of biopsychosocial therapies, fostering community connections and participation, liaison with other professionals/services/agencies including referrals, coordinating various services and providers of care, case conferencing, transition/discharge planning and ensuring continuity of care.

Under the recovery-oriented approach, the duration of clinical review and care coordination will be negotiated with the consumer with clinician guidance. The prioritisation of the team's functions is also relevant. It is recognised that each LHD and/or OPMH community service will need to use their understanding of local consumer needs and the presence of other relevant services to prioritise functions and define what constitutes 'care coordination' locally.

Each consumer may be allocated one or more key contact(s) within the OPMH community service to act as their care coordinator, in accordance with local processes, the National Mental Health Core Capabilities[132] and discipline-specific standards, competencies or curricula. The care management of suicidal older people in a community setting should be undertaken in accordance with the NSW Health policy directive Clinical Care of People Who May Be Suicidal.[178]

Shared care arrangements may be established with GPs, private psychiatrists or ACCHOs. OPMH services should develop links with specialist drug and alcohol services for referral and joint care management of consumers with significant substance misuse problems when indicated.

6.4.1 Care Coordination

Care coordination has the potential to deliver a more person-centred response to the complex multi-level health and social needs experienced by older adults with severe and persistent mental illness.[227,228] A key function of OPMH services is supporting coordination of a range of services across the spectrum of care required by older people with mental illness.[130] In line with recovery-oriented care and practice, the exact supports arranged will be driven by the unique needs and recovery goals of the individual and will maximise the choice and control of the consumer and carer.

While care coordination has a consultation/liaison component, it should not be confused with specialist consultation and liaison, which is discussed following. The NSW OPMH Service Plan 2017-2027[41] recognises the role of OPMH community services in provision of assessment, referral and training with primary care workers and GPs, residential service providers and others to address the needs of older people with mental health problems. The literature supports community mental health care for older people being undertaken within residential aged care.[130,229]

6.4.2 Clinical review

Clinical review is undertaken by individual clinicians during regular consumer contacts, as well as through a formal structured process undertaken by the multidisciplinary OPMH community team and other clinicians involved in the care of the consumer as appropriate. National and state standards and policy[68,174] require review of a consumer's treatment, care and goals to occur at least every three months. Information for the review will be presented by the relevant clinician using the Mental Health Outcomes Assessment Tools (MH-OAT) assessment or review format.[174] The clinical review meeting may consider new admissions, discharged/transitioned consumers, any consumer with a change in presentation and those consumers requiring a '13-week review'.

Clinical reviews should clearly relate to identified clinical and personal goals, and should actively involve the consumer, carer, family, and GP. Clinical reviews are usually informed by all available information, including clinical observations, the consumer's own assessment, carer and other informant reports. A review of physical health status should also be undertaken. Use of clinician and/or consumer outcome rated measures from the latest assessment is recommended. Research has found the use of routine outcome measures to be beneficial to multiple stakeholders including consumers, carers and clinicians.[230]

There are a range of behaviour outcome measures that are useful in the context of BPSD. The Dementia Outcome Measurement Suite (DOMS)[183] lists a number of recommended tools that assist in monitoring behavioural and/or psychological symptoms of dementia (also called non-cognitive symptoms, neuropsychiatric symptoms and challenging behaviours) and for evaluating the effects of interventions.

Clinicians may choose to monitor a consumer's progress towards personal goals by using tools designed to measure recovery outcomes. A review of safety (risk management) plans should be considered as part of the clinical review process, balanced against dignity of risk considerations.

Following clinical review, the care plan should be updated in collaboration with the consumer and provided to the consumer, as well as their carer and GP as appropriate. The consumer has a right to seek a second opinion if there are concerns regarding treatment or procedures after they have been discussed with the treating team.[231]

Rehabilitation Approaches

Rehabilitation in mental health is defined by Killaspy et al (2005) as 'A whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.'[232] Current mental health rehabilitation guidance is helpful in the care of people with well-established severe or complex psychotic illness.[232] However, it does not cover any adaptations that may be required for older people or for some mental health conditions common in older people.

The NSW Mental Health Inpatient Rehabilitation Model of Care Framework[233] provides good practice guidance that has broad application to mental health rehabilitation in older people. It identifies key principles underpinning mental health rehabilitation practice, highlighting the importance of recovery-oriented practice, fostering therapeutic optimism, delivering individualised, person-centred care, and providing access, equity and social inclusion. These principles align with the key philosophies and principles of care in the OPMH community services MoC. The Framework highlights specific key considerations for older people in relation to comprehensive assessment, planning and review (eg assessing cognitive strengths and impairments, attention to mobility and falls risk), attention to physical health needs, and the involvement of family and carers.

Published studies on mental health rehabilitation for older people highlight the importance of social reintegration, of older people regaining optimal functioning, and of neglected wellness domains.[234,235] Evidence from consultations, models of care and evaluations in NSW provides some guidance to support key directions in rehabilitation for older people with mental illness. All emphasize multidisciplinary care, individualized, recovery-oriented approaches, and being inclusive of consumers with a broad range of diagnoses (most notably schizophrenia, depressive disorders, dementia-related disorders and bipolar disorder) and comorbidities. Findings from the PCLI evaluation identify key practices relevant to mental health rehabilitation for older people, including: person-centred, individualized assessment, transition planning and care; embedding of recovery orientation within routine practice; and working with a person's strengths, capacities and preferences.[40,236]

A recent published study of the evidence base for rehabilitation for older people with mental illness provides questions to guide service and practice development in this space.[201] It highlights that a rehabilitation approach should inform all phases of care to: identify and consolidate strengths from the point of first contact (including sense of identity); prevent decline or deconditioning secondary to interventions, and facilitate easier regaining of functioning and wellness. Rehabilitation approaches with older people may require OPMH community services to overcome the ageism that can inhibit the hope of professionals, the older person and those close to them. For people with dementia, support from families and carers is critical in enabling a person's continuing sense of identity.

Good practice features – Care Coordination

1. Each LHD and/or OPMH community service defines what constitutes 'care coordination' locally, based on their understanding of local consumer needs and the presence of other relevant services, and with reference to the prioritisation of functions.

Good practice features – Clinical Review

1. The consumer is clearly involved in review processes and decisions. This may involve:
    a Direct involvement of consumer and/or carer/family in reviews.
    b Explicit consideration of the consumer's perspectives, concerns and wishes.
    c Monitoring and considering consumer-rated outcome measures.
    d Updating the collaborative care plan with the consumer and providing them with a copy.
2. With consumer consent, the consumer's carer, family and GP are involved in review processes and decisions. This may involve:
    a Direct involvement of the carer/family in the review process, particularly when the consumer is preparing to exit the OPMH community service.
    b Explicit consideration of the perspectives, concerns and wishes of the carer/family.
    c Actively engaging the consumer's GP and inviting participation in the review process when it would assist with the consumer's care management.
    d Provision of new and revised care plans to the carer and/or GP.
3. Clinical reviews clearly relate to identified clinical and personal recovery goals. This may include:
    a Recognising the strengths and uniqueness of the individual consumer and supporting the recovery desired by the consumer and their carer/family.
    b Treating each consumer with dignity and respect, supporting self-determination and providing real choices to the consumer.
    c Monitoring and measurement of progress towards the consumer's agreed treatment goals.
    d Review and discussion of the recovery/ wellness plan.
    e Review of physical health care requirements and other needs outside the direct remit of the OPMH community service.
    f Discussion of the level of consumer and carer/family involvement in care planning.
    g Recognising and supporting the importance of partnerships (with consumers, carers/families, GPs and other service providers) and communication.
4. OPMH community services clearly identify expected standards for monitoring progress at reviews. This may include:
    a Outcome measures (including agreed measures for BPSD and mandated mental health outcome and assessment tools or 'MH-OAT').
    b. Meeting milestones in goals of care.
5. OPMH community services have clear internal guidelines or procedures with regards to multidisciplinary clinical review of older consumers. The following are to be considered:
    a. Frequency of multidisciplinary team clinical review meeting.

b. Process for ensuring that all consumers have an 'in-person' clinical review at least 3 monthly or more frequently when required.

c. Current relevant standards and policies, including those outlined in this guideline.

d. The makeup of the clinical review team (including a 'senior' clinician and any other clinicians outside of the OPMH community service).

e. The competencies or levels of experience required of staff to supervise a clinical review.

f. Use of relevant MH-OAT documentation.

g. The expected preparation required by clinicians prior to clinical review.

h. Review of key admission goal achievement against milestones, or against a documented instrument.

i. Reviews due to change in presentation or clinical incidents.

j. Allocation of tasks for follow up.

k. Completion of tasks set during previous reviews.

l. Process for contacting GP (and follow-up provider) to feedback review outcome at 3 monthly reviews.

6. Consumer progress is reviewed by an OPMH community clinician during regular contacts and considers:
   a. Mental state review.
   b. Outcome measures and progress towards goals (including personal recovery goals) utilising relevant tools as required.
   c. Physical observations.
   d. Review of risk assessments (e.g. suicide, falls, delirium, violence).
7. OPMH community services identify and monitor relevant information from clinical reviews to guide service improvement.

Good practice features – Rehabilitation approaches

1. OPMH community services use care planning and review to identify consumers who would benefit from mental health rehabilitation approaches in partnership with other services.

6.5 Crisis and urgent care

The role of OPMH community services in crisis care will depend on local arrangements. In most LHDs, crisis care functions and dedicated staffing / teams are the remit of adult mental health services. Community crisis services or intensive community teams for the care of older people with mental illness have been found to reduce the need for hospital admission for some older people, support earlier discharge, reduce the length of stay of hospital admissions, and reduce referrals to residential care.[237] Further need for supported residential care in the community remains, while gradual expansion of programs such as the SDCP and MHRAC supported placements, and continuation of the PCLI program, contribute to the transition of mental health consumers from hospital to the community.[9]

A range of universal and targeted suicide prevention strategies, including the development of suicide care pathways in NSW, have enhanced care pathways, care and support for older people in suicidal distress.[24,179] Specific population groups including male, Aboriginal, CALD, and LGBTIQ+ and gender diverse populations, have gained increased access to information and support for suicide prevention and post-vention.[24,109,146,179]

Good practice features – Crisis and urgent care

1. OPMH community services have agreed processes in place with partners for the appropriate provision of care to consumers during periods of crisis and after-hours. These processes are discussed with the consumer, carers and family/supporters involved in their care and outlined in care plans where required.
2. OPMH community services have clear processes that describe the support they can provide to crisis or after-hours services.

6.6 In-hospital care

In relation to the role of OPMH community services in hospital care, specialist consultation and liaison refers to specialist clinical mental health expertise provided by OPMH community clinicians to older people admitted under the care of a non-OPMH team *within inpatient settings*. This is a developing area for OPMH community services in NSW, and it is a function that may be integrated with either community or inpatient OPMH services.[238] Further information regarding such services may be found in the OPMH Acute Inpatient Unit Model of Care Guideline.[55]

As reported in the NSW OPMH Service Plan[41] there is some evidence for the effectiveness of liaison-style OPMH consultation-liaison services in medical wards, particularly in relation to recognition of and treatment outcomes for depression. Two RCTs have also demonstrated reduced length of stay and costs, and one of these has demonstrated fewer nursing home admissions.[239–241]

Published evidence,[42] the NSW OPMH Service Plan mid-term evaluation[51] and OPMH benchmarking findings highlight that a significant number of older people with mental illness receive care in non-specialist inpatient services, including emergency departments, geriatric and acute medical units, and adult mental health units. Specialist OPMH consultation-liaison can support appropriate, effective care in these settings.

6.6.1 Specialist consultation and liaison in the inpatient setting

OPMH community services will need to consider their role in providing specialist consultation and liaison to other inpatient services such as geriatric medical units in the context of their overall OPMH service approach, the local spectrum of services, and the skills and capacity of their OPMH community teams. Specialist OPMH consultation-liaison and collaboration with key services such as geriatrics can support appropriate, effective care for older people with mental illness, including people with mental health problems in the context of dementia and/or severe BPSD.

6.6.2 Mental health inpatient liaison

OPMH community teams will benefit from a strong relationship with the OPMH acute inpatient units within a network of relationships with relevant community partners. Adult mental health inpatient units, aged care services and OPMH community services can collaborate to meet the complex interrelated physical and social, behavioural or psychological needs of older people.[242] Specialist OPMH consultation-liaison can support appropriate, effective care in adult mental health inpatient settings.

Good practice features – Specialist consultation and liaison

1. OPMH community services clearly define their role, if any, in specialist inpatient consultation-liaison. Where a team has a role with an OPMH inpatient service, it aligns with guidance in the OPMH Acute Inpatient Model of Care.

Good practice features – Adult mental health inpatient liaison

1. OPMH community services clearly define any role they may have in the provision of consultation-liaison into adult mental health inpatient units.

6.7 Transitions of care

Successful transition of care between services for older people is dependent upon a well-planned, coordinated process that maximises the choice and control of the consumer and carer and facilitates continuity of care. Aspects of clinical and personal recovery should be considered, and linkages made with other service providers and agencies as required. This should include safety assessment and planning (balanced against dignity of risk considerations), and escalation of care by transition to inpatient settings from community settings when required.

> "Consultations highlighted the importance of involving consumers and carers in discharge planning, communicating clearly about plans for transfer of care and ongoing care, and having information about how to reconnect with OPMH services if needed.

> 'Good if you are ready for discharge, but only if it's true'
>
> **Consumer and carer consultations, 2017 & 2025**

Communication between the OPMH community service and the consumer, carer and consumer's GP is critical in the transition of care process, and includes the provision of written discharge summary or letter.[45] The relevant transfer/discharge summary template on eMR, as supported by the Mental Health Clinical Documentation policy directive,[174] should be used to document the current episode of care and its outcomes.

The Mental Health Act 2007[14] outlines the actions that mental health services must undertake when planning for transitions of care to ensure best practice. This includes consulting with the consumer and carer, consulting with agencies involved in providing services to the consumer, carer or family members, and providing appropriate information on follow-up arrangements to the consumer and carer. The NSW Health policy Discharge Planning and Transfer of care for consumers of NSW mental health services[243] also provides principles for ensuring the quality, safety and efficiency of transfers of care that are relevant to OPMH community services.

OPMH community clinicians should support successful discharge from inpatient units as per Section 3.3.2 of the Discharge Planning and Transfer of care for consumers of NSW Mental Health Services policy,[243] and may also initiate transfer of care of a consumer to an adult inpatient mental health unit or for general health care if required. OPMH community clinicians may also have a role in supporting consumers who are transferred from inpatient care into residential services such as supported housing, Residential Aged Care Homes (RACHs) or mental health-residential aged care (MH-RAC) partnership services. Transition planning processes developed under the Pathways to Community Living initiative support individualised, recovery-oriented transitions into residential aged care. OPMH community services may also have a role in transitioning older people with severe BPSD into Specialist Dementia Care Units (SDCUs) and providing specialist clinical support to SDCUs under the Commonwealth's Specialist Dementia Care Program (SDCP). Processes must be in place to facilitate seamless transition of care both in and out of inpatient care.

At community transitions of care, the person usually remains in the same environment with the same people supporting them, including their GP. OPMH processes should empower that person to maintain this goal. Any unmet needs outside the remit of the OPMH community service should be considered and contact made with other service providers and partners as required to ensure that post-discharge supports are in place.

Planning for transition of care should begin at the time of admission to the OPMH service. Barriers to transition of care should be identified at the time of admission and specific planning initiated to address these. In planning a transition of care for an older person with mental illness, particular consideration should be given to the complex interaction of physical health and mental health problems, level of physical impairment, risk of elder abuse, impacts of BPSD (e.g. on the consumer's accommodation arrangements or community participation), role of any guardian, and

requirements for referrals to specialist care and support services such as RACHs or aged care assessment services (through the Single Assessment System).[243]

It is recognised that consumers will move in and out of OPMH services depending on their needs at a particular point in time. For a particular consumer, the intensity of OPMH service involvement will vary over time and easy transition out and back in as required should be supported and facilitated.

Good practice features – Transitions of care

1. Planning for a transition of care commences from the first contact with the OPMH community service and is regularly reviewed in collaboration with the consumer and carer/family. This may involve:
    a Setting and regularly reviewing progress towards discharge goals and estimated date of transition (discharge).
    b Criteria for transition/discharge from the OPMH community service, including when it is appropriate to 'disengage' and when there should be ongoing involvement, even when clinical recovery has occurred but there are ongoing unmet needs that could be best met by OPMH services.
2. Transition of care planning maximises the control of the consumer and carer(s) and facilitates continuity of care. Actions that support this include:
    a Consumers and carers/families are consulted in the development of discharge/transition of care plans, including around the exact timing of transfer.
    b Transition of care/discharge planning includes reviewing the Wellness Plan, ensuring it includes elements of relapse prevention planning and actions to take if re-entry to the OPMH service is required. If a service utilises separate safety plans, these should also be reviewed.
    c Carers/families, other health care providers and community support services participate in the process of planning for transition of care/discharge as appropriate.
    d OPMH community clinicians work with consumers to obtain their consent that if they are admitted to hospital unexpectedly, the clinician may contact the treatment team to provide advice as appropriate on the consumer's mental health history to support continuity of care.
    e Electronic communication (including electronic medical records) is utilised as appropriate to maximise sharing of information and coordination of ongoing care and services.
    f A system is in place to ensure that contact with the GP, private psychiatrist (where relevant), and any other follow-up providers has occurred, and that this has been documented, prior to discharge.
    g Discharge decisions and plans are informed by OPMH community clinicians with a good knowledge of the services available locally, including Community Managed Organisations that can provide support for older consumers relevant to personal recovery goals. This may include: accommodation support; employment and education; leisure and recreation; suicide prevention, family support and carer programs; programs to support social connection; self-help and peer support; helpline and counselling services, and information, advocacy and health promotion.
    h A discharge summary is completed for all older consumers at the time of discharge and is written in a manner the consumer (or carer if most appropriate) can read and understand.
    i Discharge communication includes relevant information regarding the older consumers' mental health, medical, functional and behavioural support needs, current mental state and medications (as per Australian Commission on Safety and Quality in Healthcare: Medication Safety Standard). In addition, advice is provided on how to contact OPMH community service for advice or guidance if required.

j A system is in place to ensure that the discharge summary is dispatched to the consumer's GP, private psychiatrist, or other receiving service provider and other support services within 12 hours of discharge/transfer, or earlier as clinically indicated.

k Where a consumer is transferred to an inpatient mental health or general health unit, a system is in place to ensure that verbal communication occurs with, and the transfer summary is dispatched to, the primary follow-up service provider on the day of transfer.

l There is a team review of planned, or actual, ambulatory discharges/transitions of care.

3. The OPMH community service has clear expectations regarding planning for transition of care or discharge that are consistent with relevant standards and policies as outlined in the Guideline.
4. The OPMH community service has clear internal guidelines or procedures for transition of care/discharge, including:

a Criteria for consumer transfer to more acute mental health or medical care, and procedures to facilitate this.

b The roles of various members of the multidisciplinary team in planning and coordinating transitions of care and discharge.

c A clear mechanism within the team to determine who is responsible for decisions about when a community consumer is discharged, and for ensuring that the clinician responsible for making this decision has appropriate skills and qualifications.

d A clear mechanism for managing any conflicting views of the consumer, carer and the senior clinician regarding timing and readiness for transition of care.

e A specific staff member (but not necessarily the one person) being responsible for coordinating each transition/discharge. This person ensures the discharge plan is fulfilled but does not necessarily make all the arrangements themselves.

Section 7. Staffing: Who provides care?

In relation to staffing, consumer and carer consultation (2025) highlighted that it was important to most consumers that they receive care from a mental health clinician specialising in working with older people. Carers supported this. Consumers valued access to a broad range of health care professionals to address their mental health and physical health care needs. In relation to their mental health care, they indicated a desire for increased access to a range of specific professionals, particularly psychologists, psychiatrists, and allied health professionals to enable access to the range of therapies (see *Appendix B*).

> "Consumers expressed a preference for receiving care from a mental health clinician specialising in working with older people and wanted access to a broad range of health care professionals to address their mental health and physical health care needs.
>
> **Consumer and carer consultations, 2017 & 2025**

In the 2017 consultations informing this model of care, consumers and carers reported that they particularly valued the role of OPMH services in providing specialist mental health care/treatment for older people with acute, severe and/or complex mental health problems (including moderate-severe behavioural and psychological symptoms of dementia or BPSD). Clinicians also noted the importance of OPMH community services staff having expertise in older people's mental health and highlighted that multidisciplinary teams are best practice for delivering comprehensive and coordinated care.

> "During the consultations, the need for older people to receive care from mental health professionals with specialist skills working with older people, including those with BPSD, was frequently stated.
>
> **Consumer and carer consultations, 2017 & 2025**

A number of national and state policy documents provide guidance regarding mental health workforce planning and development. These include the National Mental Health Workforce Strategy 2022-2032,[244] NSW Health's NSW Health Workforce Plan 2022-2032[245] and NSW Health Workforce Planning Framework.[246]

The findings from a 2023 statewide OPMH workforce survey indicate that attracting and training, supporting and retaining skilled OPMH staff in NSW will be key to ensuring a strong and resilient OPMH workforce, equipped to deliver high-quality care to older people with mental illness.[247] The workforce survey findings highlight the importance of tailored training approaches to address the training needs of both experienced OPMH staff and staff that are less

experienced in OPMH-specific clinical skills, investing in experience to keep skilled, experienced staff onboard, and resourceful innovation to build upon existing foundations.

Staffing mix of OPMH community services

7.1 Leadership and governance

The NSW OPMH Service Plan highlights that local clinical and strategic leadership of OPMH services is a key enabler of high quality, innovative services. Clinician consultations to inform this model of care indicated the importance of specialist OPMH leadership, both clinically and organisationally, and specialist OPMH clinical supervision in OPMH workforce development and support. OPMH community services should be supported by clear operational and clinical leadership and governance arrangements. Research highlights the importance of leadership in recovery-oriented service delivery at both the service management and individual practitioner level.

Leadership and governance of mental health services is driven by a number of key national policies including the National Safety and Quality Health Service Standards (2nd Edition),[67] National Mental Health Workforce Strategy[244] and the Fifth National Mental Health Plan[53]. Relevant professional associations such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and specific OPMH sub-groups (such as the Faculty of Psychiatry of Old Age), play a key leadership role with their members and in the specialty area of older people's mental health.

At the state level, policy leadership in OPMH is provided by the Mental Health Branch of the NSW Ministry of Health. A number of statewide committees also provide strategic guidance across OPMH services and OPMH more broadly. The delivery and further development of OPMH services is guided by the NSW OPMH Service Plan.

OPMH community services are a clinical service of LHD Mental Health Services and are therefore operationally responsible to the LHD Mental Health Service and supported by local clinical and corporate governance arrangements. The clinical and corporate governance arrangements of OPMH services vary between the LHDs, with most having an OPMH Clinical Director (usually a psychiatrist) providing clinical leadership and/or a Service Manager/ Coordinator providing strategic leadership. In some LHDs, some or all of the functions of the Service Manager are undertaken as part of other strategic leadership roles.

7.2 Multidisciplinary staffing

The published literature, expert opinion and consultation to inform this model of care emphasises the importance of a multidisciplinary staffing profile and approach so OPMH community services can address consumers' unique values, goals and needs and enable a range of therapies to be offered.

The literature suggests that community mental health teams for older people should comprise of mental health nurses, psychiatrists, social workers, occupational therapists, psychologists and support workers and have direct access to other specialties such as physiotherapy and dietetics (see Section 7.4 for discussion of peer workers). Community OPMH services should be multidisciplinary in nature,[15,31,32,100] so consumers can access appropriate multidisciplinary assessment and ongoing care. Multidisciplinary care is when professionals from a range of disciplines work together to delivery comprehensive care that addresses as many of the consumer's needs as possible.[248]

Interdisciplinary team approaches are characterised by a high degree of collaboration and communication among health professionals and the establishment of comprehensive treatment plan to address the biological, psychological and social needs of a consumer.[249] The membership of the interdisciplinary health care team will depend on the needs of the consumer. National and state policies and standards require mental health services to have formal processes in place to support and sustain interdisciplinary care.[113,245,250] Core competencies for inter-professional collaborative practice include competencies relating to values/ethics for inter-professional practice, communication, team functioning and role clarification, and inter-professional conflict resolution and reflection.[251,252]

Professional diversity within teams must be respected and valued.[244] Staff from different disciplines offer unique perspectives and specialised skills, and in larger teams a range of disciplines is desirable. In all teams, large and small, each team member should have an area of professional expertise that is recognised and utilised. However, particularly in small or rural teams, innovative inter-professional practice

will be required. Such practice respects discipline strengths whilst supporting staff development to meet identified consumer needs across some traditional discipline roles (e.g. structured brief psychotherapy by any discipline). Active use of skills and services in partner organisations can increase the access of consumers to appropriate services and therapies, especially in social domains.

Staff working in OPMH community services will have core skills as outlined in the National Mental Health Core Capabilities, and discipline-specific skills, as per the discipline-specific standards, competencies or curricula. There is an area of overlap between core and discipline-specific skills acknowledging that the 2023 OPMH workforce survey[247] findings identified the need to enhance and ensure presence of OPMH-specific clinical skills within the OPMH workforce given the limited specialist clinical workforce.

The number and range of staff and their skill levels vary across OPMH community services. The skill mix in a team may be a result of the types of clinicians available. Some services, particularly in rural locations, have very small teams.[253–255] The majority of staff working in OPMH community services have a nursing background, followed by allied health (social worker, psychologist, occupational therapist), and medical. Staff may work across inpatient and community OPMH services and it is recognised that such horizontal integration may support transitions in care and maximise care continuity.

Lived Experience Workforce (Peer workers)

Peer workers have a lived experience of mental illness (as a consumer or carer), personal knowledge of the mental health service (as a consumer or carer) and a consumer/carer perspective. Job titles and related tasks vary, but responsibilities may involve peer support, individual and/or systemic advocacy, coordination and management of programs/activities relevant to their role, health promotion, education and training, and involvement in quality improvement processes/projects and research. Some peer workers facilitate peer support groups.[256]

> "Consumers regarded the opportunity to receive support from others who have a lived experience as very valuable.
>
> **Consumer and carer consultations, 2017 & 2025**

NSW Health policy supports the development of the lived experience (peer) workforce. Peer work roles are defined as lived experience roles within NSW Health where lived experience expertise is an essential requirement of the role. The scope of the peer work role has broadened and professionalised without losing sight of the connection with, and needs of, the consumer. The Elevating Lived Experience Expertise Framework aims to strengthen a thriving, well-supported and empowered peer workforce through guidance on best practice. Domains of the role include peer support, individual advocacy, systems advocacy training and education, health promotion, quality and research, and leadership and management.

Research supports the contribution of peer workers, with increasing evidence about their effectiveness. In an OPMH context, peer workers can bring a level of maturity and experience that benefits the workforce and consumer in many ways.[257,258] The available evidence and frameworks suggest that the employment of peer workers may provide benefits to consumers including hope and role modelling for recovery, a minimisation of the power differential in the professional-consumer relationship, and effective peer support and advocacy.[256,258–267] Grey and O'Hagan reviewed 33 peer-reviewed papers and associated literature and found consumer-run services are effective in supporting recovery.[268] It must be recognised, however, that not every consumer will want access to a peer worker and consumers' choices must be supported.

Current guidance for peer work in mental health identifies many benefits, including increased service user satisfaction, increased consumer hope, reduced consumer fear and stigma, enhanced recovery-oriented care, building understanding within the multidisciplinary team and building respect and cooperation, developing a focus on self-determination and person-centred care, and improving consumer outcomes.[256,263,269] There are also a number of barriers and challenges relating to the peer workforce that are consistently highlighted in projects,[266,269–271] the literature[256,258,268] and by consumer groups.[269]

A number of key national and state policy directives, reports and standards support the development of the peer workforce,[11,43,53,244,250] recognising this workforce as a key component of recovery-oriented mental health services. Both the Commonwealth and NSW Health are progressing initiatives to grow and support the lived experience workforce.[245,256,267,271,272] Progress has been made to address training

requirements and the national Certificate IV in Mental Health Peer Work was endorsed in 2012.[273] There are many government-funded and private institutions that offer education and training programs to train people in peer work.[273-275] The NSW Mental Health Commission has developed information resources to assist in building and strengthening the peer workforce in the mental health sector, including the suicide prevention lived experience workforce.[264] The importance of further developing the suicide prevention lived experience peer workforce is highlighted as an opportunity in the area of older people's mental health.[276]

While the peer workforce is NSW has grown significantly, and some general adult peer workers work with older people, there has been only modest growth in the OPMH peer workforce. The relative gap in OPMH-focused peer workers has been recognised, and some OPMH services have developed OPMH peer worker roles. Published evidence and expert consensus highlights that:

- OPMH peer workers should be mature in age and have extensive life experience, not just personal experience of mental illness, as this can assist them to connect with older consumers and support them effectively [257,258]

In 2021 and in 2022 the Ministry held two forums to seek the experience of OPMH service managers in establishing OPMH peer worker positions, including successful approaches, specific considerations and challenges to be addressed. Some key themes from the forums included:

- Evidence and experience suggests that the matching of peers to the person is a common element of success in models to date.
- Peer interventions for older people are unlikely to be reliably effective unless lived experience of ageing (or substantial life experience) is considered in addition to lived experience of mental illness.
- Challenges to be considered in developing an OPMH peer workforce include targeted recruitment and retention strategies preparing teams and creating clear guidelines to support OPMH peer workers and OPMH teams in working effectively with OPMH peer workers.
- OPMH peer workers should have an understanding of long-term effects of psychiatric medication with ageing, physical and cognitive impacts, understanding of ageism and the invisibility of older people to the general community.
- Conditions that would help an older peer worker to be successful in the workplace include assistance with use of information technology where required, flexibility in work practices, and utilising job share.

7.3 Workforce development

The National Mental Health Core Capabilities,[132] together with the National Practice Standards for the Mental Health Workforce, the National Safety and Quality Health Service Standards[67] and discipline-specific standards and competencies provide guidance to mental health clinicians on knowledge and skill development. The Core Capabilities document[132] identifies and describes expected workforce behaviours across the range of mental health workforce roles and services and has a specific focus on the essential values, attitudes and behavioural skills required of all people working in mental health.

The Ministry's Mental Health Branch developed the SMHSOP Core Competencies and Measurement Criteria for Beginning Clinicians[277] in 2011 to guide professional development, clinical supervision and performance review for beginning OPMH community clinicians in particular. An evaluation of these competencies found them to be a positive workforce development strategy, assisting with processes such as recruitment and orientation, performance development and educational initiatives, and that they had been implemented widely within OPMH services.[277] The NSW Health Mental Health-Pathways in Practice (MH-PiP) initiative offers opportunities to support OPMH-specific competencies and practice development linked to these.

The Intellectual Disability Mental Health Core Competencies Framework: A Manual for Mental Health Professionals describes the specific skills and attributes required by mental health professionals when working with people with an intellectual disability, identifies the core competencies required by workers and provides examples of resources that support professional development in intellectual disability mental health.[168,278]

While recognising that professional development is an individual practitioner's responsibility, the extent to which staff of OPMH community services are supported to access work-related training and skill development within work time is variable, affected by factors such as staffing levels, backfill, funding and availability of appropriate training. Online education is a mitigating factor to some extent. OPMH community

clinicians also access on-the-job upskilling and 'in-service' training sessions and participation in clinical reviews can be a good learning opportunity for staff.

All staff working in NSW Health services are required to undertake mandatory training across a range of areas, including cultural competency. Cultural competency is a key strategy for reducing inequalities in healthcare access and improving the quality and effectiveness of care for Aboriginal people[279] and CALD people. The Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery provides clinicians with practical and achievable strategies to increase the cultural responsiveness of their practice.[125] The National Cultural Competency Standards for the Australian mental health sector were introduced in 2010 and are now informed by more recent work in multicultural mental health.[113,125,280–282] Multicultural Mental Health Outcomes and Assessment Tools were developed by the Transcultural Mental Health Centre and NSW Health to assist health care professionals to provide culturally appropriate care to their culturally and linguistically diverse (CALD) clients.[124]

Within statewide OPMH benchmarking processes and workforce surveys, OPMH community managers and clinicians have identified a number of priority areas for education and training that are aligned with OPMH core competencies and current practice priorities. These priority areas relate to knowledge and clinical skills specific to older people's mental health (as distinct from general adult mental health) and working with people with ageing-related issues including dementia.[247,282,283]

Clinical supervision

The NSW Health Clinical Supervision Framework[284,285] provides guidance to community OPMH services in undertaking clinical supervision and defines what clinical supervision is in practice. Clinical supervision should focus on issues relating to, or impacting on clinical practice and the delivery of care, with the clinician supported to critically reflect on professional practice and take responsibility for their clinical practice.[284,286]

Clinical supervision should be a clinician-led activity, with the clinician choosing their own supervisor.[284,286] However, this does not always occur, with the type of supervision, how it is provided, and whether it is OPMH-specific varying across OPMH community services. Some services have an OPMH-specific Clinical Nurse Educator who offers specialist OPMH supervision to OPMH community nurses. Other clinicians, particularly allied health workers, may be supervised by their relevant discipline senior who may not have specific experience in OPMH. Clinical supervision around OPMH-specific issues may be provided from different disciplines. Some staff access supervision external to the LHD. All supervisors should be fully conversant with recovery principles and philosophy of practice.

Clinical supervision is embedded in professional standards and may be a requirement of professional association membership/registration for some professions, however it is not mandated.[283,287] The National Safety and Quality Health Service Standards (2nd Edition)[67] and National Practice Standards for the Mental Health Workforce[113] can guide clinical supervision and assist individual practitioners to identify their own level of knowledge and skill to practice mental health care. These are a useful tool in supervising practice. In some locations, particularly in rural areas, accessing clinical supervision can be challenging, with some teams utilising videoconferencing where required.[288]

Good practice features – Staffing

1. Staffing composition of OPMH community services maximises consumers' and carers' access to biopsychosocial assessment and therapy options, including access to the perspectives and skills of differing professions.
2. Recruitment, professional development and training practices of OPMH community services support consumers' and carers' access to staff with:
    a. Specialist skills in OPMH relevant to their local context.
    b. The aptitude and skills to provide recovery-oriented, trauma-informed, and culturally safe care.
3. OPMH community services use formal and informal partnerships to support access to a range of biopsychosocial therapies, and their culturally responsive use.
4. Mechanisms are in place to support and sustain the ability of the multidisciplinary team to provide interdisciplinary, high quality and appropriate care.
5. There are established operational and clinical leadership and governance processes in place that support the integration of OPMH service elements (inpatient, community and residential) and quality improvement.

Section 8. Monitoring and improving performance

Quality is driven by local systems and the individuals within them, supported by state and national systems to maximise consistency in performance and standards, and reduce duplication of effort in developing systems.

8.1 Standards

The National Safety and Quality Health Service Standards (2nd Edition)[67] and the National Safety and Quality Health Service Standards[67] provide health services with a framework for the implementation of systems to deliver safe care and continuously improve the quality of the services they provide. Implementation of both sets of standards is seen as important in meeting the safety and quality requirements for people with lived experience of mental health issues accessing the mental health sector, with neither set of standards able to stand alone.[289]

8.2 Indicators of performance and benchmarking

OPMH community services are required to comply with mandated data collections including the Key Performance Indicators (KPIs) outlined in the National Mental Health Performance Framework 2020[289] and the KPIs included in the Service Agreements between the NSW Ministry of Health and LHDs guided by the NSW Health Performance Framework.[290] The National Mental Health Performance Framework includes health system KPIs in the domains of effectiveness, safety, appropriateness, continuity of care, accessibility, efficiency and sustainability. The NSW Health Performance Framework outlines the performance expected of NSW Health services and organisations to achieve the required levels of health improvement, service delivery and financial performance. Both national and NSW KPIs relevant to community mental health services continue to develop.

Consumer and carer experience measures are important for understanding the appropriateness of health services and guiding quality improvement. The Your Experience of Service (YES) and Mental Health Carer Experience Survey (CES) are national measures of consumers' and carers' experiences of public mental health services based on the recovery standards of the National Safety and Quality Health Service Standards.[113] These measures are used across NSW public mental health services including OPMH community services.

Activity-Based Funding (ABF) and Activity-Based Management (ABM) have been introduced into the Australian health care system, including public mental health services. ABM is an approach that focuses on patient level data to inform strategic decision-making and to identify areas for improvement. These approaches are increasingly important to the way health and mental health services are funded and managed, and the way performance is measured.[291,292]

The OPMH benchmarking model continues to be an effective model for promoting quality and practice improvement in OPMH community services across NSW. Benchmarking allows OPMH community services to learn from each other and understand current service delivery, determine best practice and improve care. Benchmarking in NSW has led to significant and sustained improvements in OPMH community services.

8.3 Data collection

NSW public community mental health services data collection comprises a number of types:

- Client clinical outcomes reporting through standard outcome measures (MH-OAT data collection) – for which the required tools for older people include the HoNOS 65+, RUG-ADL, LSP-16 and K10+-LM/ K10-L3D. See Section 6.2.
- Activity reporting through the Mental Health Ambulatory (MH-AMB) collection.
- Australian Institute of Health and Welfare's Metadata Online Registry (METEOR) [293]
- Health Establishment Registration Online (HERO) System, the Mental Health Establishments National Minimum Data Set (MHE NMDS), and the National Mental Health Establishments Database (2005 to 2024)
- Financial reporting and monitoring.

The NSW Health data collection and reporting systems link to relevant national collections such as the National Outcomes and Casemix Collection[294] and the National Minimum Data Sets.[295]

8.4 Systems for monitoring and improving performance

At the national level, the Australian Commission on Safety and Quality in Health Care and the Australian Institute of Health and Welfare have a whole-of-health system focus, providing direction for the mental health sector. The National Mental Health Commission has a key role in monitoring and reporting for the mental health system nationally. Key national policy documents outlining priority areas for improvement in mental health services include the Fifth National Mental Health and Suicide Prevention Plan[53] and National Mental Health and Suicide Prevention Agreement. In NSW, the NSW Health pillar organisations - Clinical Excellence Commission, the Agency for Clinical Innovation and the Bureau of Health Information – support clinicians and managers to improve performance and provide safe and effective healthcare.

8.5 Research

All health services in NSW are guided by the strategies outlined in the NSW Health Research and Innovation Strategy 2025-2030.[296] The strategy emphasises the role that NSW Health services play in driving research and innovation for health impact. OPMH community services can contribute to this by developing and adapting therapies for older people with mental illness, developing, implementing and evaluating new models of care and approaches, and translating research into practice.

Good practice features – Monitoring and improving performance

1. OPMH community services have clear processes for monitoring and improving the performance of the service.
2. OPMH community services collaborate with other services for quality improvement.
3. OPMH community services participate in statewide strategies to support implementation of this model of care. This may include:
    a. Collaborative identification of statewide priorities for monitoring variation in performance over time or between teams and promoting collaborative quality improvement as required; aligned to state priorities and state/national standards.

Section 9. Summary

Older people with mental health concerns have different needs and are seen in different contexts to younger adults. They have also communicated what is important to them. This OPMH community services model of care provides core information to guide OPMH community teams to meet these needs and relevant national standards.

The OPMH Community Services MoC sets out a consistent, evidence based framework for delivering specialist mental health services to older people across NSW. It is intended to guide policy makers, service planners, service managers and mental health professionals in providing and improving OPMH community services. It aims to promote consistent good practice in OPMH community services across NSW.

This evidence report supports the NSW OPMH Community Services MoC Guideline. It provides more detailed information about the consumer, carer, mental health professional and stakeholder advice, evidence and policies that support the Model of Care, current practice within OPMH community services, and good practice features for OPMH community services.

The Model of Care emphasises recovery oriented, person centred, trauma informed, biopsychosocial and culturally responsive care. Updates to the 2017 model reflect changes in policy, service systems, funding arrangements, and contemporary evidence, and the updated MoC is informed by extensive consultation with consumers, carers, clinicians and key stakeholders in both 2017 and 2025.

Consumer and carer consultation findings consistently highlight the importance of connection, hope, continuity, access to specialist OPMH staff, effective communication, and genuine partnership with consumers, carers and GPs. Consumers and carers strongly value personalised, face to face care delivered in their homes, residential aged care homes or other community settings, with virtual care used as a complementary option where appropriate.

The key themes of the Model of Care include:

- The importance of working in collaboration with GPs and family/carers as relationships with these support networks changes across older age.
- The integral importance of the biopsychosocial approach to care in assessment, delivery of care and staffing of OPMH community services.
- The value of OPMH service outreach to residential aged care homes, and of collaborative, partnership models between mental health services and aged care services.
- The importance of targeted, systemic approaches to suicide prevention adapted for older people and role of OPMH services in supporting older people in suicidal distress in line with NSW Health older people's suicide prevention initiatives.
- The importance of consumer and carer perspectives and preferences in driving care, service design and service improvement in line with the Agency for Clinical Innovation principles on co-design.
- Recovery-oriented care and practice in line with the National framework for recovery-oriented mental health services and NSW Older Person's Mental Health Recovery-oriented Practice Improvement Project.
- Promoting and supporting triage arrangements that facilitate access to appropriate mental health assessment and care including specialist OPMH assessment and care, in line with NSW mental health triage service initiatives and the NSW Health Policy Directive Mental Health Triage Policy (PD2012_053).
- Multidisciplinary care of older people with mental illness to enable integration of different

professional capabilities required for biopsychosocial assessment and care.

- The importance of age-specific service partnerships and collaboration to support integrated care across settings and with service providers both within and external to NSW Health to ensure that the complex needs of older people with mental illness in line with the NSW Health: Strategic Framework for Integrating Care.
- The importance of attention to the physical health needs of OPMH consumers, reflected in the NSW Health Older People's Mental Health Physical Health Practice Improvement Project Report.
- A stepped care approach to service provision, with the level of service provided matched to each consumer's needs, including 'wrap around' coordinated care for those with severe and complex mental illness. This is a key focus of the national mental health reform agenda and is relevant to OPMH community services in terms of prioritisation for OPMH care and key service partnerships.

Regarding *clinical processes*, the Model of Care emphasises the importance of: providing easy access to OPMH initial assessment following triage; supporting the 'no wrong door' approach with clear prioritisation criteria; accepting a low threshold for referral of older people in suicidal distress; having agreed processes with key service partners for managing crisis and after-hours care; supporting effective transitions of care and clear communication about OPMH service re-contact post-discharge if needed.

In relation to *techniques and therapies*, the model highlights that OPMH community services have a key role in facilitating clinical recovery and in supporting consumers to address their broader recovery goals. It emphasises that OPMH community services should enable consumers to access a range of evidence-based, biopsychosocial therapies, and that all community clinicians should provide some psychological strategies as part of care.

Strong partnerships are central to the model, particularly with GPs, adult mental health services, OPMH inpatient units, aged care, dementia services, geriatric services and NDIS services. Regarding *working in partnership*, the model emphasises that OPMH community services will need to prioritise working with services most important to the care of older people, and of services adapting as key partners evolve. In relation to *adapting for a person's location and context*, the model supports the importance of services considering and supporting where possible consumers' preferences for care setting and modality of care.

A skilled, well-led and well-supported *workforce* is fundamental to providing effective OPMH community services. The model emphasises the importance of multidisciplinary teams, strong strategic and clinical leadership, clear governance structures, growing the peer workforce and ongoing OPMH workforce development. It also highlights that benchmarking and *continuous quality improvement* can help support safe, effective and sustainable OPMH community services across NSW.

Section 10. Appendices

Appendix A

Expert Reference Group membership

Member	Organisation	Expertise
Bek Sant'Anna	NSW Ministry of Health Mental Health Branch (MHB)	Aboriginal mental health
Elizabeth Avenoso	South Western Sydney Local Health District (LHD)	Allied health
Katherine Jones	St Vincent's Hospital Network	Allied Health
Sharon Buxton	Western NSW LHD	Allied Health
Maria Cassaniti	Transcultural Mental Health Centre	CALD mental health
Eileen McDonald	Lived Experience	Carer
Armie Farooqui	Mental Health Carers Network	Carer representative
Lea Leahy	Lived Experience	Consumer
Giancarlo de Vera	BEING	Consumer representative
Eloise Layard	ACON	LGBTIQ+ representative
Catherine Leslie	Hunter New England LHD	Nursing
Raechael Deighton	Murrumbidgee LHD	Nursing
Rod McKay (Chair)	NSW Ministry of Health MHB	OPMH clinical adviser
Kate Jackson	NSW Ministry of Health MHB	OPMH policy
Bryan Hoolahan	NSW Ministry of Health MHB	OPMH policy
Yvette Black	NSW Ministry of Health MHB	OPMH policy
Suman Tyagi	Western Sydney LHD	OPMH service manager
Simon Hill	Central Coast LHD	OPMH service manager
Catherine Walker	Murrumbidgee LHD	OPMH service manager
Jessica Peters	Illawarra Shoalhaven LHD	Peer workforce
Shalini Narchal	Hunter New England LHD	Psychiatry
Mark Yates	Northern Sydney LHD	Psychiatry

Appendix B

Consumer and Carer Consultation Summary Report

NSW Health

NSW GOVERNMENT

OPMH Community Services Model of Care Review

Consumer and Carer Consultation Summary Report

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Background

The role of consumers and carers in the design, delivery and evaluation of mental health services is recognised internationally as a process that helps ensure that services focus on what really matters to people accessing mental health services.

As a part of the review and update of the NSW Health OPMH Services Community Model of Care Guideline (2017). it was crucial to seek the opinions and experiences of current users of OPMH community services (consumers) and carers of people who use OPMH community services.

The current guideline was informed by extensive consultation with consumers and carers, as well as OPMH clinicians, who contributed their experiences and ideas. These consultations helped to shape the guideline and how OPMH community services operate. The guideline review and consultation with consumers and carers was an opportunity to hear from service users if the guideline still reflects their priorities and experiences, and if new priorities or issues had emerged.

Consumer and carer consultation included a combined consumer and carer focus group, and separate consumer and carer surveys completed by consumers and carers with current or recent experience of OPMH community services. The focus group and the surveys aimed to address the main themes of the OPMH community services guideline and key areas of care provided by OPMH community services (see picture below). Questions covered the importance of key aspects of care, experiences of OPMH services and what could be improved.

OPMH community services key areas of care

Consumer and Carer Survey

Two separate surveys were developed to seek the views of consumers and carers with current or recent experience of OPMH community services.

Methodology

The surveys were designed in consultation with OPMH consumer and carer representatives and peak consumer and carer organisations (BEING and NSW Mental Health Carers Network) involved in the Expert Reference Group for the project. The surveys contained a mix of multiple-choice questions, Likert scale questions and open text fields designed to understand consumer and carer experiences of services and what was important to them in receiving care.

Local Health District (LHD) OPMH service leads/ managers across NSW were asked to assist in distributing the surveys to consumers and carers with current or recent experience of OPMH community services. Surveys were provided in hard copy as well as electronic survey links to meet the preferences of consumers and carers completing the survey. LHD OPMH service leads/managers were asked to send hard copy survey responses to the Ministry of Health project contact for combining with the online survey responses. The survey was conducted over a 4-week period in April-May 2025.

Consumer Survey: Results

There were 56 responses to the consumer survey. The profile of respondents is outlined below.

Demographics of respondents

Gender:

Male	21%
Female	79%
Other	0%

Location:

Large city	47%
Regional	31%
Rural / remote	22%

Age Group:

Male	21%
Female	79%
Other	0%

Location:

Aboriginal or Torres Strait Islander	4%
Born in Australia	61%
Born overseas	30%

The respondents were heavily weighted toward females with the majority **female (79%)**, with **male respondents making up 21%**. In terms of **location**, almost half of respondents **(47%)** live in **large cities**, while **31% reside in regional areas**, and **22% are from rural or remote communities**.

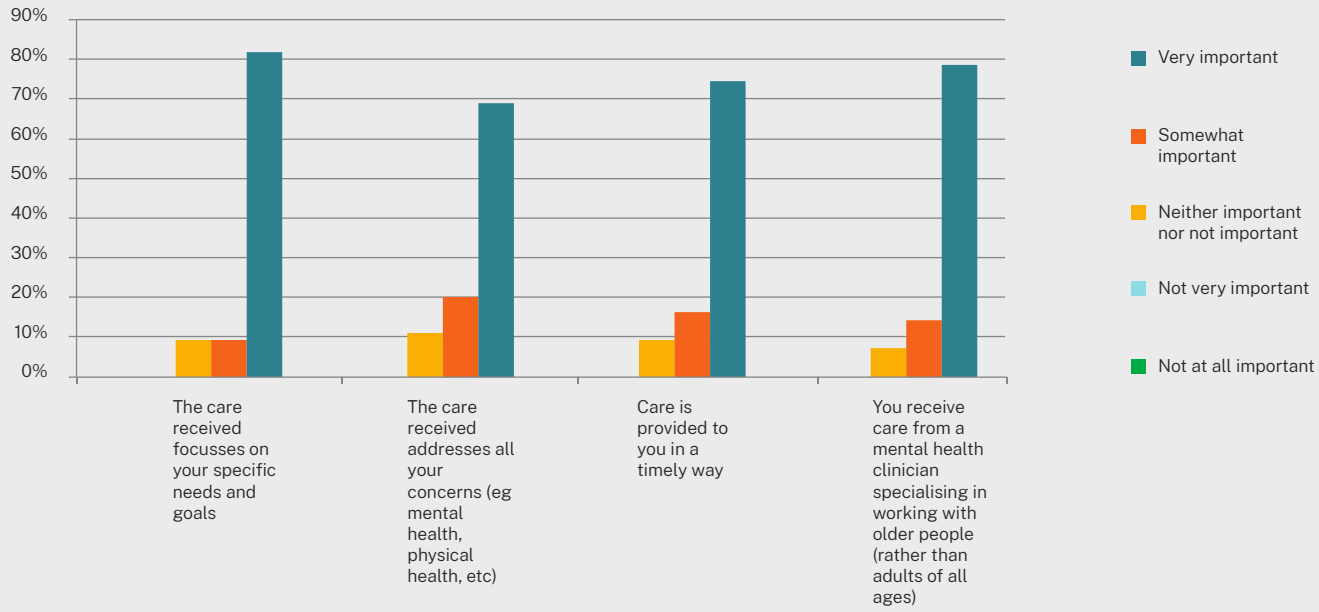
Looking at **cultural background, 4% identify as Aboriginal or Torres Strait Islander**. Most participants **(61%)** were **born in Australia**, with **30% born overseas**.

In relation to **age profile**, there were no respondents under 50 years. The largest group of respondents were aged **65 to 74 years (45%)**, followed by those aged **75 to 84 years (36%)**, and **16% are aged 85 or older**. A small proportion, **4%**, fell into the **50 to 64 age group**.

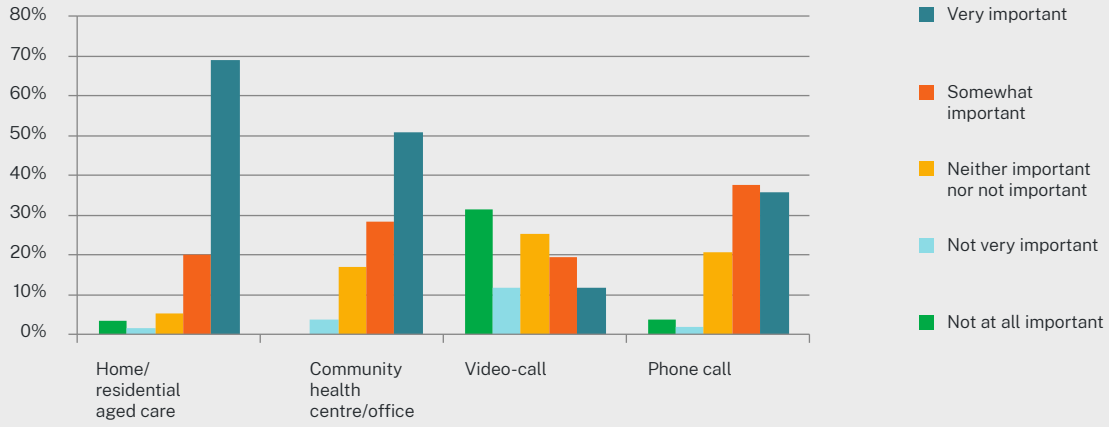
The survey respondents are a relatively representative sample of OPMH community consumers, aside from the over-representation of females.

Responses to the Survey Questions

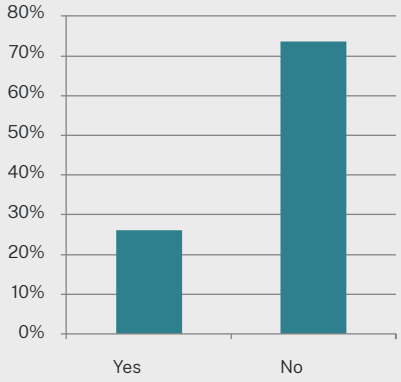
Please tell us the level of importance of each of these aspects of care



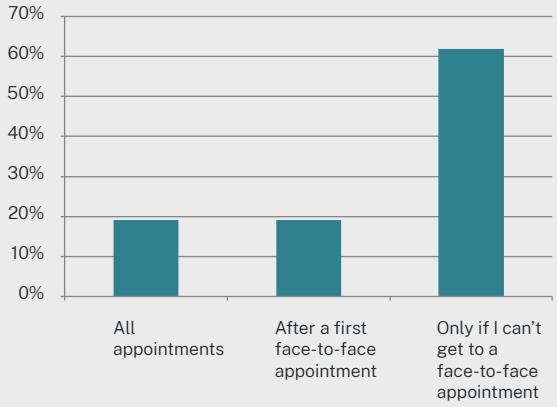
Please tell us how important it is to be seen by mental health staff at each location



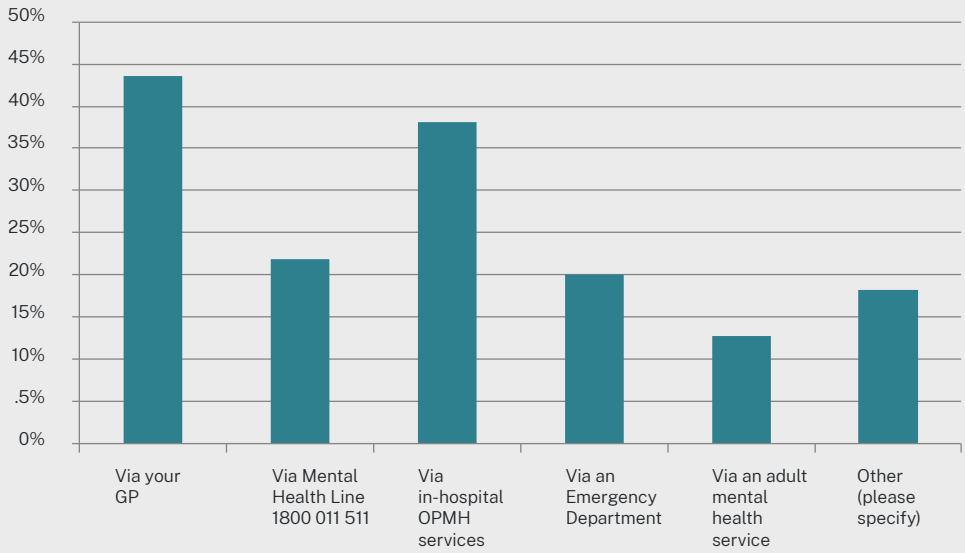
Would you use a telehealth service instead of a face-to-face appointment?



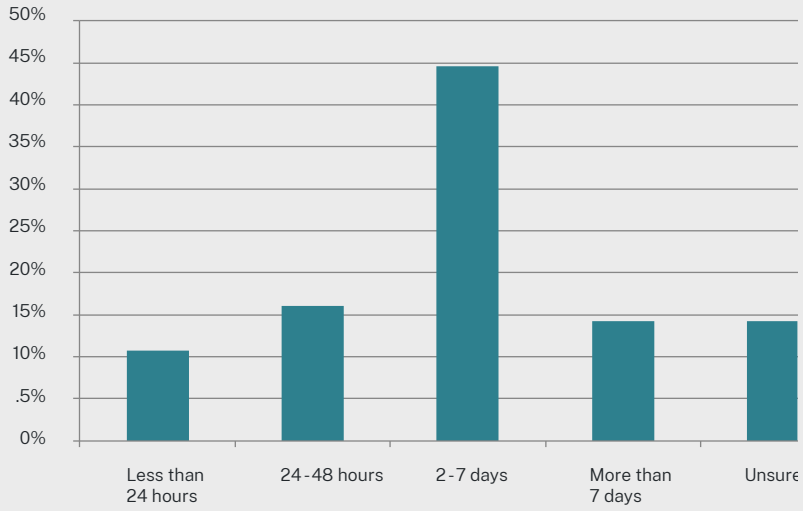
If YES, when would you prefer to use a telehealth service?



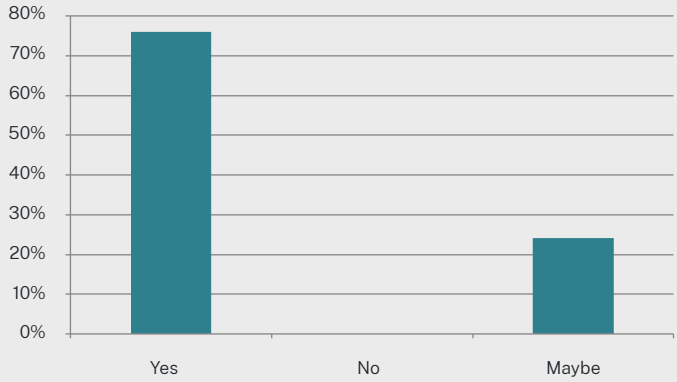
How have you previously made initial contact with OPMH community services to access care? (Select all that apply)



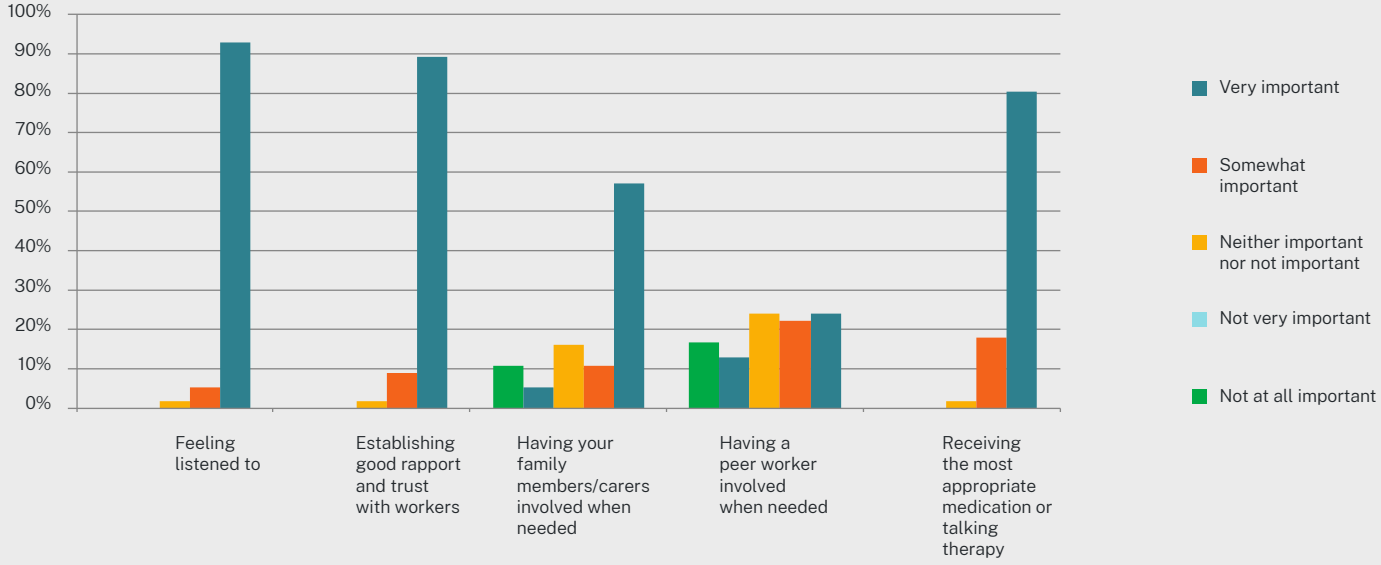
Once you have made initial contact with OPMH community services, what is an acceptable time before you are seen?



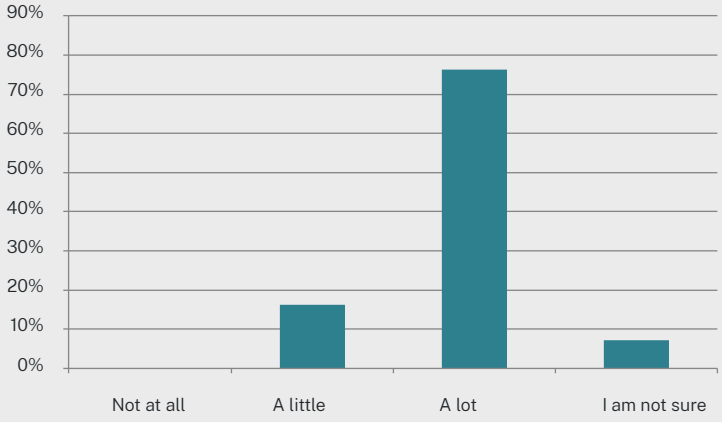
Would you prefer to keep seeing the first mental health clinician you had contact with?



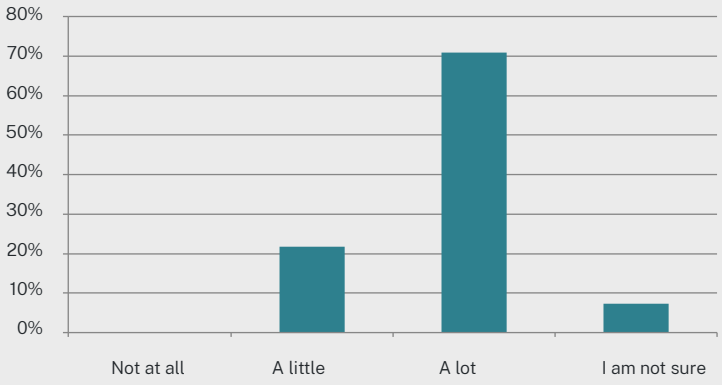
Please indicate how important these aspects of care are to you.



How much have you felt involved in making decisions and planning your care from the OPMH service?



How much choice and control have you had in planning your care?



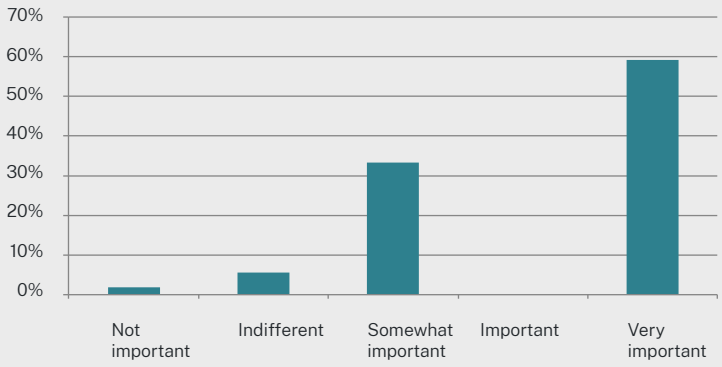
How would you like to be involved in making decisions and planning your care?

Some free text responses from consumers about how they would like to be involved in making decisions and planning their care were:

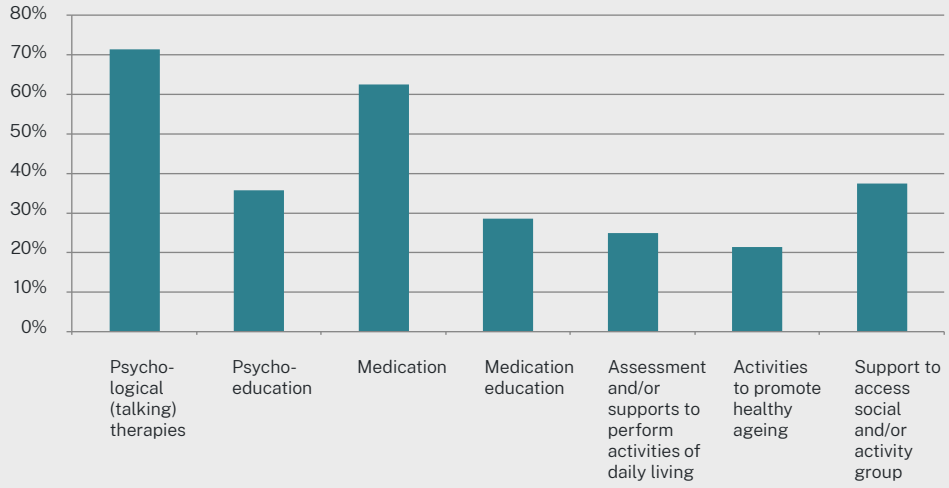
"I should always be consulted prior to making decisions and planning my care"

"Included and asked about what I think about everything"

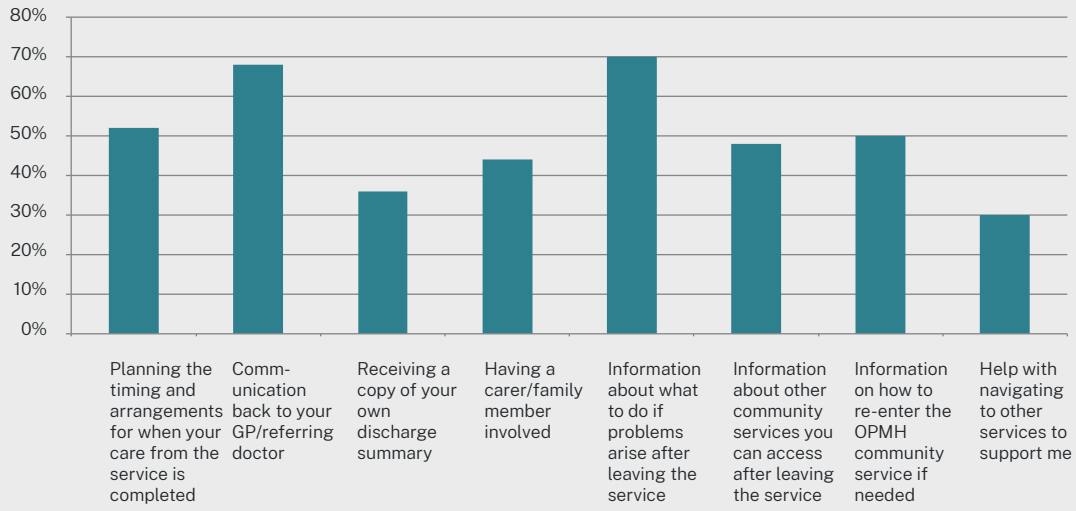
How important is it that your care includes connection to other health services that you may need?



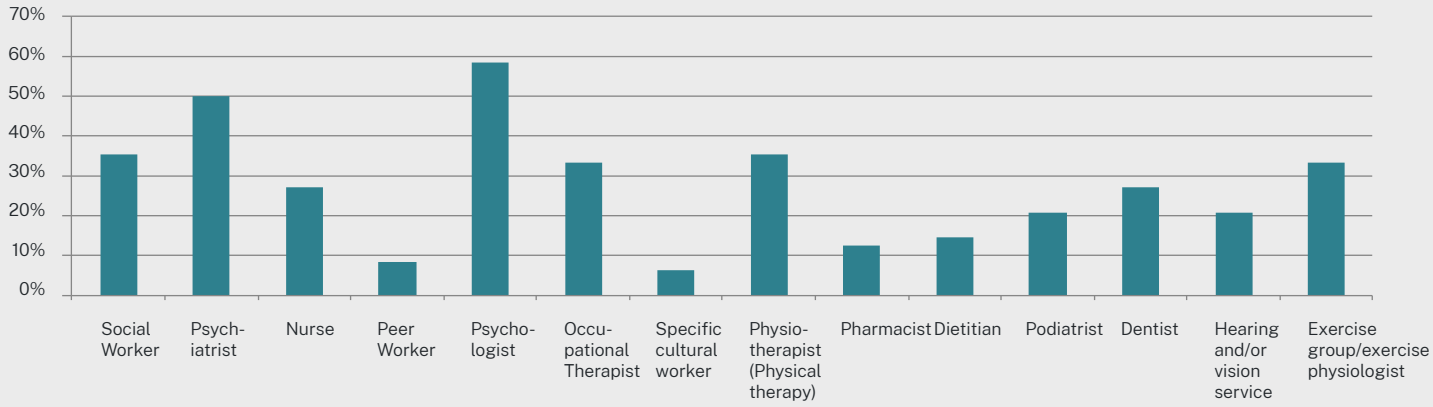
Which services provided by the OPMH community service are the most important to you? (Select up to three services)



When planning your discharge from the OPMH community service which things were most important to you? (select up to five options)



Thinking about the care you received from the OPMH community service, which of these professionals would you have liked more access to? (Select all that apply)



Please elaborate on any other aspects of care that are important to you:

Below is a word cloud representation of common themes from free text responses.

Some free text responses about aspects of care that are important to consumers were:

"Information on medications and other side-effects and how to deal with them"

"It is important to have my physical health needs addressed as well as my mental health needs"

"Continuity; expertise; communication"

Which aspects of care could have been improved during your contact with older people's mental health community services?

Below is a word cloud representation of common themes from free text responses.

Some free text responses about what consumers felt could have been improved were:

"Group sessions to meet with other peers"

"More contact visits if possible"

"Better/timely communication"

Summary of Consumer Survey Results

Following is a summary of the consumer survey results:

Preferences for care delivery

Most consumers reported that it was very important to them to receive care from a mental health clinician specialising in working with older people, and that care focussed their specific needs and goals, addressed all their concerns, and was provided in a timely manner. The preferred location for receiving care was in the home or residential aged care home, followed by a community health centre.

Consumers indicated a general preference for in-person care over virtual care. Only 26% of respondents stated they would choose telehealth over face-to-face care and 62% would choose to use telehealth only they couldn't get a face-to-face appointment (with 19% preferring to use telehealth only after a face-to-face appointment, and a further 19% preferring telehealth for receiving care). Where care was delivered virtually, phone calls were generally preferred over video calls.

Pathways to care

The most common points of initial contact with the Older People's Mental Health (OPMH) community service were through a General Practitioner (GP) (44%) or an in-hospital OPMH service (38%). Prior to engaging with the OPMH service, 67% of consumers were receiving mental health care from their GP.

In terms of appointment wait times after initial contact with OPMH services, 45% of consumers felt a 2–7-day wait was acceptable, while 26% preferred to be seen within 48 hours or less. Furthermore, 76% of respondents wanted to continue seeing the first clinician they had contact with, valuing the continuity of care this provided.

Experience of care

Respondents consistently identified the importance of feeling listened to, establishing trust and rapport with OPMH staff, and receiving appropriate medication and/or psychological (talking) therapies as central to a positive care experience. The involvement of family or carers was also valued, when needed.

Over 70% of consumer respondents indicated they had experienced a high level of involvement in planning and decision-making about their care in their contact with OPMH community services, with many highlighting that being included and informed was a high priority. Approximately 59% felt that being connected to other necessary health services was very important, and 33% considered this somewhat important.

Treatment preferences and discharge/ transfer of care planning

In relation to treatment types, the two most important services identified were psychological/ talking therapies (71%) and medication (62%). Support to access social/activity groups and psychoeducation were also valued. Consumers indicated a desire for increased access to a range of specific professionals, particularly psychologists (58%), psychiatrists (50%), and allied health professionals.

Regarding discharge planning, consumers emphasized the need for clear information on what to do if problems arise, communication with their GP, follow-up care planning, and re-entry pathways into the service if needed.

Carer Survey: Results

There were 30 responses to the carer survey, the profile of respondents is outlined below.

Demographics of respondents

Gender:

Male	47%
Female	53%
Other	0%

Age group of carer:

Under 50	22%
50 - 64	18%
65 - 74	26%
75-84	30%
85 +	4%

Location:

Large city	29%
Regional	61%
Rural / remote area	11%

Cultural background:

Aboriginal or Torres Strait islander	0%
Born in Australia	73%
Born overseas	23%
Speak a language other than English at home	17%

Relationship to the person who has a mental illness:

Spouse/domestic partner (married or de facto)	43%
Child (son or daughter)	35%
Brother/sister	4%
Other relative	13%
Friend	4%

Age group of person cared for:

Under 50	7%
50 - 64	4%
65 - 74	33%
75-84	33%
85 +	22%

The person you care for identifies as:

Aboriginal or Torres Strait islander	0%
Australian born	68%
Born overseas	24%
Speak a language other than English at home	12%

The accommodation your person lives in:

In their own home	59%
Residential aged care facility	18%
Other (please specify)	22%
e.g. SIL; shared accommodation; retirement unit; group home	33%

The carer survey respondents were an even mix of genders, with **53% identifying as female** and **47% as male**. Most carer respondents were older people themselves, with **30% aged 75–84, 26% aged 65–74**, and smaller proportions aged **under 50 (22%)** or between **50–64 (18%)**. Only **4% were aged 85 or older**. The majority lived in **regional areas (61%)**, while **29% resided in large cities** and **11% in rural or remote** locations.

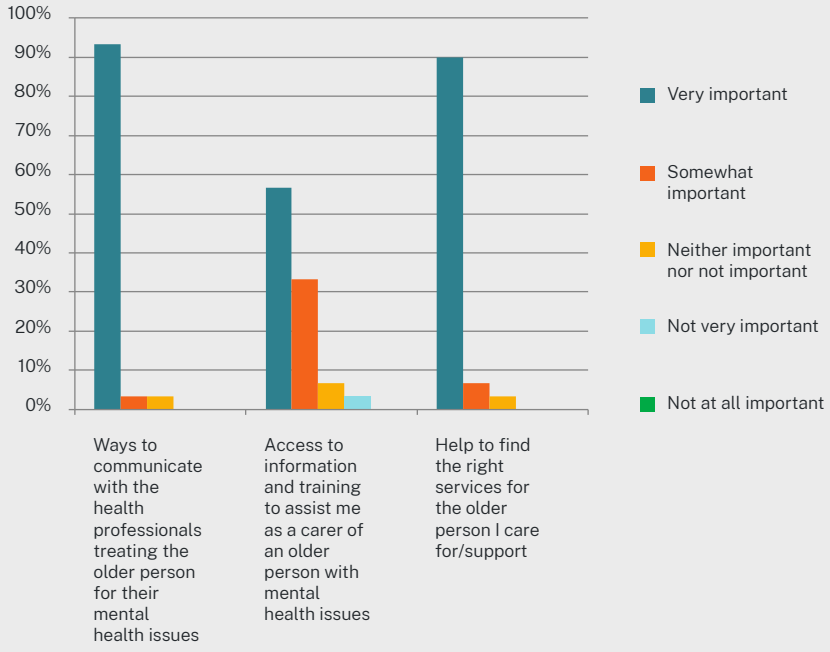
Most carer respondents were **born in Australia (73%)**, with **23% born overseas** and **17% speaking a language other than English** at home. None of the carers identified as Aboriginal or Torres Strait Islander.

In terms of their relationship to the person they care for (the OPMH community consumer), **43% were caring for a spouse or partner**, and **35% for a parent**. Others were caring for a **sibling (4%), another relative (13%)**, or **a friend (4%)**.

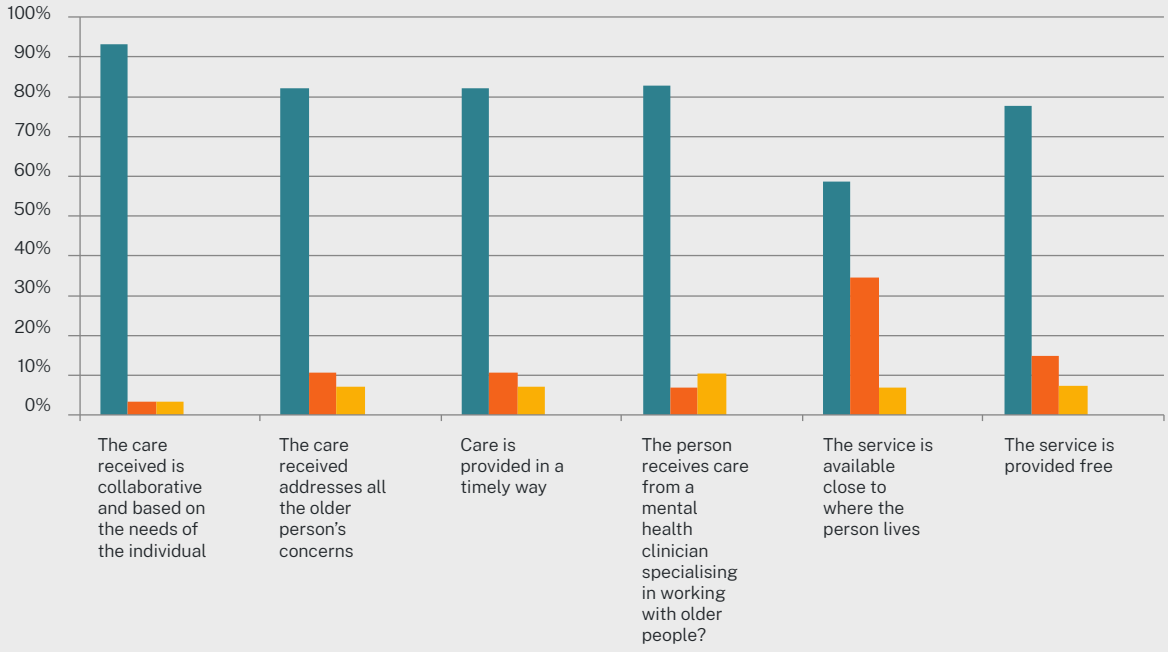
Among the people being cared for, **68% were born in Australia, 24% overseas**, and **12% speak a language other than English** at home. None identified as Aboriginal or Torres Strait Islander. Most **lived in their own home (59%)**, while others lived in **residential aged care (18%)** or other types of accommodation such as shared living, supported independent living (SIL), retirement units, or group homes (22%).

Responses to the Survey Questions

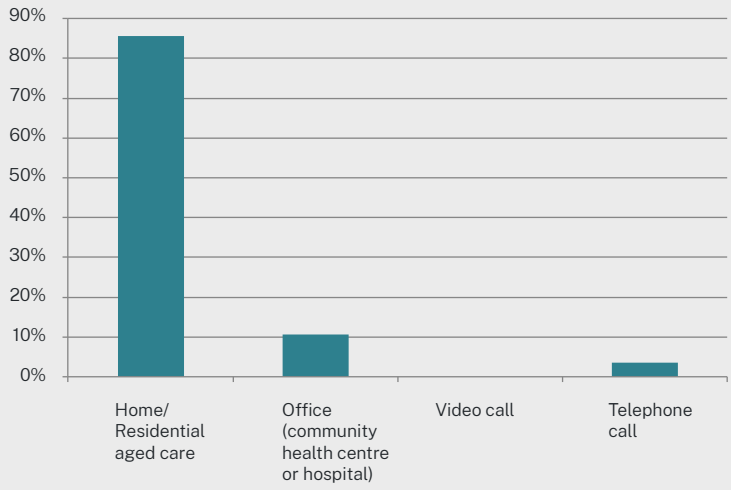
As a Carer I need:



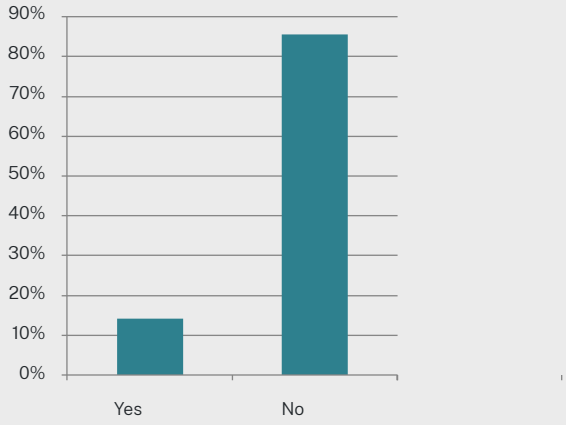
Please indicate the importance to you of each of these aspects of care for the older pers for/support



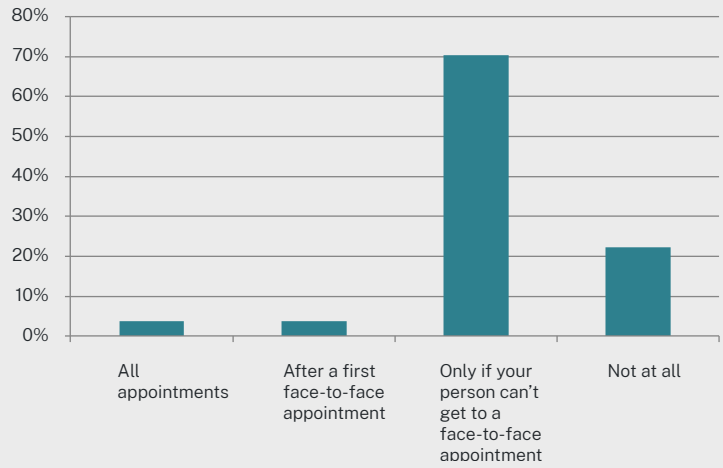
Where would you prefer the older person you care for to be seen? (select one)



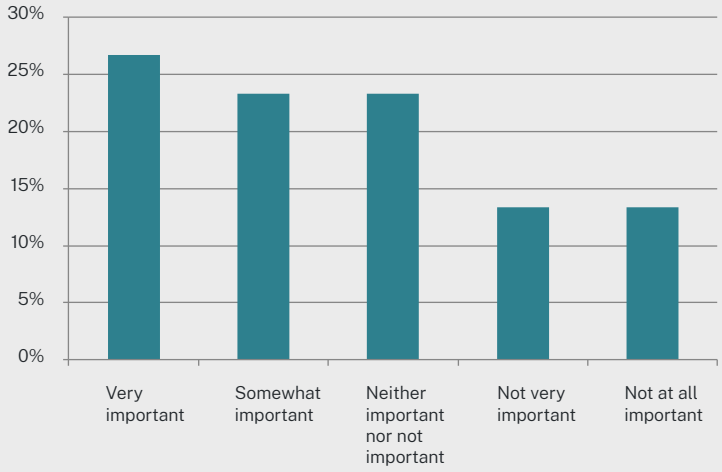
Could the older person you care for use telehealth (video and/or phone call) by themselves, without assistance?



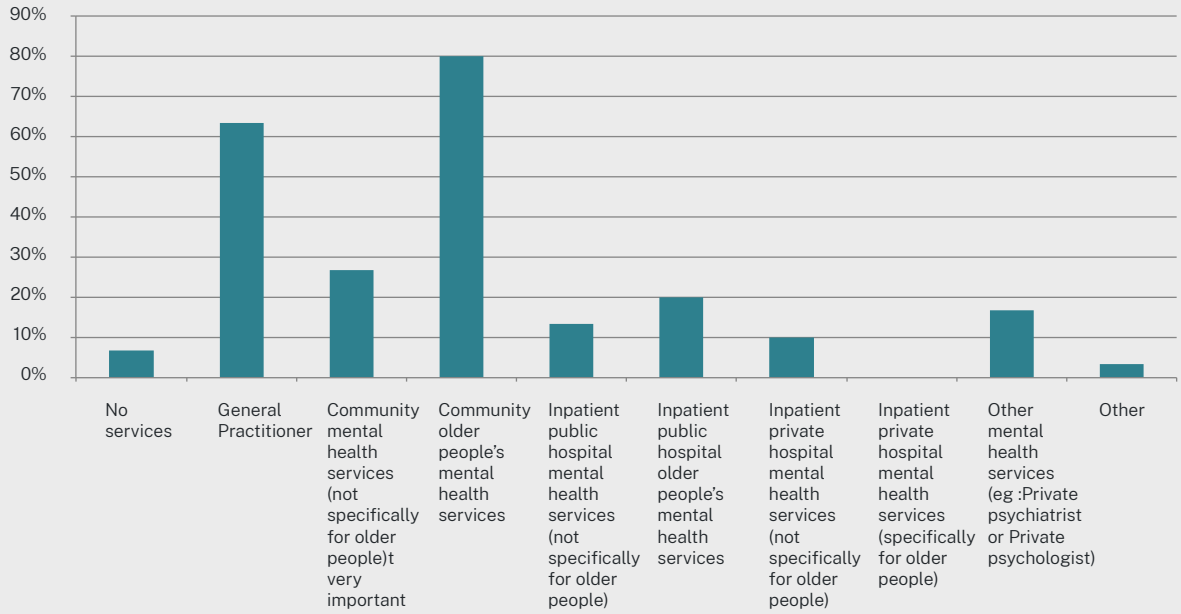
When would the older person you care for prefer to use a telehealth (video and/or phone call) service?



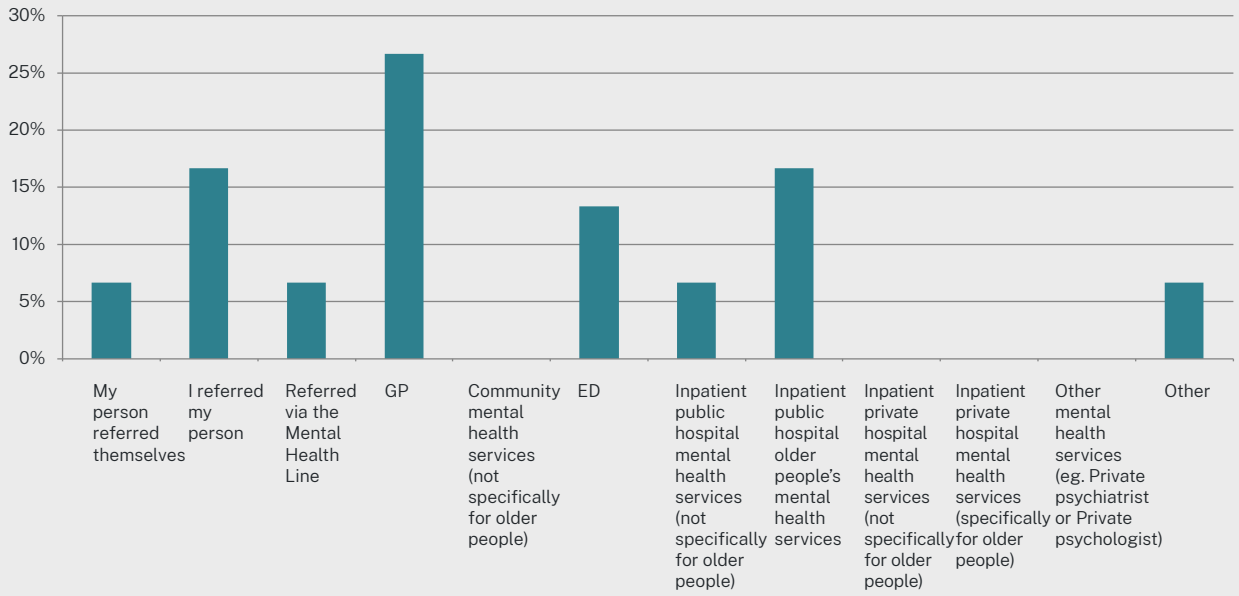
How important is it to you and the older person you care for that telehealth (video and/or phone call) is accessible for contact with older people's mental health community services?



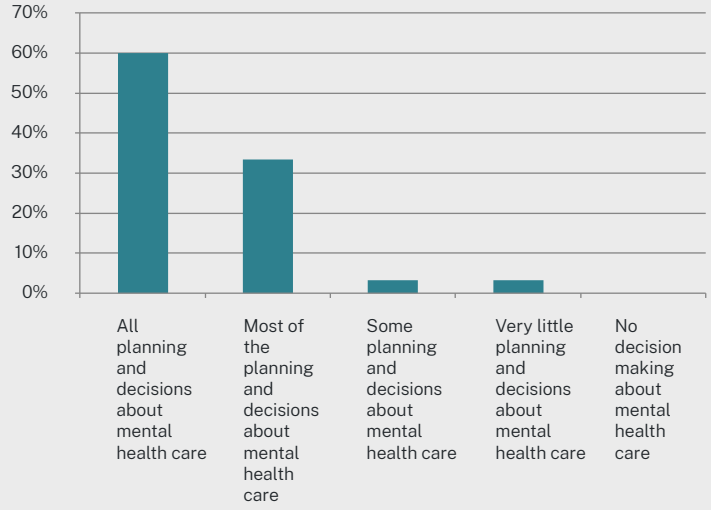
In the past 12 months, has the older person you care for received any care or treatment from the following mental health services? (Select all that apply)



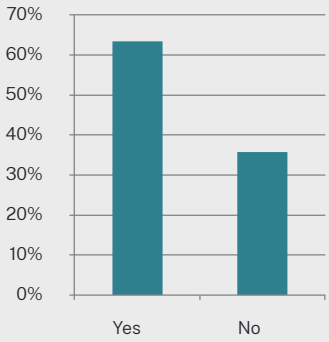
Who referred the older person you care for to the community older people's mental health service?



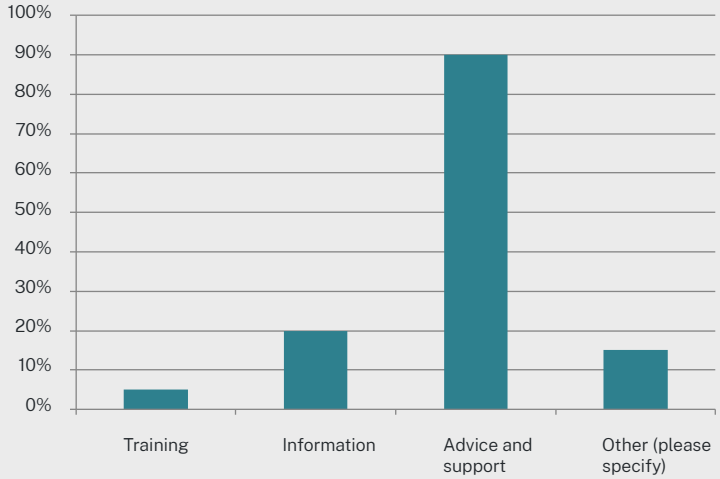
How much do the people providing mental health services to the older person you care for include you in decision making?



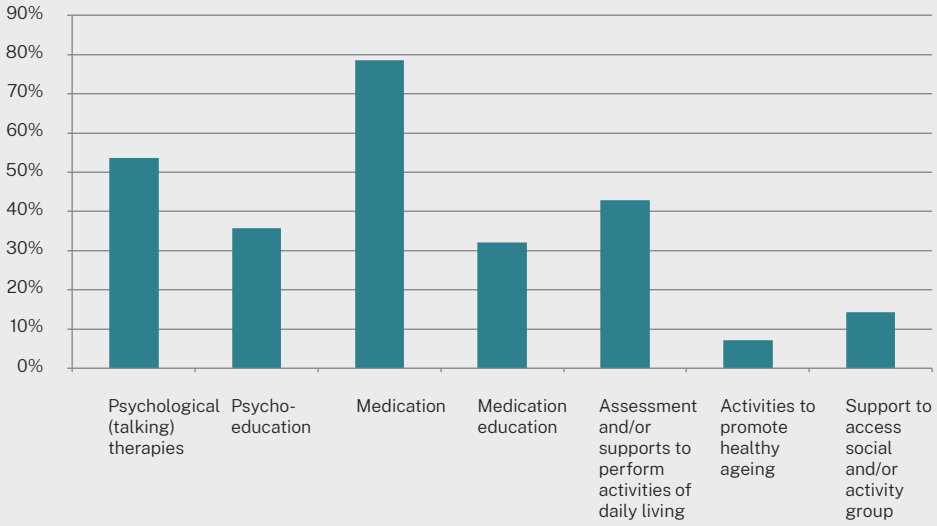
Do you need assistance in coordinating care for the older person you care for?



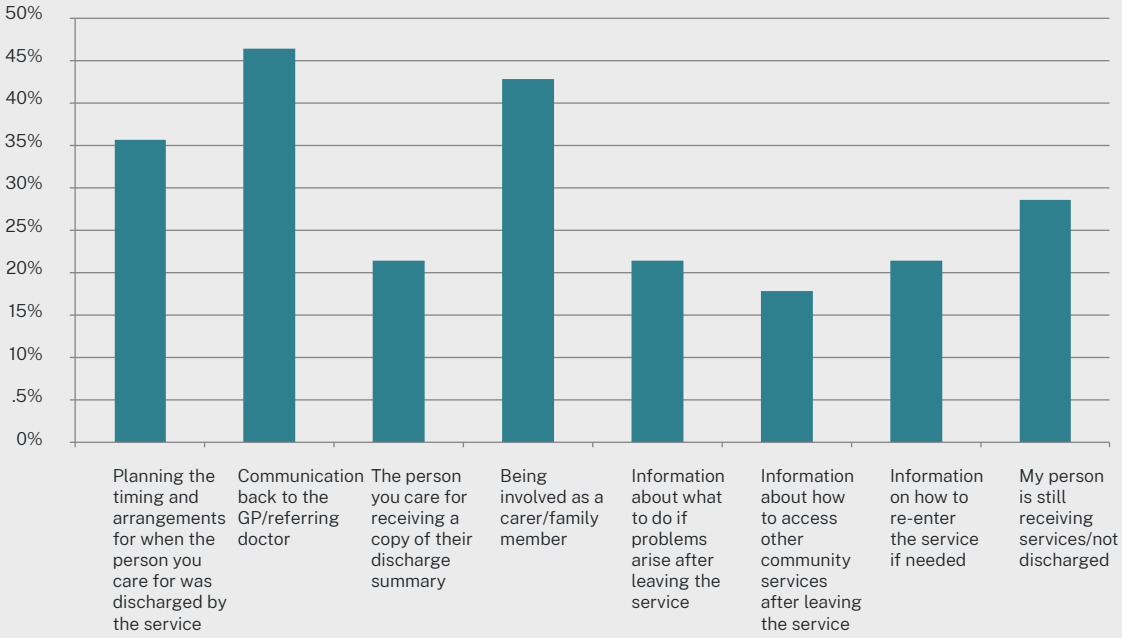
If yes, what type of assistance do you require? (Select all that apply)



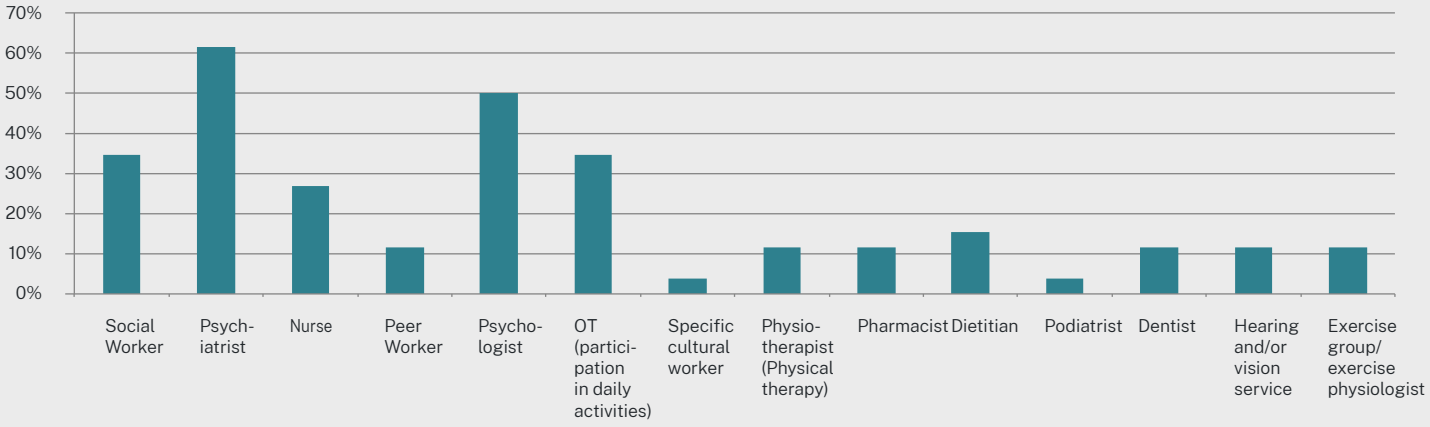
Which services provided by the OPMH community mental health service do you think are most important for the older person you care for? (select up to three options)



If the older person you care for has been discharged from the OPMH community service, which things were the most important to you as a carer in planning for discharge? (select up to three options)



Thinking about the care your person received from the OPMH community service which of these professionals would they have liked more access to? (select all that apply)



Please elaborate on any other aspects of care that are important to you as a carer:

Below is a word cloud representation of common themes from free text responses.

Some responses from carers about aspects of OPMH community care important to them were:

"It is important that aged care facilities are on the same page as community work[er]. It is sad to see the recommendations not being followed- therefore loved ones suffer"

"consistent communication with health care providers"

"being present during psychiatrist visits; communication between those involved in patient care; kindness, care and dignity from all carers"

Which aspects of care could have been improved during your contact with older people's mental health community services?

Below is a word cloud representation of common themes from free text responses.

Some responses from carers about what could have been improved in care from OPMH community services included:

"FIFO Psychiatrist are not worth it when they only [see] patient and not carer and dismiss carer- don't have time- need to see someone else. Chasing help -feeling burnt out. Finding GP to take on MH is near impossible."

"No drastic medication changes without consultation with carers. Care has to be personalised. Videocall didn't work in our experience- the psychiatrist spoke directly to the person I care for. Didn't hear my concerns. The person I care for has hearing impairment and didn't hear everything. Would nod yes as a default. I wasn't listened to."

"Help and assistance is available when needed."

Summary of Carer Survey Results

Following is a summary of the carer survey results:

Carer needs and priorities

Carers identified two key areas where they required the most support: **ways to communicate effectively with health professionals** and **assistance in finding the right services** for the older person in their care. Over **80% of carers** reported that it was **very important** that care be delivered by a **specialist clinician** who addressed all the older person's concerns, provided **individualised, timely support**, and worked in a **collaborative** manner.

Preferences for care delivery

For carers, the **preferred location** for care was overwhelmingly at **home or within a residential aged care home** (**86%** respondents). Carer survey respondents reported a **preference for in-person care**, with **70%** reporting that the consumer would prefer to **use telehealth only if the consumer couldn't get a face-to-face appointment** and 22% preferring not to use telehealth at all. However, **50%** carers surveyed also reported that it was v**ery important or somewhat important** that the **consumer could access OPMH community services via telehealth where needed**. Approximately, **86% of carers** reported that the older person they cared for **could not use telehealth independently**.

Service access and referral pathways

In the past 12 months, **80%** of carers indicated that the person they cared for had received services from a **community older people's mental health team**, and **63%** had also received care from a **General Practitioner (GP)**. The **majority** of people had been **referred** to the OPMH service by a **GP, inpatient OPMH** or **adult mental health service** or their **carer**.

Involvement in care and coordination

Approximately 60% of carers felt they had been **actively included in planning and decision-making** related to care. However, many noted that they needed **additional assistance with care coordination**, particularly in the form of **advice and ongoing support**.

Treatment preferences and discharge planning

When asked about treatment preferences, carers identified **medication (79%)** and **psychological/ talking therapies (54%)** as the most important treatments for the person they cared for. Carers also expressed a need for **greater access to a range of healthcare professionals, particularly psychiatrists (61%), psychologists (50%)**, social workers and occupational therapists.

For **discharge planning**, carers emphasized the importance of **clear communication with the GP**, being **actively involved** in the discharge process, and having a clear **plan for ongoing care**.

Communication and continuity of care

Across all aspects of care, **consistent communication with healthcare providers** was identified as a **highly valued component** of a quality service. Carers stressed the importance of clear, ongoing communication throughout the care journey.

Consumer and Carer Focus Group

Methodology

The NSW Ministry of Health project team collaborated with the NSW consumer and carer peak organisations BEING and the NSW Mental Health Carers Network (MHCN) to design and host a 1½ hour virtual focus group in May 2025. BEING and MHCN utilised their networks and communication mechanisms to seek and engage consumers and carers who were currently using, or had recently used, NSW OPMH community services.

MHCN hosted the virtual focus group, and the NSW Ministry facilitated the discussion. The discussion was an open dialogue touching on the key aspects of care, and the experiences of both consumers and carers of OPMH services.

The discussion was focussed on the key aspects of OPMH community care: entry into services/care; assessment and care planning; receiving care; checking your progress and planning how you leave the service. The questions used to focus the feedback were:

- What are your experiences of these processes – what was good and what could have been better?
- What matters to you in each of these processes and what would good practice look like?
- What could be improved in OPMH community services?

Consumer and Carer Focus Group: Results

A total of **5 carers** and **2 consumers** attended the 1½ hour virtual focus group providing valuable insights into the key elements of OPMH community services and where practice could be improved or strengthened.

The key themes from the discussion have been grouped below into relevant areas of the OPMH Community Model of Care.

Primary vision and values

Older People's Mental Health (OPMH) services should foster **connection, purpose, and hope** – central to recovery-oriented practice - using a **strength-based approach** that recognises the importance of **social connection** for the older person. **Staff** should be **friendly, warm, and comforting**, as this greatly impacts service experience.

Working in partnership

Focus group participants highlighted that effective **communication and involvement** of **carers** is essential for service navigation and support, and that providing **education** for both consumers and carers is important. Services need an **integrated** approach to **physical and mental health care** (avoiding siloed responsibility). Stronger partnerships with a range of key services, including local community support services and organisations that support social connection, could enhance service delivery.

Key process of care

Focus group participants highlighted the need for clarity about the eligibility criteria for OPMH services, and suggested that better promotion of what OPMH services provide is needed to create awareness and confidence for consumers and carers.

The role of OPMH services in providing **support in service navigation** was noted to be valuable in ensuring consumers are connected with the care and support they need. Consumers and carers spoke about the importance of having a **clear, well-communicated plan of care**, both i**n their contact with OPMH services** and as a **longer-term care plan** to support the older person's recovery journey. **Continuity of care and support** was highly valued. Having **peer support** embedded in health services was viewed as a positive development in care.

Focus group participants reported the need to improve **out-of-hours contact** and **information sharing** between public and private health services supporting the older person in their mental health care and support. They wanted to be **involved in planning their discharge** from OPMH services and to have clear **information about re-connecting with OPMH services post-discharge** if needed.

Summary and Key Findings

In the development of the *Older People's Mental Health (OPMH) Community Services Model of Care Guideline*, published in 2017, an extensive consultation process was undertaken with consumers, carers and clinicians. This process included a series of workshops that helped define the **primary vision and values** for OPMH services, as well as the **key principles and elements** of the consumer journey.

The 2017 consultations revealed a strong desire for **self-determination** and **recovery-oriented care**, with consumers and carers advocating for meaningful **involvement in decision-making and care planning**, and **effective communication**. The importance of **collaboration with government and non-government agencies** was highlighted, along with support for developing a **peer workforce**. Flexibility in service delivery across homes, aged care facilities, and hospitals was highly valued. At the time, **telehealth** received mixed feedback, with its success largely dependent on preparation and user familiarity.

From a clinician perspective, **stigma** and **low mental health literacy** were identified as significant barriers to access. **Centralised intake systems** were often perceived as impersonal and inconsistent, especially for older people with hearing impairments. OPMH services were recognised as **specialist services** requiring staff with expertise in older people's mental health. **Multidisciplinary teams** were considered best practice for delivering comprehensive and coordinated care.

The following elements of care emerged from the consultations as priorities for consumers and carers, as well as OPMH clinicians and key stakeholders, and guided the model of care.

- **Good communication and engagement** with older people from initial contact.
- **Easy and timely access to appropriate assessment.**
- **Recovery-oriented, consumer-led care**, involving **partnering with a consumer and their carer(s) and**

GP and supporting consumers in their personal **recovery journeys**.

- **Joint care planning and coordination with GPs** and other key services and health care providers, with a focus on recovery.
- **Support and good communication during transitions** between inpatient and community services, and other transitions of care.
- **Well-planned discharge processes** that included relapse prevention and clear re-entry pathways

Consumers and carers particularly valued the role of OPMH services in providing specialist mental health care/treatment for older people with acute, severe and/or complex mental health problems (including moderate-severe behavioural and psychological symptoms of dementia or BPSD).

Alignment with current consultation findings

Many of the key themes identified in the 2017 consultation have been reaffirmed through the current consultation process, as documented throughout this report. The following table provides a visual comparison of the key themes from both the 2017 and 2025 consultations. It demonstrates that many of the priorities raised previously remain highly relevant to consumers and carers today, while also highlighting a number of **new and emerging focus areas**.

Comparative Summary of Key Themes: 2017 and 2025 Consumer/Carer Consultations

Key areas important to consumers and carers	2017 Consultation	2025 Consultation
Primary vision and values, and expectations of OPMH care		
Self-determination and person-led care	X	X
Connection, purpose, hope and recovery-orientation	X	X
Access to specialised staff	X	X
Multidisciplinary care	X	
Working in partnership		
Partnership with government and non-government agencies	X	X
Partnering with peer workers	X	X
Integration of physical and mental health care		X
Working in different settings		
Home/RACF		X
Appropriate use of telehealth/virtual care	X	X

Key areas important to consumers and carers	2017 Consultation	2025 Consultation
Intake and admission		
Timely access to assessment/care	X	X
Stigma	X	
Communication	X	X
Mental health literacy	X	
Inconsistent centralised intake systems	X	
State border issues	X	
Assessment		
Having time to listen, good engagement and rapport	X	X
Physical health	X	X
Care planning		
Person-centred	X	
Partnership with the consumer and carer	X	X
Involvement of GP	X	
Short and longer term planning	X	X
Service navigation support	X	
Social connectedness		X
Medication information		X
Access to talking therapies		X
Discharge/transfer of care		
Flexible, individualised, involving consumer and carer	X	X
Support and communication in transitions of care	X	X
Easy re-entry to service	X	X
Feedback to GP	X	X

Drawing on the valuable insights shared by consumers and carers during this consultation, a number of clear priorities have emerged that should be reinforced and incorporated into the review of the Older People's Mental Health (OPMH) Community Services Model of Care Guideline. In summary, the consultation process has highlighted **five key themes** to be considered:

1. Personalised, Specialist, and Face-to-Face Care

Both consumers and carers strongly valued care delivered by **specialist clinicians** who understood their specific needs and provided support in a **timely, collaborative** manner. There was a clear preference for **face-to-face** care delivered at a person's residence, with most respondents viewing **telehealth** as a least desirable mode of care, due to accessibility and usability concerns.

2. Communication, Involvement, and Continuity

Effective communication with health professionals was a top priority for both groups. Consumers and carers wanted to be **listened to, involved in decision-making**, and informed throughout the care journey. Continuity with the same clinician, **clear discharge processes**, including **how to re-engage with service** were also highly valued.

3. Access, Navigation, and Coordination

Initial access to services was typically through **GPs** or **hospital referrals**, but many carers reported difficulty in **navigating the system** and finding the right services. **Care coordination support**, especially through **care navigators**, was identified as an important need to ensure smooth transitions and integrated care.

4. Treatment and Support Preferences

Consumers and carers both highlighted the importance of having access to **psychological/talking therapies**, as well as **medication**. They also desired **greater access to psychologists and psychiatrists**, and support during **discharge and follow-up** care planning.

5. Values, Partnerships, and System Improvements

A shared vision for OPMH services includes creating **connection, purpose, and hope**, supported by **warm, friendly staff**. Stronger **integration of physical and mental health care, greater carer involvement**, improved **service promotion**, and **collaboration with external agencies** were recommended to enhance service delivery.

This report has played a vital role in the review of the Older People's Mental Health (OPMH) Community Services Model of Care Guideline. We extend our sincere thanks to the consumers, carers, and NSW peak bodies who generously contributed their time and insights. Their input has been instrumental in ensuring that the needs of older people living with mental illness are reflected in efforts to improve OPMH services across NSW.

Appendix C

Key partners and partnership guidance

Key partners	Partnership guidance
GPs	Consumers and carers consistently highlight the importance of GPs in their ongoing mental health care, and the importance of good collaboration and communication with their GP from OPMH services. GP consultation supports this. Working in partnership with GPs is central to the way in which OPMH community services operate,[9] and GP involvement is recommended in various key process of OPMH care processes. Good communication and collaboration with GPs is particularly important in intake and admission, assessment (including physical examinations), care planning, clinical review and transition of care (where clear, timely communication of discharge plans and ongoing care and medication management plans is required).[41]
Adult mental health services	Adult mental health services play a significant role in triage, crisis and acute care, and provide mental health care (including rehabilitation) to older people. OPMH community services need to work collaboratively with adult mental health services to: • Facilitate a low threshold for referral of older people from triage/initial contact to specialist OPMH assessment, particularly for new clients. • Promote early involvement of OPMH services in the assessment of older people in suicidal distress, and in follow-up care as appropriate. • Enable the provision of the most appropriate ongoing care for older consumers, based on clinical need, complexity, service capacity and consumer preference.
OPMH inpatient services	OPMH inpatient services play a key role in providing care to older people with acute, severe and/or complex mental health problems, and in supporting coordinated, effective transitions of care to OPMH community services. OPMH community services should work closely with local OPMH inpatient services to support integrated, coordinated care for OPMH consumers. Ideally, OPMH acute inpatient units (AIU) and community teams are part of the one service. If managed differently, clear protocols are required to support integration between the two services. Where relevant, OPMH community clinicians should be involved in OPMH AIU intake processes and in multidisciplinary reviews of AIU consumers and community mental health assessment should occur prior to inpatient admission where possible.[42]

Key partners	Partnership guidance
Dementia services	Dementia services, including services funded by the Commonwealth to support people with behavioural and psychological symptoms of dementia (BPSD), are key partners for OPMH community services and can play a role in supporting older people with moderate-severe BPSD. OPMH community services should develop and maintain partnerships with local dementia services to promote pathways to alternative care for older people with dementia who are not within the OPMH target population or do not meet local prioritisation criteria. These partnerships should aim to promote a coordinated local response to meet the needs of older people with moderate-severe BPSD, while facilitating timely access to OPMH assessment and/or care for those who most need a specialist OPMH response.
Aged care services	There is substantial evidence and policy support for the role of OPMH community services in working with aged care services, particularly residential aged care services, to effectively support older people with more severe and complex mental health needs. [9,41,133–135] OPMH services should develop and maintain partnerships with local residential aged care providers, including specialist mental health-residential aged care service providers, specialist dementia care unit providers and aged care providers that support people with more complex mental health needs, including severe BPSD. This includes partnerships that promote pathways to community care for older people who are experiencing, or are at risk of, long hospital stays, or potentially preventable hospital admission, and to that support effective transitions of care.[136]
Geriatric medical services	OPMH services and geriatric medical services should cooperate to ensure the best treatment and care of older people, many of whom have complex combinations of mental and physical ill health. Older people and their carers should have access to high quality, well-integrated community, residential and hospital services which include access to old age psychiatry and geriatric medicine specialists either in person or via telehealth. It is important that health services ensure appropriate settings are available for people with both behavioural and acute medical needs.[137]
National Disability Insurance Scheme (NDIS) services	OPMH services should develop capacity to work in partnership with NDIS providers in collaboration with whole of mental health service initiatives to effectively and appropriately support older people with more severe and or complex mental health needs that emerged while they were eligible for NDIS services.

Appendix D

NSW Older People's Mental Health Community Services Model of Care Summary

Our services aim to provide recovery-oriented, person-centred, trauma-informed, biopsychosocial, culturally responsive care with the consumer, their family, carer and their GP.

Our target population

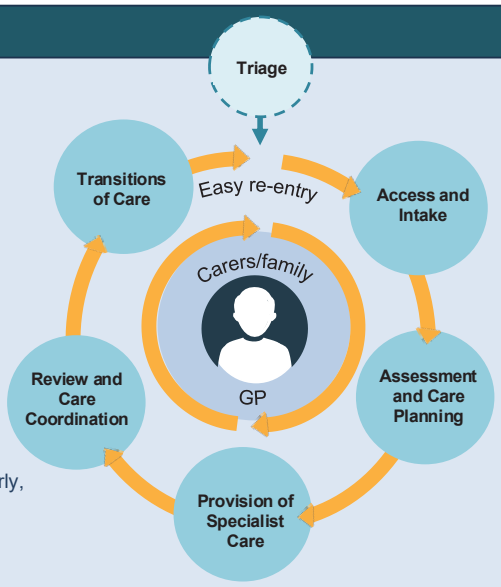
Our services care for older people with mental health problems, including those with and without dementia. People with more severe symptoms and/or complex care needs are prioritised for ongoing care. Although we generally target people 65 years and over, this age limit should not be strictly applied. Flexibility and consumer choice is paramount. Some people under 65 years may be best served by OPMH services, rather than adult MH services. We provide care for Aboriginal people aged 50 years or older who want to be cared for in OPMH services.

Our Functions

Key processes

Our services focus on:

- actively involving the consumer, carer and GP in care
- promoting easy access to OPMH initial assessment following triage
- a 'no wrong door' approach with clear prioritisation criteria
- accepting a low referral threshold for older people in suicidal distress
- a biopsychosocial, multidisciplinary approach to care
- comprehensive, multidimensional assessment — covering psychological, physical, functional, social and cultural factors
- facilitating appropriate physical health assessment and care
- collaborative, recovery-oriented care planning focussed on consumer goals
- recovery-oriented risk assessment and planning
- person-centred care coordination to meet complex needs
- regular clinical review against identified clinical and personal recovery goals
- having agreed processes with partners for crisis and after-hours care
- supporting effective transitions of care by planning early, communicating clearly, maximising consumer and carer choice and control and collaborating
- communicating clearly about OPMH service re-contact post-discharge



Techniques and therapies

- Our services have a key role in facilitating clinical recovery and in supporting consumers to address their broader recovery goals.
- Our services enable consumers to access a range of evidence-based, biopsychosocial therapies. These may be provided directly by OPMH staff or through partnerships.
- All OPMH community clinicians should provide some psychological strategies as part of care.
- Therapies remain effective in later age. Specialised knowledge or skills may be required to adapt therapies for age and cognition.
- Our services promote access to very specialised, non age-specific services (e.g. clozapine dosing, maintenance ECT, depot antipsychotic medications) by older people.

Supported by

Working in partnership

Our services partner with consumers, carers/families and a range of health and community care providers.

Our services prioritise working with services most important to older people (incl. GPs, adult mental health teams, OPMH inpatient units, dementia services, aged care and geriatric services).

We adapt as our partners evolve.

Adapting for the person's location and context

Our services consider and support consumers' preferences for setting and modality of care (e.g. face-to-face, telehealth and e-health). Telemedicine is used as an adjunct to face to face services.

Staffing

We maintain a strong culture and effective services through:

- multidisciplinary teams
- strong strategic and clinical leadership and clear governance structures
- core, specialist and discipline-specific skills.

We are growing the OPMH peer workforce and strengthening team skills, knowledge and practice through supervision and professional development.

Monitoring and improving performance

We aim to continually improve the quality and safety of our services through benchmarking, accreditation and quality improvement.

Our services align with key national and state standards and policies.

Appendix E

Key definitions

The definitions in the table below provide guidance on how key terms are used within the context of older people's mental health services in NSW.

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)	ADLs are the fundamental life skills that someone must be able to perform in order to independently care for themselves. The major domains of ADLs are feeding, dressing, bathing, and walking.
Behavioural and psychological symptoms of dementia (BPSD)	Behavioural and psychological symptoms associated with dementia (BPSD) refers to the non-cognitive presentations of dementia, such as agitation, aggression, anxiety, apathy, depression, disinhibition, psychosis and nocturnal disruption.
Biopsychosocial	The biopsychosocial approach systematically considers biological, psychological and social factors and their complex interactions in understanding health, illness, and health care delivery.
Carer	A person who provides ongoing, unpaid care and support to a family member or friend who lives with a disability, chronic or terminal illness, mental illness or frailty and ageing. Carers may be family, friends or part of kinship or cultural structures, including those recognised in Aboriginal and Torres Strait Islander, and culturally and linguistically diverse (CALD) communities.
Consent	A person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention.
Consultation-liaison	Aims to provide specialist mental health services to patients within the general hospital setting. This may include: • Conducting mental health assessments and providing advice on clinical management and early recognition of symptoms relating to mental health to the general health treating team. • Facilitating linkages between the general hospital, primary care and other health services for patients whose physical health care is complicated by their mental health problems. • Providing teaching, training and mental health promotion support for general hospital staff.
Consumer	A person with a lived experience of mental health challenges, distress or suicidality, who accesses support and care from a NSW health service. The term 'consumer' originates from the consumer movement. The term was chosen by people accessing mental health care to reflect their autonomy, choice and right to have an active role in personal recovery. Alternative terms used in NSW Health and chosen by consumers include 'people with lived experience', 'people accessing services' and 'survivors'. For the purposes of the Guideline, the terms consumer, patient, person and client are used to refer to the same individual throughout the Guideline.

Culturally responsive practice	Becoming culturally responsive is an ongoing reflective practice that will continue for as long as you provide healthcare. Over time, NSW Health staff should aim to develop the following skills and knowledge: • An awareness and understanding of different cultures, with the ability to accept differences without judgements about right and wrong. • The ability to identify risk factors among specific groups without stereotyping people. • The ability to identify risks contributing to increased vulnerability in specific groups and take action to improve their healthcare outcomes. • An awareness of your own culture and understanding your inherent biases towards your own cultural values and behaviours. • The ability to work with people from different cultures in a way that is safe and supportive and is not discriminatory or harmful. • The ability to respond appropriately to attitudes, feelings and circumstances of different people. • An understanding of the structures and services that are necessary to deliver cultural support and bring about systemic change.
LGBTIQ+	LGBTIQ+ is used in reference to lesbian, gay, bisexual, transgender and gender diverse, intersex, queer, and the + represents people of other diverse sexualities and genders not captured in the letters of the acronym. NSW Health acknowledges that communities may use other terms to describe themselves.
“No wrong door” approach	The "no wrong door" approach expresses the aim that all presenting clients will be provided with appropriate treatment services or referral, consistent with their treatment needs, regardless of where they enter the treatment system
Older People’s Mental Health (OPMH) Services	OPMH services are a specialist clinical stream of public mental health services focussed on older people with mental illness, and include inpatient, community and community residential services (generally delivered in partnership with non-government residential aged care services).
Peer worker	A person who is employed by NSW Health who draws on their personal lived experience (consumer) expertise of mental health challenges or suicide and recovery, as an essential requirement of their role. Peer workers apply peer work values, principles and scope of practice to inform their work.
Person-centred care	Care that is respectful of, and responsive to, the preferences, needs and values of the individual consumer or patient.
Phase of care	The prospective primary goal of treatment within an episode of care in terms of the recognised phases of mental health care. Whilst it is recognised that there may be aspects of each mental health phase of care represented in the consumer’s mental health plan, the mental health phase of care is intended to identify the main goal or aim that will underpin the next period of care. The mental health phase of care is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type.

Recovery-oriented practice	Recovery-oriented practice is the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. It recognises the uniqueness of the individual, provides real choices to consumers, and supports consumers to undertake the journey of individual recovery.
Stepped care	Stepped care is a staged system of interventions, from the least to the most intensive, matched to individual needs. The tailored, person-centred approach to matching care to needs and providing choice wherever possible, are key to stepped care.
Substitute consent	Subject to accepted legal and ethical standards of medical care, patients without the capacity to consent have a right to a substitute decision maker. They also have a right to be provided with care consistent with any valid Advance Care Directive that they have made.
Supported decision making	People with disability need to be involved in decisions about their health care and must be supported to make their own decisions to the greatest extent possible. This may include, for example, decisions about their preferred treatment option, whether family and carers are to be involved and how they are to be involved.
Techniques and therapies/ psychological strategies	The range of biopsychosocial therapies provided directly by each OPMH community service dependent on clinical preferences, skills, team staffing mix and size of team. "Psychological strategies" refers to the use of individual therapeutic strategies from evidence-supported psychotherapies. Formal psychological therapy refers to a process in which the consumer and consumer support network consents to engage in a series of sessions using an agreed range of psychological strategies.
Transition of care	Refers to the transfer of professional responsibility and accountability for the care of a mental health consumer to another person or professional group.
Trauma-informed care and practice	Trauma-informed care is an approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.
Virtual care	Virtual care involves any interaction between a consumer and clinician(s), or between clinicians, that occurs remotely using technology.

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