

Specialist Mental Health Services for Older People (SMHSOP)

Acute Inpatient Unit
Model of Care Project Report



Health

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Contents

Acknowledgements	3
Acronyms	4
Definitions	5
Executive summary	6
1. Introduction	13
1.1 Purpose and scope of the model of care project	13
1.2 Methodology.....	14
1.3 Policy framework and literature.....	14
1.4 Focus group consultation	15
1.5 Purpose and scope of this report	16
2. Philosophy of care, functions and target population	17
2.1 Philosophy of care.....	17
2.2 Functions.....	19
2.3 Target population	21
2.4 Exclusion criteria	25
2.5 Recommendations: philosophy of care, functions and target population.....	26
2.6 Service development guidelines: philosophy of care, functions and target population	28
3. Comorbid disorders and problems, and end of life care	30
3.1 Comorbid disorders and problems	30
3.2 End of life care.....	32
3.2 Recommendations: comorbid disorders and problems, and end of life care.....	34
3.3 Service development guidelines: comorbid disorders and problems, and end of life care	34
4. Functional relationships, location and other operational arrangements	35
4.1 Functional relationships, location, and other operational arrangements.....	35
4.2 Visiting hours and access	36
4.3 Recommendations: functional relationships, location and other operational arrangements	37
4.4 Service development guidelines: functional relationships, location and other operational arrangements	39
5. Key processes	41
5.1 Intake and admission	41
5.2 Assessment and care planning	43
5.3 Clinical review.....	45
5.4 Discharge/transfer of care	46
5.5 Recommendations: key processes	47
5.6 Service development guidelines: key processes.....	49
6. Clinical interventions	52
6.1 Milieu	52
6.2 Psychotherapy	53
6.3 Behavioural therapy and other psychosocial interventions.....	53
6.4 Pharmacotherapy.....	53
6.5 Electroconvulsive therapy (ECT).....	54
6.6 Family and carer education and therapy	54
6.7 Social and legal interventions.....	55
6.8 Other interventions.....	55
6.9 Recommendations: clinical interventions	56
6.10 Service development guidelines: clinical interventions.....	57

7. Seclusion and restraint	59
7.1 Recommendations: seclusion and restraint	60
7.2 Service development guidelines: seclusion and restraint	61
8. Facility design	62
8.1 Unit size and capacity	63
8.2 Security	63
8.3 Locking doors	63
8.4 Recommendations: facility design	64
8.5 Service development guidelines: facility design.....	65
9. Staffing	66
9.1 Medical	68
9.2 Nursing.....	68
9.3 Allied health	70
9.3.1 Occupational therapy	70
9.3.2 Diversional therapy.....	71
9.3.3 Psychology	71
9.3.4 Social work	72
9.4 Recommendations: staffing	72
9.5 Service development guidelines: staffing.....	74
10. Performance	75
10.1 Length of stay.....	77
10.2 Readmission rates	78
10.3 Outcome measurement	78
10.4 Recommendations: performance.....	79
10.5 Service development guidelines: performance.....	80
11. Conclusion and next steps	84
Appendix 1: Consultative groups and individuals that have provided advice on SMHSOP Acute Inpatient Unit Model of Care report.....	88
Appendix 2: Focus group questionnaire.....	90
References	92

Figures

Figure 1: Components of the SMHSOP Acute Inpatient Unit Model of Care	7
Figure 2: Clinical pathway for older people with potential mental health disorder	9
Figure 3: Percentage of NSW consumers admitted to inpatient mental health care in financial years 2006-09 with HoNOS65+ items scores of 2 or more.....	22
Figure 4: Clinical pathway for older people with potential mental health disorder.....	40

Tables

Table 1: SMHSOP AIU Diagnosis by age group Financial Year 2007/2008.....	23
Table 2: NSW SMHSOP benchmarking data: Inpatient Care for people with additional mobility requirements.....	31
Table 3: NSW SMHSOP benchmarking data: Inpatient Care for people with additional medical care requirements.....	31
Table 4: Total beds in all NSW SMHSOP AIUs	62
Table 5: NSW SMHSOP inpatient staffing profiles, number of beds and total Full Time Equivalent (FTE), Benchmarking Report Phase One, 2009.....	67
Table 6: Performance of NSW SMHSOP AIUs	76
Table 7: NSW SMHSOP - (Age > 60) Length of Stay – Financial Year 2007/2008	78
Table 8: NSW SMHSOP - (Age > 60) Length of Stay Greater than 7 Days – FY2007/2008	78

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Abbreviations and acronyms

ACAT	Aged Care Assessment Team	ED	Emergency Department
ACD	Advanced Care Directive	EDD	Estimated Date of Discharge
ACHS	Australian Council on Healthcare Standards	FPOA	Faculty of Psychiatry of Old Age
ADLs	Activities of Daily Living	HACC	Home and Community Care
ADRs	Adverse Drug Reactions	HoNOS 65+	Health of the Nation Outcome Scale 65+
AIU	Acute Inpatient Unit	IADLs	Instrumental Activities of Daily Living
ALOS	Average Length of Stay	ICU	Intensive Care Unit
AMHOCN	The Australian Mental Health Outcomes and Classification Network	JMO	Junior Medical Officer
AOD	Alcohol or Other Drug	LHD	Local Health District
ASET	Aged Care Services Emergency Teams	MDT	Multidisciplinary team
BPSD	Behavioural and Psychological Symptoms of Dementia	MHA	NSW Mental Health Act (2007)
CALD	Culturally and Linguistically Diverse	MH-CCP	Mental Health-Clinical Care and Prevention Model
CBT	Cognitive Behaviour Therapy	MHDAO	Mental Health Drug and Alcohol Office
CACP	Community Aged Care Package	MHNOCC	Mental Health National Outcomes and Casemix Collection
CIBRE	Clinical Information Benchmarking Report Engine	MH-OAT	Mental Health Outcomes and Assessment Tools
CL	Consultation and Liaison	MHRT	Mental Health Review Tribunal
CMO	Career Medical Officer	MoC	Model of Care
CMHT	Community Mental Health Team	PECC	Psychiatric Emergency Care Centres
ECT	Electroconvulsive Therapy	OPMH	Older People's Mental Health

PGNA	Psychogeriatric Nurses Association, Australia (Inc)
PGU	Psychogeriatric Unit
POE	Post Occupancy Evaluation
RACF	Residential Aged Care Facility
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SMHSOP	Specialist Mental Health Services for Older People
SMHSOP AIUMoC	Specialist Mental Health Services for Older People Acute Inpatient Unit Model of Care
T-BASIS	Transitional Behavioural Assessment and Intervention Service

Definitions

The term 'older consumer/s', as distinct from the term 'patient/s', is generally used throughout the project report, on advice from the NSW Consumer Advisory Group, to refer to an older person with a lived experience of mental illness. The term 'inpatient' is used as an adjective where the use of the term 'consumer' would be unclear e.g. 'inpatient unit' or when referring to consumers in general hospital or similar settings. The term 'patient', because of its special meaning, is also used in reference to consumers admitted under the Mental Health Act, as 'involuntary patients'.

Executive summary

Introduction

Specialist Mental Health Services for Older People (SMHSOP) in NSW are currently undergoing a period of significant change. The *NSW Service Plan for SMHSOP 2005-2015* [1] sets out service models structures, priorities and an implementation plan to guide staged developments in SMHSOP across NSW. The SMHSOP Acute Inpatient Unit Model of Care (AIUMoC) Project represents a body of work that will inform policy and support the further development of acute inpatient care as part of the second phase of the SMHSOP Service Plan.

Purpose and scope of the Model of Care (MoC) Project (see Section 1)

The purpose of the SMHSOP AIUMoC Project is to promote effective inpatient care and good practice in these units across NSW. The current units have been developed under a range of models of care. This project is intended to guide service improvement and service development in existing units and to inform planning for new units. It may also provide the basis for service review in existing units and post occupancy evaluations of new units. Ultimately, it is intended to support greater consistency and quality of care in SMHSOP AIUs across NSW.

This report contains detailed information regarding the current published literature and policy documents relevant to SMHSOP AIUs, along with a description of the current range of service models and practice. Based on this information, and on the consensus opinion of clinical experts, it provides recommendations regarding good practice in relation to the key components of a SMHSOP AIUMoC, as well as service development guidelines to inform service planning and service development. Service development may occur over an extended period of time and implementation of the MoC will require consideration of local service context and other factors.

To accompany this more detailed project report a summary SMHSOP AIUMoC manual will be developed as a practical resource to support state and local service planners, policy managers, and service managers in the development of new SMHSOP AIUs and the review and improvement of existing SMHSOP AIUs. This manual will summarise the literature, policy and current practice analysis in this report and translate the report recommendations and service development guidelines into succinct practical guidelines, for review on a regular (approximately 5 yearly) basis.

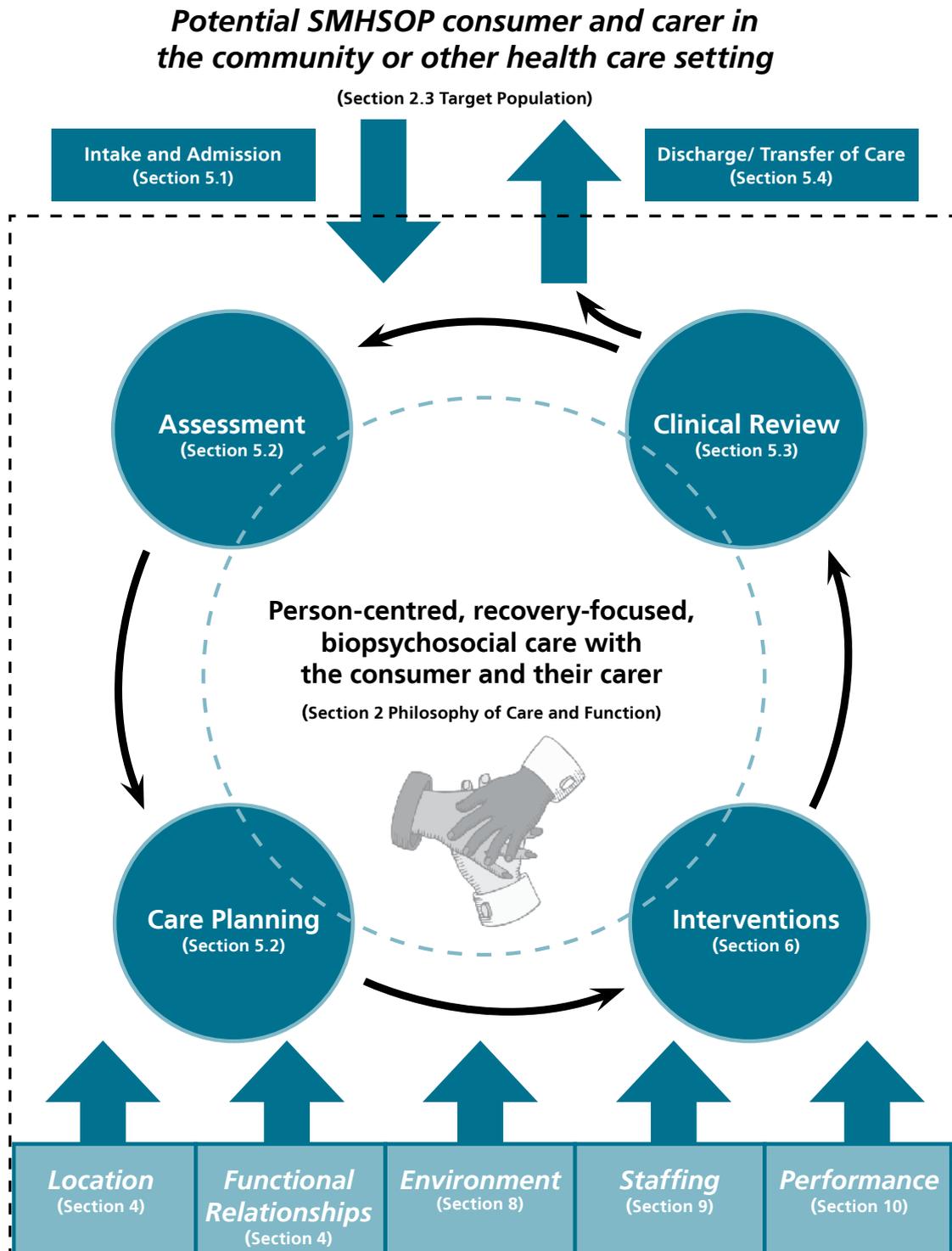
There are nine key components in the MoC:

- philosophy of care, functions and target population
- comorbid disorders and problems, and end of life care
- functional relationships, location and other operational arrangements
- key processes
- clinical interventions
- seclusion and restraint practice
- facility design issues relevant to the MoC
- staffing
- performance.

Recommendations and service development guidelines comprehensively cover each of these components in this report. Only the more significant recommendations are summarised in this executive summary. **Refer to the full report for a complete list of recommendations.**

The relationships between key service model components are outlined in Figure 1. It is conceptualised that the AIU will sit harmoniously within the community of the SMHSOP consumer and carer and that the consumer and carer flow in and out of the AIU with minimal barriers to transition. There is a close relationship between the unit's key processes/ interventions and its philosophy of care, which is person-centred, recovery-focused and biopsychosocial and lies at the centre of the model, emphasising its importance. Underpinning the model are the cornerstones of

Figure 1
Components of the SMHSOP Acute Inpatient Unit Model of Care



location, functional relationships, environment, staffing and performance, which integrate with and support the delivery of the model. The joining of hands represents the shared team approach of a multidisciplinary service working with the older consumer and carer on common goals.

Philosophy of care, functions and target population (see Section 2)

It is recommended that AIUs should adopt a person-centred, recovery-focused biopsychosocial philosophy of care, and ensure that care environments, processes and practices reflect this philosophy.

Person-centred care considers each person's needs and preferences from a holistic perspective that includes associated relationships, values, interests and the environment and culture in which they live as central to the process of providing care [2]. It also considers the impact that other people, practices and/or the physical environment may have on the individual. It focuses on the wellbeing of the individual as well as addressing ill health by acknowledging that each person is unique regardless of any illness they have.

Person-centred care is more than individualised care. It is care in which a core responsibility of all clinical staff is to understand the person, their likes and dislikes, key influences in their life, and their life goals. Goals of clinical care must be related to this knowledge and life goals. The appropriate communication of relevant information to others involved in care will allow them to continue this approach. Person-centred care allows service delivery to be focused on the principles of recovery – including seamless service provision and working with consumers, in partnership with their carers, on addressing the determinants of their mental health and wellbeing.

The AIU will be part of the continuum of care that also includes mental health promotion, prevention and early intervention, ambulatory/community services, sub-acute and non-acute inpatient care and community residential care. The primary functions of the AIU include: assessment; clinical review and care planning; management of acute risk; treatment focused on clinical symptom reduction with a reasonable expectation of improvement in the short term; and transfer of care from the unit as soon as feasible.

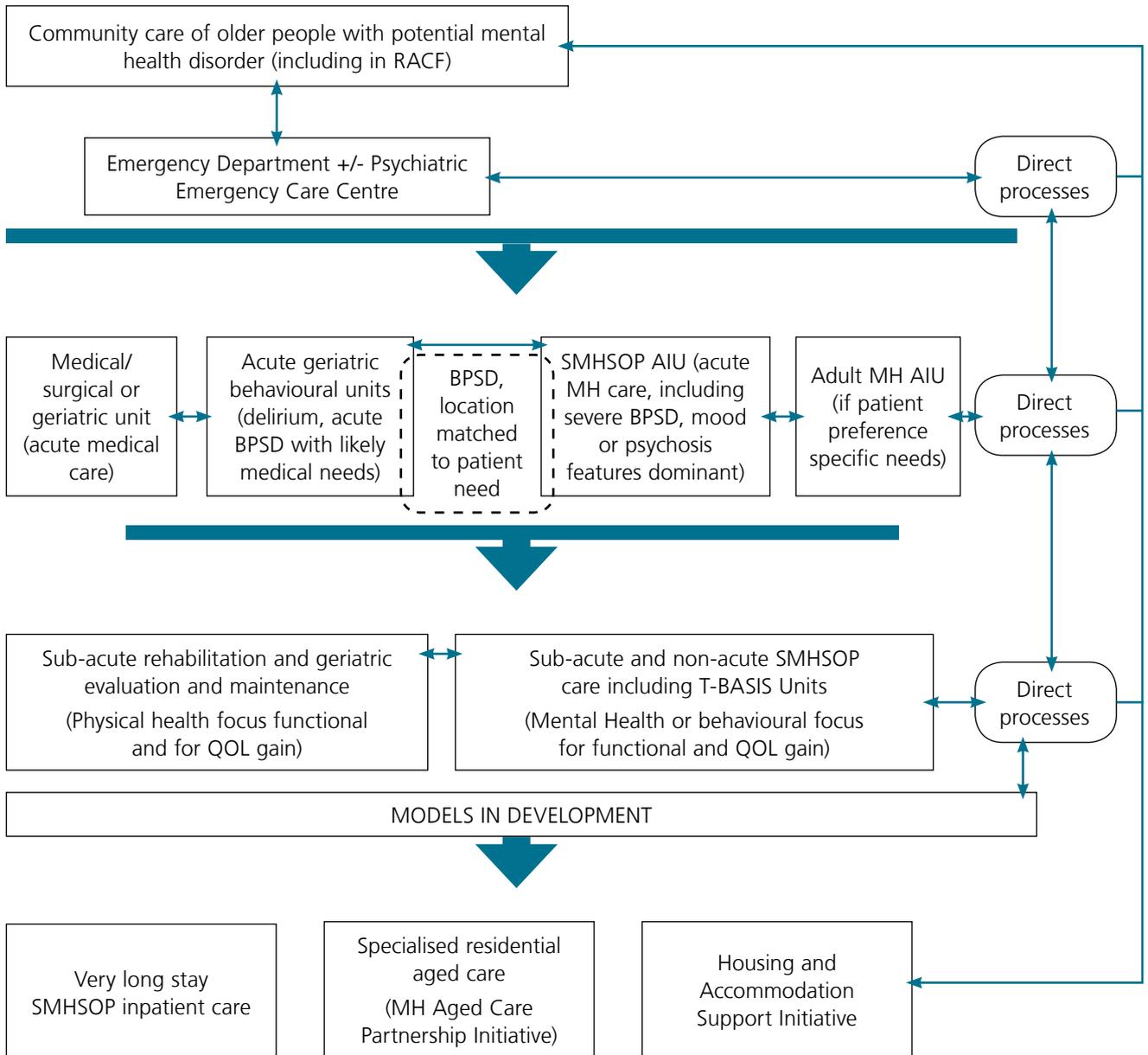
The primary target population for SMHSOP AIUs comprises older people with acute, severe clinical symptoms of mental illness that have the potential for prolonged dysfunction or risk to self or others. These units must be able to manage both voluntary and involuntary patients under the *Mental Health Act* [3].

It is preferable that SMHSOP AIUs are designed and staffed for the acute management of all mental health disorders, including severe Behavioural and Psychological Symptoms of Dementia (BPSD). Their role should be seen as complementary to the role of aged care services for older consumers with the broader range of BPSD. In general, SMHSOP AIUs will focus on older consumers with severe BPSD associated with predominant mood or psychotic symptoms, and aged care inpatient units on delirium and BPSD associated with likely acute medical needs. However, appropriate flexibility is required and consumer need should drive decisions regarding location of care within local service systems.

Where older consumers with severe BPSD display very high risk to themselves or others and cannot be managed in SMHSOP AIUs, provision must be made for their appropriate management in other inpatient facilities. All units must develop some capacity to appropriately manage severe BPSD.

The important and complementary role of acute geriatric behavioural units in the care of older people with BPSD and the importance of the functional relationships between SMHSOP AIUs and these units is illustrated in Figure 2.

Figure 2
Clinical pathway for older people with potential mental health disorder



Comorbid disorders and problems and end of life care (see Section 3)

Physical illness often precipitates psychiatric admission and complicates treatment. It is important that consumers in SMHSOP AIUs receive appropriate physical health care including procedures to identify and manage common causes of delirium that arise in the unit. It is recommended that there be regular geriatrician ward rounds and/or consultations and access to other medical and surgical care as required. AIUs must have processes in place to prevent the development of secondary comorbidity, such as falls prevention strategies.

AIUs should encourage advanced care planning early in the care of older consumers with terminal illness, including dementia. End of life care may be appropriately provided in some circumstances.

Functional relationships, location and other operational arrangements (see Section 4)

In order to provide basic services for optimal treatment, new SMHSOP AIUs need to develop effective partnerships with a range of other services, particularly SMHSOP community teams, aged care services and adult mental health services. Functional relationships with SMHSOP community teams are fundamental and the MoC must support integrated service provision across inpatient, community and residential settings. However, there is no expert consensus as to whether the SMHSOP AIU and community team should necessarily be co-located. New AIUs should be co-located with Electroconvulsive Therapy (ECT) facilities and geriatric inpatient units. Co-location on the site of a general hospital, with adult mental health inpatient facilities, emergency department (ED), imaging and pathology services is strongly desirable.

Visiting hours ought to be flexible and any restrictions determined by therapeutic need and consumer and carer preference, rather than staff routines. There should be good access to parking and public transport.

Key processes (see Section 5)

There are multiple possible entry points to the AIU. Entry procedures must ensure that consumers are initially admitted to the most appropriate setting at the outset,

without inappropriately delaying admission. Direct admission is preferable to admission via the ED, unless there are specific reasons for admission via the ED. Assessment and care planning must cover multiple domains and be appropriately inclusive of the consumer and key carers. A face-to-face medical officer review of each older consumer will occur at least once every working day, with consultant psychiatrist in-person review at least weekly. A multidisciplinary case review of the mental and physical health care of, and the care plan for, all consumers will occur at least weekly. Discharge to less intensive care will occur as soon as this can be safely and appropriately conducted. There must be systems in place to ensure continuity of care and communication with key providers on discharge.

Clinical interventions (see Section 6)

The physical and care environment should promote recovery from illness, maintenance of function and a person-centred philosophy of care. Older consumers will have tailored individual treatment plans which are developed in collaboration with the consumer and carer.

Consumers will not be excluded from particular treatments on the basis of age or dependency. Available treatments will include psychotherapy, behavioural interventions, psychoeducation, pharmacotherapy, ECT, family and carer education and therapy as well as other non-pharmacological interventions appropriate for the range of common conditions managed within the units.

SMHSOP AIUs should have local access to ECT. This must be conducted in a manner consistent with the *NSW Health Electroconvulsive Therapy: ECT Minimum Standards of Practice in NSW* [4].

Seclusion and restraint (see Section 7)

Units should aim to minimise the use of all forms of seclusion and restraint in older people. A seclusion room is not required unless specific issues indicate the necessity for this. If restraint cannot be avoided then it must only be used after clinical review, for the briefest period required to allow the consumer to regain control or their behaviour and maintain their safety, and in the form that is considered to have the least risk to the individual consumer.

More detailed guidance is available in PD2012_035 *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* and GL2012_005 *Aggression, Seclusion and Restraint in Mental Health Facilities – Guideline Focused Upon Older People* [5].

Facility design (see Section 8)

Facility design will follow the forthcoming Australasian Health Facility Guidelines for SMHSOP AIUs with particular attention to good visual access, adequate indoor and outdoor space, acoustics, and features to optimise mobility and reduce falls.

Design will significantly influence the ability of the AIU to optimally deliver the recommended MoC. Older consumers with severe agitation and/or BPSD require particular design features. For new units this will mean design will allow for segregation of older consumers with different clinical needs. For existing units this may require modification to allow the functional separation of depressed, anxious and/or frail older consumers from those with severe agitation and/or BPSD.

Consideration will also need to be given to the requirement that design features reduce the risk of suicide as well as provide for the needs of vulnerable or frail older consumers. For example, the risk of suicide by hanging needs to be balanced with the need for appropriately designed handrails and tapware.

Staffing (see Section 9)

The units will require a multidisciplinary team approach. Staff require extensive knowledge and skills, as well as the capacity to work in collaboration with a number of key stakeholders. They require specialist training to manage older consumers with mental illness and the problems associated with cognitive impairment, restricted mobility, physical illness and sensory impairment.

The multidisciplinary staffing profile and approach must enable the older consumer's goals of care to be achieved. Staff in the unit should be able to manage intravenous and subcutaneous fluids, intravenous medications, ongoing oxygen therapy and incontinence. The AIU's staffing must support the delivery of appropriate diversional and non-pharmacological

interventions. Staffing numbers required will vary significantly depending on the acuity, dependency and presenting problems of the older consumers admitted. In particular, older consumers admitted with severe agitation and/or BPSD will require higher ratios of staff as well as specific training aimed at reducing or eliminating restraint use.

Performance (see Section 10)

Local mental health services should have clear structures, governance arrangements and reporting frameworks in place to ensure monitoring and improvement of SMHSOP AIUs. The performance framework should be consistent with existing national and state performance frameworks and relevant mental health or other relevant clinical standards. The units should be involved in benchmarking activities with similar units. Key performance indicators reported in the current NSW CIBRE tool [6] include: 7 day follow-up; 28 day readmission rate; occupancy; average length of stay, and admission-discharge Health of the National Outcome Scale (HoNOS) 65+ change.

Conclusion and next steps (see Section 11)

This report particularly focuses attention on areas of SMHSOP AIU care, practice and operation where there is appropriate evidence and expert consensus, and where consistency across AIUs could be improved. The report identifies recommendations and service development guidelines to support the further development of acute inpatient care in nine key areas. Some of the priorities and most significant challenges for implementation are highlighted in Section 11 of the report.

Any model of care will continue to develop over time and the SMHSOP AIU MoC is no exception. A number of issues arose during the course of this project that were not able to be included within this report but are identified for further work. Some of these, such as the cost benchmarking issues regarding quantifying staffing and cost per bed and other funding issues, are currently the focus of existing NSW Health projects. Others, such as the development of cultural competency recommendations and service development guidelines, particularly those pertaining to Aboriginal consumers, require much more extensive and detailed work than

could be achieved in this project. Further policy development work is required regarding the need and models for specialist units to manage people with very severe BPSD, such a statewide intensive care unit for older people. Other examples where further work is required following this project include a review of teaching and research in SMHSOP AIUs, and the training and education requirements for staff to enable them to deliver this model of care. It is expected that some of these issues will be addressed in the implementation phase of this MoC project and others will require significant policy work.

The Mental Health and Drug & Alcohol Office, NSW Ministry of Health will develop an implementation strategy, in collaboration with Local Health Districts, to assist AIUs to adopt the recommendations and develop their services in line with the guidelines in the report. As noted above, this will include the development of a model of care manual to support state and local service planners, policy managers, and service managers in the development of new SMHSOP AIUs (in particular) and the review and improvement of existing SMHSOP AIUs. Related information resources for clinicians, consumers and carers will also be developed to better inform, engage and support them in the implementation of this model of care.

Introduction

In the context of an ageing population there has recently been an increased focus on the mental health of older people in NSW in health policy and service delivery. It has been recognised that mental health problems in older people are complex and specialist services are necessary in order to meet these complex needs. These specialist services need to cover the spectrum of community and inpatient care. They should be provided to older people and their families in an integrated way, in combination with primary health and aged care services, community support services, hospital services and the housing and residential aged care sectors.

The NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-15 [1] is a response to these issues. It sets out clear service models, structures, priorities and an implementation plan to guide staged developments in SMHSOP across NSW. The Service Plan outlines a SMHSOP service delivery model comprising five clinical service components: community teams; acute inpatient services; non-acute inpatient services; community residential services; and a model of care for older people with severely and persistently challenging behaviours, including Behavioural Assessment and Intervention Services (BASIS).

Phase One of *SMHSOP Service Plan* implementation has focused on the development of community SMHSOP teams and other community-based initiatives, in partnership with other key services. In this phase of service development, key initiatives have included:

- Enhancement of SMHSOP community teams
- Establishment of community-based staff specialising in clinical services and partnership activities with aged care services for older people with moderate to severe behavioural and psychological symptoms associated with dementia (BPSD) and/or mental illness
- Development of the Mental Health Aged Care Partnership Initiative (MHACPI) to support transition to long-term or community residential care for older people with moderate to severe behavioural and psychological symptoms associated with dementia (BPSD) and/or mental illness, in partnership with residential aged care providers.

A clinical service redesign project has also been undertaken to develop the Transitional Behavioural Assessment and Intervention Service (T-BASIS) Unit model of care in five existing non-acute inpatient units.

Phase Two of the *SMHSOP Service Plan* implementation focuses on service developments in acute and non-acute inpatient care and specialist rehabilitation and recovery programs, building on service development initiatives and policy development work in Phase One. The SMHSOP Acute Inpatient Unit Model of Care (AIUMoC) Project represents a body of work that will inform policy and support the further development of acute inpatient care in line with the priorities in Phase Two of the *SMHSOP Service Plan*.

There are currently SMHSOP acute or sub-acute inpatient units (AIU) in all former NSW Area Health Services (AHS), except the former North Coast AHS. It is expected that further SMHSOP AIUs will be developed across NSW over the next 5-10 years and that service improvement and redesign will be undertaken in existing units.

1.1 Purpose and Scope of the Model of Care Project

The purpose of the SMHSOP Acute Inpatient Unit Model of Care (SMHSOP AIUMoC) Project is to promote effective inpatient care and good practice in SMHSOP AIUs across NSW. The current units have been developed under a range of models of care. This project is intended to guide service improvement and service development in existing units and to inform planning for new units. It may also provide the basis for service review in existing units and post occupancy evaluations of new units. Ultimately, it is intended to support greater consistency and quality of care in SMHSOP AIUs across NSW. It addresses strategic priorities identified in the *SMHSOP Service Plan* and aligns with a range of other program developments across the service spectrum [1].

The development of a SMHSOP AIUMoC also supports priorities, principles and standards of care outlined in the *Fourth National Mental Health Plan 2009-2014* [7] and the *National Standards for Mental Health* [8]. This project has been undertaken in parallel with work in NSW on the *Mental Health Clinical Care and Prevention (MH-CCP)* planning model [9], the NSW SMHSOP benchmarking project [10], and the development of the NSW Health Mental Health Clinical Service Standards Project, as well as work to develop national Health Facility Guidelines for SMHSOP acute inpatient units [11]. It has both informed and been informed by these initiatives. The project will inform the Mental Health and Drug & Alcohol Office (MHDAO) Cost Benchmarking Project and a range of service planning, development and improvement processes across NSW.

The SMHSOP AIUMoC Project included a review of:

- Current models of care in SMHSOP acute and sub-acute inpatient units
- Management of sub-acute patients in SMHSOP acute and sub-acute inpatient units
- Post occupancy evaluations of recently established SMHSOP acute inpatient units.

This project did not include detailed examination of:

- Long stay and very long stay inpatient units
- Physical design of health facilities where this was not directly related to the model of care
- Very long stay patients in acute inpatient units
- The management of older people in general adult inpatient units
- Cost benchmarking analysis of acute inpatient units
- Models of leadership in acute inpatient units
- Models of integration with community mental health services.

The interfaces between acute inpatient units, sub-acute inpatient units, the T-BASIS Units (where they exist), and other key SMHSOP and non-SMHSOP services, are explored to some extent in this report. However, these service interfaces and functional relationships require further development on a state-wide and local basis. It should be noted that not all the recommendations contained in this report are applicable to existing sub-acute and non-acute inpatient units.

1.2 Methodology

The methodology for this project included:

- 1 A review of relevant policy and practice guidelines and the international literature.
- 2 Site visits and focus groups with SMHSOP AIU clinicians and managers to obtain information about current practice and models of care in SMHSOP AIUs, including strengths, key issues and advice, augmented with data obtained through the NSW SMHSOP Benchmarking Project (Phase 1) Report [10].
- 3 Consultation with an expert advisory group (EAG) of specialist clinicians, researchers and service and policy managers with expertise in older people's mental health (OPMH) and SMHSOP AIUs (see Appendix 1) regarding the report recommendations.
- 4 Consultation with former Area Health Service SMHSOP Clinical Coordinators (strategic planning and service development leaders) on the SMHSOP Advisory Group (see Appendix 1) regarding the service development guidelines in particular, and the project report as a whole.
- 5 Dissemination of the draft report for comment to NSW Local Health Districts (LHDs), relevant NSW Ministry of Health branches, the NSW Health Aboriginal Older People's Mental Health Working Group and the Culturally and Linguistically Diverse (CALD) Older People's Mental Health Working Group, the Commonwealth Psychogeriatric Expert Reference Group (PERG), peak mental health and aged health professional bodies, and NSW mental health carer and consumer organisations.

These key elements of the project methodology are reflected within the structure and content of the project report. It is important to note that each of the above stakeholder groups contributed very significantly to the final report, improving it considerably.

1.3 Policy Framework and Literature

The SMHSOP AIU MoC is underpinned by a range of national and state policy planning frameworks relevant to the mental health and wellbeing of older people. These include the following:

- *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015* [1]
- *Fourth National Mental Health Plan 2009-2014* [7]

- *Mental Health Clinical Care and Prevention Model (MHCCP)* [9]
- *Health Facility Guidelines - Australasian Health Facility Guidelines in NSW* [11]
- *Australian Charter of Healthcare Rights (PD2009_053)* [12]
- *National Partnership Agreement On Hospital And Health Workforce Reform* [13].

A search of the peer reviewed literature was undertaken as part of the project. The literature was searched utilising Medline (1950-2010), PsycINFO (1806-2009), EMBASE (1980-2009), Google Scholar and CINAHL (1982-2009). Search terms included 'mental health in older people', 'acute mental illness', 'service description', 'service partners', 'access', 'admission', 'discharge', 'interventions', 'safety', 'security', 'dementia', 'behavioural and psychological symptoms of dementia (BPSD)', 'challenging behaviours', 'staffing in mental health facilities', 'person-centred care', 'mobility in older people', 'delirium', 'seclusion', 'restraint', 'psychiatric', 'psychiatry' 'units', 'department', 'hospitals', 'ward', 'inpatient', 'model of care', 'environment', 'design', 'plan', 'aged', 'old age', 'geriatric', 'psychogeriatric', 'violence', 'visiting hours', 'performance', 'promotion prevention and early intervention'.

References were also drawn from those cited in key articles and policies. Data were obtained from the literature pertaining to general adult psychiatry units, geriatric or other relevant hospital settings, where there was limited information from studies of units designed for older people. Selected non-peer reviewed literature such as government reports and unpublished academic dissertations were also reviewed. A systematic review of the literature was impossible because of the diversity of the literature pertaining to SMHSOP AIUs and to their models of care. Randomised controlled studies comparing different models of care and assessing outcomes were virtually non-existent.

1.4 Focus Group Consultation

Focus groups and/or site visits were held in the following inpatient units across NSW:

- Miri Miri, Wyong Mental Health Centre, Wyong Hospital, Kanwal
- Audley Clinic, Bloomfield Hospital, Orange
- Mental Health Unit for Older People, Mental Health Centre, Waratah
- Catherine Mahoney Unit, St Joseph's Hospital, Auburn Aged Care Psychiatry Ward, Braeside Hospital, Prairiewood
- Ward C4B, Westmead Hospital, Westmead
- Euroa Unit, Prince of Wales Hospital, Randwick
- SMHSOP Inpatient Unit, Wollongong Hospital, Wollongong
- Mental Health Unit, St George Hospital, Kogarah
- David Morgan Unit, Kenmore Hospital, Goulburn
- East Wing Psychogeriatric Unit (PGU), Manly Hospital, Manly
- Riverglen Unit, Greenwich Hospital, Greenwich
- Ward 2D, Aged Care Psychiatry, Bankstown-Lidcombe Hospital, Bankstown
- Jara Unit and Ward 17, Concord Hospital, Concord

Significant numbers of older people are managed under the care of psychiatrists of old age in a number of general adult mental health inpatient units. St George Hospital was included as a comparative example representing this alternative model of care. The Lindsay Madew Unit, Hornsby Hospital and the Mental Health Unit, Sutherland Hospital, were not visited and should not be assumed to have similar models of care. Most general adult mental health inpatient units also admit older people under the care of general adult psychiatrists. None were visited as part of this project.

Two current SMHSOP inpatient units are classified as a 'sub-acute' unit but were included because of similarity in functioning and role to the acute units. Ward 2D, Aged Care Psychiatry, Bankstown-Lidcombe Hospital and Ward 17, Concord Hospital are managed by Aged Care and Rehabilitation and were included due to their interfacing role with SMHSOP acute units.

A suite of questions (see Appendix 2) was developed, for use within the focus groups. These enabled the project team to identify elements which contribute to service delivery within each unit, as well as to determine the level of support provided by other mental health services, aged care services and other agencies. The questions facilitated discussions about current models of care and the complex nature of service provision within each facility through the interactions of participants. The information gathered from these discussions was collated and integrated with collateral sources (e.g. benchmarking data) to more fully understand advantages, disadvantages and performance of the service delivery models of individual units.

Focus group participants included senior managers, nurse unit managers and other relevant nursing staff, SMHSOP clinical coordinators, psychologists, occupational therapists, social workers, consumers, psychiatrists and junior medical officers from rural, regional and metropolitan settings. Not all relevant informants were available at each site, but there was broad representation in most sites. On occasion, mental health directors, clinical directors and nurse managers were also in attendance. Older consumer and/or carer representation at each of the focus groups was minimal. This reflected under-representation by this cohort in general within SMHSOP policy and practice development processes. However, those who did attend the focus groups provided key insights into the delivery of care from the older consumer and carer perspective.

The focus groups were of two hour duration, with the majority of the participants attending in person. A small number of participants utilised teleconferencing to contribute to the focus groups. Dr John Dobrohotoff, OPMH Clinical Advisor, MHDAO OPMH Policy Unit facilitated the groups, supported by the Policy Officer, OPMH Policy Unit. The project team clarified issues raised and facilitated open communication between participants.

No unit had comprehensively documented a model of care. There were, however, policies and procedures which addressed some of the key elements in some units (e.g. admission and discharge policies).

1.5 Purpose and Scope of this Report

This report is intended to guide service improvement and service development in existing units and to inform planning for new units. It contains detailed information regarding the current published literature and policy documents relevant to SMHSOP AIUs, along with a description of the current range of service models and practice in SMHSOP AIUs.

Based on this information, and on expert consensus, it provides recommendations regarding good practice in relation to the key components of a SMHSOP AIU model of care, as well as service development guidelines to inform service planning and service development (recognising that service development may occur over an extended period of time and implementation of the model of care will require consideration of local service context and other factors).

The key components of the SMHSOP model of care covered in the report are:

- Philosophy of care, functions and target population
- Comorbid disorders and problems and end of life care
- Functional relationships, location and other operational arrangements
- Key processes
- Clinical interventions
- Seclusion and restraint
- Facility design issues
- Staffing
- Performance.

To accompany this more detailed project report (which will remain a key OPMH policy document), a summary SMHSOP AIU MoC manual will be developed as a practical resource to support state and local service planners, policy managers, and service managers in the development of new SMHSOP AIUs (in particular) and the review and improvement of existing SMHSOP AIUs. Importantly, NSW Health will develop a statewide implementation plan in collaboration with LHDs to guide implementation of the recommendations and basic service development guidelines in this report. It is envisaged that this will be complemented by further cost benchmarking work, particularly regarding the staffing and resources required to allow implementation of the recommendations and service development guidelines. It is expected that this will be accompanied by processes to allow services to audit and benchmark their performance in relation to this MoC.

Philosophy of Care, Functions and Target Population

2.1 Philosophy of Care

Literature and other expert consensus

The principles and values that underpin the development of SMHSOP are outlined in the *NSW SMHSOP Service Plan* [1] as follows:

- Promote independence, dignity and quality of life for older people with mental health problems, their families and carers
- Embrace diversity in older people
- Respect the rights of individual older people and their families and carers, and their goals in accessing care
- Respond to the needs of priority population groups
- Promote a holistic and multidisciplinary approach to care
- Take a flexible approach
- Support continuity of care for older people with mental health problems [1, p4].

Current literature increasingly recognises the need for person-centred rather than task-centred approaches that focus on the consumer's values and interests, as well as environmental and cultural aspects [14], in meeting the health care needs of clients. The SMHSOP AIU core principles of care are consistent with a person-centred care approach.

Person-centred care considers each person's needs and preferences from a holistic perspective that includes associated relationships and the impact that other people, practices and/or the physical environment may have on the individual [14]. It focuses on the wellbeing of the individual, as well as addressing ill health by acknowledging that each person is unique, regardless of any illness they have. This philosophy also values the personhood of others who interact with the individual.

Individuals are both unique and complex and there are many factors that influence the way each person views the world and responds to it. These include any relationships with other people and the impact these may have on the person, as well as the impacts that the physical environment and work practices may have on the individual [14].

Carer consultation for this project highlighted that admission to an inpatient unit removes a person from their normal environment to a managed environment in which they have less control, are in the company of strangers and are cared for by strangers. Maintaining comfort, confidence and hope for the future may be challenging for both the patient and their family in this situation. Maintaining basic rights such as the right to privacy, personal secrets and dignity may be particularly challenging when older people enter hospital settings. In order to provide person-centred care, staff need to be empathic and attuned to these basic needs. As people age, they often accept the aches that they carry with them without complaint. Older people should be treated with respect and without judgement within the AIU and in clinical processes such as care conferences.

Factors that contribute to person-centred care include enabling the person and their family and/or carers to recognise the strengths and abilities that the person has. This approach will allow staff to utilise older consumers' strengths and abilities effectively whilst an inpatient. Person-centred care also includes respecting and valuing the individual as a full member of society, providing individualised places of care that are in tune with people's changing needs and understanding the perspective of the person [15].

Person-centred care is proposed here as the cornerstone of service delivery within the SMHSOP AIU that should underpin the care that is delivered to the older person while an inpatient. This approach also ensures that the services are delivered in collaboration with the older person and their family and/or carers, [1] and takes into consideration the patient's desire for information regarding their care. It also means sharing the decision making with the patient, their family and/or carers [16].

Person-centred care approaches are influenced by the person's cultural and social contexts. Person-centred care approaches for an older Aboriginal or Torres Strait Islander person may be influenced by their connectedness to family, community and Country; their role within family and community, particularly the significant

and special place an older Aboriginal and Torres Strait Islander person may have within one or many communities; and the significant sense of loss, grief and trauma from past and current events that many Aboriginal and Torres Strait Islander people experience. The recently released *Aboriginal Older People's Mental Health Project Report* [17] and *Communicating Positively* [18] provide additional assistance in understanding key principles of service delivery and respectful communication with older Aboriginal and Torres Strait Islander people.

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, loneliness and for those who do not have extended family networks for support, are ageing in an unfamiliar cultural environment, and/or are experiencing grief, loss, shame and stigma associated with migration or displacement.

Further information for implementing person-centred care is available in recognised standard manuals such as *'Person-centred care: making services better'* [19]. Whilst there will always be individual variation, there is evidence that as consumers age they may not, as commonly thought, wish to have a more passive role in decision making [20].

The *National Standards for Mental Health Services* (2010) [8] recommend that mental health services incorporate recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery [8]. However, some older people may be suffering with progressive degenerative conditions, and be progressing towards decline, frailty and lessening of independence. Recovery is a concept that requires adaptation in older people but is closely aligned to person-centred care [8]. From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self [8]. "It is important to remember that recovery is not synonymous with cure.

Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services" [21].

As the majority of older consumers will have multiple potential needs, recovery entails allowing the consumer, in collaboration with their clinicians and families/carers, to identify their goals. The SMHSOP AIU model of care should include clear collaborative goal setting with the older consumer (and family/carer, as appropriate), and measurement of attainment of these goals. Different methods have been described for such goal focused monitoring [22, 23].

Older people with mental health disorders also have high rates of physical health conditions, cognitive impairment, family members with carer stress and face significant social and financial challenges. While they are in a SMHSOP AIU, consumers may prefer to consult their usual general practitioner (GP) in regard to inter-current physical health problems and this should be supported, possibly utilising video or telemedicine, where appropriate. Access to GP assessment and management should augment, rather than replace, other medical assessment and management.

Some consumers will be under the care of a private psychiatrist before and/or following an admission to the AIU. It is important to recognise that the care provided in the community either from private psychiatrists or public community psychiatrists working within a community mental health team usually occurs over a much longer period than the inpatient care. Person-centred care means that the views of such providers should be carefully considered by the staff of the SMHSOP AIU.

Normal ageing processes may require a slower paced approach to the care of the older person. Services should allow for this slowing without criticism or impatience. For example, this may include the consideration of the effects of poor dentition in this population by allowing extra time for meals. Person-centred care must support not only the mental health needs of the target population but also these other relevant needs in the biopsychosocial domains [22].

Current Practice

There was little explicit discussion of person-centred care in NSW SMHSOP AIUs in the focus groups for this project. One unit nominated this philosophy as the basis of their service delivery model but few participants appeared familiar with the concept. None gave examples of individualised 'places of care' or processes designed to utilise older consumers strengths and abilities.

The degree to which individual units are able to provide a broad range of biological, psychological and social interventions is addressed in the 'Interventions and Staffing' sections of this report. There was no evidence that current SMHSOP AIUs were providing care that was restricted to a narrow range of purely physical or biological interventions or limiting care to passive 'caretaking' or 'custodial' approaches.

2.2 Functions

Policy and literature

The function of the SMHSOP AIU is to provide appropriate facilities for the reception, multidisciplinary assessment, admission, diagnosis and treatment of older people presenting with known or suspected psychiatric conditions and behavioural disorders along with assessment of physical health and psychosocial issues. Episodes of care are usually precipitated by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self or others. Clients may have no previous history of psychiatric illness or may be individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of clinical symptoms that cannot be managed in the community [1]. In a unit which has been declared as a mental health facility within the meaning of the *NSW Mental Health Act* (MHA) [3], patients may be admitted on a voluntary or involuntary basis.

Treatment is focused on clinical symptom reduction with a reasonable expectation of considerable improvement in the short term [1]. Inpatient treatment can also contribute to the prevention of chronic institutionalisation by ensuring that patients receive appropriate treatment, rehabilitation and re-socialisation [11]. Multidisciplinary assessment may assist with early identification and treatment of both acute and chronic problems and prevent functional decline and delays in discharge.

Research and policy clearly articulates the importance of, and expectations for, delivering culturally competent mental health services. Cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable the system, agency or those professionals to work in cross cultural situations (24). A culturally competent system is one that is aware of its cultural world view, assumptions and biases; has a positive attitude towards cultural differences and demonstrates cross-cultural communication skills; is conscious of the dynamics that occur when culture interacts; and adapt service delivery to reflect an understanding of the diversity between and within cultures (24).

Consultation with carers highlighted that another potential function of the AIU is to assist older consumers and their families in the process of reconciliation. Personal relationships, particularly marital relationships, often suffer during an episode of mental illness. This may be especially important to address in older people as this is a time when outside activities can become difficult to sustain, mobility suffers and old friends pass away. When an older couple rely on their own company to be happy together and an episode of mental illness disrupts the relationship, reconciliation is an essential step in recovery.

It is not clear how effective the acute hospital treatment of mental disorders is in old age. There is lower quality (level III/IV), albeit consistently positive, evidence that acute hospital treatment by old age psychiatry services is effective. Overall, the majority of consumers are reported to make significant symptomatic improvement during hospitalisation with 82-86% globally improved at discharge. However, which mental disorders are best treated in hospital or community settings has not been adequately addressed in research [25]. Analysis of all HoNOS 65+ data reported in Australia to the Mental Health National Outcomes and Casemix Collection (MHNOCC) data set from 1 July 2006 to 30 June 2009 found that 70% of consumers had a change score of 4 or more between admission and discharge on the HONOS65+ acute focus of care item. This meets the accepted threshold for significant change [26].

Options for acute inpatient treatment depend on the population size and needs of the catchment area, the infrastructure, workforce and resources of the area, and the area's Mental Health Clinical Services Plan [1].

Older consumers require equitable access to services based on clinical need, within an appropriate time frame, regardless of religious or cultural beliefs, marital status, disability or gender. They have a right to be cared for in a safe environment and to expect themselves, their family, friends and carers to be treated with dignity and respect, as well as the right to receive information regarding treatment options and services [27].

Older consumers also have the right to be involved in decision making and choices regarding care and are encouraged to participate in decisions about their ongoing health care needs. Older consumers are asked to nominate a carer who is to be informed of admission and discharge. Older consumers who are unable to consent to their assessment or treatment may be admitted under the *NSW Mental Health Act* [3] or *NSW Guardianship legislation* [28]. Access to interpreter services for older consumers that prefer to speak a language other than English is imperative (29).

Staff in the SMHSOP AIU are required to maintain confidentiality regarding health care and to ensure information is shared with other health care providers only with the consumer's consent. The patient also has the right to provide comment on any aspect of care and expect that concerns will be addressed at the appropriate level [29].

Further information concerning the rights of consumers and others using the Australian health system may be found in the *Australian Charter of Healthcare Rights* [12]. The Charter recognises that "people receiving care and people providing care all have important parts to play in achieving healthcare rights which allows patients, consumers, families, carers and services providing health care, to share an understanding of the rights of people receiving health care". It also recognises the importance of developing partnerships with those who access health care in NSW public health facilities. These rights help to ensure that, wherever and whenever care is provided, it is of high quality and is safe [29].

SMHSOP roles may also include the provision of consultation-liaison services to older people admitted to other hospital settings. The core inpatient consultation-liaison role of SMHSOP lies in assisting in the management of older consumers known to the service and in supporting staff of adult mental health and geriatric medical wards (or their equivalents

in rural areas) in managing older people with mental health disorders [1]. The *SMHSOP Service Plan* [1] does not specify how consultation and liaison are delivered or by whom as this is a local operational issue.

Current Practice

In general, the current SMHSOP AIUs in NSW do provide the above functions. However, they do so in quite different ways. The *NSW SMHSOP Benchmarking Project (Phase One) Report* [10] highlighted that SMHSOP AIUs across NSW have developed under a range of models of care. The site visits confirmed significant variations in the current models of care between the different AIUs. The most significant of these are briefly outlined here. It was notable that, in general, participants were very satisfied with the model of care and functions provided by their own SMHSOP AIU.

Fourteen of the fifteen units visited have now been 'declared' as mental health facilities within the meaning of the MHA. One unit cannot admit involuntary patients and does not have the protections for patients and their carers' rights which are enshrined in the MHA. All units may detain patients under the *NSW Guardianship Act* [28].

Currently, there remains significant inequity in access to SMHSOP AIUs across NSW, although this has been improved through developments under the *SMHSOP Service Plan*. Overall, the numbers of SMHSOP AIUs are below MH-CCP estimated need and these units are not evenly distributed across the state. Six LHDs do not have SMHSOP AIUs: Far West; Northern; Mid North Coast; Murrumbidgee; Nepean Blue Mountains; and St Vincent's and Mater Health Sydney. One entire former Area Health Service region (now the Mid North Coast and Northern NSW LHDs) does not have a unit.

Some units either exclude or admit few older consumers with Behavioural and Psychological Symptoms of Dementia (BPSD). Units have different approaches to the management of BPSD, with high variability noted in the types of restraint and the rates of restraint in different SMHSOP AIUs. Some units do not have ECT availability and require older consumers to be transferred to an alternative unit for this treatment. These units had low utilisation of ECT. A more detailed examination of these variations, along with recommendations for improvement, is provided below.

Mental health promotion, prevention and early intervention (PPEI) are mostly provided via community models rather than through acute inpatient services. However, AIUs do have a role in PPEI given they often represent the public face of mental health services and provide opportunities for prevention that are sometimes more accessible for families and carers. This may include psychoeducation or other supportive interventions with carers who are at high risk of mental illness. SMHSOP AIUs can also have a role in secondary prevention for older consumers, such as preventing decline in physical or social functioning during admission.

SMHSOP AIUs in NSW also provide functions that are more consistent with non-acute care or very long stay. There are very few designated SMHSOP inpatient beds that cater for older consumers requiring longer periods of care of a less acute nature. Defining the role and functions of non-acute SMHSOP inpatient units is outside the scope of this project. Nevertheless, the availability and configuration of such units will impact significantly on the functioning of SMHSOP AIUs.

Mental health consultation and liaison (CL) services to non-mental health hospital settings are organised differently within different services. In general, specialist (non-SMHSOP) CL clinicians and teams provide CL services across the age spectrum during business hours. In some cases SMHSOP clinicians provide CL services to specific units, such as acute geriatric units, or as a 'second opinion' for the general CL team. These clinicians are often community based, working within a community SMHSOP team, in line with the *SMHSOP Service Plan* [1]. Usually these clinicians have limited availability to respond to an acute episode and SMHSOP clinicians are available to provide advice after hours in very few hospitals. There is potential for the SMHSOP AIU to augment existing CL services through the provision of expertise with regard to mental health problems in older people.

Finally, it is not known to what degree care provided in SMHSOP AIUs is of high quality or safe. All SMHSOP AIUs are, however, subject to accreditation via the Australian Council on Healthcare Standards (ACHS), and are required to comply with a range of policies and procedures to support quality and safety, and promote quality improvement.

2.3 Target Population

Policy and literature

The *NSW SMHSOP Service Plan* [1] defines the SMHSOP target population as older people (65 years and over) who:

- Develop, or are at high risk of developing, a mental health disorder at the age of 65 years and over, such as depression, acute psychosis, anxiety, late onset schizophrenia or a severe adjustment disorder
- Have had a lifelong or recurring mental illness, and now experience age-related problems causing significant functional disability (i.e. become 'functionally old')
- Have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by SMHSOP
- Present with severe behavioural or psychiatric symptoms associated with dementia (BPSD); or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others.

Older consumers with severe BPSD requiring admission to a SMHSOP AIU may have depression, anxiety, aggression, agitation, hoarding, wandering, vocally disruptive behaviour, be sexually disinhibited, or have a tendency to abscond. Younger people who develop functional disorders normally associated with ageing, primarily those with 'younger onset dementia' may also be appropriately admitted to the SMHSOP AIU in some circumstances [30, 31].

The life expectancy of Aboriginal people in NSW is, on average, 20 years less than the general population, and Aboriginal people are affected by the early onset of diseases and conditions usually associated with old age. In this context, planning and service delivery for SMHSOP (consistent with aged care planning and service delivery) targets Aboriginal people 50 years and over [1].

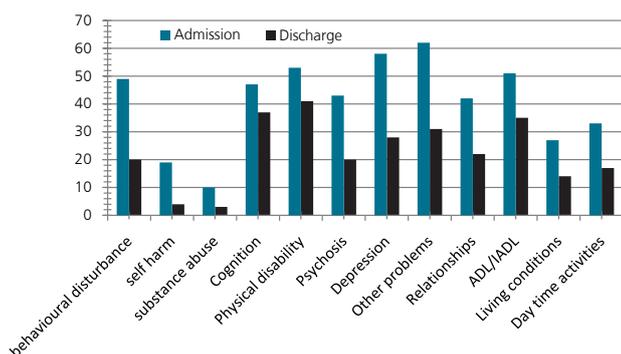
To meet the mental health needs of older Aboriginal people, it will be important to improve the responsiveness and appropriateness of both mainstream and Aboriginal mental health services.

As aged care services are targeted to this population from the age of 50 years, SMHSOP AIUs should be able to provide care to Aboriginal people from the age of 50 years if they identify themselves with the older population and/or the specific needs of older consumers. This should not preclude this population from accessing mainstream mental health units if this is most appropriate for their needs [1].

The families and carers of older people are also included in the *NSW SMHSOP Service Plan* as part of the broader target group for SMHSOP. Families and carers require skills, resources and support to carry out the role of caring for older people with mental health problems. Clinicians need to consider the mental health aspects of the carers, being alert to indications that they may be experiencing difficulties in navigating a complex health system. This may be due to a lack of understanding of symptoms and lack of appropriate information on mental health conditions associated with old age [1].

NSW data extracted from national benchmarking data (see Figure 3 below) regarding the disability levels of older people within inpatient mental health care indicates high levels of cognitive, physical and functional disability; but also that the majority of older consumers do not have major levels of such disability. There is little policy or literature to indicate if or when older people with lifelong or recurring mental illness but without age related problems causing significant functional disability should be admitted to a SMHSOP AIU in preference to a general adult Mental Health AIU.

Figure 3
Percentage of NSW consumers admitted to inpatient mental health care in financial years 2006-09 with HoNOS65+ items scores of 2 or more [10]



Current Practice

Generally SMHSOP AIUs accept for admission all people aged 65 years and older who are within their target population. One unit does not accept older consumers who have had the onset of their mental illness prior to age 65. Most units generally accept younger people with age-related disorders when beds are available.

Younger people without age-related disorders are usually excluded but many SMHSOP AIUs accept overflows of consumers due to lack of available adult mental health beds. Consumers in this category are referred to as 'sleepovers' when the SMHSOP AIU provides overnight care but the consumer is otherwise managed in an adult acute inpatient unit during the day. This practice impinges on continuity of care, increases risks to both the younger patient and older consumers, and impacts on the access of older people to the SMHSOP AIU.

Some focus groups reported that families and carers were dissatisfied when younger and older consumers were admitted together. Some families fear that younger patients may be dangerous.

Problems also sometimes arise when older people with chronic mental illness, usually managed by adult mental health community services, are admitted into SMHSOP AIUs. Some focus groups felt that clinicians in the adult acute units had greater expertise in the management of these older consumers than the SMHSOP clinicians. When these older consumers are admitted to the SMHSOP AIU there is a common expectation that they will be case-managed by SMHSOP community services once discharged from the AIU. In at least one service, older people admitted to the adult acute unit are referred to adult mental health services for follow up on discharge, regardless of their clinical presentation. Generally the links between SMHSOP AIUs and adult mental health services are not as strong as they should be.

In general, the mix of older people with acute symptoms of mental illness and/or BPSD with adult acute mental health patients was identified as an issue which creates dissatisfaction among staff. In a general adult inpatient unit it is a challenge to provide an environment that meets the needs of both older people and other adult consumers. However, anecdotal information suggests that some older people prefer to be managed in general adult mental health AIUs.

Table 1 (below), summarises the diagnostic and age profile of patients in 2007/08 in the 7 SMHSOP AIUs participating in the NSW SMHSOP Benchmarking Project [32].

Depression was the major diagnosis for consumers separated in the 2007/2008 year from these SMHSOP acute inpatient units. This group accounted for 32.1% of the consumer population across the cohorts from ages 61-95 years. Affective disorders (excluding depression) comprised an additional 12.8% of the population. The next largest diagnostic groups were consumers with a primary diagnosis of schizophrenia (17.5%) and dementia, presumably with BPSD (17.1%). Note that BPSD does not have a separate code within mental health reporting systems and patients with BPSD might have been also be coded in a number of other categories. Coding issues with BPSD mean that it is likely to be under-reported as the primary issue needing care in these statistics. It should also be noted that the above table refers to the primary diagnosis and most patients in SMHSOP AIUs have additional comorbid psychiatric and medical diagnoses.

The different age profiles of the diagnostic groups reflect both the course and onset of particular illnesses and the demography of the general population [32].

All focus groups agreed that older consumers with delirium in the absence of other mental disorders do not meet the criteria for admission to the SMHSOP AIU and should be managed in medical settings. However, older consumers with a primary diagnosis of delirium are admitted inadvertently from time to time because of incorrect initial diagnosis.

If a older consumer develops a delirium during admission, complicating a primary mental health disorder, this is usually managed within the unit, with support from geriatric or other medical or surgical services within the hospital, as required. Some units have limited access to support services, especially those lacking an aged care medical ward within the main hospital or those not co-located on the site of a general hospital.

Table 1
SMHSOP AIU Diagnosis by age group Financial Year 2007/2008

Diagnosis	Age ranges (percent)							Total number	Primary diagnosis
	61 - 65	66 - 70	71 - 75	76 - 80	81 - 85	86 - 90	91 - 95		
F32-f33 depression	4.8	20.0	25.5	16.6	18.6	11.0	3.4	163	32.1
F30,f31,f34,f38,f39 affective disorders	16.1	25.0	33.9	16.1	8.9	0.0	0.0	65	12.8
F20-f29 schizophrenia	15.1	26.0	21.9	20.5	13.7	2.7	0.0	89	17.5
F00-f03,g30 dementia	6.0	10.8	20.5	28.9	21.7	8.4	3.6	87	17.1
F40-f48 neurotic, stress related disorders	0.0	26.3	10.5	31.6	10.5	10.5	10.5	23	4.3
F04-f09 symptomatic mental disorders	5.3	10.5	15.8	31.6	15.8	5.3	15.8	21	3.9
F10-f19 mental disorders due to substance abuse	11.1	33.3	22.2	33.3	0.0	0.0	0.0	10	2.0
F50-f59 behavioural syndromes	0.0	0.0	0.0	0.0	0.0	100.0	0.0	1	0.2
F60-f69 personality disorders	0.0	50.0	50.0	0.0	0.0	0.0	0.0	2	0.6
F99 mental disorder not specified	0.0	0.0	0.0	0.0	0.0	66.7	33.3	6	1.6
Others (non-mental health diagnosis and no diagnosis entered)	9.7	6.5	19.4	32.3	9.7	19.4	3.2	38	7.5
Z rehab codes	0.0	0.0	0.0	0.0	100.0	0.0	0.0	2	0.4
Total	8.4	19.0	23.3	21.9	15.6	8.4	3.4	508	

Management of BPSD

The focus groups had differing views regarding the admission of people with BPSD into SMHSOP AIUs, with opinion divided on whether these consumers should be admitted at all. However, the majority of participants agreed that management of BPSD required specialist knowledge and skills and could be managed within a SMHSOP AIU if there was separation from older consumers with functional mental illness.

There appear to be five (5) different models currently operating for the management of BPSD. These are outlined below:

1. Exclusion of people with BPSD
2. Admission of people with dementia/BPSD and people without dementia to a single mixed unit
3. Admission of people with dementia/BPSD and people without dementia into a dual unit with capacity for functional separation
4. Minimal admission of people with dementia/BPSD and occasional long term specialising of older consumers with BPSD
5. Minimal admission of people with dementia/BPSD and referral to alternative settings such as T-BASIS Units and adult mental health units (for aggressive patients) wherever possible.

The focus groups from AIUs which excluded BPSD cited the layout and design of the building, inadequate access to outdoor areas, the inability to segregate older consumers with BPSD from frail vulnerable older consumers with other disorders, lack of staff with the necessary specialist skills, experience or interest in this area, lack of appropriate ward programs, local policy and the availability of alternative inpatient facilities as reasons for excluding this cohort of consumers. Some stated that most consumers with BPSD could be managed in community settings. This includes Residential Aged Care Facilities (RACF) including dementia-specific hostels, with SMHSOP/ Behavioural Assessment and Intervention Service (BASIS)/ Dementia Behaviour Management Advisory Service (DBMAS) or Aged Care management, and this approach had advantages in sustaining consistent management plans. Long term specialising for the management of very difficult older consumers was also utilised as a strategy to ensure the safety of staff and consumers. However, attendees at the focus groups reported that this was not sustainable due to cost constraints.

Data derived from the NSW SMHSOP Benchmarking Project did not necessarily reflect stated policy and practice of individual SMHSOP AIUs. Some units which reported excluding older consumers with BPSD had significant proportions of older consumers with dementia as a primary diagnosis. This may be a result of poor data quality.

Older consumers with BPSD were sometimes admitted into the SMHSOP AIU even when there was a T-BASIS unit located nearby. In some cases, the local adult mental health acute inpatient unit or the aged care (geriatric) unit admitted older consumers with BPSD in preference to the SMHSOP AIU. Facility design, capacity, current models of care and safety factors contributed to this approach. Some AIUs identified resource constraints which impinged on their ability to manage BPSD. The classification of sub-acute units that had high rates of admission of older consumers with BPSD was problematic as these units were not adequately resourced to manage increased acuity levels in older consumers with challenging behaviours due to their classification.

As outlined above, strategies that services utilise to manage older consumers with BPSD in order to minimise or avoid admission to the SMHSOP AIU include:

- Management in situ through SMHSOP BASIS and DBMAS teams
- Admission to T-BASIS units
- Admission to adult mental health units if the person is aggressive. Sometimes such older consumers are discharged early to suboptimal settings (e.g. an inadequately resourced or skilled RACF). In some LHDs they are managed in geriatric medical and/or aged care settings.

Focus groups which reported that older consumers with and without dementia were admitted into a single mixed unit reported increased use of restraint. Units with limited outdoor space reported difficulties associated with the management of older consumers with BPSD and this was felt to influence the amount of restraint used in these facilities.

Units which had the capacity to functionally separate older consumers with and without dementia into a dual unit reported this model was effective in the management of BPSD and other challenging behaviours. Staff felt that the availability of better outdoor areas reduced the need for restraint use.

The adult mental health unit which had dedicated SMHSOP beds outlined difficulties associated with the admission of older consumers with BPSD, reporting this model was not ideal due to the patient mix and lack of resources appropriate to manage the needs of older people. It was also reported that these beds were utilised to accommodate adult admissions on a regular basis due to lack of beds in the adult setting.

The units which accepted older consumers with BPSD generally had some sort of secure area. The majority of units were locked at the entrance. However, two units could separate older consumers with functional mental illness from those with organic disease and were able to keep doors unlocked in one end of the unit.

Units that had admitted older consumers with BPSD but did not have appropriate settings or programs to manage them reported that discharge to a more appropriate facility was often delayed. It was reported that this had a negative impact on overall length of stay and was associated with significant over use of restraint.

One LHD commented that the best service configuration for meeting the needs of people with severe BPSD is a combination of an AIU with capacity for functional separation of people with BPSD and a Special Care Unit/ Program within a RACF. One LHD reported that the limited number of SMHSOP AIU beds available meant that there was limited capacity to manage people with severe BPSD within mental health units.

2.4 Exclusion Criteria

Policy and literature

Delirium is a common presenting symptom of almost any medical and surgical disease in frail older people and is often unrecognised. It is a complex clinical syndrome characterised by disturbed perception, behaviour and cognitive function and can be difficult to differentiate from BPSD [33]. Delirium has high morbidity and mortality [34] and is considered a medical emergency [35].

This condition is often unrecognised or misdiagnosed and is commonly mistaken for dementia, depression, mania, or a primary psychotic disorder in older people. In some settings up to 42% of referrals into an acute mental health unit for a depression may be due to delirium [35]. A sudden decline in the ability to perform activities of daily living is an indicator of possible delirium [36].

The *NSW Dementia Services Framework 2010-2015* [37] recommends that there be agreed pathways of care for individuals with cognitive impairment through ED, acute and sub-acute care for all hospitals. It is suggested that services develop purpose-built inpatient acute behavioural units for people with delirium/dementia and behavioural difficulties. The Framework emphasises the need for effective collaboration between aged care services and SMHSOP.

Current Practice

The majority of focus groups felt that delirium in the absence of other mental disorders did not meet the criteria for admission to any current SMHSOP AIU and that older consumers presenting with delirium should be excluded due to an inability to properly manage the physical condition. Reasons for being unable to safely manage the condition included lack of access to medical services, lack of staff expertise in managing the condition and lack of an appropriate environment to manage these older consumers.

Inadequate nurse to consumer ratios were also cited as a reason not to accept older consumers with delirium due to the increased strain which this condition places on staffing levels. Some units have limited access to the necessary support services, especially those lacking an aged care medical ward within the main hospital or those not co-located on the site of a general hospital. However, most SMHSOP AIUs reported that patients with a primary diagnosis of delirium are admitted inadvertently from time to time. If a consumer developed delirium during admission it was usually managed within the unit, with support from geriatric or other medical or surgical services within the hospital as required.

Pressure from medical services to accept older consumers with challenging behaviours also resulted in inappropriate admission of consumers with delirium. It was reported that when a medical cause or causes for delirium had been established it often remained difficult to transfer older consumers to an appropriate medical setting for further care. SMHSOP AIUs employed a variety of strategies to avoid this outcome and often delayed admission of consumers with undifferentiated diagnoses until this was clearer.

Most AIUs had little or no access to acute behavioural units designed for the assessment and management of consumers with BPSD of unclear aetiology.

Some units excluded some consumers 65 years or older on the basis that they were most appropriately managed by adult mental health services and this is consistent with the NSW SMHSOP Service Plan [1]. These older consumers tended to have adult onset disorders and/or primary psychotic disorders, and limited access to a SMHSOP AIU, either because of geographic factors or because available beds were in scarce supply.

2.5 Recommendations: Philosophy of Care, Functions and Target Population

Philosophy of Care

1. SMHSOP AIUs Units will adopt a person-centred, biopsychosocial philosophy of care, and ensure that care environments, processes and practices reflect this philosophy.
2. Service delivery will be focussed on the principles of recovery - including individualised care based on the consumer's own goals, seamless service provision and working with older consumers on addressing the determinants of their mental health. Care will be provided in partnership with the person's carers. Contact with carers should be made as soon as possible following admission and always occur within seven days of admission.

Function of the SMHSOP AIU

3. The SMHSOP AIU will be part of the continuum of care for the SMHSOP target population that covers the following clinical service components: ambulatory community care services (performing a range of functions including promotion, prevention and early intervention); sub-acute and non-acute inpatient care services; and community residential care services. The functions of the SMHSOP AIU must be provided with reference to this spectrum of care and SMHSOP AIUs should have links to other key services. SMHSOP AIU functions may be delivered by a single specialist unit or a unit with other functions.
4. The primary functions of the SMHSOP AIU are:
 - Multidisciplinary assessment of older consumers and their supports, and appropriate care planning
 - Involvement of carers, if so desired, as a part of care planning and provision
 - Promotion of recovery and prevention of secondary morbidity
 - Provision of mental health interventions that cannot be provided outside the acute inpatient setting
 - Treatment to achieve a reduction in acute mental health symptoms and related behaviours
 - Assessment and management of acute risk
 - Clinical review
 - Planning for transfer to less intense care that maintains continuity of care.

5. This must be accompanied by:
 - Management of relevant comorbid conditions as required to achieve the above goals to improve, or at least maintain, existing levels of function
 - Facilitation of reconciliation in important relationships
 - Ongoing monitoring and improvement of practice and performance
 - The development of appropriate consultation-liaison services to other inpatient services in the LHD that manage older consumers who are within the NSW SMHSOP Service Plan target population. This includes engaging Aboriginal and multicultural specific services to facilitate culturally competent assessments, treatment and care planning
 - Management of, and compliance with, relevant legislative requirements
 - Appropriate education, training and/or research activities.
6. Transfer of care from the SMHSOP AIU will occur as soon as feasible. Usually transfer will be to community care (including residential care), but may also be to other acute inpatient care, or sub-acute or non-acute inpatient care:
 - when function remains impaired after improvement in acute symptoms
 - if, after 35 days of care, there are ongoing symptoms and/or behaviours that require extended inpatient care to enable the consumer to return to the community, and this care can be provided outside of a SMHSOP AIU.
7. SMHSOP AIUs must be able to manage voluntary and involuntary patients under the NSW Mental Health Act; and be able to support appropriate hearings and inquiries.

Target Population

8. The primary target population for SMHSOP AIUs comprises older people with acute, severe clinical symptoms that have the potential for prolonged dysfunction or risk to self or others, who:
 - Develop or are at high risk of developing a mental health disorder at the age of 65 years and over, such as depression, psychosis, anxiety or a severe adjustment disorder
 - Have had a lifelong or recurring mental illness, and now experience age-related problems causing significant functional disability (i.e. become 'functionally old')
 - Have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by SMHSOP
 - Present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include: depression, severe physical and/or verbal aggression, severe agitation and psychosis
 - Aboriginal people aged 50 years who develop, or are at high risk of developing, a mental health disorder and identify themselves with the older population and/or the specific needs of older consumers.

SMHSOP will not generally provide services for older people with a primary diagnosis of drug and alcohol disorder or delirium, as drug and alcohol services and geriatric medical services respectively have the primary expertise and responsibility for managing these clients. However, SMHSOP will exercise appropriate flexibility in providing assessment for older people with complex and unclear aetiology. This includes, for example, people with an intellectual disability. It is important to note that *Ageing, Disability and Home Care (ADHC), NSW Department of Family and Community Services* has primary responsibility for the care and support needs of people with an intellectual disability. SMHSOP services may be provided through a consultation liaison model, for example, to an alcohol or other drug (AOD) or ADHC setting.
9. Local prioritisation of older consumers for admission to SMHSOP should include consideration:
 - of the availability within the LHD of alternative service options for this population
 - that some older people may prefer to be managed in adult mental health AIUs
 - that some older people may be more appropriately managed in adult mental health AIUs.
10. The families and carers of these older people are also part of the broader target group for SMHSOP
11. It is preferable that SMHSOP AIUs are designed and staffed for the acute management of both severe BPSD and other mental health disorders. This should be seen as complementary to the role of aged care services for patients with the broader range of BPSD. In general, SMHSOP AIUs will focus on older consumers with severe BPSD associated with predominant mood or psychotic symptoms, and aged care inpatient units on older consumers with delirium and BPSD associated with likely acute medical needs. However, appropriate flexibility is required and consumer need should drive decisions regarding location of care within local service systems.
12. Where older consumers with severe BPSD cannot be managed in SMHSOP AIUs, provision must be made for the appropriate management of these older consumers in other inpatient facilities (such as T-BASIS Units, adult mental health units, acute geriatric behavioural units) with appropriate support from SMHSOP. All units must develop some capacity to appropriately manage severe BPSD.

Exclusions

13. Exclusions for admission to SMHSOP AIUs are older consumers:
 - whose physical health care is the primary focus of care and those who have unstable medical conditions
 - whose physical health care needs cannot be safely met within the SMHSOP AIU. This includes patients with an acute delirium.

Delirium is an acute medical condition, and it should primarily be treated in a GP-ambulatory care/specialist physician-hospital track, rather than in the SMHSOP program. Older consumers with resolving delirium may be appropriate for SMHSOP AIU if they meet other admission criteria. This is not an easy delineation and admitting such patients requires careful assessment of the risks and benefits as physical health concerns may remain.

14. The co-location of consumers from outside the SMHSOP target group within SMHSOP AIUs must consider the impact upon the SMHSOP consumers and staff, and the unit's ability to meet all consumers' needs.
15. Older consumers with very high risk of serious harm to themselves or others may require care in an adult mental health high dependency or intensive care unit, especially where the SMHSOP AIU is not designed or staffed to manage high dependency consumers.
16. Older people with primary AOD disorders are outside the target population. They should be treated in AOD settings. However, older consumers with comorbid AOD disorders are not excluded if they are otherwise appropriate for admission based on their presenting mental health problems.
17. Older consumers requiring respite in the absence of acute severe clinical symptoms are outside the target population for the AIU.

2.6 Service Development Guidelines: Philosophy of Care, Functions and Target Population

As SMHSOP AIUs are at different stages of development it is recognised that they will need to work towards the recommendations in this model. These developmental recommendations are focused on elements relatively specific to SMHSOP practice, and intended to inform this process.

Philosophy of Care

Basic specific features

Staff orientation includes an orientation to the philosophy of care of the unit. This will reflect cultural and social information relevant to the service catchment area's demographic.

Philosophy of care is evident in relevant policies, procedures and training.

Advanced specific features

Philosophy of care is used to inform recruitment practices.

Access to specific training relevant to the philosophy is facilitated.

Audit processes include assessment of the extent to which the unit is meeting this philosophy (e.g. at *Victorian Department of Health Person Centred Care – the Toolkit*).

Innovative specific features

Development and evaluation of specific strategies to improve incorporation of the philosophy of care into practice.

Functions of the SMHSOP AIU not specified in other sections of the model

Basic specific features

The SMHSOP AIU is part of a continuum of care that includes promotion, prevention and early intervention, community care, non-acute inpatient care and residential/long-term care.

LHD Clinical Services Plans (or equivalent) reflect population needs and the principle of equitable access to prioritise development of SMHSOP AIU facilities and functions.

SMHSOP AIUs are declared as Mental Health Facilities under the NSW Mental Health Act and staff are proficient in meeting the requirements of this Act.

SMHSOP AIU staff are proficient in meeting the requirements of the NSW Guardianship Act and liaising with the NSW Trustee and Public Guardian.

SMHSOP clinical staff provide advice within working hours to support Aged Care Services Emergency Teams (ASET) and mental health staff within Emergency Departments (ED) or Psychiatric Emergency Care Centres (PECCs) in the care of older people with acute mental health symptoms.

SMHSOP AIU consultation services are provided on request to other public hospital inpatient services in the LHD who manage older consumers who are within the NSW SMHSOP Service Plan target population. These will be prioritised as follows:

- a) Older people with mental illness in adult mental health wards or geriatric wards.
- b) Older people with mental illness in other general hospital units, following either mental health consultation and liaison (CL) or geriatric involvement.

Advanced specific features

SMHSOP staff provide, on request, in-person support to ASET and mental health staff within EDs or PECCs, in the care of older people with acute mental health symptoms.

Phone advice is available after hours from on-call SMHSOP clinical staff to support ASET and Mental Health staff within EDs or PECCs.

Regular consultation-liaison services are provided to other inpatient services in the LHD that manage older consumers who are within the NSW *SMHSOP Service Plan* target population. This includes older people with mental illness in adult mental health wards, geriatric wards and other hospital settings.

Teaching is provided to both undergraduates and postgraduate medical, nursing and allied health staff.

Innovative specific features

Development of innovative models for older consumers admitted to adult mental health inpatient units.

Consultation-liaison services provided to private hospital settings.

Research units focused on improving outcomes for older people with mental health disorders and their families.

Target Population

Basic specific features

The unit has clearly defined:

- Target population
- Admission criteria
- Prioritisation criteria.

The above criteria are distributed to key service partners and referral services.

The unit has an agreed approach to managing older consumers with severe BPSD if required, and has key resources required to support this approach.

Where local prioritisation results in SMHSOP AIUs not covering a subset of older consumers meeting the *NSW SMHSOP Service Plan* target group criteria, there are clearly documented pathways to alternative care providers.

There is an agreed dispute resolution process between key partners to resolve any conflict regarding appropriate location and treatment arrangements for individual consumers, or groups of consumers.

Advanced specific features

The unit has models of care for older consumers with severe BPSD that allow this to be a 'core' function that does not adversely impact on other consumers.

The target population, admission and prioritisation criteria are refined in consultation with key partners, and regularly evaluated to identify relevant populations with unmet needs in the LHD.

The SMHSOP AIU complements and supports purpose-built acute inpatient behavioural units for people with delirium/dementia and behavioural difficulties.

Innovative specific features

The unit has design features and models of care for older consumers with severe BPSD that allow this to be a 'core' function that does not adversely impact on other consumers.

Regular assessment of how well the needs of the target population are being met by the network of relevant services within the LHD is completed.

Exclusions

Basic specific features

Exclusion criteria are distributed to key service partners and referral services.

There is an agreed dispute resolution process between key partners to resolve any conflict regarding appropriate location and treatment arrangements for individual consumers, or groups of consumers.

There is a policy that defines when the co-location of consumers from outside the SMHSOP target group within SMHSOP AIUs may be appropriate. This must consider the impact upon the SMHSOP consumers and staff, and the ability to meet all consumers' needs.

There is a policy that defines when comorbid conditions or acute physical health needs may result in exclusion from admission (see Section 3 for recommendations).

Advanced specific features

The above criteria are refined in consultation with key partners, and regularly evaluated to identify relevant populations with unmet needs in the LHD.

Innovative specific features

Development and evaluation of specific models of care for older consumers with comorbid medical conditions and/or specific disabilities is completed.

Comorbid Disorders and Problems, and End of Life Care

3.1 Comorbid Disorders and problems

Policy and Literature

Comorbidity is defined as the simultaneous presence of two or more diseases in the same person [38]. It also refers to the hazardous and harmful use of substances when there is a diagnosis of mental illness [39].

Older people are at considerable risk of multiple complex comorbid physical health, mental health and substance use disorders due to the many challenges they face, including age and disease related deficits and illnesses, major life changes, death of loved ones and friends and adapting to retirement [40, 41]. Comorbidity increases the risk of suicide and the need for greater utilisation of services [41].

In one study comorbid psychiatric conditions were recorded on 73% of admissions, the most common being dementia, substance abuse, delirium, personality disorder, other organic brain syndromes, schizophrenia and depression due to medical conditions [42]. The majority (75% or more) of older consumers admitted to a psychiatric unit hospital have at least one of the common medical illnesses seen in old age [43, 44]. In fact most geriatric psychiatry inpatients have more than one concurrent medical problem and Zubenko *et al.* [45] reported an average of 4.4 medical problems in their inpatient dementia population.

Both osteoporosis and falls are common problems in older consumers admitted to SMHSOP AIUs. Together they have the potential to cause serious adverse events and must be carefully assessed and managed in this population. Suggestions related to falls prevention may be found in the recently released NSW Health policy *Prevention of Falls and Harm from Falls among Older People: 2011-2015* [46]. The *Musculoskeletal Network of the Agency for Clinical Innovation* recently released a model of care for fracture prevention [47].

Physical illness often precipitates psychiatric admission and complicates treatment. In one study more than half of admissions were precipitated by medical illness and 25% had significant previously unrecognised medical problems (e.g. vitamin B12 and folate deficiency, hyperparathyroidism, congestive heart failure, 'sick sinus' syndrome, postanoxic encephalopathy) [48]. Medical problems affected psychiatric care negatively in most instances, delaying or preventing psychiatric intervention.

The Physical Health Care of Mental Health Consumers Guidelines [49] along with the *Physical Health Care within Mental Health Services Policy Directive* [50] outlines the responsibilities of Area Mental Health Services (AMHS) in relation to providing physical health care for consumers with a mental illness. Information sheets have been developed to inform mental health staff, consumers, families, carers and GPs about what physical health care is provided by local mental health services [50].

Mental health consumers have a right to receive health care that is in line with the general population. The family and/or carers also play a vital role and should be encouraged to participate in the delivery of health care through the provision of a detailed physical history as well as providing support to the person [50].

Chief Executives of NSW health services are provided with discretion to determine when to implement smoke-free environments in mental health care facilities, based on local circumstances and consultation. The NSW Health guideline *Guidance for Implementing Smoke-Free Mental Health Facilities in NSW* [51] provides practical advice to Health Services who are planning to implement the NSW Health *Smoke Free Workplace Policy* [52] in mental health care facilities. The *Guide for the Management of Nicotine Dependent Inpatients* [53] provides advice on how to manage nicotine withdrawal and promote ongoing smoking cessation among inpatients. These documents are currently under review and revised versions will be available via the NSW Health policy directive distribution system when finalised.

Current Practice

NSW SMHSOP benchmarking data [32] identified medical and mobility exclusion criteria for each of the seven AIUs that participated in the benchmarking project (Table 2, Table 3). The analysis of data was presented in two ways:

- At admission and developed during admission
- By mobility and medical requirements.

There were significant inconsistencies in the acceptance for admission of older consumers who were bed bound or unable to mobilise (Table 2). Bed bound consumers were only admitted into two units. Other units continued to manage consumers who deteriorated in mobility during the admission (Table 2). Physical aggression was cited as a problem when walking sticks were used as weapons by inpatients but all benchmarking units admitted consumers who required mobility aids.

Table 2
NSW SMHSOP benchmarking data: Inpatient Care for people with additional mobility requirements

Current practice for admission and management of patients with mobility issues identified at admission and/or developed during admission (Part B SMHSOP Survey July 08 QA,B,C,D n=7)	Admits		Continues to manage		Admits		Continues to manage	
	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage
Inpatient Unit	Bedbound		Chairbound		Mobilise with assistance		Requires mobility aid	
Unit 1								
Unit 2								
Unit 3								
Unit 4								
Unit 5								
Unit 6								
Unit 7								

Not Available
Sometimes
Yes - Available



Table 3
NSW SMHSOP benchmarking data: Inpatient Care for people with additional medical care requirements

Current practice for admission and management of patients with care requirements identified at admission and/or developed during admission (Part B SMHSOP Survey July 08 QA,B,C,D n=7)	Admits		Continues to manage		Admits		Continues to manage		Admits		Continues to manage	
	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage	Admits	Continues to manage
Inpatient Unit	Req subcut fluids		Req IV medication		Req IV fluids		Req oxygen ongoing		Incontinence			
Unit 1												
Unit 2												
Unit 3												
Unit 4												
Unit 5												
Unit 6												
Unit 7												

Not Available
Sometimes
Yes - Available



All units admitted people with comorbid medical conditions to the SMHSOP AIU. The decision whether to admit people with comorbid disorders to the SMHSOP AIU is made in the context of a number of factors which varied from unit to unit. These factors included the degree of support available from psychiatric and non-psychiatric medical staff, nursing staff skills and the degree of access to alternative settings.

Few units were confident to manage older consumers requiring intravenous fluids (IV) and preferred parenteral therapy for rehydration to be given sub-cutaneously (SC) if required. Some felt it was both unsafe and impractical for IV and/or SC fluids to be administered in the AIU and that it was the role of medical/surgical wards to administer such treatments. All units were able to admit and manage older consumers with incontinence (Table 3).

3.2 End of Life Care

The Literature

Old age psychiatry has had a recognised role in the care of dying older consumers for some time and the provision of palliative care is consistent with the aims of person-centred care [54]. Palliative care is defined as: “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” [55].

The standards for providing palliative care include respecting the uniqueness of the person, their family and/or carers rights to be included in the decision making and planning of their care needs. This includes acknowledging the holistic needs of the person and developing strategies to address those needs. Ongoing care is coordinated to minimise burden and the primary care giver is given all the necessary information, advice and support to ensure the needs of the dying person are accommodated and their dignity maintained [56]. Access to palliative care should be available to all people who require this care, regardless of age, cultural background, diagnosis or location. Staff need to have appropriate qualifications for the type of care required and demonstrate a commitment to ongoing professional development in this field [57].

The target population for the delivery of palliative care services are those who have an advanced and progressive life threatening illness (including dementia), their primary carer and/or family. Complex psychological, social and physical needs require responsive service models. They include highly individualised care plans, implemented and evaluated by skilled staff in collaboration with the primary care providers. Such care is best provided close to the individual’s community and family and those receiving this care need to be able to move freely between services in response to needs and medical care [57].

Death and dying for Aboriginal and Torres Strait Islander people can sometimes be understood in regard to historical and/or current contexts; the importance of Country and sometimes the preference to die on Country; sensitivity surrounding the topic of death for the person dying and their community; spirituality and/or religious beliefs; and the diversity of rituals before, during and after the dying process. Working with the person, their family/community and relevant Aboriginal specific service providers and/or clinicians is essential in the provision of palliative care for Aboriginal and Torres Strait Islander people.

There are many different CALD communities with varying backgrounds, customs and values, religious beliefs, and other beliefs and practices with regard to death and dying. Working with the person, their family/community, and any appropriate multicultural appropriate services to provide culturally appropriate end of life care for people from CALD communities is necessary.

The underlying principles of care on which SMHSOP services are based make it clear that SMHSOP AIUs may sometimes be appropriate environments for palliative care [1]. In SMHSOP AIUs the issue of palliative care most often arises in the context of end stage dementia. Compared to older consumers with cancer, people with dementia have similar frequencies in their last year of life of confusion, urinary incontinence, pain, low mood, constipation and loss of appetite. However, few people with dementia die in a hospice or gain access to specialist palliative care services, with the majority dying in residential aged care settings or at home [54].

Dementia is often not seen as a life-threatening illness and this may contribute to problems in an acute setting. Staff working in Mental Health facilities generally have very little or no experience or expertise in managing the consumers who are in the terminal stages of illness and this can present challenges when the SMHSOP AIU may otherwise be the most appropriate setting for an older consumer's death. There is compelling evidence that the care of people with dementia, especially towards the end of their lives, is less than optimal in both psychiatric and acute hospital wards [54]. The terminal stages of dementia may well require specialist end of life care and older consumers in SMHSOP AIUs commonly have impaired capacity to determine their own medical treatment, especially those with advanced dementia.

There appears to be significant variation in the ways that health care professionals currently approach situations where the use of life-sustaining treatment is being considered [58]. There are concerns that such treatments are being used in terminally ill consumers resulting in overzealous treatment or, less frequently, inappropriate under-treatment. Advanced care planning may allow for use of life sustaining treatments in ways that are more consistent with the individual's choices and priorities at the end of life [58].

Patients may be involuntary under the *NSW Mental Health Act* [3], in which case the Medical Superintendent is the substitute decision maker. The *NSW Guardianship Act* is the governing legislation for the appointment of guardians and for guardianship practice in NSW [28]. End of life treatment decisions may be made by informal ('person responsible') or formal guardians under this legislation.

Current Practice

Older consumers with a primary diagnosis of a terminal medical condition are not admitted into SMHSOP AIUs for end of life care. However, palliative care consumers may sometimes require or benefit from treatment for a comorbid mental health disorder in a SMHSOP AIU. Some SMHSOP AIUs are co-located with palliative care services and this enables an integrated approach. Two SMHSOP AIUs had long term residential consumers who may receive palliative care in these units if necessary.

There is a lack of clarity in NSW regarding how end of life decisions are best made within the current medico legal framework, especially for consumers in mental health AIUs. As yet there is no Advanced Care Directive (ACD) law in NSW and these matters come under Common Law and the *NSW Guardianship Act* [28]. It is understood that clinicians must follow the direction given by an ACD unless there is significant doubt that the ACD was made correctly, for example due to incapacity or undue influence.

Information regarding Not for Resuscitation (NFR) orders or ACD was not sought from units in the focus groups. However, it was reported during the consultation phase of this project that many AIUs would find it challenging to provide end of life care within their current models of care. Consumers who die in mental health units are reported to the NSW Coroner and this can lead to reluctance to manage older consumers in the SMHSOP AIU who are dying or have a high mortality risk.

3.2 Recommendations: Comorbid Disorders and Problems, and End of Life Care

Medical/surgical management

1. Falls prevention strategies are implemented.
2. There are arrangements for regular Geriatrician ward rounds and consultations.
3. SMHSOP AIUs are able to manage patients with IV and SC fluids, IV medications and incontinence.
4. Older consumers requiring assistance with mobility are provided with the appropriate physical and mobility aid support.
5. Older consumers who are bed bound because of a comorbid disorder or the severity of their mental health condition may be appropriate for admission if they have mental health conditions which may be appropriately managed in the SMHSOP AIU.
6. SMHSOP AIUs facilitate access to other medical and surgical care including Aboriginal community controlled or other relevant medical services, as required.

End of life care

7. End of life care may be appropriately provided in SMHSOP AIUs in some circumstances.
8. SMHSOP AIUs should encourage advanced care planning early in the care of older consumers with terminal illness.

3.3 Service Development Guidelines: Comorbid Disorders and Problems, and End of Life Care

Medical/surgical management

Basic specific features

Older consumers' falls risk is assessed and managed from the time of admission.

Older consumers have mobility aids prescribed when appropriate.

Ability to identify and manage common causes of delirium that arise, with the support of geriatric or medical expertise.

Advanced specific features

Ability to manage more complex medical comorbidities in conjunction with geriatric or medical expertise.

Regular geriatrician wards rounds e.g. weekly.

Innovative specific features

Joint ward rounds with Geriatrician for patients with complex comorbidities.

Advanced Geriatric trainees are seconded to the SMHSOP AIU on a regular basis.

End of life care

Basic specific features

The unit is able to manage end of life care when necessary. It is expected that this will only be in exceptional circumstances.

Staff are aware of any existing advanced care directives at the point of admission.

Advanced specific features

Availability of specialised palliative care services in the SMHSOP AIU.

Innovative specific features

Functional Relationships, Location and Other Operational Arrangements

4.1 Functional Relationships, Location, and Other Operational Arrangements

Policy and Literature

Acute inpatient care for older people should be considered as part of the continuum of care for those with psychiatric disorders. Ideally, a variety of health care settings, including adult mental health inpatient units, aged care services and SMHSOP community services should be available to best meet the complex interrelated physical and social, behavioural or psychological needs of older people [59]. SMHSOP services need to develop effective partnerships with GPs, aged care services including Aged Care Assessment Teams (ACATs) and dementia support services, Home & Community Care (HACC) services, residential aged care facilities (RACF), geriatric medical services, Aboriginal service providers such as Aboriginal Medical Services and multicultural services [1].

Aged care services in NSW have a role in the assessment and management of older people with BPSD that overlaps with the role of SMHSOP, particularly in the area of mild to moderate BPSD. However, a recent survey of aged care services, adult mental health services and SMHSOP services in NSW found there was inadequate liaison and support between these services. Joint case conferences, education, increased funding of SMHSOP and cross-referral were considered ways to address these issues [60].

People with more severe and persistent BPSD are likely to benefit from SMHSOP assessment and management. Therefore, integrated aged care and mental health assessment processes and improved care and management across the continuum of care is required [1]. Functional relationships which are considered the most critical for SMHSOP AIUs include relationships with adult acute mental health, acute geriatric inpatient units, and other physical assessment units such as medical imaging and pathology [1].

Combined psychogeriatric and geriatric medical wards are described as being particularly useful in the management of the medically unwell behaviourally disturbed patient. However, apart from length of stay, discharge and mortality data in case series, there are no other reported outcomes, and their effectiveness has yet to be firmly established [25].

Current Practice

There is significant variation in the locations, functional relationships, and hours of operation of SMHSOP AIUs in NSW. AIUs are located in large and small acute general hospitals, sub-acute hospitals without Emergency Departments (ED), and within stand-alone mental health facilities. Many large teaching hospitals do not have SMHSOP AIUs. Most rural hospitals do not have adult mental health inpatient units, let alone SMHSOP acute inpatient units. One former AHS, now comprising two LHDs, does not have a SMHSOP AIU. The Far West Local Health District has no dedicated SMHSOP AIU, admits and manages older people under the care of a general adult psychiatrist and is approximately 900km from the nearest SMHSOP AIU. Adult acute mental health inpatient facilities sometimes include a nominal number of SMHSOP beds.

There was variation in views of focus group participants regarding whether AIUs should be co-located on the site of a general hospital with acute geriatric services. Co-location was generally associated with better access to medical, surgical, geriatric and other on-site services. However, units identified varying relationships with acute geriatric inpatient units. Co-location did not necessarily ensure effective functional relationships. The single integrated co-located geriatric and psychogeriatric unit reported good outcomes for older consumers with behavioural problems secondary to delirium. Staff in the unit felt that this model prevented inappropriate admissions to other mental health inpatient units [61]. Other focus groups also reported very effective functional relationships, but many others noted problems regarding criteria for referring older consumers to either

service. For example, some acute geriatric inpatient units were reluctant to accept older consumers with BPSD and sometimes referred older consumers with delirium complicated by problematic behaviours to the SMHSOP AIU. Effective consultation/liaison services were reported to be very important in developing and maintaining good working relationships with geriatricians and inpatient geriatric services.

Well-functioning relationships between SMHSOP and aged care services often resulted from long standing collegial relationships between individual clinicians. While there was usually no evidence of formal arrangements to sustain functional relationships between SMHSOP and aged care services, there were collaborative care agreements between some services. It was felt that some services required additional resources to be able to provide optimal models of liaison and support between services.

Some SMHSOP AIUs were not located near acute geriatric beds. In these areas it was common for older people with challenging behaviours of unknown aetiology presenting to ED to be referred directly to the SMHSOP AIU. Immediate access to medical services when required was reported as most problematic when the SMHSOP AIU was located in a stand-alone unit.

All units had some access to medical and surgical specialist consultations, medical imaging, pathology, nutrition services, physiotherapy, audiology, and pharmacy services. However, problems were reported in transporting older consumers to attend investigations or medical appointments, particularly when the SMHSOP AIU was not on the site of a general hospital. Sometimes 'non-charge' inpatients were charged for privately provided services.

It was noted that there appeared to be poor integration of public mental health services and private services in some areas. In particular, the continuity of care for consumers who were discharged from SMHSOP AIUs to private psychiatrists for follow up could be strengthened to ensure more consistency of care between these sectors.

All units reported lack of access to step-down beds, subacute and long stay beds for older people with mental health problems. It could be argued that having non-acute beds physically available within or adjacent to acute beds can make it easier and more consumer-

friendly for older consumers to be stepped up or down from acute beds. Access to appropriate services for people with BPSD (e.g. T-BASIS units) was particularly problematic in virtually all areas.

Participants cited potential disadvantages to location of the SMHSOP AIU on the site of a general hospital. They felt that the majority of inpatient admissions were 'semi elective' and that the quality of care and efficiency of the unit benefited from a planned admission in normal working hours. Also, some participants reported that location of the AIU on a site with an ED was associated with undue pressure to admit consumers who may be outside the target population, resulting in high rates of inappropriate admissions.

4.2 Visiting Hours and Access

Policy and Literature

Ease of access for visitors to hospital is not only a reasonable expectation but has also been shown to be beneficial and is recommended in longstanding government guidelines [62]. Consumer choice is increasingly a driver for improvements in health care but allowing consumers to be involved in decisions on visiting can lead to conflict [63], for example, when relatives want unrestricted visiting but managers and clinicians prefer limitations because of concerns about disrupting clinical care. Historically, very restricted visiting times were introduced to general hospitals because of epidemics of infections in the 19th century [63]. In the 1960s and 1970s, more liberal policies were slowly introduced. But in the 1980s and 1990s, many hospitals started restricting visiting again. This was in response to nursing staff concerned that disruption by and demands of visitors could interfere with the running of the wards and hamper consumer care. Other concerns included privacy, consumers' stress levels and confidentiality during ward rounds [64]. Flexible visiting hours improve consumers' experience but there is little consensus about what is best [63]. Most studies to date have focussed on visiting in relation to critical care (coronary care and ICUs). It is noted that "patient centred care is particularly important in these areas" [65].

A survey of visitor and nursing satisfaction with an open visiting policy found that nursing staff allowed more flexible visiting depending on consumer and family need and circumstances. It was suggested that this could be

formalised by 'visiting contracts' between nursing staff, consumers and the family [64]. Another survey during an open visiting policy found that consumers and visitors appreciated flexibility of hours but preferred a quiet hour with no visiting, and uninterrupted mealtimes.

Conversely most staff preferred set times with little flexibility [66]. Berwick [65] reported that three concerns doctors and nurses had about open visiting were increased physiological stress, physical and mental exhaustion of the consumer, and interference with provision of care. Some of these concerns are unsubstantiated; some evidence suggests that stress, measured by heart rate and blood pressure, is actually reduced by the presence of close family members [65].

Published opinion includes that "it seems strange that close family members may be seen as interfering with provision of care. Surely most would understand and encourage the optimum delivery of care? Indeed some would be happy to participate in the nursing and personal care of their relative, including feeding at meal times...it is often during visiting time when staff can connect with patients and their carers. This can lead to new perspectives on consumer' home and social circumstances and greater understanding of the interactions and dynamics of the family" [63]. While this opinion was in regard to general hospital settings, it seems equally, if not more, applicable to SMHSOP settings.

Exhaustion of family and friends has also been raised as a concern. However, one study found that open visitation had a beneficial effect on 88% of families and decreased anxiety in 65% of families [67].

Current Practice

The importance of the role that visitors play in the SMHSOP AIU was highlighted in the consultation process for this project. It was noted that hospitalisation can

separate and isolate people from their usual supports. Carers expressed the view that where the role of visitors was not valued or optimally managed there was often a detrimental affect on the recovery of the care recipient.

Consultation feedback on the draft report for this project suggested that there can be a mismatch between the perceptions of families and those of staff regarding visiting and access to the AIU. Families can feel that staff see them as intruding and interfering, whilst staff perceive themselves as effective in involving families in care and making them feel welcome.

All units had designated visiting times which usually coincided with the main hospital times. Some units preferred to limit these hours to the afternoon to accommodate clinical practices each morning such as attendance to activities of daily living (ADLs), ward rounds etc. Other units permitted visiting between 10am - 8pm. There was a variation in the degree of flexibility which individual units employed to cater for the needs of elderly relatives and carers who may have to travel long distances to visit inpatients. Only one unit allowed open visiting (visiting at any time and of any duration) and this was specifically to accommodate the needs of their large culturally and linguistically diverse (CALD) population group. This was reported as very successful in preventing agitation and aggression among CALD patients.

High costs associated with parking in hospitals and the lack of public transport, or distance from public transport facilities for relatives and carers, was reported as being a significant problem. Costs of parking on the hospital site were as high as \$17 and, even so, parking was often a significant distance (up to one km) from the SMHSOP AIU. Frequently there was no available parking on the hospital sites at all, particularly during day time visiting hours.

4.3 Recommendations: Functional Relationships, Location and Other Operational Arrangements

Functional relationships

1. Each LHD will have a Clinical Services Plan which addresses population needs and prioritises the development of new SMHSOP AIUs according to local needs.
2. Local decisions regarding capacity and location of units will be based on the principles of providing optimal access while providing effective, safe service delivery.
3. The SMHSOP AIU will optimise its functional relationships with older consumers and carers, and its integration with the local health care community. This should include relationships with local Aboriginal Medical Services.

4. The SMHSOP AIU will optimise important functional relationships with the following inpatient services and facilities:
 - Geriatric units (or other medical inpatient units in rural areas)
 - Acute adult mental health inpatient units
 - Emergency Departments (including access to wardsmen and security personnel)
 - ECT facilities
 - Imaging facilities and pathology services
 - Pharmacy services
 - Other relevant units specialising in the care of older people (such as acute medical behavioural units, T-BASIS units or other SMHSOP sub- or non-acute inpatient units).

The SMHSOP AIU will optimise important functional relationships with the following community services:

 - General Practitioners
 - Private psychiatrists and other community mental health providers
 - SMHSOP, BASIS and DBMAS community teams
 - Mental Health Review Tribunal (MHRT), Guardianship Tribunal and Office of the NSW Public Trustee
 - Acute (crisis teams) and other adult mental health community teams
 - Emergency services (police and ambulance)
 - Aged Care Assessment Teams (ACATs)
 - Aged care community teams
 - Home and Community Care (HACC) services
 - Residential aged care facilities, including specialist units where available
 - Housing and squalor services,
 - Aboriginal Medical Services and other Aboriginal specific services
 - Multicultural service providers.
5. Service practices must support and develop these relationships. This should be via a range of mechanisms, appropriate to local needs, which could include: clear expectations around timing and mechanisms of communication; joint case conferences; joint assessments, cross referrals or joint assessments; consultation-liaison services; joint involvement in planning of services, and formal agreements outlining service roles and responsibilities.

Location

6. The AIU will provide prioritised access for referrals from key service partners. This will have particular impact upon the function and staffing requirements of the unit. It will be particularly important for the SMHSOP AIU to be located in close proximity (preferably co-located) in order to have close functional relationships with the following services:
 - ECT facilities
 - Geriatric inpatient units.
7. Co-location with the following units/services is also strongly desirable:
 - On the site of a general hospital with a range of acute services
 - Adult mental health inpatient unit
 - Emergency Department
 - Imaging and pathology service.
8. The AIU will be accessible by both public and private transport for both older consumers and visitors.

Visiting Hours and Access

9. Visiting hours ought to be as flexible as possible to accommodate the varying needs of older consumers, enable better access for family and carers, and encourage appropriate involvement of families in care.
10. Training in person-centred care should include strategies to address the mismatch between families' perceptions of themselves as intruding or interfering and staff perceptions of themselves as effectively involving families in care.
11. Information is required pertaining to the large number of family and community that may visit the older consumer and for some families, person centred care may also include having a family member stay with the consumer during their inpatient care. This is particularly important to Aboriginal and Torres Strait Islander consumers, families and communities.
12. Restrictions to visiting hours will be determined by therapeutic need, client preference and carer/family preference rather than staff routines.
13. Units should ensure that the risk of cross infection from visitors is reduced by the use of hand washing or application of bactericidal hand wash.
14. Older consumers should have appropriate access to phones and other communication devices, except where there are clinical reasons for limiting access.
15. Parking for older visitors should be affordable and located close to acute inpatient units. Where general hospital parking for visitors is unsatisfactory units should advocate for alternative arrangements to be negotiated for SMHSOP AIU visitors.

16. When appropriate, units should advocate for affordable local accommodation options for carers, particularly those travelling from rural or remote areas.
17. Units should provide visitors with access to areas of the unit which allow an appropriate level of privacy during visits.
18. Units should ensure the availability of refreshments for visitors, especially for those travelling longer distances.

4.4 Service Development Guidelines: Functional Relationships, Location and Other Operational Arrangements

Functional Relationships

Basic specific features

The SMHSOP AIU participates in mental health promotion activities in the local community.

The unit is well integrated into the wider hospital community and there are smooth consumer flows between the AIU and the geriatric unit, other mental health units and the ED.

Patients have timely access to imaging and pathology services.

Advanced specific features

The local community has a high level of awareness of the role of the SMHSOP AIU and it is perceived positively in the local community.

There are formal service level agreements and joint planning of services with aged care services to ensure there are clear agreed pathways for the care of older people.

SMHSOP clinicians participate in Medical Grand Rounds and aged care case conferences.

Geriatricians participate in Mental Health Grand Rounds.

Innovative specific features

SMHSOP and aged care services are involved in joint research and quality improvement activities.

Location

Basic specific features

The AIU should ideally be on an acute hospital site but other options may be feasible if limitations to role or function are addressed in other ways in the LHD.

Advanced specific features

ECT facilities are on site.

The SMHSOP AIU will be co-located with geriatric and other medical services where possible.

The SMHSOP AIU will be co-located with other mental health inpatient facilities, ED, imaging, pathology and other medical specialist services.

Innovative specific features

Remote areas have local facilities and services which provide a comparable model of care to that provided in a SMHSOP AIU.

Visiting Hours and Access

Basic specific features

Visiting hours will be as flexible as possible to accommodate the varying needs of older consumers and enable better access to families and carers.

Parking for older visitors is affordable and located close to acute inpatient units.

Advanced specific features

Public transport is available from all parts of the SMHSOP AIU catchment area.

The hospital provides frequent regular shuttle buses from railway stations.

Innovative specific features

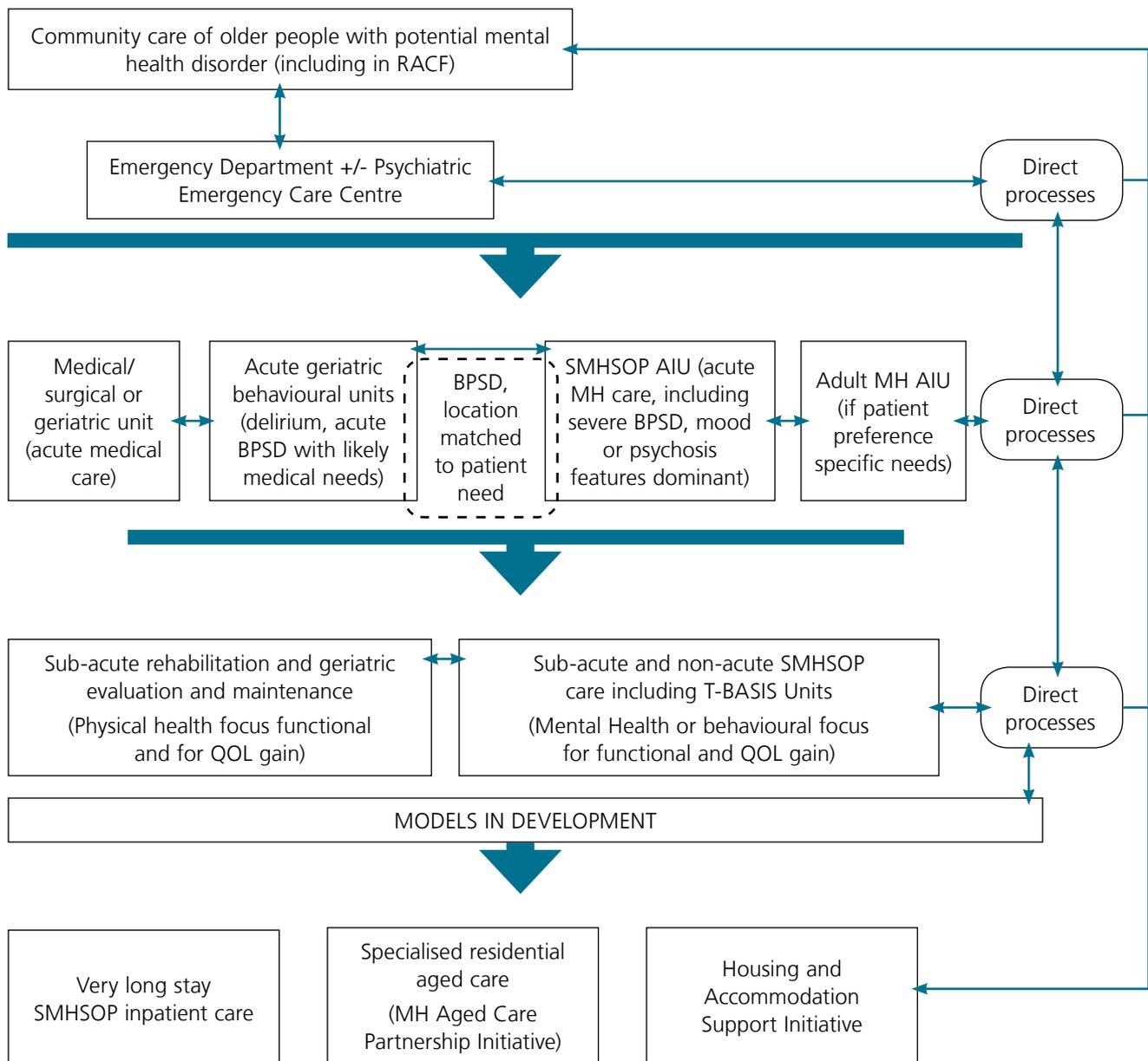
Public transport timetables match visiting hours.

Access to communication devices such as email or internet access could be developed where it is clinically appropriate and safe to do so.

The NSW SMHSOP Service Plan [1] outlines the clinical pathway for the SMHSOP consumer. This pathway forms the basis of this section, which covers key processes and components of the clinical pathway, including: intake and admission; assessment and care planning; clinical review; and discharge/transfer of care.

The flow chart presented below is a further iteration of the clinical pathway in the Service Plan, focusing on the role of the SMHSOP AIU in the spectrum of care, but with reference to the complementary and collaborative roles of geriatric medical services (and adult mental health services) in acute and sub-acute/non-acute inpatient care.

Figure 4
Clinical pathway for older people with potential mental health disorder



Key Processes

5.1 Intake and Admission

Policy and Literature

There are multiple possible entry points to the SMHSOP AIU. Whenever possible, screening evaluations should take place at the relevant entry point, prior to admission to the SMHSOP AIU. Where there is unclear or complex aetiology or the person has an acute medical problem, then an assessment from one or more relevant service partners may be required prior to admission [1].

Home assessment before hospitalisation is often recommended but there is little formal evaluation of this practice [25]. One retrospective study of 205 first admissions found that pre-admission home assessment was feasible, and defined criteria that clarified reasons for hospitalisation and ensured appropriate admission [68].

The evidence suggests that the philosophy of the service makes a difference to the way acute beds are used and managed [69]. It is argued that if a consumer can be waitlisted then they may not need admission to an AIU. An acute psychogeriatric unit (PGU) in Victoria was able to abolish waiting lists through a number of strategies. These strategies included: an approach in which admission of older consumers, especially those with dementia, was considered as a last resort option; development of a policy of not allowing respite admissions into the inpatient unit; and development of a policy of not accepting admissions to the inpatient unit purely for a social crisis [69].

The NSW SMHSOP Benchmarking Project Phase One, introduced a set of agreed standards to improve and maintain consistent intake and bed management processes at admission. These form part of the SMHSOP Self-Audit Tool [70]. It is suggested that:

1. At all times of day the publicised intake phone line is answered by a clinician (including through diversion of phone)
2. Mental Health intake and/or bed management systems coordinate requests for SMHSOP admission from EDs, other inpatient units and community teams
3. Intake and/or bed management systems prioritise access to specific SMHSOP beds for consumers who meet local SMHSOP intake criteria
4. Intake systems provide for referral information to be communicated via phone, secure fax and/or mail
5. A proforma is available to assist referrers in providing appropriate information with referrals and that there are clear processes for its use
6. Intake and referral systems have clear mechanisms for screening for likely delirium or acute medical deterioration
7. Intake and referral systems actively seek the involvement of GPs wherever possible as part of the intake process
8. The intake system provides for referring agencies to be notified if a referral is not accepted. Such notification should include reasons for non-acceptance, and advice or actions to facilitate access to appropriate ongoing care
9. Intake criteria are based upon local prioritisation of the *NSW SMHSOP Service Plan* target group criteria
10. Where local prioritisation results in SMHSOP services not responding to a subset of older consumers meeting the *NSW SMHSOP Service Plan* target group criteria, there are clearly documented pathways to alternative care providers for these consumers.

When an older person is admitted as an involuntary patient, the *MHA* mandates certain procedures to be followed. This includes the nomination of a primary carer who must be notified of the admission within 24 hours, notified of all mental health inquiries, and all aspects of the person's care [3].

Current Practice

Admission to SMHSOP AIUs occurs through a variety of pathways including, but not limited to, SMHSOP community teams, consultation/liason services, adult acute inpatient units, adult community mental health teams and via EDs.

Current active clients of community mental health teams who are assessed in community settings as requiring admission may or may not be 'processed' through ED. Sometimes admission via the ED appears to improve the access to early physical assessment and to the inpatient unit, although it may result in delays and unnecessary transitional care in a suboptimal environment. Currently, this is often the only way to access an emergency assessment, especially after hours. It is preferable to admit older consumers directly into the SMHSOP AIU, bypassing the ED if safe to do so.

Processes for admission vary, with some units restricting access to 'business hours'. In most cases the SMHSOP AIU's old age psychiatrist is involved in decision making regarding admission in business hours. All units had some process of assessment before acceptance for admission. These practices enabled each unit to filter older consumers whose presentations were complicated by medical or behavioural problems and the varied processes assisted in admitting older consumers with comorbidities into the most appropriate setting.

Problems occur after hours when older people are assessed as not requiring admission due to a lack of knowledge of mental health problems in older people. It has been suggested that this may be minimised by having SMHSOP consultants on call at all times. In rural and remote areas this may not be possible due to the significant resource implications and it has been suggested that decisions regarding the availability of on-call old age psychiatrists are best left to local arrangements.

The project team identified four AIUs with documented admission policies. The criteria for admission were consistent with acute episodes of mental illness characterised by the recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self or others. Clients may have no history of previous mental illness or may have an acute exacerbation of a continuing psychiatric disorder, if the person also has developed an aged-related condition. Older consumers presenting with BPSD are included in the admission criteria in most units.

Sometimes admission criteria were not adhered to due to limited availability of general adult mental health beds, with this cited by focus group participants as the reason they accepted consumers outside their criteria. Pressure from EDs and medical services for SMHSOP AIUs to accept consumers with undifferentiated BPSD resulted in inappropriate admissions of consumers with delirium.

Some SMHSOP AIUs employed strategies to avoid this outcome. For example, delaying admission of consumers with undifferentiated diagnoses pending further assessment and investigations until the diagnosis was clearer. The effectiveness and efficiency of these strategies were dependent on the strength of partnerships with EDs and aged care services. In some services this was enhanced by historical factors such as the presence of a "Medical Psychiatric" ward and joint management of older consumers in such wards.

After-hours admissions often provided additional challenges due in part to the reduced availability of senior SMHSOP clinicians. In many units the decision to admit rests with general adult psychiatrists after hours. Sometimes this lead to policies of older people being admitted into adult units, or younger 'settled' consumers transferred into SMHSOP AIUs to accommodate the older person in the adult acute inpatient unit after hours. Reasons cited for these practices included lack of experienced mental health clinicians in the SMHSOP AIU.

SMHSOP AIU beds were often utilised by adult mental health units to cater for the overflow of consumers in adult units. Reports indicated this is a common practice in most units.

5.2 Assessment and Care Planning

Policy and Literature

Comprehensive assessment of the older person is a 'multidimensional process that considers the whole life situation of an older person' [71] and enables a holistic care plan to be developed through a multidisciplinary process to address immediate as well as determine long term physical and support needs [71].

The assessment process in the SMHSOP AIU will cover a range of psychological, functional, physical and social aspects of the person and consider these in the context of the person's environment as well as the risks and vulnerabilities associated with the environment for the person's family and/or carers. The goal of this assessment is to address and/or minimise any identified risks in relation to the care plan [71].

The *Aged Care Assessment and Care Planning Framework* [71], includes the following principles of care:

- Comprehensive assessment is a continuous, interdisciplinary, multidimensional process that identifies and evaluates all factors affecting an older person's health and wellbeing and links diagnostic conclusions to targeted intervention strategies
- Within the Framework, the target group for comprehensive assessment is older people with complex, often interacting, medical, physical, psychological and socio-economic problems who are at significant risk of poor health outcomes
- Comprehensive assessment provides an evaluation of an older person's restorative, physical, medical, psychological, cultural and social dimensions of care and also considers the needs of the carer/advocate, where appropriate
- Comprehensive assessment identifies the older person's restorative potential and builds on their strengths, abilities and resources
- Comprehensive assessment of an older person is conducted in a variety of settings by competent assessors with the appropriate skills, knowledge and capacities for that environment using valid and reliable tools
- Comprehensive assessment focuses on the met and unmet therapy and support service needs and preferences of the older person and their carer relevant to what the service offers and is independent of the interests of health and service providers. Service availability does have an impact on care planning strategies

- Comprehensive assessment is well coordinated and does not overburden the older person, their carers or family or health staff with unnecessary processes
- Comprehensive assessment is based on accessing and considering all assessment information gathered on the older person's client journey
- The older person, their carer and family are active participants in comprehensive assessment and care planning processes. They are informed of assessment outcomes and participate in the development of negotiated plans of care.

An older person participating in a comprehensive assessment process has the right to privacy and confidentiality, be informed, have carer or advocate involvement and to complain or request corrections to their information. It is often most informative to undertake screening evaluations at the patient's residence to give a better idea of the physical and social assets or liabilities of the individual and to assess how the person relates to his/her family and caregivers in the natural setting [72-74]. This screening helps to establish proper prioritisation, prevent unnecessary or inappropriate admissions and prepare realistic plans for discharge [40].

Research indicates that frail, vulnerable, isolated and dependent older people are at heightened risk of abuse. Common forms of abuse of older people include neglect, physical abuse, sexual abuse, psychological abuse and financial abuse. Indicators of neglect may include dehydration, poor skin integrity, malnutrition, inappropriate clothing, poor hygiene, unkempt appearance under/overmedication, unattended medical or dental needs, exposure to danger or lack of supervision, absence of required aids or an overly attentive carer in the company of others. Indicators of physical abuse may include bruises on different areas of the body, lacerations, abrasions, scratches, burns, sprains, dislocations and fractures, hair loss, missing teeth, or pressure sores as a result of physical restraint. Sexual abuse may be indicated by injuries, sexually transmitted infections, human bite marks, and anxiety around the perpetrator. Indicators of psychological abuse include depression, anxiety, demoralisation, feelings of helplessness, disrupted appetite or sleep, tearfulness, confusion, agitation or unexplained paranoia. Financial abuse may be indicated by unexplained or sudden inability to pay bills, significant withdrawals, drastic changes to wills, unexplained disappearance of possessions, lack of funds for food or clothing, disparity

between living conditions and money, or recent addition of a signature on a bank account [75].

It is important to note that the presence of one or more indicators does not necessarily mean that abuse has occurred and many inpatients in the SMHSOP AIU could be expected to have one or more of these indicators on admission. Clinicians should remain vigilant to the possibility of abuse when these indicators are present.

The *Physical Health Care of Mental Health Consumers Guidelines* [49] and the *Physical Health Care within Mental Health Services Policy Directive* [50] were released in 2009. They outline the responsibilities of Area Mental Health Services (AMHS) in relation to providing physical health care for consumers with a mental illness. The *Physical Health Care of Mental Health Consumers Guidelines* provides guidance regarding undertaking an initial assessment and consent [49].

Older people are at particular risk of problems relating to:

- Multiple medication use
- Malnutrition
- Falls
- Pressure areas due to reduced mobility
- Constipation
- Musculoskeletal limitations and pain
- Visual and hearing impairment
- Delirium.

The physical assessment will include mandatory testing of vital signs such as temperature, pulse, blood pressure and respirations when a person is admitted into the SMHSOP AIU [50]. This should occur in the context of obtaining a medical and drug and alcohol history utilising the clinical assessment documentation. Information should also be obtained on relevant family history regarding diabetes, heart disease or other major medical history. A history of health-related behaviours such as smoking, diet or exercise should also be obtained [50].

The SMHSOP AIU should have access to a well-lit examination area which has a bed or couch suitable for undertaking the physical examination and appropriate equipment.

Clients who are admitted into a SMHSOP AIU are given a comprehensive assessment utilising the reviewed modules in the *NSW Health Guideline Mental Health Clinical Documentation* suite [76]. Base modules include the Triage, Assessment, Care Planning and Review, Transfer and Discharge. Additional modules which are to be used as appropriate for older people include:

- Physical Examination
- Physical Appearance
- Risk Assessment
- Substance Use Assessment
- Functional Assessment (Older People)
- Cultural Assessment
- Cognitive Assessment (RUDAS)
- Cognitive Assessment (3MS/MMS)
- Domestic Violence.

These modules allow for documentation of both the background and current situational factors relevant to the presentation in the SMHSOP AIU and underpin the requirements of a comprehensive mental health assessment. The amount of detail recorded in the modules may be balanced by issues such as previous mental health history and access to mental health services [76].

Based on the information gathered during the assessment, clinicians should complete the HoNOS65+ and other relevant outcome measures and record the results in the Assessment module under 'Measures'. The Care Plan module provides a framework for summarising the goals and clinical issues that are the targets for the episode of care with the intent of aiding the monitoring of clinical status [76].

The *Physical Examination* module provides a structured format for the completion of a physical examination. This is undertaken by a medical officer [76]. Research also indicates that some warning signs of deterioration in a patient's physical condition can be recognised early. NSW Health has developed a program called '*Between the Flags*' to standardise the way clinicians respond to these signs. This program supports doctors and nurses in making clinical decisions on when to seek help and in identifying the sort of help required [77].

Falls assessment tools and other suites of assessment tools may be beneficial to determine the complexity of the presenting problem and determine the care needs of the person.

These include assessment of skin integrity (e.g. Waterlow Scale), hydration and nutrition, dentition, nail care, management of continence and grief and loss issues.

The use of standardised assessments for Aboriginal and Torres Strait Islander people, and people from CALD communities sometimes misrepresents the actual abilities [7]. There are a number of factors to consider when implementing standardised assessments, including [8]:

- the interpretation of the attributes being assessed for different cultural groups
- the omission of potentially relevant cultural attributes
- modalities used to access these attributes, both verbal and non-verbal
- cultural taboos in the exploration of certain attributes
- the intrapsychic versus public expression of attributes
- the validity of comparisons of attributes across cultural and other differentiating boundaries
- cultural and political context of the assessment and setting.

To support mental health clinicians to conduct culturally accurate clinical and psychosocial assessments for clients from CALD communities, the *Transcultural Assessment Checklist (TAC)* was developed and can be used to support culturally appropriate assessments [78].

Current Practice

The project team was unable to establish the degree to which assessment was comprehensive in SMHSOP AIUs. It was not clear whether most units had policies or procedures in place and to what degree they were followed. NSW SMHSOP benchmarking data suggested that rates of outcome measurement were lower than the established targets.

There was evidence that valid and reliable screening instruments and assessment tools were routinely utilised in most units. Those cited by participants in the focus groups included the HoNOS 65+, Kessler Psychological Distress Scale (K10), Resource Utilisation Groups - Activities of Daily Living Scale (RUG-ADL), Folstein Mini-Mental State Examination (MMSE or MMS), Modified Mini-Mental State (3MS), Geriatric Depression Scale (GDS), and Waterlow Scale.

The *Physical Health Care of Mental Health Consumers Guidelines* [49] had not yet been implemented in most units at the time of the site visits.

At least one experienced clinician felt that assessment standards had slipped. All older consumers should have full a physical examination on admission including a neurological examination. If the consumer is too distressed or aggressive, this should be documented and the physical examination should be completed at the first opportunity. Vital signs should always be taken on arrival at the unit.

5.3 Clinical Review

Policy and Literature

Clinical review occurs by individual clinicians as well as in multidisciplinary teams.

Key elements of good practice in clinical review identified in the SMHSOP Self-Audit Tool [66], include the following:

- There is a multidisciplinary case conference at least weekly
- Every consumer has an in-person review by a psychiatrist.

A multidisciplinary clinical review is a meeting at which all clinicians involved in the care of the consumer participate in a structured review of the consumer's progress towards the objectives/goals of the management plan [79]. Regular structured handover and clinical review meetings are an opportunity to improve the quality and ensure the safety of responses, assessments, treatment and rehabilitation.

A community SMHSOP clinician should be present in person or via telephone/video link for a SMHSOP AIU consumer clinical review meeting. The older consumer should also be involved and offered the opportunity to have the primary carer involved. The community SMHSOP clinician should, where possible visit consumers at least once prior to discharge [79].

Information for the review will be presented by the relevant mental health worker using the Mental Health Outcomes Assessment Tools (MH-OAT) assessment or review format and should include any outstanding aspects of care delivery [80]. Tasks for follow-up will be allocated and staff responsible for actions will be recorded. The meetings should ensure that all appropriate referrals to other services have been made and followed up [79].

Outcomes will be recorded on the relevant MH-OAT assessment or review forms and placed in the older consumer's health record. The management plan is to be discussed with the older consumer and the older consumer should sign the review management plan. A copy of the review should be securely faxed to the community clinician. Care plans should be updated by the nursing representative at the time of the review [79]. Clinical staff of the AIU should participate in a shift handover meeting at each change of shift.

All older consumers should be reviewed by a registrar or career medical officer (CMO) at least three times each week and psychiatrist at least once each week [79].

The older consumer has a right to seek a second opinion if there are concerns regarding treatment or procedures after they have been discussed with the consultant and/or treating team [29].

Current Practice

Not all units have documented procedures for clinical review. There is only partial implementation and compliance with the above procedures and policies. There is no procedure available to guide the requirement for the psychiatrist to seek a second opinion in the event of poor outcomes in a consumer's clinical progress.

Some units are addressing some of the gaps through the SMHSOP benchmarking forums and local quality improvement processes.

Consultations on this report highlighted that, although older consumers are the centre of any case conference, no case conference should give the impression that the older consumer is being judged. Older people should be treated with respect and without judgement within the AIU and in all clinical processes.

5.4 Discharge/Transfer of Care

Policy and Literature

Effective discharge planning is essential to the safe and successful transition of mental health consumers from hospital to the community [81].

The *NSW Mental Health Act* [3] requires that when planning for discharge from a mental health facility action must be taken to:

- Consult with the consumer and their primary carer
- Consult with agencies involved in providing relevant services to the consumer, their primary carer or the dependants of the consumer
- Provide appropriate information to the consumer and carer as to types of medications and dosages administered and details of follow-up care.

Caring Together: The Health Action Plan for NSW [82] was released in 2009 in response to the recommendations made by Commissioner Garling following his Inquiry into Acute Care Services in NSW public hospitals. These recommendations include:

- Provision of a transfer of care summary to a GP
- That clinically appropriate information is provided to the patient and/or carer on transfer of care
- That an estimated date of discharge is allocated at the earliest opportunity in a way which is consistent with good care

Key elements of good practice relevant to transfer of care from acute SMHSOP AIUs identified in the SMHSOP Self Audit Tool [70], include the following:

- A system is in place to ensure that contact with the GP and any other follow-up providers has occurred, and been documented, prior to discharge
- A NSW Mental Health Discharge Summary is completed on the day of discharge
- A system is in place to ensure that a discharge summary begins conveyance to the consumer's GP on the day of discharge
- A system is in place to ensure verbal communication occurs with, and the discharge summary is conveyed to, the primary follow-up provider on the day of discharge
- There is a process to ensure consumers discharged from inpatient care are contacted by inpatient or community SMHSOP clinicians, by telephone or in person, within seven days of discharge.

'Discharge' of older consumers is a misleading term in relation to older consumers transferring from a SMHSOP AIU to community care or 'admission' to a residential aged care facility. Very few older consumers will not require ongoing assessment and management by SMHSOP or adult mental health community services and 'transfer' is the preferred term to reflect the continuity of care required. Clinicians also require sensitivity in responding to the needs and abilities of carers when planning the older person's transition to the community.

A copy of the current Care Plan is also attached to the Transfer/Discharge Summary module when the consumer is discharged to facilitate transfer of care and enable ongoing management of the person in the community [76].

The purpose of the *Transfer/Discharge Summary* is to provide documentation of the current episode of care and outcomes from that care. It also allows for issues that require ongoing management to be addressed when care is being transferred to another mental health service or care provider. This module should be completed on or before the day of discharge [76].

A copy of the completed *Physical Examination* module and a copy of the Consumer Wellness Plan (if applicable) should accompany the Transfer/Discharge Summary at the time of discharge [76].

Current Practice

The project team was unable to establish the quality of information provided to relevant parties on discharge.

5.5 Recommendations: Key Processes

Admission or Entry

1. SMHSOP AIUs should address the following in intake and admission processes:
 - Have documented admission and intake policies that cover SMHSOP specific issues
 - Have clear preadmission screening assessment processes in place, and mechanisms to conduct these without inappropriately delaying admissions
 - Inform older consumers and carers of the nature of the unit and the types of disorders which are managed in the unit
 - Involve GPs, private psychiatrists, community mental health teams, Aboriginal health workers/ Aboriginal mental health workers, bilingual counsellors and other cultural brokers in this process, where ever possible and relevant, in the intake process
 - Ensure older consumers and their carers are made to feel welcome in a comfortable environment
 - Avoid unnecessary admission via the ED where direct admission to the AIU is deemed appropriate and safe, based on recent assessment and consultation with the SMHSOP consultant responsible for admission and consideration of the risk of acute medical illness
 - Whilst admissions should be at the optimal times, units should maximise their ability to accept admissions 24 hours per day and have provision for the availability of SMHSOP senior clinicians to make decisions about admissions and care after hours
 - Aim to admit older consumers on the day of referral
 - Where local prioritisation results in SMHSOP not catering to a subset of older consumers, ensure that there are clearly documented pathways to alternative care providers.

Assessment and Care Planning

2. Assessments must ensure the following domains are considered:
 - Language, cultural and spiritual issues
 - Sensory impairment
 - Current and past social, residential and occupational situation, to inform a person-centred approach and discharge planning
 - Residual strengths
 - Goals of care for the consumer
 - Risk of delirium or acute medical conditions
 - Other key risk issues (e.g. harm to self or others, allergies, falls, pressure areas, polypharmacy, absconding, abuse)
 - Relevant past mental health history and current mental health state, including cognitive assessment
 - Relevant past and current medical and family medical history
 - ADL and IADL functioning including ability to manage finances and driving and whether Enduring Power of Attorney and Enduring Guardianship have been considered
 - Carer's needs.
3. Assessments must be appropriately inclusive of key carers as well as the consumer's GP and private psychiatrist, where relevant, with the consumer's consent.
4. All older consumers should have a full physical examination on admission, including a neurological examination. If an older consumers is too distressed or aggressive, this should be documented and the physical examination should be completed at first opportunity. Vital signs should always be taken on arrival.
5. Where older consumers are not able to provide informed consent, assessment and care planning must be undertaken in a manner consistent with the *NSW Guardianship Act* and/or *NSW Mental Health Act*.

6. Assessment within SMHSOP AIUs must be multidisciplinary, timely, comprehensive and consistent with relevant professional and policy standards. Current relevant standards include:
 - NSW Health Guidelines and Policy: *Physical Health Care within Mental Health Services*
 - NSW Health Aged Care Assessment and Care Planning Framework principles
 - NSW Health Guidelines and Policy: the *Mental Health Clinical Documentation Suite* and associated training materials
 - SMHSOP Self-Audit Tool standards
 - Vic Health *Best care for older people everywhere - The toolkit*
 - *Falls Best Practice Guidelines 2009* (Australian Commission on Safety and Quality in Healthcare)
 - *Dementia Outcome Measurement Suite Final Report*.
7. Assessments must utilise relevant standardised instruments.
8. Assessments should aim to minimise any cultural biases.
9. Units must have clear guidelines regarding the availability of medical specialty consultations and how to access these.
10. SMHSOP AIUs must have mechanisms for multidisciplinary care planning that is as collaborative as possible with older consumers and carers. Such care plans must be reviewed at defined periods.
11. Care planning must include factors relevant to transfer of care such as post discharge accommodation, follow up and review.

Clinical Review

12. Unit policies must ensure appropriate practice with regards to:
 - Multidisciplinary clinical review meetings
 - Shift handover, including when multidisciplinary participation is indicated
 - Reviews following clinical incidents
 - Frequency of reviews by designated professional groups.
13. SMHSOP AIUs will have clear expectations regarding multidisciplinary review of older consumers that are consistent with relevant standards. Current relevant standards include:
 - NSW Health Guidelines and Policy: *Physical Health Care within Mental Health Services*
 - NSW Health Guidelines and Policy: *Mental Health Clinical Documentation Suite* and associated training materials
 - SMHSOP Self-Audit Tool Standards
 - NSW Clinical Excellence Commission '*Between the Flags*' Program
 - NSW Health Policy: *Clinical Handover - Standard Key Principles*
 - NSW Health: *Incident Management Policy*

Discharge/Transfer of Care

14. SMHSOP AIUs will have clear expectations regarding planning for discharge or transfer of care that are consistent with relevant standards. Relevant staff must be familiar with such standards, and how to access appropriate support from mental health and aged care focused resources. Discharge planning should commence at the time of the admission assessment and be regularly reviewed during admission in collaboration with the consumer and key carers.
15. Current relevant standards policies include:
 - NSW Health *Discharge Planning for Adult Inpatient Mental Health Services*
 - NSW Health Guidelines and Policy: *Physical Health Care within Mental Health Services*
 - NSW Health Guidelines and Policy: *Mental Health Clinical Documentation Suite* and associated training materials
 - NSW Health *Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit*
 - NSW Health *Aged Care Assessment Teams Protocols & Procedures for ACATs in NSW*
 - SMHSOP Self-Audit Tool standards.

5.6 Service Development Guidelines: Key Processes

Admission or Entry

Basic specific features

Staff are aware of entry and admission policies relevant to the SMHSOP AIU.

Preadmission processes include screening for likely delirium or acute medical deterioration in a manner that does not unnecessarily delay admission.

Intake and/or bed management systems operated or used by SMHSOP are able to coordinate requests for SMHSOP admission from different sources e.g. ED, other inpatient units and community teams.

Intake processes involve carers and families.

In preadmission processes, staff actively contact and seek involvement of GPs wherever possible.

Wherever possible, community mental health assessment occurs prior to admission to determine if admission can be appropriately avoided.

If there are older consumers awaiting admission to the unit, there is a clear process to document key aspects of their condition and location, and a process for daily prioritisation of potential admissions.

Where local prioritisation results in SMHSOP not catering to a subset of older consumers, there are clearly documented pathways to alternative care providers.

A consultant psychiatrist with experience appropriate to the management of SMHSOP consumers can be contacted every working day.

Advanced specific features

Community resources can be focused upon urgent assessments for designated periods at times of maximal demand for SMHSOP AIU beds.

Urgent assessments in the community do not rely on physical assessment in the ED and clinicians can facilitate direct admission.

Admissions can occur on a '24 hours a day, 7 days a week' basis.

Innovative specific features

Through the coordinated management of all inpatient and community SMHSOP and aged care resources, older consumers can be reliably admitted on the day of referral, including out of regular hours.

Where admission is not urgent, a pre-admission meeting opportunity is provided involving the consumer, their family, the admitting psychiatrist and nursing staff to address questions and concerns that the consumer and carers may have. This might occur, for example, 7-10 days before a proposed admission.

A consultant psychiatrist with experience appropriate to the management of SMHSOP consumers can be contacted at all times.

Assessment and Care Planning

Basic specific features

The SMHSOP AIU has clear guidelines regarding the expected timing of relevant assessments detailed above, and the responsibilities of staff who are conducting these.

Assessment is coordinated by an appointed care coordinator who is a member of the multidisciplinary team.

Staff with appropriate specialist skills conduct in depth assessments to clarify the extent or nature of any deficits where this may impact upon care or prognosis.

All older consumers have a full physical assessment on admission, including a neurological examination. If an older consumer is too distressed or aggressive to co-operate with a physical examination, this is documented and a physical examination completed at first opportunity. Vital signs should always be taken on arrival.

The SMHSOP AIU regularly audits compliance with *Physical Healthcare Guidelines*, and has a system for improving any deficiencies.

The SMHSOP AIU has at least twice weekly access to a consultant physician with skills relevant to the physical health needs of older people.

Unless there are no involved carers, or the consumer opts out, there is an early (7-10 days) post admission meeting between family (in person or via teleconference) and staff to discuss assessment and care plans.

Advanced specific features

The consumer and carers are informed of the assessments which will be undertaken while in the unit.

The SMHSOP AIU regularly audits the quality and timing of relevant assessments, and has a system for improving any deficiencies.

The SMHSOP AIU has daily access to geriatric medical and/or other consultant physician consultation or review.

Assessment includes a pharmacist review for potential adverse drug interactions.

Assessment includes a nutritionist assessment.

Assessment includes a formal mobility assessment.

Care planning includes maintenance and review of 'at risk' functions, particularly mobility and cognition.

Innovative specific features

There are agreed criteria for joint management between psychiatrist and consultant physician for older consumers with primary mental health problems who have acute physical health needs which are best managed in the SMHSOP AIU.

The unit regularly reviews relevant data from assessments and care plans to evaluate the service and guide future developments.

Clinical Review

Basic specific features

Daily nursing mental state review occurs.

Physical observations are consistent with relevant guidelines.

Medical Officer in-person review of all older consumers occurs at least every working day.

Consultant psychiatrist review of all older consumers occurs in-person at least weekly, with at least one additional review each week in person, or by a registrar or CMO, under supervision.

Multidisciplinary case review of the condition of, and care plan for, all older consumers occurs at least weekly with:

Attendance including medical, nursing and allied health staff

Relevant community team representation in-person or via telephone/video link

Tasks for follow up are allocated

Review of the completion of tasks set during previous reviews

Review of key admission goal achievement against milestones, or using a documented instrument (this can include the Mental Health Care Plan progress scale or any other appropriate instrument).

Nursing handover occurs in a manner consistent with NSW Health policy.

Support and training is provided for appropriate monitoring of common mental health-related factors (e.g. aggression, agitation, anxiety, and depression).

Risk assessments (e.g. suicide, falls, delirium, violence) are reviewed and appropriate interventions implemented.

Advanced specific features

Multidisciplinary handover of the condition and care plan for all older consumers occurs every weekday.

All goal achievement is reviewed against milestones, or using a documented instrument.

Protocols available for case conference clearly delineate staff roles, the expected preparation prior to case review, and the linkage of review to assessment or outcome instruments.

A pharmacist is included as part of the review team.

Review includes direct involvement of older consumers, carers and/or consumer consultants.

Innovative specific features

Multidisciplinary case review explicitly includes the perspectives of the consumer and/or carer.

The unit regularly reviews relevant data from clinical reviews to evaluate the service effectiveness and guide future developments.

The service has additional specific measures to promote integration of care across inpatient and community settings.

Discharge/Transfer of Care

Basic specific features

A system is in place to set and regularly review estimated dates of discharge (EDD).

Discharge to less intensive care occurs as soon as this can be safely and appropriately conducted.

Criteria exist for consumer transfer to more acute mental health or medical care, and procedures are in place to facilitate this.

Discharge planning and making arrangements for discharge are the role of various members of the multidisciplinary team.

Staff responsible for discharge planning have appropriate orientation, education and/or training about both mental health and aged care policies and resources relevant to discharge planning.

Prior to discharge, appropriate written information is provided to the consumer and/or carer about their condition, follow up, and re-entry options.

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 been documented, prior to discharge.

A NSW mental health *Discharge Summary* is completed for all older consumers on the day of discharge. Discharge communication includes relevant information regarding the older consumers' mental health, medical, functional and behavioural support needs, current mental state and medications.

A system is in place to ensure that the discharge summary is dispatched to the consumer's GP and private psychiatrist where relevant, on the day of discharge.

A system is in place to ensure that verbal communication occurs with, and the discharge summary is dispatched to, the primary follow-up provider on the day of discharge.

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

Discharge will only take place when essential services are in place and it is considered safe for the consumer to leave the hospital.

A system is in place to ensure appropriate follow up care is provided when a consumer is discharged while on leave.

There is a process to ensure older consumers discharged from inpatient care are contacted by inpatient or community SMHSOP clinicians, by phone or in person, within seven days of discharge, including for older consumers discharged to destinations outside the unit's catchment area.

Advanced specific features

Community follow up intensity can be increased for designated periods to facilitate early discharge from inpatient care at times of maximal demand for SMHSOP AIU beds.

Behavioural management plans are adapted for the post discharge environment prior to discharge, and discussed with follow up care providers prior to discharge.

Discharge planning includes relapse prevention planning.

The AIU has a discharge checklist that is specifically tailored towards the needs of SMHSOP older consumers.

A regular review occurs after discharge to ensure that key actions have occurred.

Innovative specific features

Intensive community mental health and functional support and follow up is available for older consumers for whom this can appropriately facilitate earlier discharge from hospital.

The service has additional specific measures to promote integration of care across inpatient and community settings.

Clinical Interventions

The aims of clinical interventions in the SMHSOP AIU are to address the treatment goals of the consumer and carer and to prevent secondary morbidity. Initial treatment goals will be established either prior to admission or through goal setting during an early assessment phase of the admission. Goals are not limited to mental health issues but may cover comorbid physical and social problems, improving functional status and the older consumers and carer's health and social needs.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommend the following interventions should be available within all adult inpatient services:

- Pharmacological interventions
- Psychological interventions
- Electroconvulsive therapy (ECT)
- A range of psychoeducational programs
- Family/carer (formal and informal) education and therapy.

Additional assessment and treatments should include but not be limited to [83]:

- Functional status and required assistance to maintain and where possible improve mobility and activities of daily living
- Diagnosis, prevention and management of emergent delirium not requiring transfer to other care settings
- Assessment, diagnosis and evaluation of cognitive status including dementia
- Stabilisation and prevention of further cognitive decline
- Medication management including psychotropic and non-psychotropic agents
- Assessment of fitness for anaesthesia associated with ECT
- Maintaining continence
- Maintenance of skin integrity
- Maintenance of nutrition and hydration
- Maintaining existing links to aged care and primary services

- Assessment and management of risk to self and others through deliberate acts
- Assessment of inadvertent risk including falls, vulnerability to others, neglect of self care, nutrition and property
- Cultural and spiritual needs
- End of life and grief and loss issues.

6.1 Milieu

Ward milieu is thought to influence consumer outcomes and behaviour [84], as well as staff morale [85]. The 21st Century concept of a therapeutic milieu or 'optimal healing environment' focuses on person-centred care, continuous healing relationships, safety as a system priority and co-operation among clinicians within a holistic practice atmosphere [86]. It is noteworthy that at least one study suggests that a therapeutic milieu does not exist in contemporary acute inpatient psychiatric care [87].

Group and ward meetings serve to facilitate communication and give a sense of community. On a SMHSOP AIU the milieu should be conducive to dealing with problems common to its population. These include adjusting to losses, adjusting to retirement, difficulties in finding worthwhile activities and maintaining self-esteem, adapting to changes in family relationships or changes in residence and dealing with increased dependency needs [11].

The milieu should also be conducive to an eventual return home or good integration in residential aged care. Wearing one's own clothes, using kitchen facilities, laundry facilities and maintaining as much independence in ADLs and IADLs are all important for older consumers who will be discharged home [11].

Special consideration should be given to the appropriate milieu for Aboriginal or Torres Strait Islander people, people from CALD backgrounds and for people who have experienced trauma.

6.2 Psychotherapy

The myth of ageing is that the elderly cannot change and that psychotherapy and other forms of interpersonal intervention are of little effect. This is an erroneous concept which has been repeatedly disproved [38].

Individual psychotherapy such as cognitive behavioural therapy (CBT), supportive therapy or grief therapy is often appropriate in AIUs. Although some inpatients may not be suitable candidates for psychotherapy prior to discharge, the treatment team should have sufficient understanding and familiarity with psychodynamic therapeutic interventions to provide empathic listening, gentle confrontation (e.g. pointing out obvious avoidance) and clarification to help older consumers recognise feeling states they may be unaware of.

Interpretation of unconscious process is a rare intervention on most short-term treatment units [88]. Many clients are suitable for CBT and psychoeducation about their presenting symptoms and will benefit from engagement in these therapies facilitated by staff members. Behavioural activation is an important process for recovery from depression. There are some psychological approaches devised specifically for older people, such as reminiscence and life review [89].

6.3 Behavioural Therapy and other Psychosocial Interventions

Various techniques of behavioural therapy and modification can be useful for selected inpatients. These techniques have been studied mostly in long term care or outpatients setting but can be applied to a limited extent to the inpatient, acute care population. All behavioural interventions must be based on individual presentation and rigorous and individualised assessment.

The most commonly used forms of behaviour therapy are relaxation training and desensitisation for anxiety-related disorders and biofeedback, which may be helpful in the management of chronic pain. Other interventions include behavioural activation, in vivo exposure and imaginal exposure [43].

Behaviour modification techniques, which can be applied by staff in the overall approach to consumers include positive reinforcement of adaptive behaviour, counter conditioning and reciprocal inhibition [43].

It is not possible to offer prescriptions for interventions; rather, each person's background, needs and circumstances must be comprehensively assessed within the context of the emotional and physical environment in which the behaviour is occurring.

Potential behavioural strategies for agitated older consumers with BPSD include distraction, diversion, music, exercise, socialisation and avoidance of identified triggers. Environmental factors such as appropriate levels of light and sound, orienting cues, presence of familiar objects and people, family support, crowd reduction and presence of adequate numbers of consistently rostered staff who are trained in managing older consumers with BPSD may augment specific behavioural strategies.

A recent review of psychosocial treatments of behaviour symptoms of dementia suggested that positive interaction between the person with dementia and a family member or care attendant might be an important basis for the effectiveness of many such interventions [48]. The authors found the best evidence was for aromatherapy, one-to-one social interaction, bed baths, person-centred bathing, preferred music and muscle relaxation training.

6.4 Pharmacotherapy

Psychotropic medications are considered to be only one part of a multifaceted treatment program, and should only be initiated after a careful review of risks and benefits. Specific target symptoms should be chosen for monitoring, and reassessment of efficacy should occur regularly. Because the elderly are extremely sensitive to the side-effects of psychotropic medications, staff should be vigilant for adverse drug reactions [90].

The role of pharmacotherapy in older consumers with dementia remains controversial. There is evidence that antipsychotic medications have modest effectiveness in treating the delusions and hallucinations associated with dementia and that comorbid major depression may respond to antidepressants. Both are widely used for these indications in clinical practice [48]. It is not desirable, however, to treat fearfulness, dysphoria, irritability and other "negative" affects solely with psychotropic medications, all of which work variably and can have adverse effects.

6.5 Electroconvulsive Therapy (ECT)

The Literature

Electroconvulsive therapy (ECT) remains one of the most effective treatment modalities for several psychiatric conditions. The main indication for the use of ECT in the elderly is major depressive disorder with melancholia and/or psychotic features and/or suicide risk, which is severe and/or unresponsive to medication [91]. Other factors influencing the decision to use ECT include the need for a rapid response to treatment, severe agitation, a previous response to ECT, the ability of the consumer to tolerate the anaesthetic and the consumers' preferred treatment modality [92]. Its use in depression and catatonia has been consistently and empirically validated in adult consumers [93].

Although there is little doubt among clinicians practising in old age psychiatry about the efficacy and safety of ECT in depression, opinions about acceptability differ widely [94]. A Cochrane review examined the evidence of the efficacy and safety of ECT in elderly with and without comorbid disorders such as cerebrovascular disease, Alzheimer's dementia, vascular dementia and Parkinson's disease. There were few randomised controlled trials. There were no negative studies with respect to efficacy. The review concluded that ECT is effective in the treatment of acute late life depression. It is generally safe although a number of serious complications possibly related to ECT have been described. However, all trials had major methodological shortcomings and reports were mostly lacking the essential information required to perform a quantitative analysis. Randomised evidence on the efficacy and safety of ECT in depressed elderly with concomitant dementia, cerebrovascular disorders or Parkinson's disease was lacking completely.

A recent retrospective chart review suggested that continuation-maintenance ECT is effective in reducing depressed older consumers' hospital re-admissions [95].

It has been estimated that 30 to 50 consumers per 100,000 population per year require ECT [96]. For unclear reasons wide variation in ECT practice seem to exist regionally [97] and surveys over the last 20 years have suggested declines in ECT treatment rates in the USA [98, 99] and the UK [100].

Current Practice

The focus groups generally agreed that it was important to have access to ECT. However, three units did not have availability of ECT on site and older consumers required transfer to another hospital for this treatment. These units reported very low utilisation of ECT and tended to use alternative management strategies for the treatment of conditions that may have been treated with ECT if it had been more easily accessible. These units had a relatively higher proportion of older consumers with BPSD, and correspondingly lower proportion of older consumers with major depressive disorder such that rates of ECT utilisation were not directly comparable.

The Far West Local Health District has no capacity to provide ECT other than to transfer to another facility in Dubbo or Orange. The option of maintenance ECT is therefore not viable in this LHD.

ECT was conducted in operating theatres at all but one unit which had its own dedicated ECT suite. Units reported varying levels of accessibility to operating theatres. One SMHSOP AIU required an ambulance to transport older consumers across the campus of the main hospital.

All units reported that staff were required to provide direct older consumer care and supervision from the time of ECT until recovery and transport back to the SMHSOP AIU. This generally required up to four hours and placed a strain on staffing levels within the units on the days ECT was conducted.

6.6 Family and Carer Education and Therapy

The RANZCP has recommended that family/carer education and therapy should be available in all adult inpatient services. In regards to older consumers with mental disorders, family intervention has been shown to benefit the consumer and caregiver alike [101, 102]. Both the known morbidity associated with caring, and the impact of the carer on the outcome of mental disorder in the elderly suggests that family work is an appropriate intervention in older people's inpatient units.

The *Aboriginal Older Peoples' Mental Health Project Report* [17] highlights that family and community connections are considered very important to older

Aboriginal and Torres Strait Islander people, particularly their connections and passing of cultural knowledge onto younger people. Understanding culture and older Aboriginal and Torres Strait person's contribution to, and inclusion within, culture and family are important factors that may impact on family/carer education and therapy. The incorporation of a holistic view of mental health and social and emotional wellbeing is also important, as well as the understanding that older Aboriginal and Torres Strait Islander people may experience mental health not only at an individual level but also at the community level. The impact of transgenerational trauma for both the older Aboriginal and Torres Strait Islander person and their family/communities is also an important factor. Aboriginal service providers and clinicians can facilitate and enhance the effectiveness of family/carer education and therapy for Aboriginal and Torres Strait Islander people.

Alleviation of carer burden, and strain in the carer-consumer relationship have been linked to rates of recovery, relapse and suicide in depressed older consumers [44, 103]. For consumers with dementia, working with the family reduces carer burden and depression [104, 105], assists in the management of BPSD [106], reduces time to placement in residential care [107] and facilitates placement. Family-centred counselling is part of person-centred care and addresses a range of issues such as daily living with dementia, family problems and family conflict [108]. Addressing family conflict in dementia has potential benefits for caregiver and older consumer alike due to its effects on caregiver mental health (e.g. depression and anger), perceived burden [109, 110], guardianship applications [111] and the provision of care for the older consumer [112]. Psychosis in older people has significant effects on family relationships and can cause alienation of family members, family conflict and social isolation of the older consumer.

Family work can be a productive adjunct to other treatments in the setting of dementia, psychosis and depression in old age. This includes provision of psychological intervention for anxiety and depressive symptoms in the form of CBT and supportive/grief counselling.

While there are a diverse range of approaches in family and systems therapy (e.g., psychoeducational, behavioural/problem-solving, systemic, strategic, psychodynamic), there are many similarities in the various models which can be applied usefully to family work in

inpatient units, and the choice of approach will depend on the skills, training and resources of staff and older consumer needs.

Through being community-oriented and community-based, non-government organisations (NGOs) including Aboriginal medical services, are often sensitive to new issues and changing community needs and can be well placed to develop innovative forms of service delivery. In many instances they may act as advocates for their clients and frequently provide services for those groups which feel alienated from, and have difficulty accessing mainstream health services. *Mental Health Carers ARAFMI NSW* and *Carers NSW* are dedicated to the needs of families and carers. They provide education for carers and families directly or with the help of professional services. They are a useful first contact for families in whom someone has recently been diagnosed with a mental illness, especially when the family may be fearful of the mental health service.

6.7 Social and Legal Interventions

Social and legal interventions are often a key component of care in the SMHSOP AIU. These will often involve interventions related to administration of the Mental Health and Guardianship Acts, and liaison with related agencies. Such interventions may also involve linking older consumers with appropriate community services or residential care, which can require extensive knowledge of a complex array of available resources. The provision of such services is often fundamental to successful reintegration of older consumers into the community. Some older consumers will require alternative accommodation to be found, protection from financial exploitation or medico-legal assistance.

6.8 Other Interventions

There are many other interventions which are reported to be useful in SMHSOP AIUs. These include such diverse interventions as functional and skills retraining, strength and balance training for falls prevention, wound care, podiatry, speech therapy, nutritional interventions, dental care and welfare support, such as paying bills. In addition, older consumers in SMHSOP AIUs may benefit from exercise, diversional therapy, tailored activity programs, carer support, provision of equipment, hairdressing, home care assessments and assistance with vision and hearing.

6.9 Recommendations: Clinical Interventions

Milieu

1. The physical and care environment should promote recovery from illness, maintenance of function and a person-centred philosophy of care.
2. Older consumers will not be excluded from particular treatments on the basis of age or dependency.
3. Older consumers will have tailored individual treatment plans.
4. This should include measures for the functional separation of older consumers likely to be adversely affected by frequent interactions such as depressed, anxious or very frail older consumers from older consumers with BPSD or similar degrees of behavioural disturbance and/or disorganisation.

Psychotherapy and education

5. All staff should consider the therapeutic value of their interactions with older consumers and/or carers and be supported by appropriate training. All older consumers and/or their carers should receive appropriate psychoeducation and/or skills training.
6. All older consumers should have access to appropriate specific psychotherapy if indicated.
7. Behavioural interventions tailored to individual consumer needs should be augmented by a general environment which complements specific therapies.

Pharmacotherapy

8. Pharmacotherapy must be based upon relevant guidelines, with appropriate adaptation for age, frailty and/or medical comorbidities.
9. Decisions to initiate medication should only occur after careful review of risks and benefits; and appropriate discussion with the consumer and/or carer.
10. Consent must be obtained for voluntary older consumers, and should be sought from all older consumers or their substitute decision makers (if appropriate).
11. Information about medications, and access to these after discharge, must be discussed with the consumer and/or their carer and GP, prior to discharge.

ECT

12. All SMHSOP AIU should have local access to ECT. This must be conducted in a manner consistent with the NSW Health ECT Guidelines. This is ideally in a dedicated ECT facility within a theatre complex, with dedicated staffing. Stand-alone ECT suites can provide excellent and clinically effective ECT.

Family and Carer Education and Therapy

13. All families and carers should have access to appropriate education and interventions in inpatient units. This may include anxiety management, support and grief counselling, as well as other interventions based on identified needs.
14. Staff must ensure carers and families understand the interventions and provide education and strategies to reduce the stress and stigma associated with some of the treatment options.
15. Families should be encouraged to utilise appropriate support such as ARAFMI NSW, Carers NSW, Alzheimer's Australia and other family and carer support services.

Other interventions

16. SMHSOP AIUs must develop non-pharmacological interventions appropriate for the range of common conditions managed within the units. Such strategies must be based upon a person-centred assessment and care plan and may involve both group and individual activities.
17. Person-centred care and non-pharmacological management should be emphasised in the management of BPSD and less reliance placed on psychopharmacology.
18. If the overall level of older consumer dependency is high, AIUs should ensure that staffing is adequate to provide safe and appropriate care.

6.10 Service Development Guidelines: Clinical Interventions

Milieu

Basic specific features

The environment is perceived as familiar, welcoming and non-threatening for older consumers and their families.
There is an ability to include 'personal' features to help orientate older consumers and/or make them less anxious about admission.
There exists a facility for older consumers to be able to retreat to private areas within the unit as required.
There is utilisation of admission information to facilitate person-centred care.

Advanced specific features

There is segregation of older consumers with BPSD from other vulnerable consumers.

Innovative specific features

There is regular independent assessment of the overall ward milieu with input from older consumers and carers.

Psychotherapy and education

Basic specific features

Staff receive training regarding person-centred care techniques, aggression minimisation in older people, and reflective listening.
Staff are resourced and trained to provide psychoeducation and information regarding:

- Sleep hygiene
- Simple relaxation techniques
- Common mental health conditions in older people
- Medication compliance
- ECT
- Common psychiatric medications used in older people
- Community and residential supports for older people.

There is access to time-limited clinical psychologist input for selected cases.

Advanced specific features

There is the availability of regular access to clinical psychologist input and psychology interventions.
There is the availability of aromatherapy, bed baths, person-centred bathing and preferred music for older consumers with BPSD.
Staff are resourced and trained to provide psychoeducation regarding:

- Consent issues in older people
- Structured problem solving.

Innovative specific features

There is availability and/or provision of psychotherapy in an integrated manner across inpatient and community settings.

Pharmacotherapy

Basic specific features

SMHSOP AIUs have:

- a review of medication charts by a pharmacist at least weekly
- availability of prescribing guidelines for psychotropic medications
- a process for review of all medication-related incidents
- a process for direct consultant psychiatrist involvement in the commencement and regular review of all medications.

Advanced specific features

SMHSOP AIUs have:

- a pharmacist present at team case reviews
- availability of prescribing guidelines for psychotropic medications with specific guidance for use in the SMHSOP target population
- a process for review of trended information regarding SMHSOP AIU medication related incidents.

Innovative specific features

A process for review of trended information regarding SMHSOP AIU medication related incidents and prescribing patterns.

Basic specific features

The indication for the use of ECT is clearly documented in the consumer's file including both the diagnosis and the reason for the choice of ECT.

A second opinion from a psychiatrist experienced in the practice of ECT is sought:

- when there is any uncertainty about the recommendation of ECT
- when ECT is being considered for indications other than those listed in the Guidelines: *ECT Minimum Standards of Practice in NSW* [4].

All older consumers undergo assessment of cognitive function prior to ECT, during the ECT course, and at the completion of the course. Unusual levels of confusion or memory problems prompt a review of ECT.

A pre-ECT work-up is performed and documented, including a thorough history, physical (including neurological) examination, clinically relevant investigations and specialist consultations. A CT brain scan is performed if raised intracranial pressure is suspected. A pre-ECT anaesthetic consultation occurs. Other consultations are available as required.

A medication review occurs prior to ECT in order to minimise psychotropic medications.

Specific requirements of the NSW Mental Health Act govern the information that must be provided for informed consent for ECT. It is particularly important that the older consumer is aware of and understands the risks of the treatment as might apply to the older consumer's own circumstances.

ECT is administered to an involuntary older consumer in accordance with an ECT determination made by the MHRT at an ECT Administration Inquiry.

ECT services are designed in a consumer-focused manner that respects the need for autonomy and privacy. Minimum standards for ECT facility and recovery design, equipment and staffing are adhered to.

A medical officer who has clinical privileging for providing ECT is present at each treatment.

If ECT is not available onsite then the consumer is able to be transferred to an appropriate facility for the course of ECT, with the appropriate communication to ensure continuity of care.

Achievement and maintenance of ECT minimum standards of clinical practice is overseen by a Standing Committee.

Advanced specific features

Cognitive assessments occur during the treatment course to assist in early detection of cognitive deficits and facilitate alterations in treatment technique to minimise adverse cognitive effects.

ECT is administered within an appropriate day-only procedure area or theatre. It is strongly recommended that it is not administered in the recovery area or other areas that lack privacy.

There is dedicated staffing provided for ECT.

While there are many factors that influence electrode placement, electrode placement should be unilateral, with appropriate supra-threshold dosage, for many older consumers.

Following the end of a treatment course and discharge from hospital it is recommended that the consumer be monitored regularly by a psychiatrist or community team in conjunction with the GP for a minimum of six months.

Continuation, maintenance and outpatient ECT is available locally and given in accordance with the *Guidelines: ECT Minimum Standards of Practice in NSW* [4].

All consumers have access to ECT locally. This is ideally in a dedicated ECT facility within a theatre complex.

Innovative specific features

Both consultant psychiatrists and anaesthetists attend every ECT.

There is a regular forum for peer review of older consumers with challenging problems e.g. area wide ECT Grand Rounds.

Other Interventions

Basic specific features

There are a range of appropriate diversional therapy activities.

There is access to appropriate exercise activities.

There are appropriate activities to promote socialisation and maintenance of role (e.g. 'morning tea' with older consumers possibly including carers assisting with preparation).

There is the availability of person-centred behavioural assessment and modification techniques, with appropriate staff training and availability of resources.

There are appropriate procedures, and staff training for the management of severe aggression.

Advanced specific features

There is the availability of individualised diversional therapy based on appropriate assessment.

There is a 'quiet' or 'modified stimulation' room with appropriate procedures and staff training.

Innovative specific features

There is implementation and evaluation of other forms of non-pharmacological management.

There is availability of relaxation training, desensitisation, habit retraining, biofeedback, and behaviour modification techniques.

There is an emphasis on behavioural management of BPSD and less reliance on psychopharmacology.

Seclusion and Restraint

The Literature

The NSW Health Policy Directive, PD2012_035 *Aggression, seclusion and restraint: preventing, minimising and managing disturbed behaviour in mental health facilities in NSW* [5] discusses interventions to be undertaken in NSW mental health facilities to minimise and manage disturbed behaviour. Its major focus is on the prevention of aggressive behaviour. It also includes information about seclusion and restraint practices. It emphasises the minimisation of all forms of seclusion and restraint and early intervention with person-centred care to assist this. It recommends that seclusion rooms not be provided in SMHSOP AIUs. The guideline for implementation of the Policy Directive for older people in mental health settings supports this policy directive [5].

There is no research available on the use of seclusion for older people, and very limited research on the use of restraint of older mental health consumers [113]. The only published case series regarding the safety of physical restraint in older mental health consumers [114] found injury rate incidence of 2% for older consumers and 9.2% for staff. Injuries to arms were most common for both groups.

It is important to note that older consumers from an Aboriginal and Torres Strait Islander background may be at particular risk of self-harm whilst in seclusion, and should be monitored closely. Staff should note the following recommendation in the *Final Report Of The Royal Commission Into Aboriginal Deaths In Custody* [115] “Wherever possible, Aboriginal detainees should not be placed alone in a police cell” (Recommendation 144). The report reinforces “the importance of maintaining human contact as a means of reducing the risk of self-harm as the isolation experienced can markedly increase the distress reactants” [115].

Observational studies in other settings indicate that physical restraint may increase the risk of falls, serious injury and an increased length of stay in hospital [116]. Restraint use is recommended to only be used as a short

term solution to a circumstance or behaviour of concern. It should only be considered after a comprehensive assessment has been undertaken to determine the cause of the behaviour and preventative strategies undertaken [117].

Restraint devices include locked exit doors in facilities and fenced areas with locked gates, which are considered the least restrictive forms of restraint [117].

Other forms of restraint include [117]:

- Chairs with deep seats
- Rockers and recliners
- Large pillows/ bean bags on floors
- Comfort or supportive chairs which prevent a person slumping or support posture
- Any skeletal support that restricts mobility
- Lap rugs with ties
- Lap sashes (waist restraints)
- Hand mitts
- Geri/protective chairs with tables
- Wheelchair safety bars
- Seat belts on chairs
- Concave mattresses
- Rolled blankets or swimming noodles under sheets — (the person may believe they cannot get past them).

Manacles or hard shackles, leg or ankle restraints, soft wrist or hand restraints, Posey criss-cross vest and seclusion are considered as extreme restraints and are not to be used in Aged Care. Bed rails and the use of medications (chemical restraint) are high risk restraint procedures. Consultation, assessment and communication is required prior to the administration of sedatives or tranquilisers [117].

Sensory modulation has been shown to be effective in the management of agitation and anxiety, thereby reducing restraint [118].

The NSW Health Policy Directive and guideline for implementation has further and more specific material regarding the prevention of aggression, and safest approaches to the use of seclusion and restraint in older people. It provides the most comprehensive and current recommendations for the use of seclusion and restraint in older people in AIUs [5].

Current Practice

No SMHSOP AIU in NSW currently has a seclusion room within the unit. A number of SMHSOP AIUs, however, are co-located with Adult AIUs that include seclusion rooms. Focus groups reported that it was rare, but not unheard of, for inpatients to be transferred to the Adult AIU for the purposes of seclusion. NSW SMHSOP Benchmarking in 2010 found seclusion was only used in one unit and the seclusion room located in the adult mental health unit. There was no support expressed for seclusion within current older people's inpatient units.

Units which managed older consumers with BPSD or admitted younger consumers identified very high levels of aggression within their units. The units which admitted older consumers with BPSD reported use of restraint as a tool to care for these consumers.

Reasons cited for utilising restraint revolved around older consumer and staff safety and were diverse, ranging from lack of appropriate space for consumers with challenging behaviours and the mix of consumers within the units. However, not all units that managed older consumers with BPSD appeared to use mechanical restraint at the same rate. Both the physical environment and clinician preference appeared to play a significant role in the decision to use restraints.

NSW SMHSOP benchmarking in 2010 found physical or mechanical restraint was reported to be used in 75% of participating units. Responses and forum discussion suggested that variation in practice impacted upon admission criteria and decisions to transfer older consumers to other units related to behavioural management.

No unit in NSW has access to a sensory modulation room or equipment.

7.1 Recommendations: Seclusion and Restraint

Seclusion and restraint

1. Units should aim to minimise the use of all forms of seclusion or restraint in older people.
2. Units should:
 - Not include a seclusion room unless specific issues indicate the necessity for this
 - Have clear policies regarding when the use of a courtyard or other larger area may be considered seclusion
 - Have clear guidance regarding indications for transfer to an alternate unit of a consumer due to need for seclusion to ensure that such transfers are appropriate and safe.
3. The use of restraint and seclusion is guided by the following principles:
 - The safety and wellbeing of the person is vital
 - The safety and wellbeing of staff is vital
 - Seclusion or restraint is used for the minimum period of time
 - All actions undertaken by staff are able to be justified and proportional to the consumer's behaviour
 - Any restraint used must be the least restrictive to ensure safety
 - The consumer is regularly reviewed and monitored so that any deterioration in their physical condition is noted and managed promptly and appropriately.
4. If restraint cannot be avoided then it must only be used:
 - After clinical review
 - For the briefest period required to allow the consumer to regain control of their behaviour and maintain their safety
 - In the form that is considered to have the least risk to the individual consumer.

7.2 Service Development Guidelines: Seclusion and Restraint

Seclusion and restraint

Basic specific features

Relevant NSW Policy and relevant Guidelines are adhered to.

Regular review of all episodes of seclusion or restraint use in accordance with NSW Health policy.

Falls prevention strategies are in place to reduce the need for restraint aimed at preventing falls.

Advanced specific features

Programs to enhance mobility are a core activity within the unit.

Quality initiatives occur that focus upon preventing occurrence of incidents potentially requiring seclusion or restraint.

Innovative specific features

Seclusion and restraint is eliminated through preventative strategies.

The AIU has a sensory modulation room/equipment.

Facility Design

Physical design of the SMHSOP AIU is outside the scope of this project except where it is directly related to the model of care.

Policy and Literature

Physical environment plays an important role in the care of people with mental health problems. There are special environmental issues for people with dementia [119] but designing the SMHSOP AIU for dementia may compromise the optimal environment for other older consumers.

Clients who suffer BPSD have symptoms which tend to fluctuate over time, including restlessness, intrusiveness, physical violence and aggression [1]. Staff caring for older consumers with challenging behaviours need to be able to identify the factors which may lead to challenging behaviours, including facility design factors. The model of care would need to consider design in a therapeutic way to reduce or alleviate any problems which this may cause [120].

Fleming [119] states that patterns of care frequently change, as do the needs of the populations served, therefore it is critical that physical environments

are flexible and can adapt over time in response to changes in practice and treatment. This flexibility should be provided in ways that will maintain a positive and therapeutic physical environment and requires consultation with key stakeholders to ensure physical environments are safe and enhance the delivery of high standards of consumer care. Therefore it is essential that service managers, older consumers and clinicians are consulted regarding the operational policies and models of care in each facility [11].

The unit must provide a high level of security and have the capacity to contain an aggressive and agitated older consumer who may present a risk to themselves or others [120]. A recent literature review highlighted the importance of unit design in managing the mix of older consumers commonly admitted to SMHSOP AIUs [121]. Segregation of older consumers with severe agitation is critical to the safe and effective functioning of the unit. Sensory modulation has been shown to be effective in the management of agitation and anxiety leading to reduced need for restraint [118].

Table 4
Total beds in all NSW SMHSOP AIUs

Facility	Description	Number of beds	Location
Miri Miri	Acute	15	Wyong Hospital, NSCCH
Riverglen	Acute	20	Greenwich Hospital, NSCCH
East Wing PGU	Acute	10	Manly Hospital, NSCCH
Audley Clinic	Acute + long stay	16 + 12	Bloomfield Hospital, GWAHS
SMHSOP Inpatient Unit	Acute	14	Wollongong Hospital, SESIAHS
Euroa	Acute / Neuropsych	6/2	Prince Of Wales Hospital, Randwick, SESIAHS
St George MHU	Adult MH	Nominal 6/28	St George Hospital, SESIAHS
Catherine Mahoney Unit	Acute	15	St Joseph's Hospital, SWAHS
Ward C4B	Acute	10	Westmead Hospital, SWAHS
Ward 2D	Acute	20	Bankstown-Lidcombe Hospital, SSWAHS
Jara	Acute	30	Concord Hospital, SSWAHS
Braeside OAMH	Subacute	16	Braeside Hospital, SSWAHS
Mental Health Unit for Older People	Acute	18-22	Mental Health Centre, Waratah, HNEH
David Morgan Centre	Acute + long stay	16 + 16	Kenmore Hospital, Goulburn, GSAHS

Current Practice

There are concurrent processes in place to address facility design through the development of Australasian Health Facility Guidelines for Older Person's Acute Mental Health Inpatient Units [120]. However, the focus groups highlighted the impact that their current facility design had on their model of care, either through lack of suitable space to manage some older consumers, especially those with BPSD, or inappropriate location such as the fourth floor of hospital with no access to outdoors.

It should be noted that the newer units were generally superior in their physical design to the older facilities, yet sometimes even fairly new units had major problems, e.g. not located on the ground floor, lack of outdoor access, poor acoustics and inadequate storage. The general noise level can be shattering, commonly from a blaring television in a large common area or banging bedroom doors. The most recently constructed AIUs that the project team visited were among the most problematic in noise attenuation; even when the designers had been asked to carefully address this issue by the 'user groups'. A lack of handrails in units was also problematic, due to the increased risk of falls in this client group.

8.1 Unit Size and Capacity

Policy and Literature

The total unit size and capacity are determined by local service needs. The *Health Facility Guidelines* [120] provide specific advice about optimal unit size and configuration. Bed numbers are recommended to be between 8 and 12 beds per cluster depending on local factors. Larger facilities may be more confusing for older consumers and high quality care is easier to provide in small groups [119]. Groups of eight beds have been found to be sufficiently small for the care of mobile, confused and disturbed older people. An 18-24 bed unit, consisting of multiple clusters, is considered to be efficient from a staffing and budget perspective [120].

Current Practice

The total number of beds in each current unit varies from 6-32. The larger units have separate wings and segregate older consumers according to acuity and sometimes gender. The maximum non-segregated group was 20 beds.

8.2 Security

Policy and Literature

Protecting People and Property, *NSW Health Policy and Guidelines for Security Risk Management in Health Facilities* [122]) states that the following aspects need to be considered:

- Safety of consumers, staff and visitors
- Consumers' legal rights
- The status of the hospital or part thereof under the *NSW Mental Health Act*
- Legislation in force at the time of development.
- Procedures in safety and security should cover:
 - Admission and inpatient assessment
 - Discharge planning and process
 - Delirium and falls risk management (may be that of overall service or hospital)
- ECT
- Medication provision and risk management
- Inpatient care including maintenance of functional mobility and the frail older person in hospital
- Behavioural emergencies including management of severe risk to others.

8.3 Locking Doors

Policy and Literature

Over time psychiatric inpatient wards have gone through several phases where doors were either open or locked [123]. The issue of whether or not psychiatric facilities should generally be locked continues to be debated. There is no literature as to whether the doors on wards for voluntary PGU consumers should be locked or not.

The prevalence of locked psychiatric units in the UK and Sweden ranges from 25-73% [124, 125]. A recent literature review of locked doors in adult acute inpatient

units summarised 11 empirical papers. Both staff and consumers reported advantages (e.g. preventing illegal substances from entering the ward and preventing consumers from absconding and harming themselves or others) and disadvantages (e.g. making consumers feel depressed, confined and creating extra work for staff).

Gudeman [126] stated that acute psychiatric units in general hospitals and psychiatric hospitals are locked because of the community perception of consumer dangerousness, for the convenience of staff and because of stigma and hospital wide resistance. His opinion is that when units have been opened few disasters have occurred and consumers are less stigmatised and better able to integrate into the community. Haglund *et al.* [124] found that the staff mentioned more disadvantages than advantages to having locked doors. The effect of locked doors on key outcomes such as prevention of harm, use of psychopharmacology or staffing levels has not been

investigated. On the other hand Rae [127], concludes that there are overall benefits to improving safety by the locking of doors in adult acute inpatient units.

Within the AIU, consumers' desires to lock their bedroom doors may conflict with the needs of staff to have access to them in case of mishap. Psychiatric Intensive Care Units (PICUs) in the UK have evolved, somewhat paradoxically, in synchrony with the development of 'open door' policies [128] supports the notion of segregation of consumers according to risk/diagnosis.

Current Practice

As elsewhere in the world, and in adult acute inpatient units [123] there is a trend towards SMHSOP AIUs once again becoming locked on a permanent basis. The majority of the current units in NSW are locked.

8.4 Recommendations: Facility Design

Facility Design

1. Follow design guidelines (Australasian Health Facility Guidelines for Older Persons Acute Mental Health Inpatient Units) with particular attention to adequate space for BPSD, acoustics, features to optimise mobility and reduce falls.
2. The environment will be stimulating and include regular sessions of therapeutic activities or appropriate occupation to aid consumer recovery.
3. Functional separation of older consumers with BPSD from older consumers' vulnerable to adverse impacts from co-management is essential to this model. Therefore the Health Facility Guideline 'optional' feature of a high dependency unit should be prioritised in the construction of new SMHSOP inpatient units.
4. Ground floor location and access to outdoor garden areas is highly desirable.

Unit Size and Capacity

5. 8-12 beds per cluster. 6-8 per BPSD cluster.

Security

6. Access to security services and staff, duress alarms, and behavioural emergency response teams should be consistent with that of other acute mental health units. Behavioural response teams must have appropriate training to respond to behavioural emergencies involving consumers with dementia.

Locking doors

7. Flexible door policy with both secure and non-secure parts of the unit.
8. Older consumers at high risk of harming themselves or others should have access to a secure high dependency ward area.

8.5 Service Development Guidelines: Facility Design

Facility Design

Basic specific features

Good visual access to all parts of the unit and avoidance of areas where older consumers may fall and not be observed.
Reduction of unnecessary stimuli and highlighting of useful stimuli.
Provision of space for planned wandering.
Provision of opportunities for both privacy and community.
Environment is as domestic as possible to encourage older consumers to use their abilities.

Advanced specific features

Ground floor location with access to outdoor garden areas.
Excellent natural lighting and views of nature.

Innovative specific features

Segregation of older consumers with BPSD.

Unit Size and Capacity

Basic specific features

The unit has large enough common spaces and corridors to minimise aggression due to crowding.
Ideally there should be 8-12 beds per cluster, with separate 6-8 beds per BPSD cluster.

Advanced specific features

Capacity of the unit is such that occupancy does not exceed 85%.

Innovative specific features

Capacity for growth to occur within the expected lifespan of the unit.

Security

Basic specific features

All staff carries duress alarms.

Advanced specific features

Separate secure and non-secure areas.
Security should be unobtrusive such that the unit does not look like a prison.

Innovative specific features

Flexible door policy.

Locking doors

Basic specific features

Ability to lock exit doors when required.

Advanced specific features

Older consumers at high risk of harming themselves or others should have access to a secure high dependency ward area.
Unit doors may not then need to be locked.

Innovative specific features

Staffing

Policy and Literature

The assessment and management of the complex physical psychiatric and social needs of SMHSOP inpatients require a multidisciplinary team approach [129]. Staff require specialist training to manage the problems associated with cognitive impairment, restricted mobility, physical illness and sensory impairment and to bring extensive knowledge and skills to their practice as well as the capacity to work in collaboration with a number of key stakeholders [130].

Orientation is an essential and important part of the recruitment process and creates a framework for new employees to become effective members of the organisation [131]. "The entry of new employees into the workplace represents a unique opportunity for managers and colleagues to initiate the development of professional and constructive relationships, and model behaviour and attitudes which support the achievement of the goals of the Health Service" [131]. The orientation program should not be seen simply as a 'one-off' event, but linked to a range of structured activities and support processes which may last several weeks or months. The program should include the following components: essential information regarding duties; employment conditions; policies relating to the AIU; fire safety evacuation procedures and other emergency protocols; an ongoing support system (e.g. mentoring, coaching or 'buddy' system) which is linked to the organisation's performance management system; appropriate level of aggression minimisation and management training; occupational health and safety; quality improvement process; and cultural awareness education and training among others [131].

Patience, social competence and calmness are important traits for staff to display when caring for older consumers. They also require the ability to analyse and interpret situations and have a good understanding of mental health and aged related conditions. Ongoing professional development is required to develop and maintain these skills [59].

Learning and development are supported in NSW Health facilities [132]. Current policy includes that learning activities should be made available to all eligible staff to promote the development of a highly trained skilled and versatile workforce supporting the provision of safe, quality health care. A number of principles are outlined to support this. They include the concept of NSW Health as a "learning organisation in which each staff member is encouraged and supported to locate and create their own learning opportunities" relevant to actual work situations, as well as the concept that "each employee must share the responsibility for their own development" [132]. Relevant training for staff who undertake assessment and care planning includes: risk assessment and management; suicide awareness and prevention; processes of referrals to other agencies; assessing carers' needs; discharge planning; dementia awareness and how to assess and support people with visual or hearing impairments.

Each health service must also make decisions relating to whether particular training is mandatory. "The trigger for this may be external stimuli such as government grants or legislation, internal organisational factors such as temporary skill shortages, or required training in fire safety, infection control, and occupational health and safety, for example" [132].

Staff may work across inpatient and community SMHSOP, facilitating continuity of care and other theoretical advantages [133]. However, there appears to be a current trend against this model in the UK, where it has traditionally been implemented.

Staffing numbers required will vary significantly depending on the acuity and presenting problems of the older consumers admitted. In particular, older consumers admitted with BPSD will require higher ratios of nursing staff. Gonski *et al* [134] report 24 hour staffing for a behavioural unit in an acute hospital of at least two nurses / six consumers (or more depending on severity of behaviour). Shortage of staff, especially those adequately trained, increases incidence of violence [135].

Current Practice

The range of staffing and their skill levels varied across all units. Many staff have limited experience in mental health, though may have extensive experience in aged care settings. Conversely, some mental health trained staff have limited expertise in assessing and managing common geriatric medical comorbidities.

SMHSOP AIUs reported that promoting learning and development to enhance staff expertise is of crucial importance. Units have found it to be a very valuable investment over time.

Focus group participants reported inadequate staffing numbers and that higher staff-to-consumer ratios were needed due to issues such as the high prevalence of comorbidity in the AIUs. It was felt that older consumers with BPSD required higher staffing ratios.

Staff shortages were reported as impacting on the quality of care provided. Focus groups also identified that lack of dedicated multidisciplinary staff in acute units meant that available therapies were limited in some units. Reasons for staff shortages were identified as either due to lack of funding or issues with recruitment.

In small rural and remote facilities it remains an ongoing challenge to recruit, develop and maintain staff with the appropriate mix of skills, knowledge and attitudes.

Vertical integration was discussed in the focus groups to gauge interest in this type of staffing arrangement. This model refers to the concept of staff seamlessly working across both inpatient and community settings. It has been proposed as a solution to disjunctions in transitions of care and to maximise continuity. Most units supported vertical integration in principle but there appeared to be only limited implementation in practice. It was felt easiest to implement for psychiatrists and most difficult for nursing staff, for whom there were often financial disincentives. Some argued that, even for psychiatrists, any benefits of vertical integration might be offset by a weakening in clinical leadership in the inpatient unit. It was noted that those units that had a consistent psychiatrist presence over a number of years tended to have more well defined and functional models of care and this tended to reinforce the argument against the vertical model.

Units who participated in Benchmarking Phase 1 [10], provided data regarding staffing profiles. These data are outlined in Table 5.

Table 5
NSW SMHSOP inpatient staffing profiles, number of beds and total Full Time Equivalent (FTE), Benchmarking Report Phase One, 2009

Unit	Number of Beds*	Nursing FTE	Managerial FTE	Admin FTE	Medical staff FTE	Allied health FTE	Domestic FTE	Other non-clinical FTE	Total FTE Current
Unit 1	16	17.0	1.0	1.0	2.6	2.5	1.4	0.0	25.5
Unit 2	8	16.4	2.0	0.0	3.0	4.6	3.4	0.0	29.4
Unit 3	32	20.0	1.0	0.6	1.8	1.4	10.7	0.0	35.5
Unit 4	15	13.7	2.0	1.8	5.0	3.5	2.0	1.0	29.2
Unit 5	10	7.0	1.0	1.0	3.0	3.0			15.0
Unit 6	16		1.0			2.2			3.2
Unit 7	15	#	#	#	#	#	#	#	#

Note: * Some units also include subacute, neuropsychological or long stay beds.
Data not provided

9.1 Medical

Consultant psychiatrists provide clinical expertise and clinical leadership across mental health services. This role is particularly important in acute inpatient settings where the psychiatrists' expertise and experience is essential to diagnosis, management, communication with consumers and families, risk management and consumer safety [136]. All consumers receiving inpatient care are admitted under a consultant psychiatrist. The psychiatrist is responsible for overseeing their care and safety and communicating with the consumer's primary carer and/or relatives.

Registrars, career medical officers (CMOs) and resident medical officers (RMOs) provide support to the consultants.

Access to other medical staff is required, including geriatricians, rehabilitation specialists, general and specialist physicians, surgeons, anaesthetists, ophthalmologists, ENT, palliative care and radiologists. Of these, geriatricians are the most critical and arrangements need to be made for regular ward rounds and availability for consultation in the SMHSOP AIU.

9.2 Nursing

The Literature

The focus of nursing care in SMHSOP AIUs is to assist the older person to attain the greatest degree of functioning and optimal level of health and wellbeing as well as to care for, and meet, consumers' physical, psychological, social and spiritual needs [137]. Nursing staff should have knowledge in gerontology and mental health, an understanding of the nursing process, and skills and competence in implementing this care [137]. Additionally, nursing staff require an appreciation of the social context in which mental illness may manifest and the management options available if effective and appropriate consumer and carer outcomes are to be achieved [137].

In SMHSOP AIUs nurses undertake biopsychosocial assessments and participate in the development of care plans relevant to the clinical needs of the consumer, their carers' and family. Additionally, nursing staff monitor consumers' mental state, complete comprehensive risk assessments (such as harm to self and others, and falls), monitor and maintain skin integrity, mobility, assist with

continence needs [79] and activities of daily living and provide treatments as required. These structural and contextual dimensions of patient care are commonly represented through a variety of nursing care models [138].

"A nursing model pertains solely to the practice domain of nursing" [139]. There are many nursing models of care which have traditionally been used to organise the way nurses provide care to consumers. These models include team, or functional nursing, in which the care to patients is provided by a registered nurse (RN) as the team leader within the unit. This model provides direction for less skilled staff by registered nurses, and allows for reduced numbers of registered staff within the unit [140]. Another nursing model is consumer allocation (total nursing care) where one nurse takes full responsibility for the care of a group of patients. This model allows the nurse greater autonomy as the staff has control over what happens each day. The model requires a high percentage of RNs within the unit due to the increased level of responsibility undertaken by the staff member [133]. One specific nursing model of care has been developed for a mental health unit in NSW [141].

The model described in the literature as being the most relevant to mental health nursing across the lifespan is the 'Tidal Model'. The Tidal Model is a "recovery based approach to mental health care" [142]. This model "provides a structure for the development of person-centred, collaborative care in any setting" and "is an internationally accepted theory for the practice of mental health recovery". The model emphasises nurses adapting their response to consumers' needs "as they progress toward getting their life back on track" [142].

In consultations it was suggested that fundamental elements of the nursing model of care should be a recovery focus enhanced by close interpersonal relationships. However, there is no literature available which has evaluated a specific model of care. Regardless of which model of nursing care is used the goal is "to support safe delivery of patient care while sustaining professional autonomy and professional development for nurses" [138]. It has been proposed that nurses should uphold a philosophy that highlights the nursing paradigm (the nurse, the individual, their environment and health) and provide a consistent approach to positive patient and carer outcomes [143].

In 2008 the *Special Commission of Inquiry into NSW Public Hospitals (Garling Report)* [144] placed very great importance on the need to “review and redesign the role of the nurse unit manager (NUM) so as to enable the NUM to undertake clinical leadership in the supervision of patients and the enforcement of appropriate standards of safety and quality in treatment and care of patients in the unit or ward for which they are responsible” [144]. This redesign needs to encompass either the transfer of a range of duties from the NUM to other existing staff members or alternatively the creation of a role of clinical assistant to the NUM to undertake those tasks. The aim of the redesign is to ensure that the majority of the NUM’s time is applied to clinical duties rather than administration, management and transactional duties [144].

Clinical Supervision

Clinical supervision (CS) is a process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues” [145]. When nurses undertake CS the processes of reflection are employed in order to identify and meet professional development needs. The purpose of CS is to improve nursing practice and therefore should be focused on nurse-patient interaction [146].

Research has shown that CS promotes professional accountability, knowledge development and skills, as well as providing peer support and stress relief for nurses. It enables nurses to discuss patient care in an environment which is safe and supportive. Nurses participating in CS are able to provide input and feedback to colleagues which increase understanding of clinical issues. CS also provides opportunities for nurses to develop a consistent approach to consumers, families and/or carers, thus creating opportunities to improve patient care and facilitate maintenance of standards of care [147]. CS can be undertaken in small groups or individually. The process is different from performance management which is associated with achieving the goals of the organisation. It is also not to be confused with preceptorship which relates to staff orientation and training. CS is similar to peer review, but provided by a more experienced colleague [148].

The Australian College of Mental Health Nurses recommends the following guidelines for CS [148]:

- Supervisees choose their own supervisors
- Supervisors be selected on the basis of their professional experience and expertise
- Supervisors are trained in the provision of small groups and individual clinical supervision
- A signed agreement is negotiated which sets ground rules and appropriate goals
- Support arrangements, reciprocity and the allocation of time for CS are negotiated with the line manager
- Regular sessions are planned at least on a monthly basis, with the understanding that some areas of practice may require increased frequency and duration. This will also include group supervision
- Sessions are conducted free from interruption and away from the workplace or clinical area
- Small group supervision rather than individual is preferred when possible
- A record of dates, times and participants is kept by the supervisor
- All participants respect confidentiality and privacy, particularly concerning the content of sessions and potential conflicts within the workplace.

Current Practice

The range of staffing varied across units. Two units didn’t have a dedicated SMHSOP NUM which caused staff to feel there was a lack of understanding amongst mental health service management regarding the needs of older people. One former Area Health Service operates on a hospital-based NUM program which means the SMHSOP acute inpatient NUM does not apply for a designated position within the unit and can be relocated anywhere within the facility. SMHSOP Clinical Coordinators also reported an inability to participate in recruitment and selection of nursing staff within inpatient units due to local protocols which governed the selection of staff within facilities. Various models of nursing care operated within the units including team nursing, primary nursing and consumer allocation.

Despite most units not identifying a formal model of nursing care operating in their unit (at the time of focus group consultation), it was suggested that fundamental elements of such a nursing model of care should focus on recovery enhanced by close interpersonal relationships with consumers. In NSW detailed nursing staff reports,

including the use of agency staff, are monitored and reported via the Department of Health Reporting System (DOHRS) [149]. This data is reported monthly and provides nurse managers and program managers with information to assist in the monitoring of human resources. Information from DOHRS may be used for workforce planning purposes including determining funding for Nurse Strategy Reserve initiatives.

9.3 Allied Health

KPIs collected from participating organisations as part of National Benchmarking [150], indicates the following:

- The majority of allied health professionals saw clients on referral only, but once referred there was regular contact throughout the admission
- All organisations participating in the benchmarking reported allied health staff were involved in discharge planning, with the social worker (SW) and occupational therapist (OT) the most involved
- The physiotherapist undertook falls prevention activities in four organisations
- The diversional therapist (DT), physiotherapist and OT undertook exercise programs in five organisations. In three organisations it was reported that the DT undertook this activity
- Four organisations had a policy in place for consumers to be seen by a SW within one week
- Behavioural management, cognitive behavioural therapy (CBT), counselling, supportive therapies and other psychotherapies were provided by the SW, OT and/or clinical psychologist/neuropsychologist in six organisations
- Formal family meetings were attended by the SW and/or OT in seven organisations
- One organisation had a recreation officer who undertook exercise, behavioural management, CBT, counselling/supportive therapy as well as a music therapist who provided counselling/supportive therapy. This organisation did not appear to have a diversional therapist.

9.3.1 Occupational Therapy

The Literature

OTs have an important role in optimising the independence, autonomy and occupational performance of older consumers with mental illness and / or cognitive

impairments: assisting consumers to be actively engaged in their life activities [151, 152]. OTs assess the impact of mental illness on performance of these occupations and any age related physical comorbidities which further compromise ability to function [153]. Holistic assessment of older consumers therefore includes their ability to problem solve and adapt performance in novel situations, as well as their ability to complete familiar basic and instrumental activities of daily living. OT assessment involves direct observation of consumers performing functional tasks, use of standardised assessment tools and assessment of consumers' homes, community and psychosocial environments. OTs work with consumers individually or in groups.

Interventions are framed on consumer directed goals and may include strategies to improve functional performance utilising existing strengths and abilities [154]. This may include task modification; structuring daily routines and facilitating community integration; equipment prescription; home modifications; and risk reduction strategies comprising falls prevention and community living skills, including driving [151, 153, 155]. Some practices utilised in rehabilitation settings may also be relevant depending on comorbidities, such as physical strengthening programs.

OTs also have a major role in discharge planning to ensure consumers are safe and optimally supported in the community. Safe discharge home can be implemented in spite of the presence of unresolved symptoms of mental illness and/or cognitive impairment. Interventions on discharge can include education of carers about consumers' best ability to function, timing and type of assistance required, (such as training carers in how to assist and cue behaviours and actions), safety precautions and use of compensatory strategies, including adaptive equipment [154].

Current Practice

All units acknowledged the importance of occupational therapy within acute units, but there were varying levels of access to OTs in each of the units. Some units reported dedicated staff while others had access to hospital based personnel. Some units did not have access to OT at all and reported difficulties in conducting holistic assessments as a result.

9.3.2 Diversional Therapy

The Literature

Therapies appropriate in the SMHSOP AIU depend significantly on the older consumers' diagnoses. There is an evidence base of supporting strategies for those with BPSD which includes massage, individually tailored music, aromatherapy, reminiscence, light exercise, visual and tactile stimulation, and horticulture therapy.

Pharmacological interventions should only be considered if the older consumer is severely distressed or if there is an immediate risk of harm to themselves or others [23].

For older consumers without cognitive impairment a greater level of stimulation and challenge is generally required and the DT is able to engage individuals in a therapeutic way that meets the emotional, social and creative needs of the person. Engaging with the client in this way enables those with cognitive impairment to be stimulated through praise and positive reinforcement [156]. Research has also shown that activities which are both social and productive require less physical exertion than more structured fitness based activities and are therefore beneficial for frail elderly people [157].

There may be varied perceptions and understanding on the causes of BPSD from within the community so therapeutic interventions which have individualised and culturally relevant psychosocial actions need to be encouraged within the team [158]. For example, when DTs manage Aboriginal or Torres Strait Islander people who display symptoms of BPSD there are a number of issues to consider. These include the high level of comorbidities, communication difficulties and a high level of sensory loss which may present as a pseudo-dementia in Aboriginal older consumers [158].

Current Practice

Not all units had DTs but acknowledged the importance of this therapy in the SMHSOP AIUs. Where there was an appropriate member of staff available, therapies included craft, cooking, 'mental challenge' and physical exercise. Some units displayed items made during these groups within the units which created a sense of homeliness and engagement with older consumers.

9.3.3 Psychology

Services offered by psychologists in AIUs cover a broad range of activities, including assessing people for suspected dementia, offering education and counselling for families, assisting staff in managing BPSD, offering suggestions to improve daily functioning and quality of life for a person with dementia, and providing evidence-based treatment for psychological disorders as required [159, 160].

Psychological services for older adults may also be provided for a wide variety of comorbid physical disorders and problems, including incontinence and chronic pain [161, 162]. Provision of diagnostic and prognostic information is one of the main roles for psychologists in SMHSOP AIUs. Recommendations for planning for the future and determination of decision-making capacity are also provided. Neuropsychologists are best placed to conduct comprehensive assessment, and are in a good position to evaluate a person's capacity for making decisions on medical treatments, financial decisions, and other important matters. Determination of decision-making capacity requires clinical skills, knowledge of the relevant legislation, and particular skills in questioning consumers to evaluate their reasoning about decisions [163]. Depending on the reason for referral, a neuropsychological assessment will generally take between four and six hours, and may be completed over several sessions with due regard for the consumer's age. Test results are evaluated with regard given to the consumer's age, background and reasons for referral. A detailed typed written report is usually provided, often with recommendations for management. Appropriate feedback based on the consumer's level of cognitive function is given regarding the results of the assessment. Overall, it is not uncommon for a complex neuropsychological assessment to take 12 hours [164].

Clinical psychologists are well placed to provide advice on the management of BPSD, particularly through direct behavioural approaches [165, 166] and have demonstrated the efficacy of such an approach. This research has also shown that psychosocial approaches can be more cost-effective than psychiatric management of BPSD [167].

There remains a shortage of well-trained psychologists who can complete the neuropsychological evaluations that are critical for the necessary diagnostic work in the pre-clinical stages of dementia [159]. Many who start such work feel a lack of appropriate skills and do not remain long in positions for work with older people. This is

frequently attributed to the lack of proper training for psychological work with older people. Two programs have been started specifically to train psychologists for work with older people, the first at Edith Cowan University, which is no longer active, and the second at James Cook University. Other universities have been encouraged to start such training and some have begun to develop additional courses.

9.3.4 Social Work

Social workers are integral to the successful management of older consumers with mental illnesses in the acute care setting, working with and supporting people to achieve the best possible levels of personal and social wellbeing [168]. They meet with consumers and their families to complete a comprehensive psychosocial assessment which is focused on the consumer's needs and includes determination of personal, social, and financial resources. Through multidisciplinary clinical review processes social workers contribute to care planning [168].

Social work assistance is particularly valuable for consumers who have complex psychosocial problems or vulnerabilities. Social, financial and consumer advocacy comprise a large component of the role. Reporting to legal bodies within the mental health jurisdiction, such as the Mental Health Review Tribunal, and taking the major co-ordination role with applications to the Guardianship Tribunal of NSW are significant processes where social workers provide the interface between consumers and the multidisciplinary team, working towards an optimal outcome for consumers.

Identifying the social systems for consumers and interdependent relationships that exist with families and others in the community is central to the social work domain [168]. Engaging with carers and families is crucial – it provides the team with collateral information which may assist with management of the mental illness, as well as providing counselling, support and education for carers regarding the clinical aspects of delivery of care. Families are often faced with complex issues and interventions may be necessary to assist carers to support consumers post discharge. Such interventions may include education and stress management strategies, and normalisation of consumers' difficult behaviours is sometimes also helpful to reassure and support the family [159].

Other key roles of social workers include discharge planning, maintaining continuity of care and facilitating community reintegration [159, 169]. Education and liaison with community-based services, other government services and non-government services is essential. Where available services do not meet consumer needs, social workers are faced with the challenge of exploring how to best match consumers' needs with service availability. Discharge planning strives towards facilitating consumers to return home to the community where possible. However, placement in a residential aged care facility is a common outcome. Placement issues can be more complex for SMHSOP consumers because of overlapping medical and psychiatric needs [169].

9.4 Recommendations: Staffing

General

1. Units should adopt the person-centred, biopsychosocial, goal focused care philosophy and recruit, educate and train staff accordingly.
2. Staff should be trained in cultural awareness and cultural competence.
3. All staff should promote mental health and support prevention and early intervention for older consumers, families and carers.
4. All staff should have the appropriate skills, knowledge and attitudes to provide safe and effective care, and this should be supported by recruitment, professional development, clinical supervision and performance review (with reference to relevant core competencies).
5. Staff should be able to manage intravenous and sub-cutaneous fluids, intravenous medication, ongoing oxygen therapy, and incontinence with training provided as required.
6. Staff should be able to manage severe BPSD especially aimed at reducing or eliminating restraint use, with training provided as required.
7. Staff are informed how to access policies, procedures and guidelines and are able to do so when required.
8. All staff are consulted in the development of policies, procedures and guidelines that relate to their practice.
9. Managers audit the implementation of policies and procedures and provide feedback to all staff.
10. There is a policy and procedure on the recruitment and use of volunteer staff on the unit.
11. The unit has an agreed minimum staffing level across all shifts and this is consistently met.
12. There are systems in place to ensure that all factors that affect staff numbers and skill mix are taken into account, and staffing levels are reviewed on a daily basis. The factors include: levels of observation; sickness and absence; training; supervision; escorts; therapeutic engagement; risk of falls; risk of violence, and physical health needs.
13. Staff are given planned and quarantined time to ensure key activities and interventions are provided regularly and routinely.

Leadership and Governance

14. The SMHSOP AIU has a local clinical governance group that relates to key local and service-wide clinical governance structures and processes.
15. There are clear clinical leadership arrangements in place, supported by clinical leadership training for senior staff members.
16. Consultants are actively engaged and committed to improving the acute care pathway and developing improved ways of working.

Human resource management

17. All staff should receive appropriate orientation and induction relevant to the SMHSOP AIU in accordance with *PD2005_187* [131]. This will include allocation of a mentor or preceptor; mandatory training in line with hospital policy. (fire, CPR, manual handling, aggression minimisation) and as part of their induction all staff receive basic training in how to assess capacity and an understanding of the *NSW Guardianship Act* and *NSW Mental Health Act*.
18. All staff are aware of their level of authority and what decisions they can and cannot take, and have access to advice from senior colleagues as required.
19. Staff who undertake assessment and care planning should be supported in relevant training in accordance with *PD2006_066* [131]. These may include risk assessment and management, suicide awareness and prevention, processes of referral to other agencies, assessing carer's needs, discharge planning, dementia awareness, and how to assess and support people with visual or hearing impairments.
20. Staff should have training in cultural awareness and use of interpreter services, in line with existing policies and strategies, including SMHSOP strategies.
21. In line with existing policies [170] staff should receive an annual performance review, as well as professional development planning and clinical supervision.
22. Detailed nursing staff reports, including the use of agency staff, should be monitored and reported via DOHRS [137].
23. Managers should receive feedback from staff exit interviews [171].

Unit staff mix

24. The multidisciplinary staffing profile and approach must enable the consumer's goals of care to be achieved.
25. The unit should have a dedicated NUM with expertise in OPMH.
26. The NUM should provide clinical leadership in the supervision of patients and the enforce appropriate standards of safety and quality in treatment and care of patients in the AIU. The NUM should be supported by other staff to ensure that majority of the NUM's time is applied to clinical duties rather than administration, management and transactional duties.
27. There will be an appropriate mix of RNs, ENs, CNSs and AINs.
28. There will be access to a Clinical Nurse Educator who has expertise in OPMH.
29. There will be access to a Clinical Nurse Consultant and Nurse Educator.
30. There will be 24 hour cover of the AIU by at least one registered nurse who has relevant experience in mental health.
31. The range of allied health staff will include dedicated social workers, occupational therapists, diversional therapists, clinical and neuropsychologists and physiotherapists.
32. Older consumers will have access to specialist practitioners of psychological therapies for at least one session (four hours) per week.
33. Staffing will reflect the dependency level of the older consumers on the unit, but should be flexible enough to provide extra staffing should consumers require one to one care or supervision.
34. Sufficient consultant psychiatrist cover should be provided to supervise registrars and provide teaching, review older consumers twice weekly, provide C/L role and follow up older consumers on discharge.
35. Sufficient registrar cover should be available to ensure older consumers are seen at least once each week day.
36. At all times a doctor should be available to attend an alert by staff members within 30 minutes.

Supporting staff

37. There will be access to Aboriginal Mental Health workers for consultation as required.
38. There will be access to speech therapists, podiatrists, nutritionists and dentists as required.
39. There will be availability of consumer and carer consultants.
40. There will be access to data managers and quality and safety personnel as required.
41. There will be availability of administrative staff to support the functioning of the unit and allow clinical staff to maximise clinical care.
42. There will be access to security staff.

9.5 Service Development Guidelines: Staffing

General

Basic specific features

Units should adopt the person-centred, biopsychosocial, goal focused care philosophy and recruit, educate and train staff accordingly. Clinical supervision is provided for all staff.

Advanced specific features

Core competencies are utilised in recruitment, professional development and performance review.

Innovative specific features

Regular monitoring of staff satisfaction and quality improvement activities to address dissatisfaction.

Medical

Basic specific features

Sufficient registrar availability to ensure older consumers are seen each week day.

Sufficient consultant cover to review older consumers at least weekly and to participate in weekly clinical review.

Advanced specific features

Sufficient consultant cover to supervise registrars, review older consumers twice weekly, provide C/L role, teaching and follow up older consumers on discharge.

Innovative specific features

SMHSOP AIU considers a vertical integration model.

Consultant involvement in continuous quality improvement activities in the unit.

Nursing

Basic specific features

The nursing model and staffing profile must enable the older consumers goals of care to be achieved.

Staff trained to be able to manage IV fluids, SC fluids, IV medication, ongoing oxygen therapy, and incontinence.

Dedicated NUM, CNC, CNE with expertise in OPMH.

Advanced specific features

Staff trained to be able to manage severe BPSD especially aimed at reducing or eliminating restraint use.

Innovative specific features

Allied health

Basic specific features

Dedicated allied health staff with expertise in OPMH will include some but not necessarily all of the following disciplines: social workers, occupational therapists, diversional therapists, clinical and neuropsychologists and physiotherapists.

Advanced specific features

Dedicated allied health staff with expertise in OPMH will include all of the following disciplines: social workers, occupational therapists, diversional therapists, clinical and neuropsychologists.

Innovative specific features

There is a dedicated physiotherapist with expertise in OPMH.

Supporting Staff

Basic specific features

There is agreed access to speech therapists, podiatrists, nutritionists and dentists as required.

There is availability of consumer and carer consultants.

There is access to data managers and quality and safety personnel as required.

There is access to Aboriginal mental health workers for consultation in the AIU.

There is access to interpreters, bilingual staff and multicultural workers.

There is appropriate level of access to security staff.

Advanced specific features

Innovative specific features

Performance

Policy and Literature

NSW Health recognises that there is a responsibility to assess, achieve and maintain competence at an organisational, team and individual level to ensure the delivery of health care which is safe and effective.

Performance Managing for A Better Practice Approach for NSW Health outlines the key features to be included in Health District performance management policies [170].

Mental health services utilise the Health of the Nation Outcome Scale 65+ (HoNOS 65+) to measure severity of symptoms and health status of older people in SMHSOP services [172].

Functioning in older people is measured by the Resource Utilisation Groups – Activities of Daily Living Scale (RUG-ADL) [76, 172].

Current Practice

The National Mental Health Benchmarking project, undertaken in 2006 was a collaborative initiative undertaken to promote the sharing of information and increase understanding of the role benchmarking plays in improving service quality. Benchmarking forums within the four main programs in the public mental health sector were developed. Braeside Hospital (SSWAHS) participated in the Older Person's forum [173, 174].

The Mental Health Program Council (MHPC) endorsed the development and implementation of the SMHSOP national benchmarking project in December 2006. The aim of this project was to enable SMHSOP services to learn from each other and improve understanding of current service delivery, determine best practice and improve care. Benchmarking has since been established in NSW for the same purpose.

NSW Health recently introduced the CIBRE tool to collect data for benchmarking across NSW mental health services. The data available was extracted from the NSW Health Information Exchange (HIE) in March 2010, for the reporting period 1 July to 31 December 2009.

The peer group averages for SMHSOP AIUs across NSW against KPIs are outlined in table 6.

Table 6
Performance of NSW SMHSOP AIUs [5]

KPI	FY: Jan-June 2008	FY: Jan-June 2009
7 day follow up (%)	26.9	31.1
28 day re-admission (%)	8.6	9.9
Occupancy (% of funded beds)	86.6	82
Separations (Total #)	55.0	51.4
Admissions (% via ED)	22.7	24.9
Average length of stay (days)	49.4	116.5
Average length of stay (% Primary diagnosis)		
	Psychoses	
	44.5	204.0
	Affective Disorders	
	52.6	85.4
Average age (years)	73.6	74.3
Male Gender (%)	43.7	40.8
Resides out of area (% of sep)	8.6	6.2
Primary diagnosis (% of sep)		
	Psychotic disorders	
	23.9	27.3
	Affective Disorders	
	44.8	45.4
	Substance Disorders	
	1.9	2.4
Comorbid Diagnosis (% of sep)		
	Comorbid Personality Disorder	
	4.4	2.9
	Comorbid Substance Abuse	
	9.0	7.1
Admission HoNOS (% of sep)		
	Overactivity/Aggression	
	44.0	34.4
	Psychosis	
	43.3	48.0
	Substance problems	
	14.1	11.3
HoNOS(% of sep)		
	Any valid HoNOS	
	40.3	48.7
	Valid admission HoNOS	
	24.7	27.9
	Valid discharge HoNOS	
	30.9	32.7
	Admission/Discharge Pair	
	17.3	16.9

SMHSOP AIUs reported that nursing staff complete the *Standard Outcomes Measures* [172] on admission and discharge. Although completion rates are improving they remain low.

According to NSW SMHSOP benchmarking data [10], there were 538 discharges from the SMHSOP AIUs participating in the NSW SMHSOP benchmarking project in financial year 2007/2008.

While SMHSOP units are considered to service consumers aged over 65, all analysis for the benchmarking has used 60 years of age as the lower boundary as staff believed that the 60 to 65 age cohort contributed substantially to their workload. Consultation with area health services has indicated: some units may receive consumers as overflows from other units; and, local admission practices may underestimate admission figures [10].

10.1 Length of Stay

Policy and Literature

The severely mentally ill geriatric population differs from the general adult population in several ways that would be expected to lengthen hospitalisation. Greater levels of functional disability, cognitive impairment and medical problems make their overall care more complex. This complexity is coupled with more polypharmacy and higher rates of institutionalisation.

In one study [175] factors significantly associated with longer length of stay (LOS) were receiving ECT, greater severity of psychiatric symptoms, falling, pharmacology complications, multiple prior psychiatric hospitalisations, involuntary status, consultation delays and not performing ECT on weekends.

Moss *et al.* [176] found that LOS in an acute psychogeriatric unit in Victoria bore little relation to diagnosis, age, sex or cognitive function. Consumers with an organic mental disorder were more likely to enter long-term institutional care, but 78% of consumers were able to return to the same level of accommodation (own home, hostel or nursing home) that they had occupied prior to admission.

Studies reporting shorter lengths of stay also report a lower percentage of consumers being able to return home. For example, in one study 50 per cent of consumers were able to return home following average LOS of 32 days [129], where as only 28 per cent returned home following an average LOS of 23 days in the other study [177]. Most acute units strive for short lengths of stay. However, the costs of premature discharge – for example, costs associated with the inability to return to independent living owing to significant residual symptoms, cost of readmission for the same diagnosis within one year, and costs associated with the need for adjunct services of institutionalisation – have not been systematically studied and compared with the costs of longer inpatient admissions [40].

Knight and Carter [178] demonstrated that an intensive case management program (which included a clear commitment to getting the consumer well as quickly as possible, combined with active coordination of aftercare) was successful in reducing the length of stay for older adults admitted to their psychiatric inpatient unit.

Current Practice

Members of the SMHSOP national benchmarking forum undertook a project on length of stay as well as the inclusion of additional key performance indicators (KPIs). The data collected also included falls and the utilisation of allied health services in SMHSOP. All participants submitted data on long and short LOS. Significant differences were reported in diagnosis LOS, with schizophrenia, schizotypal and delusional disorders having a longer LOS. Those with 'other' as a diagnosis were less likely to stay greater than 7 days. The report from national benchmarking highlighted significant difference in LOS for those older people who received ECT, with this cohort more likely to stay greater than 60 days. Those who were transferred or discharged to a RACF were also more likely to stay greater than 60 days [173].

Data collected in the NSW SMHSOP benchmarking project (2008) indicated that the average length of stay for discharged (separated) consumers on the benchmarking acute units was 45.6 days and average length of stay ranged from 23 to 69 days across the units (Table 7). There was also a very large variation between each unit's average length of stay for consumers with a primary diagnosis of dementia, from 112 to 13 days with an average length of stay of 66 days.

Benchmarking data for the financial year (FY) 2007/08 found that overall, stays of seven days or less accounted for 30% of all admissions (Table 8).

Table 7
NSW SMHSOP - (Age > 60) Length of Stay – Financial Year 2007/2008

Inpatient unit	Number of beds	Number of discharges	Los mean	Los median	Los mode
Unit 1	28	58	51.1	35.5	2
Unit 2	16	68	57.5	41.5	33
Unit 3	32	68	69.2	40.5	29
Unit 4	6	72	23.4	19.5	1
Unit 5	19	78	54.2	40	5
Unit 6	10	108	31.4	24	7
Unit 7	15	86	43.1	29	4
TOTAL	126	538	45.6	29	7

Table 8
NSW SMHSOP - (Age > 60) Length of Stay Greater than 7 Days – FY2007/2008

Inpatient unit	Number of beds	Number of discharges	Los mean	Los median	Los mode
Unit 1	28	48	59.7	42	10
Unit 2	16	51	59.7	50	33
Unit 3	32	47	67.8	37	29
Unit 4	6	49	31.6	28	8
Unit 5	19	55	59.8	44	25
Unit 6	10	84	40.1	33.5	42
Unit 7	15	60	49.3	37	30
TOTAL	126	394	51.4	35	8

There appeared to be an association between average length of stay (ALOS) and the number of beds, with the smaller units appearing to have shorter ALOS. Units on the site of an Emergency Department also tended to have shorter ALOS.

10.2 Readmission Rates

Policy and Literature

Studies of the relationship between length of stay and readmission rates have had mixed results. Heeren *et al.* [179] found that although it was difficult to demonstrate causality, there appears to be a temporal association between decreasing length of stay and rate of readmission in a university hospital psychogeriatric unit. Philpot, *et al* [180] found that over a 5-8 year period, 50% of consumers were readmitted to a PGU. Readmissions were less likely in a service that had a community orientation, following longer admissions and where outpatient and community psychiatric nurse follow-ups were arranged.

Current Practice

In 2007/08 the average 28 day readmission rate for the SMHSOP Benchmarking partners ranged from 3.5% to 16.7% [181].

10.3 Outcome Measurement

Policy and Literature

Reporting of mental health outcomes data is mandatory [172].

Current Practice

SMHSOP AIUs who participated in Benchmarking Phase One reported that 426 HoNOS 65+ admission forms were completed in FY 2007/08 representing 538 separations in the same period. Most units utilised the HoNOS 65+ suite of documentation on admission and discharge. Allied health and medical staff completed the documentation in some units, but outcome measures were more commonly completed by nursing staff. One facility did not utilise this documentation as it was managed as an aged care service and not formally classified as a mental health unit [181].

10.4 Recommendations: Performance

Managing Performance

1. Mental Health Network management and performance structures should ensure that there is clear Mental Health Executive responsibility for the monitoring and improvement of the SMHSOP AIU. These duties should consider all of the *National Mental Health Performance Framework* domains.
2. SMHSOP AIUs should have a consultant psychiatrist and nursing unit manager with specific responsibilities related to monitoring and improving the performance of the SMHSOP AIU.
3. There will be consumer and carer involvement in mechanisms to monitor and improve the performance of the SMHSOP AIU.
4. The SMHSOP AIU should have mechanisms to coordinate and conduct SMHSOP-specific quality improvement activities involving staff of all relevant disciplines.
5. The SMHSOP AIU should receive regular reports to support the monitoring of performance.
6. The SMHSOP AIU should have a regular forum for all staff at which service performance and consumer outcomes are examined, informed by the above and other relevant data.
7. The SMHSOP AIU should be involved in benchmarking activities with similar units to monitor performance.

The following recommendations are adapted from the National Health Performance Framework (except #9 which has been added independently):

Effectiveness

8. The SMHSOP AIU shall monitor if the care, interventions and action provided achieves desired outcomes.
9. All units should have a process for review by a second consultant of older consumers with a prolonged LOS.

Appropriateness

10. The SMHSOP AIU shall monitor if the care, interventions and action provided are relevant to the client's needs and based on established standards.

Efficiency

11. The SMHSOP AIU shall monitor if it is achieving desired results with most cost effective use of resources. Note that cost/financial reporting will be part of performance reporting for SMHSOP AIUs. Cost benchmarks will be considered in the context of current NSW and national cost benchmarking work and activity-based funding.

Responsive

12. The SMHSOP AIU shall monitor if the service provides respect for clients, is client-orientated and supports dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.

Accessible

13. The SMHSOP AIU shall monitor the ability of people in the unit's catchment to obtain health care at the right place and right time irrespective of income, physical location and cultural background.

Safe

14. The SMHSOP AIU shall monitor the service's avoidance, or reduction to acceptable limits, of actual or potential harm from health care management or the environment in which health care is delivered.

Continuous

15. The SMHSOP AIU shall monitor its ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

Capable

16. The SMHSOP AIU shall monitor if the service's capacity to provide a mental health service based on appropriate skills and knowledge.

Sustainable

17. The SMHSOP AIU shall monitor its capacity to provide ongoing infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).

10.5 Service Development Guidelines: Performance

Managing Performance

Basic specific features

There is a clear responsibility within the Mental Health Network Executive for the monitoring and improvement of the SMHSOP AIU.

Mental Health Network performance and reporting frameworks include explicit data regarding the performance of the SMHSOP AIU.

The SMHSOP AIU shall have a consultant psychiatrist and nursing unit manager with specific responsibilities related to monitoring and improving the performance of the SMHSOP AIU. These staff receive relevant aspects of the above reports.

SMHSOP incidents and adverse outcomes are explicitly included in Mental Health review processes.

At some level of the Mental Health Network, there is consumer and carer involvement in mechanisms to monitor and improve the performance of the SMHSOP AIU.

The SMHSOP AIU has a regular forum at which service performance and consumer outcomes are examined, informed by the above, and other relevant data.

The SMHSOP AIU is involved in benchmarking activities with similar units to monitor performance.

The SMHSOP AIU shall conduct regular file audits to monitor key aspects of care and inform service improvement.

The SMHSOP AIU shall conduct SMHSOP-specific quality improvement activities linked to the above actions.

Advanced specific features

Mental Health Network management and performance structures shall ensure that there is clear Mental Health Executive responsibility for the monitoring and improvement of the SMHSOP AIU. These duties shall consider all of the Mental Health Performance Framework domains.

The SMHSOP AIU shall have a consultant psychiatrist as director of the unit and a specific nursing unit manager, with specific responsibilities related to monitoring and improving the performance of the SMHSOP AIU.

There is specific SMHSOP consumer and carer involvement in mechanisms to monitor and improve the performance of the SMHSOP AIU.

The SMHSOP AIU shall receive regular reports targeting any specific SMHSOP needs to support the monitoring of performance.

The SMHSOP AIU is involved in benchmarking activities with similar units to monitor performance and practice, and inform the prioritisation of improvement projects.

The SMHSOP AIU shall have mechanisms to coordinate and conduct SMHSOP-specific quality improvement activities involving staff of all relevant disciplines.

Innovative specific features

There is an individual with specific responsibility for the monitoring and improvement of the SMHSOP AIU within the Mental Health Network management and performance structures. These duties shall cover aspects of all of the Mental Health Performance Framework domains.

The SMHSOP AIU shall have access to a SMHSOP clinical nurse consultant and senior allied health staff with SMHSOP experience, who have specific responsibilities related to monitoring and improving the performance of the SMHSOP AIU.

There are SMHSOP specific multidisciplinary mechanisms to specifically review incidents and adverse outcomes.

The SMHSOP AIU shall have mechanisms to coordinate and conduct SMHSOP-specific quality improvement activities involving older consumers, carers and staff of all relevant disciplines.

Effectiveness

Basic specific features

28 day readmission rate is monitored by the SMHSOP AIU, and reasons investigated for rates of greater than 10%, marked variation from historical performance, or the performance of benchmarked units.

HoNOS 65+ change indicator is monitored by the SMHSOP AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Advanced specific features

Analysis of 28 day readmission rate, and any related quality activities, conducted in conjunction with relevant community services.

Innovative specific features

HoNOS 65+ change indicator is used by the SMHSOP AIU, to identify consumer with deterioration or lack of improvement during admission; for multidisciplinary review processes.

K10 or other consumer completed measurement data are monitored by the SMHSOP AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Carer perception measurement data are monitored by the SMHSOP AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers who return to their original place of residence is monitored, and reasons investigated for marked variation from historical performance.

Appropriateness

Basic specific features

SMHSOP AIU participates in accreditation processes utilising the *National Mental Health Standards*.

The SMHSOP AIU has policies or procedures defining acceptable interventions within the unit that draw on or are consistent with this model of care.

Advanced specific features

File audits are conducted regularly that monitor the occurrence and/or quality of key assessments or interventions.

Services include clinicians from geriatric services in monitoring and reviewing the appropriateness of care interventions.

Innovative specific features

File audits are conducted regularly that monitor the performance of key elements of care reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

Efficiency

Basic specific features

Average length of stay is monitored by the SMHSOP AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units (typically 35-50 days).

Regular file audits identify the proportion of admissions with Estimated Date of Discharge set at admission.

SMHSOP AIU participates in mental health monitoring of costs and budget.

All clinicians attend training in the use of measures, and are familiar with the protocols for their use.

Measures of complaints or concerns are acted upon in accordance with policy timeframes.

Advanced specific features

Analysis of length of stay, and any related quality activities, is conducted in conjunction with relevant community services.

Innovative specific features

The service identifies consumer groups at increased risk of prolonged length of stay and considers the need for service redesign processes, e.g. intensive case management and active coordination of aftercare for selected older consumers.

Older consumers with LOS greater than 150% of the AIU's ALOS will be referred for a review by another psychiatrist who is expected to provide at least one new recommendation.

There is measurement of:

- Empowerment of older consumers to engage in decision making
- Whether carers are informed and supported
- Carer assessment
- Whether cultural spiritual or communication needs are met.

The service participates in cost benchmarking against similar units and there is investigation of marked variation from historical performance, or the performance of benchmarked units.

Measurement of:

- Appropriate and timely admissions
- Multidisciplinary assessment
- Symptom resolution or optimisation
- Degree of Optimum functioning
- Delays in discharge
- Communication with GPs
- Positive feedback from older consumers and carers of their experience in hospital
- Staff satisfaction.

Responsive

Basic specific features

The proportion of older consumers completing a K10 at admission and discharge from the service is monitored and there is investigation of any marked variation from historical performance.

Regular file audits identify the proportion of admissions in which a conference occurs within 10 days of admission involving the consumer, carer (if one exists), psychiatrist and another mental health professional.

Regular file audits identify the proportion of admissions in which a consumer is identified as having a preferred language other than English, and an assessment with an interpreter occurs at least twice during the admission.

Advanced specific features

SMHSOP AIU conducts regular assessments of consumer and carer perceptions of care, and utilises these to inform need for service improvement. The proportion of older consumers completing a K10 at admission and discharge from the service is monitored and there is investigation of any marked variation from historical performance, or the performance of benchmarked units.

Regular file audits identify the proportion of admissions in which a consumer is identified as having a preferred language other than English, and an assessment with an interpreter occurs at least every week during the admission.

Innovative specific features

SMHSOP AIU conducts regular assessments of consumer and carer perceptions of care, and reasons investigated for any marked variation from historical performance, or the performance of benchmarked units.

Accessible

Basic specific features

The 'source of admission' of admitted older consumers is monitored through CIBRE data, and reasons investigated for significant variation from historical performance, or the performance of benchmarked units.

Advanced specific features

The total number of 'waiting days' (cumulative total of days spent by older consumers on a waiting list for admission) is monitored, and reasons investigated for marked variation from historical performance.

The proportion of older consumers aged 65 or over who require mental health admission who require that admission to an adult general mental health unit is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of consumers aged under 65 who require mental health admission to the SMHSOP AIU is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The diagnostic and HoNOS 65+ item profile of admitted older consumers' is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers who are born outside Australia is monitored and reasons investigated for marked variation from catchment demographics, historical performance, or the performance of benchmarked units.

Innovative specific features

The proportion of older consumers admitted directly from the community is monitored and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The total number of 'waiting days' (cumulative total of days spent by older consumers on a waiting list for admission) is monitored, and reasons investigated for marked variation from historical performance or the performance of benchmarked units.

An indicator of proportion of older consumers admitted out of area for SMHSOP AIU care is implemented and utilised.

Formal feedback is sought from key stakeholders regarding accessibility to the unit, and any groups for whom this is problematic.

The SMHSOP AIU shall monitor the ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.

Safety

Basic specific features

The SMHSOP AIU has a system compliant with NSW Health guidelines for the management, review, and analysis, of incidents.

The service monitors performance data regarding:

- Seclusion
- Restraint
- Falls
- Aggressive incidents resulting in harm to self or others.

Advanced specific features

The service monitors performance data regarding:

- Seclusion
- Restraint
- Falls
- Aggressive incidents resulting in harm to self or others.

These data are monitored, and reasons investigated for marked variation from historical performance or the performance of benchmarked units.

Innovative specific features

The SMHSOP AIU minimises harm from health care management or the environment in which health care is delivered.

Continuous

Basic specific features

Seven day follow up rate is monitored by the SMHSOP AIU, and reasons investigated for marked variation from historical performance, or the performance of benchmarked units.

The proportion of older consumers with an identified GP is monitored and reasons investigated for marked variation from historical performance.

Advanced specific features

Analysis of seven day follow up rate, and any related quality activities, conducted in conjunction with relevant community services.

The proportions of admissions in which the discharge summary is completed on the day of discharge is monitored and reasons investigated for marked variation from historical performance.

Innovative specific features

The proportions of admissions in which the discharge summary is completed on the day of discharge, and

Given to the consumer and/or carer; is monitored and reasons investigated for marked variation from historical performance

Sent to the GP; is monitored and reasons investigated for marked variation from historical performance

Able to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

Capable

Basic specific features

The service has access to a regular in-service program regarding SMHSOP related issues.

The proportion of admissions with paired admission and discharge HoNOS 65+ data are monitored and reasons for marked variation from historical performance, or the performance of benchmark partners is investigated.

Advanced specific features

The proportion of staff with postgraduate training in mental health or aged care is monitored and used to inform internal training and quality improvement projects.

The AIU has access to a regular quality improvement in-service program with its outcomes evaluated.

Innovative specific features

The SMHSOP AIU monitors the service's capacity to provide a mental health service based on appropriate skills and knowledge.

Sustainable

Basic specific features

Staff turnover, sick leave and overtime are monitored and consistent with the performance of benchmarked units.

Advanced specific features

Staffing mix and levels are benchmarked against benchmarking partners in a cost benchmarking framework; and marked variations considered in mental health executive planning.

Innovative specific features

There is networking of senior clinician positions with those in community SMHSOP services and other SMHSOP AIUs to support leave coverage and continuity of care in times of staff vacancies.

The SMHSOP AIU shall monitor the system or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).

Conclusion and Next Steps

This model of care report summarises the literature, policy and expert opinion as to what constitutes effective inpatient care and good practice in SMHSOP AIUs. This is considered in the context of the care currently being provided in SMHSOP AIUs in NSW. The report particularly focuses attention on areas of SMHSOP AIU care, practice and operation where there is appropriate evidence and expert consensus, and where consistency across AIUs could be improved. The project has identified recommendations and service development guidelines to support the further development of acute inpatient care in nine key areas. Some of the priorities and most significant challenges are highlighted below.

1. Philosophy of care, functions, and target population

It is recommended that SMHSOP AIUs adopt a person-centred biopsychosocial philosophy of care that focuses on understanding the consumer's roles, values, interests, as well as environmental and cultural factors [2], and ensure that care environments, processes and practices reflect this philosophy. This is perhaps the most significant recommendation in the report and underpins more detailed recommendations throughout this model of care. This has implications for many of the later sections, especially staffing, and will require significant effort to be optimally implemented in both existing AIUs and new AIUs. It will require a number of strategies to be undertaken and these will vary in existing AIUs depending on each AIU's current gaps. This report highlights the need for staff orientation and development of relevant policies, procedures and training if these do not currently exist. Other examples of possible strategies might include workshops for clinical leaders and managers, a focus on philosophy of care at a benchmarking forum, including philosophy of care as a standard agenda item in each unit's team meetings, and visual displays in the unit to promote the philosophy of care amongst the staff.

Ultimately all staff will need to be oriented to the philosophy of person-centred biopsychosocial care and it is necessary for the most senior staff to provide the necessary leadership in implementing and sustaining this.

Another very significant recommendation in this section is that SMHSOP AIUs should preferably be designed and staffed for the acute management of both severe BPSD and other mental health disorders. This role should be seen as complementary to the role of aged care services for patients with the broader range of BPSD. However, a number of existing SMHSOP AIUs do not have the appropriate physical environments to manage both BPSD and other mental health disorders. Most significantly, units may not have the capability to segregate consumers with BPSD from more vulnerable consumers. In some units bed numbers would also need to increase in order to cater for all consumers in the recommended target population. The general lack of SMHSOP non-acute inpatient units contributes to the difficulties in meeting the needs of the target population by SMHSOP AIUs. This recommendation will perhaps be the most challenging to implement, particularly for existing AIUs and will require a staged approach.

Firstly, where existing SMHSOP AIUs do not currently provide care to all consumers in the target population, and this function is being provided by aged care services, it is important to maintain service provision through collaboration between SMHSOP and aged care services. This requires agreement to be reached regarding pathways to care for consumers with BPSD in each LHD. This may need to be facilitated at the executive level. Secondly, it is clear that longer term capital and service development planning will be required (primarily at the LHD level) to address the recommendations in this report. In many units staff will also need to be up-skilled in BPSD management, building on current and previous BPSD training initiatives supported by NSW Health. Increasing the engagement of specialist clinicians with expertise in managing BPSD (e.g. BASIS or DBMAS workers) may be an effective interim strategy in some inpatient settings.

2. Comorbid disorders and problems and end of life care

Effective collaboration with aged care services is also important both in order to optimise the physical health care provided to consumers and to minimise the exclusion of consumers based on their physical health care needs. The recommendation that AIUs are able to manage consumers requiring IV and SC fluids and medications will be challenging for some units and may require significant education and support of AIU staff. Benchmarking activities and effective adoption of the philosophy of care to incorporate such principles as the right for individual older people to access care, to promote holistic care, to take a flexible approach, to support continuity of care and to have individualised care will assist in meeting these challenges. This recommendation may be implemented through local clinical practice improvement (CPI) projects, values clarification exercises with staff, and 'Essentials of Care' projects.

The provision of end of life care will remain an uncommon experience for SMHSOP AIUs and therefore challenging for staff, particularly when there are cultural factors involved. Resolving when and how to provide end of life care will be enhanced initially by the same processes and implementation strategies that will support the adoption of a person-centred philosophy of care more generally. Specific strategies such as NSW Health policy directives (currently under review) and implementation strategies in this area and benchmarking processes will also assist.

3. Functional relationships, location and other operational arrangements

Effective functional relationships as outlined in this report are critical to the implementation of this model of care. The relationships between the unit, the consumer and their carer/s and the components of the model of care are depicted in Figure 1 (p.8) and emphasise the importance of minimal barriers between the AIU and other hospital and community services. Each AIU will have its own priorities and challenges in this area. It is suggested that LHDs firstly review their current functional relationships and then develop priorities for improving their key functional relationships in line with local priorities. Some SMHSOP AIUs will need to

prioritise the relationships with geriatric or other aged care services (as above) while others will require collaboration with adult mental health services to enable optimal continuity of care, for example. Many AIUs will want to improve the integration with local community services including Aboriginal Medical Services.

Few units currently have the availability of flexible visiting hours. The adoption of the recommendations regarding visiting may be one of the less challenging to implement early for many units and may be best addressed through benchmarking and quality improvement processes.

4. Key processes

Avoiding unnecessary admission via the ED where direct admission to the AIU is deemed appropriate and safe will be difficult in a number of units, especially after hours, due to the way that services are structured and resourced. It is anticipated that ensuring that assessment and care planning cover all necessary domains and are inclusive of consumer and key carers will require significant CPI projects in some units. Each SMHSOP AIU will need to review their current processes against the other basic specific features in the service development guidelines of this report and prioritise strategies to address any gaps. This will be assisted through benchmarking processes.

5. Clinical interventions

The range of clinical interventions available in each SMHSOP AIU, although not directly measured in this project, is likely to be quite variable. Each AIU will need to address gaps in available interventions and the priorities are likely to vary across individual units. While it is recommended that each AIU have local access to ECT, it is recognised that this will not be achievable in all existing SMHSOP AIUs at this time. Over a longer period of time addressing this will require capital and clinical services planning processes at the LHD level. In the meantime, it is important that all consumers in SMHSOP AIUs do have access to ECT in instances when it is the most appropriate clinical intervention. SMHSOP AIUs without local access to ECT will need to prioritise implementation strategies to ensure that consumers are able to be transferred to an appropriate facility for ECT when necessary. This may require negotiation between LHDs as an interim measure.

6. Seclusion and restraint

Units should aim to minimise the use of all forms of seclusion and restraint in older people. In AIUs which do not currently seclude or restrain consumers it is important to maintain this approach. Units which do seclude or restrain consumers will be required to follow NSW policy and relevant guidelines when they are published and it is anticipated that this will assist in reducing the rates of seclusion and restraint while maintaining the safety and wellbeing of the consumer and staff. In addition, AIUs may implement specific quality improvement projects and/or focus on improvement through benchmarking processes.

7. Facility design issues

Achieving the model of care outlined in this report will be contingent on appropriate facility design of the SMHSOP AIU. The concurrent development of health facility guidelines for SMHSOP AIUs complements this model of care such that all new units should have good visual access, adequate indoor and outdoor space, good acoustics and features to optimise mobility and reduce falls. Perhaps most critically, the guidelines will identify that units should be designed to allow for the segregation of consumers with different clinical needs including those consumers with severe agitation and/or BPSD. It is recognised that existing units may require significant renovation or even rebuilding in order to meet the recommendations within this report. In some cases existing units may be deemed a priority for minor capital works but in many cases this may require longer term planning and/or major capital projects. There will need to be consideration of the optimal location of future units to meet the recommendations for the availability of the range of necessary clinical interventions and key functional relationships.

8. Staffing

The implementation of this model will require significant investment in staff orientation, training and ongoing professional development. In some units the adoption of this model of care will mean that staff will be caring for consumers who were previously excluded from the unit. This could include consumers with BPSD or consumers with more complex comorbidities, requiring IV or SC fluids, and consumers may be more physically dependent. In some units increased numbers of

Aboriginal consumers and/or consumers from a CALD background may be admitted over time. Carers may be able to better contribute. All of these potential changes will require staff to change the way they do business. It is anticipated that these changes may be challenging for all staff to adopt. Ongoing support of clinical leaders will be required and programs such as the NSW Health Clinical Leadership Program, Essentials of Care projects and benchmarking processes will assist in implementing and maintaining meaningful cultural change.

Separate work outside of this project is required to determine staffing numbers required to implement this model of care.

9. Performance

The recommendations and service development guidelines in this SMHSOP AIU model of care indicate that a number of specific audits should be undertaken as well as outlining a comprehensive list of features that will support continuous service improvement. As outlined in the report, local services have the responsibility for monitoring and improving their SMHSOP AIU(s). Many of the necessary features will already be in place and LHDs should review any gaps. At the state level, a checklist proforma could be developed for local adaptation for managing relevant performance features. In addition, many KPIs and performance measures (e.g. outcome measures) are currently reported through benchmarking activities. It is important all SMHSOP AIUs continue to participate in benchmarking.

Any model of care will continue to develop over time and the SMHSOP AIU MoC is no exception. A number of issues arose during the course of this project that were not able to be included within this report but are identified for further work. Some of these are the focus of current NSW Health and national projects, for example, the cost benchmarking issues regarding quantifying staffing and cost per bed and other funding issues. Others, such as the development of cultural competency recommendations and service development guidelines, particularly those pertaining to Aboriginal consumers, require much more extensive and detailed work than could be achieved in this project. These issues include exploration of the context and meaning of end of life care for an Aboriginal person, the significance of returning to Country, and issues around losing a family/community member. The cultural aspects of family and

carer education and therapy also need further exploration and policy development. It has not been explored whether there are specific cultural implications for the use of restraint in Aboriginal people and this needs further work. Continued partnerships with the Aboriginal mental health workforce will contribute to the understanding of and appropriate responses to older Aboriginal peoples' mental health issues.

NSW Health is currently reviewing its policy regarding the use of Advanced Care Directives and Enduring Guardianship Orders, including the issues for older consumers requiring end of life care who are in mental health units. Perceived conflict with the MHA is yet to be resolved. This work will be relevant to SMHSOP AIUs. Further policy development work is required regarding the need and models for specialist units to manage people with very severe BPSD, such a statewide intensive care unit for older people. Other examples where further work is required following this project include a review of teaching and research in SMHSOP AIUs, and the training and education requirements for staff to enable them to deliver this model of care. It is expected that some of these issues will be addressed in the implementation phase of this MoC project and others will require significant policy work.

The Mental Health and Drug & Alcohol Office, NSW Ministry of Health will develop an implementation strategy, in collaboration with LHDs, to assist AIUs to adopt the recommendations and develop their services in line with the guidelines in the report. This will include the development of a model of care manual to support state and local service planners, policy managers, and service managers in the development of new SMHSOP AIUs (in particular) and the review and improvement of existing SMHSOP AIUs. It is envisaged that this manual will summarise the literature, policy and current practice analysis in this report and translate recommendations and service development guidelines in this report into succinct practical guidelines, for review on a regular (approximately 5 yearly) basis. Related information resources for clinicians, consumers and carers will also be developed to better inform, engage and support them in the implementation of this model of care.

Consultative groups and individuals that have provided advice on SMHSOP Acute Inpatient Unit Model of Care report

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Dr John Dobrohotoff (Project Manager) - Clinical Advisor, MHDAO OPMH Policy Unit

Mr Peter Hutten – Carer. Mr Hutten has considerable personal experience in the care of an older person with mental health issues.

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Mr Peter McHale – Executive Manager of Care Services, Catholic Homes Inc

Dr Stephen Judd – Chief Executive Hammond Care

**NSW Ministry of Health MHDAO Aboriginal
OPMH Working Group**

**NSW Ministry of Health MHDAO CALD
OPMH Working Group**

NSW Consumer Advisory Group

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Ms Joanne Smith – Director, Centre for Health Advancement, NSW Ministry of Health

Ms Robyn Burley – Director, Health System Support Workforce Development & Innovation, NSW Ministry of Health

Focus group questionnaire

Section one: Current Model of Care

1. Does your unit have a model of care?
2. What are its strengths and weaknesses?
 - Strengths:
 - Weaknesses:
3. How could it be improved?
4. Number of beds?
5. Occupancy and average length of stay (ALOS)?
6. What impacts on your ALOS?
7. Do you have waiting lists?
8. What happens to pts waiting?
9. Should there be waiting lists into the acute unit?
10. Do you admit patients with BPSD?
11. Should patients with a diagnosis of BPSD be admitted into an acute unit?
12. Do you have falls in the unit?
13. What do you think is the cause of falls?
14. Are there incidents of aggression in the unit?
15. What do you think is the cause of aggression?
16. What is the age range of patients?
17. Are there any problems with the age mix?
18. What proportion of patients under Mental Health Act?
 - Voluntary?
 - Involuntary?
19. Guardianship?
20. What proportion of patients has dementia?
21. Does this mix work?
22. Is the unit unsuitable for certain types of clients?
23. If answer to above question is yes, why is unit unsuitable?
24. Are the following therapies available?
25. ECT
26. Behavioural
27. Psychological
28. Cognitive
29. Supportive
30. Occupational
31. Social
32. Psychoeducational
33. Pet therapy
34. Others
35. Seclusion and restraint:
36. Availability and use
 - Restraint:
 - Seclusion:
37. Are there any environmental factors impacting on risk within the unit?
38. Is your unit locked?
39. Do you lock bedroom doors?
40. Do you have access to observation unit/MHICU
41. Do you accept clients with medical co-morbidities?
42. What is the process for assessing physical status?
43. Do you accept clients with a diagnosis of delirium?
44. What issues do you have with mobility?
45. Do you have protocols around the use of IV fluids?
46. Does your unit have access to T-Basis
47. Does your unit have access to step down beds?
48. Do you have access to subacute/long stay beds?
49. Do you have access to home based treatment?
50. Do you have access to crisis teams?
51. Does your unit have palliative care/NFR protocols?
52. What percentage of clients has alcohol and other drug issues?
53. What screening instruments are used for the following?
54. Cognition?
55. Falls risk?
56. Skin integrity?
57. Others?
58. Who completes the standard outcomes measures?

Section two: Admission/ Discharge Process

59. Describe admission process
60. What are your admission criteria?
61. Do you admit via ED?
62. Do you have a dedicated SMHSOP admission team?
63. Do you admit direct from community team?
64. Do you admit direct from private psychiatrist/GP/geriatrician?
65. What do you think your admission criteria should include?
66. Do you accept admissions only in hours or after hours as well?
67. Do you accept out of area admissions?
68. What are your inclusion criteria?
69. Do you have an exclusion criterion?
70. If yes what is the criteria for exclusion from admission?
71. Do you admit for assessment only?
72. Who does the assessment?
73. Describe assessment process.
74. Describe discharge process
75. Does it include:
76. Communication with GPs,
77. Communication with community teams?
78. Communication with others?

Section three: Access

79. Is the unit located in the best place?
80. How far must families and carers travel?
81. Is public transport available?
82. Is parking available near the unit?
83. Do you have visiting hours?
84. What are the visiting hours?

Section four: Staffing

85. What is your mix of RN/EN?
86. Do you have a mix of gen trained and MH trained staff?
87. Do you have dedicated allied health staff in the unit?
88. What allied health services do you have access to?
89. Do you have dedicated medical staff?
90. What medical staff do you have access to?
91. Describe access to security, pharmacy, pathology, physiotherapist, dietician

Section five: Physical Environment

92. Does the physical environment impact on the model of care provided in the unit?
93. Describe the impact
94. Do you have handrails in the unit?
95. What type of flooring do you have?
96. Is the unit noisy?
97. Do you receive good natural light in the unit?
98. Is your unit pleasant and homelike or stark and safe?
99. Do you have protocols around privacy/dignity?
100. Is there good access to outdoors?
101. Do you have access to hydrotherapy?
102. Is the unit smoke free?
97. Is there an undercover area provided for patients and visitors?

Section six

98. Is there any additional information you would like to include?

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