



Project commissioned by the NSW Ministry of Health
*Evaluation of the NSW Older people's mental health
(OPMH) community services model of care*

Summary report

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Acronyms

BASIS	Behavioural Assessment and Intervention Service
BPSD	Behavioural and psychological symptoms of dementia
CALD	Culturally and linguistically diverse
CLS	Community Living Support
DBMAS	Dementia Behaviour and Psychological Management Advisory Service
eMR	Electronic medical record
GP	General practitioner
HASI	Housing and Accommodation Support Initiative
HONOS 65+	Health of the Nation Outcome Scale 65+ (assessment tool)
K10	Kessler Psychological Distress Scale
LHD	Local Health District
LSP-16	Life Skills Profile (assessment tool)
MH-AMB	Mental Health Ambulatory (data collection)
MH-OAT	Mental Health Outcomes and Assessment Tool
NSW	New South Wales
OPMH	Older people's mental health
PCLI	Pathways to Community Living Initiative
RUG-ADL	Resource Utilisation Group Activities Daily Living (assessment tool)
SMHSOP	Specialist Mental Health Services for Older People
SMHTAL	State Mental Health Telephone Access Line
T-BASIS	Transitional Behavioural Assessment and Intervention Service

Introduction

1

In January 2017, the New South Wales (NSW) Ministry of Health (Ministry) released a Guideline documenting the *Specialist Mental Health Services for Older People (SMHSOP) community services model of care* (NSW Ministry of Health, 2017b). In December 2017, SMHSOP underwent a name change to older people's mental health - 'OPMH' - which will be used throughout this report.

The OPMH community services model of care defines how community services for older people with mental illness should be delivered: person-centred, recovery-oriented, and attentive to consumers' biopsychosocial needs. The implementation of the model was supported by additional recurrent funding to Local Health Districts (LHDs) from 2017-18.

The Ministry engaged Health Policy Analysis to undertake a formative evaluation to assess LHD's progress with the implementation of the model and identify any initial impacts and outcomes, and to make recommendations to support the implementation of the model.

The OPMH community services model of care

The *Specialist Mental Health Services for Older People (SMHSOP) community services model of care* (NSW Ministry of Health, 2017b) defines how community services for older people with mental illness should be delivered. The Guideline outlining the model contains recommendations to support its implementation, recognising the different starting points of health services, and varying local service contexts.

In December 2017, SMHSOP services underwent a name change to older people's mental health (OPMH) services to align with the new *NSW Older People's Mental Health Service Plan 2017-2027* (NSW Ministry of Health, 2017a). The term OPMH is used throughout this report.

The NSW Ministry of Health, Local Health Districts (LHDs) and other key partners developed the OPMH community services model of care to:

- Improve the capacity of older people's mental health (OPMH) services to meet the increased demands generated by a growing older population.
- Ensure that OPMH community services can adapt to changes occurring in the mental health, aged care and disability systems.
- Respond to economic and community demands for specialised mental health care to be available in the community.
- Reduce the variation in clinical practice amongst NSW OPMH services.

The model is a component of the *NSW Older People's Mental Health Services Service Plan 2017-2027* (NSW Ministry of Health, 2017a), which outlines the key strategic priorities for the development, delivery and improvement of OPMH services.

Scope

The model of care relates to specialist services for older people with mental illness delivered in the community. 'Community' includes people's homes and residential care facilities. The model applies to community as well as Behavioural Assessment and Intervention Service (BASIS) teams.

Mental illness includes depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, alcohol and substance misuse disorder, and behavioural and psychological symptoms of dementia.

Target group

The model of care is for people who develop a mental illness in their older age and for people growing older with a continuing experience of a mental illness that developed earlier in their lives. It adopts the principle of 'no wrong door' and requires community OPMH

services to accept any person referred for secondary triage and/or initial assessment following triage.

Policy context

The OPMH community services model of care was developed to align with key national and state standards and policies¹, including:

- *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (NSW Mental Health Commission, 2014)
- *NSW 2021: A Plan to Make NSW number one* (NSW Government, 2011)
- *NSW Health Community Mental Health Strategy 2007-2012* (NSW Department of Health, 2008)
- *NSW Integrated Care Strategy* (NSW Ministry of Health, 2016a)
- *NSW Carers Strategy 2014-2019* (NSW Government Department of Family and Community Services, 2014)
- *National Standards for Mental Health Services* (NSMHS)
- *National Safety and Quality Health Service (NSQHS) Standards* (Australian Commission on Safety and Quality in Health Care, 2012)
- *National Framework for Recovery-Oriented Mental Health Services* (Australian Health Ministers' Advisory Council 2013)
- *Fourth National Mental Health Plan 2009-2014* (Commonwealth of Australia, 2009)
- *COAG Roadmap for National Mental Health Reform 2012-2022* (Council of Australian Governments, 2012)
- *Contributing Lives, Thriving Communities - National Mental Health Commission's Review of Mental Health Programmes and Services* (National Mental Health Commission, 2014)
- *NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005-2015* (NSW Department of Health, 2006) (now superseded)
- *NSW Aboriginal Health Plan 2013-2023* (NSW Ministry of Health, 2012a)
- *NSW Aboriginal Mental Health and Wellbeing Policy* (NSW Ministry of Health, 2012b).
- *NSW Older People's Mental Health (OPMH) Benchmarking Participants Manual* (NSW Ministry of Health, 2016b).

Funding to support implementation

Under the *Specialist Mental Health Services for Older People NSW Service Plan 2005-2015* (SMHSOP Service Plan) (NSW Department of Health, 2006), there was a significant focus on developing community service teams and community-based OPMH service initiatives. This focus has been continued under the new NSW OPMH Service Plan, supported by enhancement funding provided under the NSW Mental Health Reforms. From 2015-16, 12 LHDs received additional recurrent funds to expand OPMH services in the community, with six of these being specifically to support long-stay mental health inpatients transitioning to residential care (under the Pathways to Community Living Initiative (PCLI)). In 2017-18, all

¹ Some of these have been superseded but were used to develop the model.

LHDs received additional recurrent funds to expand consumers' access to OPMH community services.

Model components

The OPMH community services model of care has seven key components, which are outlined below.

Philosophy and principles of care

The OPMH community services model of care adopts the same philosophy as the acute inpatient and Transitional Behavioural Assessment and Intervention Service (T-BASIS) models: It is person-centred, recovery-oriented, and attends to consumers' biopsychosocial needs.

The model of care promotes consumers having control over their own care. This requires clinicians to get to know each person and their circumstances, and to share decision making and deliver services in collaboration with them and their carers.

Person-centred care also considers consumer's cultural and social context, particularly for Aboriginal people, culturally and linguistically diverse (CALD) people and lesbian, gay, bisexual, transgender and intersex people.

Recovery-oriented practice supports consumers to live a meaningful life as determined by them. Clinicians collaborate with consumers to develop a Wellness Plan, incorporating consumers' strengths and goals into the plan.

The biopsychosocial approach considers biological, psychological, and social factors and their complex interactions in understanding health and illness, and in designing care.

Partnerships

The OPMH community services model of care recognises that community services are part of the broader system of care and support for older people with mental illness. Other key partners include: families and carers; the broader community; primary health care services including general practitioners (GPs); non mental health community care and support services; residential services; specialist private practitioners and facilities; community managed/ non-government organisations providing counselling, crisis services, community care, rehabilitation and psychosocial support services, and NSW Health services, including mental health services (non-age specific and OPMH, community and inpatient).

The model supports an integrated and co-ordinated approach to care and requires services to develop linkages and referral pathways with partners, including formal processes for inter-agency and inter-sectoral collaboration.

Working in different ways and in different settings

To support consumers' choice and ensure access, flexibility to provide care in a range of settings is optimal. Face-to-face care may be provided at the community service's premises or other community space, or in a person's place of residence (which may be a residential care facility or supported accommodation). Telehealth and/or e-health modalities may also be used where appropriate. However, decisions about settings must prioritise the safety and wellbeing of the consumer, carers, families, visitors and staff. Transport, telehealth facilities and staffing should be considered.

Key processes

The OPMH community services model of care identifies good practice features in the following areas:

- access and intake
- assessment and care planning
- clinical care and co-ordination
- recovery-oriented risk assessment and planning
- clinical review
- transitions of care
- specialist consultation and liaison in the inpatient setting
- crisis care
- promotion, prevention and early intervention.

Techniques and therapies

A variety of techniques and therapies are available to address the recovery and treatment goals of consumers. OPMH community services have a primary responsibility for facilitating clinical recovery of their consumers, while also supporting them in other aspects of their recovery goals, (e.g. by referrals to and partnerships with appropriate health and community care services and psychosocial supports). Biopsychosocial approaches often involve the OPMH community service supporting the consumer to manage their self-care, improve social and relationship skills and achieve a broader quality of life (including in the areas of physical health, social connectedness, housing, education and employment). The model promotes clinicians to use a variety of tools in therapy, and to facilitate consumer and /or carer self-management, recovery, resilience and empowerment.

Where consumers require therapies that are not provided by staff of the community services, the model requires services to identify processes for accessing these, including through inter-professional practice and partnerships.

The model of care requires consumers to have access to very specialised, non age-specific services (e.g. clozapine dosing, maintenance electroconvulsive therapy and depot antipsychotic medications). Where these are not readily available, OPMH community services should negotiate access for their consumers that require them.

Each OPMH service should also develop appropriate clinical governance processes, service delivery arrangements and organisational supports for providing appropriate therapies, tools and techniques.

Staffing

The model of care is supported by a strong service culture, conveyed to staff at orientation and ongoing. Clinical supervision, workforce development, and multidisciplinary staffing are key features. Ongoing support of clinical leaders is required, along with programs that support change management and quality improvement.

The model encourages the integration of peer workers in OPMH community services (treated as members of OPMH community teams and engaged in all team activities relevant to their roles). Peer workers, who have a lived experience of mental illness (as a consumer or carer), can provide peer support, individual and/or systemic advocacy, co-ordination and

management of programs/activities relevant to their role, health promotion, education and training, and involvement in quality improvement processes/projects and research.

Performance

LHDs are required to monitor and improve their performance in areas highlighted in the model: recovery-oriented services/practices, access, care co-ordination with GPs, capabilities and responsiveness.

The Ministry of Health offers a benchmarking program, which comprises an ongoing set of activities aimed at achieving local change amongst OPMH services. The activities include:

- Service-based improvement activities. The program encourages the identification and implementation of local improvement initiatives.
- Six-monthly statewide benchmarking forums. The forums are intended to facilitate the development of LHD-based quality projects stimulated by a review of the LHD's performance in comparison to others' and collaboration with other services presenting examples of good practice.
- Self-audit. The process uses a tool which lists elements of good practice that OPMH teams assess themselves against. It is intended to stimulate reflective practice and identify areas for improvement.

Evaluation approach

3

The aims of the evaluation were to:

1. Review the progress of implementing the OPMH community services model of care.
2. Evaluate any initial impacts and outcomes associated with implementing the model.
3. Recommend ways to support the ongoing implementation of the model.

A logic model for the OPMH community services model of care (Appendix 1) was developed to guide the evaluation, specifically, identifying questions and indicators to assess the program's effectiveness and/ or to make improvements. Logic models are used to understand the design of a program², articulating the logical relationships between the resources, activities, outputs and outcomes.

In the logic model of the OPMH community services model of care at Appendix 1, activities are shown separately for the Ministry of Health and the LHDs, reflecting the different responsibilities of these groups. The Ministry and the LHDs also produce different outputs. However, both are working towards the same impacts and outcomes. The inputs are also shown jointly for the two groups, as they include joint ventures (e.g. the development of the OPMH community services model of care), and other programs/ resources relevant to both groups.

Quantitative data used for the evaluation included:

- a survey of clinical staff in OPMH community services
- a survey of partner organisations: CLS and HASI providers
- a survey of GPs
- the Mental Health Ambulatory (MH-AMB) repository
- the Mental Health Outcomes and Assessment Tool (MH-OAT) repository
- the 2018 self-audit of OPMH community services, including progress with the implementation of the model of care (and the statewide report of the 2017 self-audit).

There were 76 responses to the survey of clinical staff. Of these, 51% (39) of staff identified as a mental health nurse, 14% (n=11) as a social worker, 12% (n=9) as an occupational therapist, and the remaining responders included psychiatrists (n=6), psychologists (n=5), peer worker (n=1), and other (n=5). Most staff who responded were employed full time (62%), had worked in their current position for more than three years (51%) and they represented 11 LHDs and Justice Health and Forensic Mental Health.

Eight GPs completed a survey. There were also eight responses to the partner surveys with the partner organisations being either from CLS or HASI or a combination.

Mental Health Ambulatory (MH-AMB) and Mental Health Outcomes and Assessment Tool (MH-OAT) data from all LHDs was used for the evaluation. Similarly, all community teams' data from the self-audit of OPMH community services were used.

² 'Program' is used loosely and can refer to any initiative intended to deliver a benefit to recipients, such as the SMHSOP community services model of care.

Face-to-face interviews were conducted in two locations within the state, one in a Metropolitan region (Central Coast LHD) and one in a Rural region (Western NSW LHD). Additional interviews were conducted with three other LHDs via telephone (Northern Sydney, South Western Sydney, and Illawarra Shoalhaven). Representatives interviewed included:

- LHD and OPMH service managers
- OPMH service clinicians
- key service partners, including OPMH acute inpatient units and GPs
- residential and aged care community service providers
- other community and carer organisations and support networks.

Focus groups with consumers and their families and carers were conducted in the two locations in which face-to-face interviews were undertaken.

Interviews were also undertaken with:

- Representatives of residential care facilities that are members of the NSW Mental Health-Residential Aged Care Network (MH-RAC Network) and operate under an OPMH service-residential aged care partnership model.
- A representative of Mental Health Carers NSW.

Interviews and focus groups were recorded and transcribed, and data were analysed using framework analysis involving:

- **Familiarisation.** Involved becoming familiar with the transcribed data.
- **Identifying themes.** Themes were identified based on the components of the model (e.g. partnerships, key processes), as well as other key areas for the evaluation (e.g. governance).
- **Indexing.** This involved assigning the text to the themes. The qualitative data analysis software package – MaxQDA – was used.
- **Charting.** This involved summarising and synthesising the data within each theme.
- **Mapping and interpretation.** Involved drawing conclusions from the data to answer the questions set out for the evaluation.

The following documents were also reviewed for the evaluation:

- *Specialist Mental Health Services for Older People community services model of care* (NSW Ministry of Health, 2017b)
- *Community older people's mental health services: A guide for older people with mental health problems, and their families, carers and friends*
- *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (NSW Mental Health Commission, 2014)
- *Living well in later life. The case for change* (Mental Health Commission of New South Wales, 2017)
- *NSW Older People's Mental Health Services Service Plan 2017-2027* (NSW Ministry of Health, 2017a)
- NSW Specialist Mental Health Services for Older People (SMHSOP) benchmarking project. Community Teams Self-Audit Report 2017.
- *Evaluation of the Mental Health Aged Care Partnership Initiative* (Health Outcomes International, 2011)

- *Evaluation of the Mental Health Aged Care Partnership Initiative: NSW Health Policy Response* (NSW Ministry of Health, 2011)
- *Your Experience of Service. What consumers say about NSW Mental Health Services. 2015-2016* (InforMH, 2016)
- *Your Experience of Service. What consumers say about NSW Mental Health Services. 2016-2017* (InforMH, 2017).
- *NSW Older People's Mental Health (OPMH) Benchmarking Participants Manual* (NSW Ministry of Health, 2016b).

Findings

Overall progress with implementing the model of care

All LHDs are endeavouring to implement the model of care. Those that were practising the principles of the model prior to the release of the model of care document by the Ministry (the 'early adopters') tended to report being more advanced in their implementation. They also reported stable staffing, strong operational and clinical leadership, and a systematic approach to identifying their service's strengths and gaps (resulting in clear motivations for change). The LHDs that were not as progressed (the 'late adopters') were ones with a higher staff turnover.

LHDs had made progress in the following areas articulated by the model of care:

- Embracing recovery-oriented care with older people.
- Providing care to consumers in the location they prefer.
- Endeavouring to implement the 'no wrong door' approach.
- Assisting consumers to access a range of supports and services identified for their personal and clinical recovery and assisting carers to access information.
- Making available a greater range of capabilities amongst teams, resulting from additional funding provided as part of the new model of care.
- Completing assessments such as the Health of the Nation Outcome Scale 65+ (HONOS 65+), Resource Utilisation Group Activities Daily Living (RUG-ADL) and Life Skills Profile (LSP). These assessments assist in identifying the needs of consumers, and when done before and after interventions, measure changes attributable to interventions.
- Developing and maintaining good relationships and communications with acute inpatient units.
- Actively monitoring performance.
- Increasing the completion rates of the YES survey among consumers of OPMH community services.

Access

The MH-AMB data indicate there has been a small increase in the number of new consumers aged 65 years or older³ using OPMH community services between January-June 2016 and July-December 2017 (Figure 1 and Figure 2), and a larger increase in the number of consumers who received a service during that period (Figure 3 and Figure 4).

The primary barrier to access reported by interviewees was GPs' and other referring organisations' awareness of OPMH community services. A secondary barrier was the maturity

³ The data presented here refer to consumers aged 65 years and over only, and not all consumers of OPMH services, as some are younger.

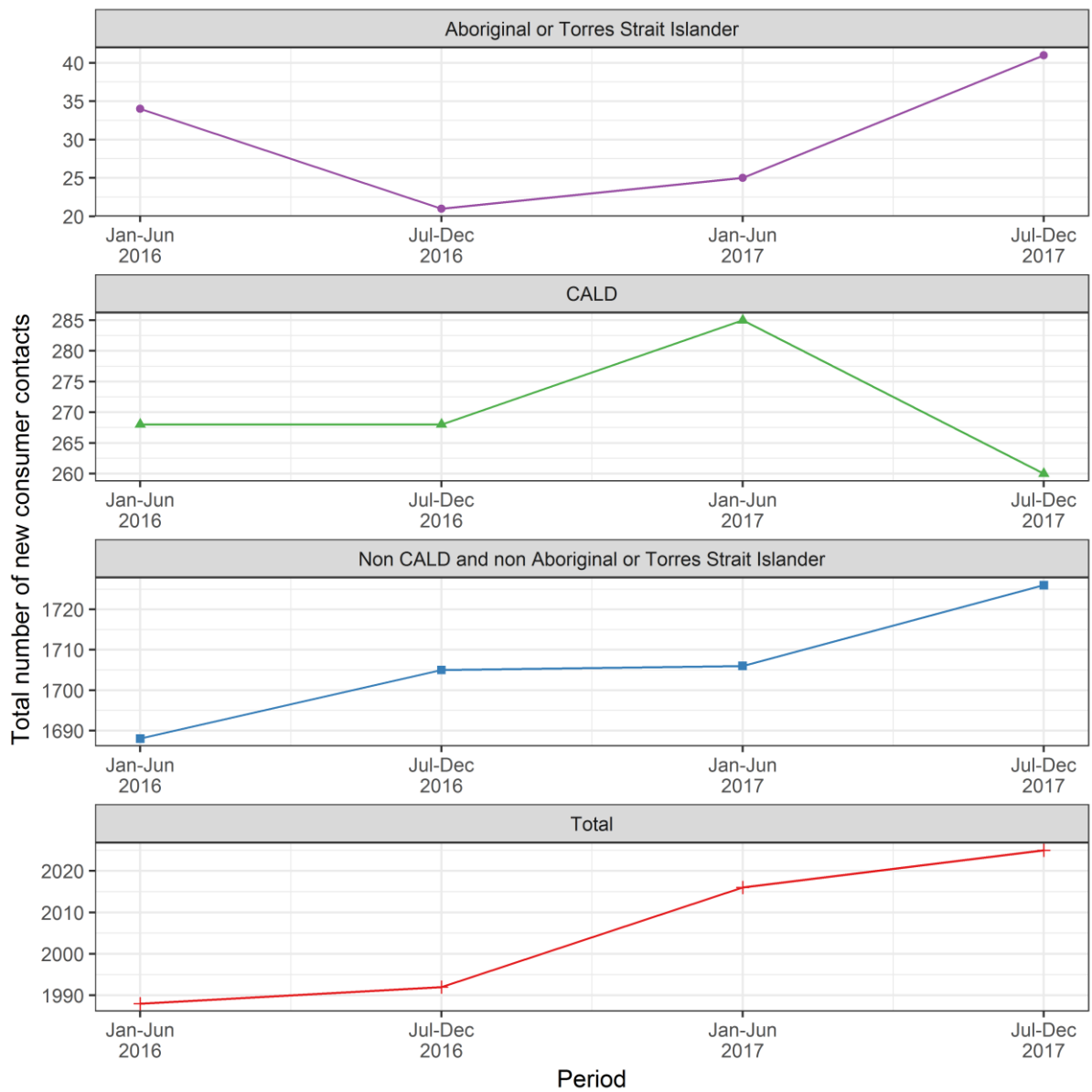
of partnerships between OPMH community services and the referrers (or organisations representing the referrers).

There was an increase in the number of service contacts at which the consumer was present, from 117,589 in the period from January to July 2016 to 131,036 in July to December 2016. The increase was greatest in the 65-69 and 70-74 year age groups (Figure 5). In the last six months of 2017, there was an increase in the total time that consumers were seen present at the service contact (Figure 6). Although there was a dip during the study period, face-to-face contact time increased from an average of 31 hours to 33 hours between January-July 2016 and July-December 2017. A longer time series is required to determine whether these are trends.

The data suggest there hasn't been an increase in the number of people from CALD or Aboriginal and Torres Strait Islander population since the introduction of the model of care (Figure 1).

Clinicians are aware that Aboriginal people are under-represented in the consumer population of OPMH community services relative to the size of the population and known burden of mental illness. Services continue to promote themselves with local Aboriginal Medical Services and other organisations that have the potential to refer Aboriginal and Torres Strait Islander people. In the self-audit, 73% of community teams said their referral processes are inclusive of Aboriginal health/mental health workers and Aboriginal service providers. In one LHD, the OPMH community team was running clinics in the Aboriginal Medical Services. In another, the lead clinician attends meetings with 'Partners in depression' group for Aboriginal carers. Another LHD runs 'OPMH forums' in the local Aboriginal Community Centre. And there was often an individual within the community services team who was proactive in developing relationships with Aboriginal groups. But these activities were still not resulting in increased referrals to OPMH services. One reason may be that Aboriginal people are accessing other services for their mental health care, such as Aboriginal Community Controlled Health Services.

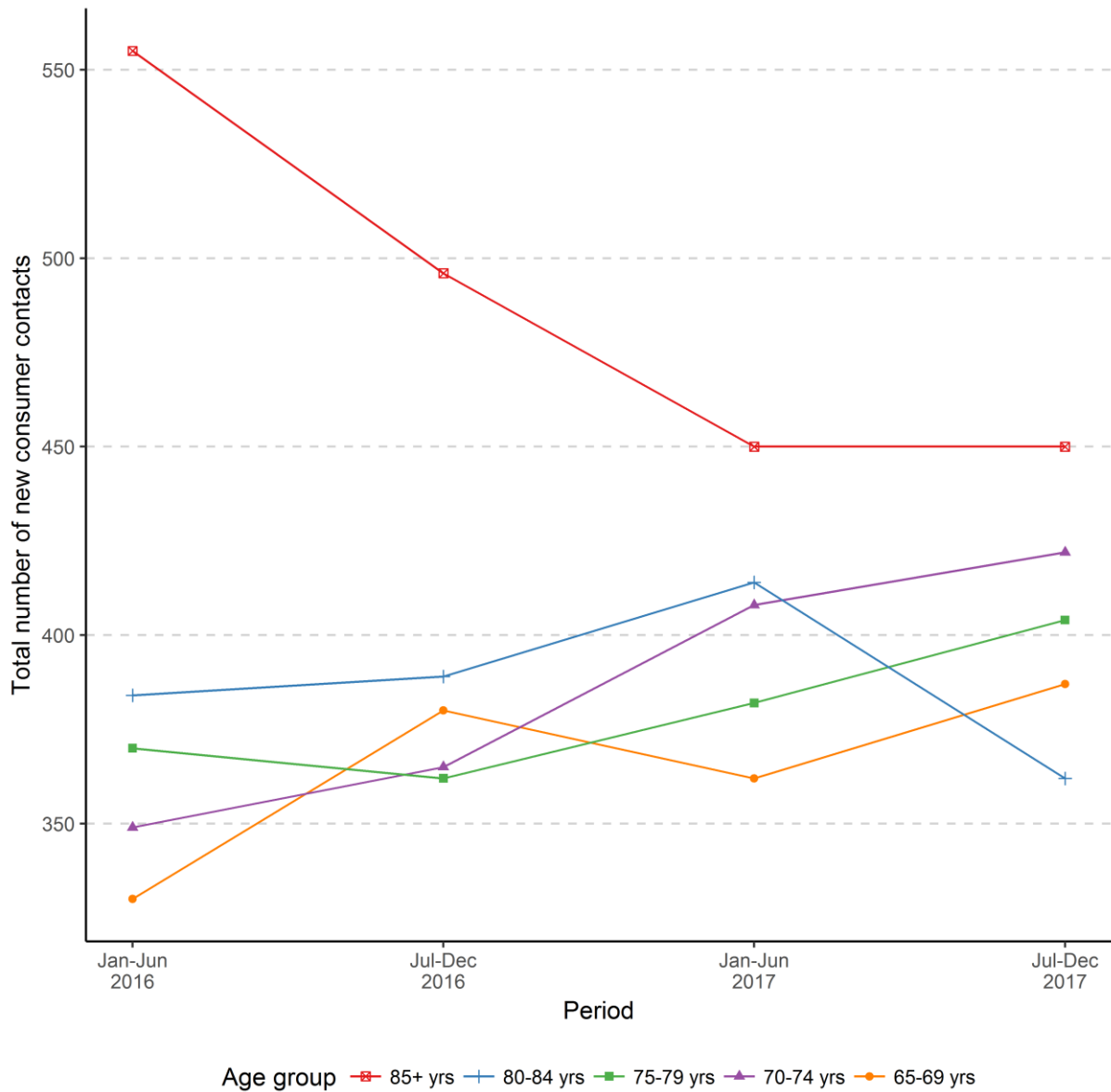
Figure 1 – Number of new consumers to the OPMH community service, Jan 2016 to Dec 2017



Note: A 'new consumer' is a consumer who hasn't been seen by the NSW public mental health services in the previous five years. CALD refers to people from culturally and linguistically diverse backgrounds.

Source: MH-AMB data

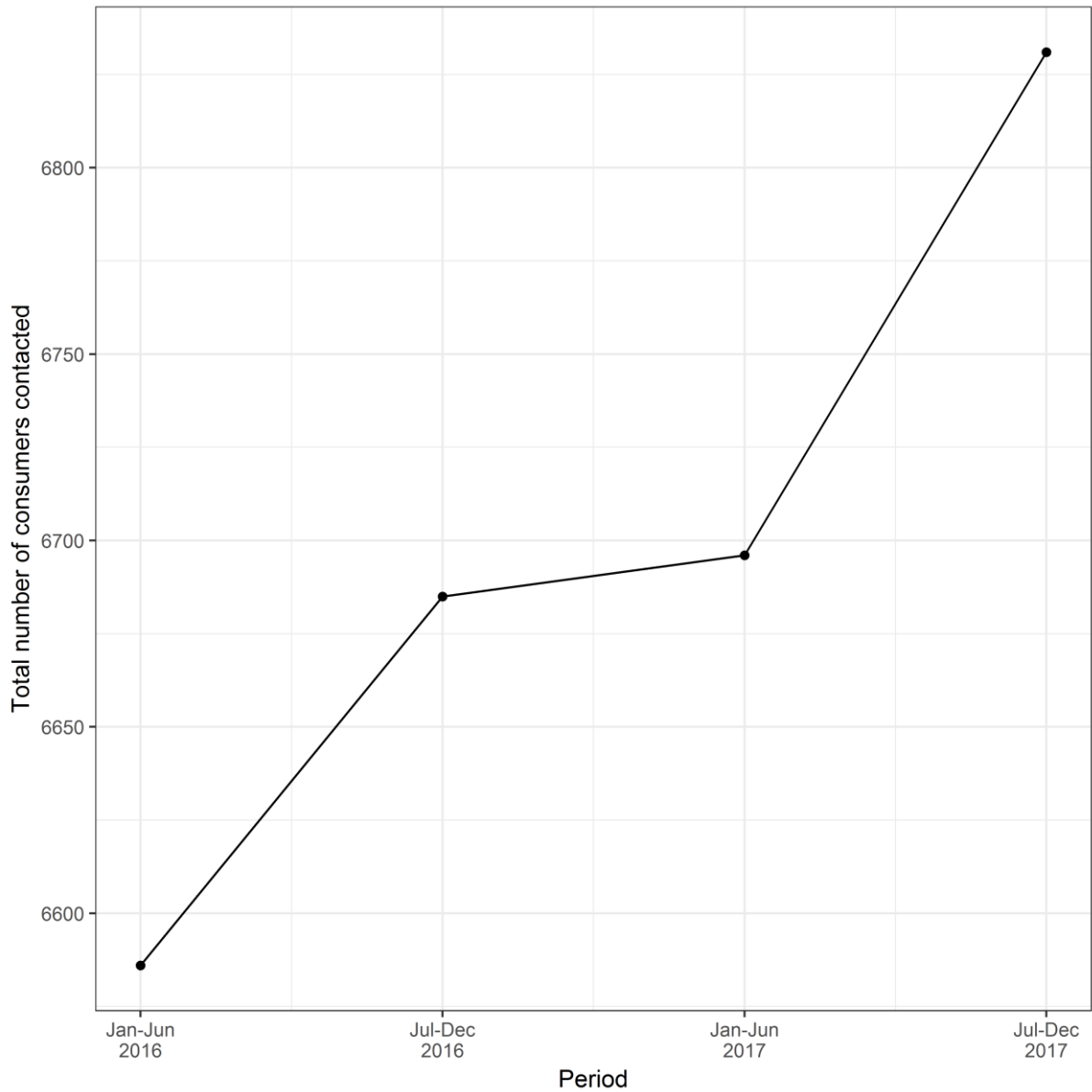
**Figure 2 – Number of new consumers to the OPMH community service, Jan 2016 to Dec 2017
– by five-year age group**



Note: A 'new consumer' is a consumer who hasn't been seen by the NSW public mental health services in the previous five years.

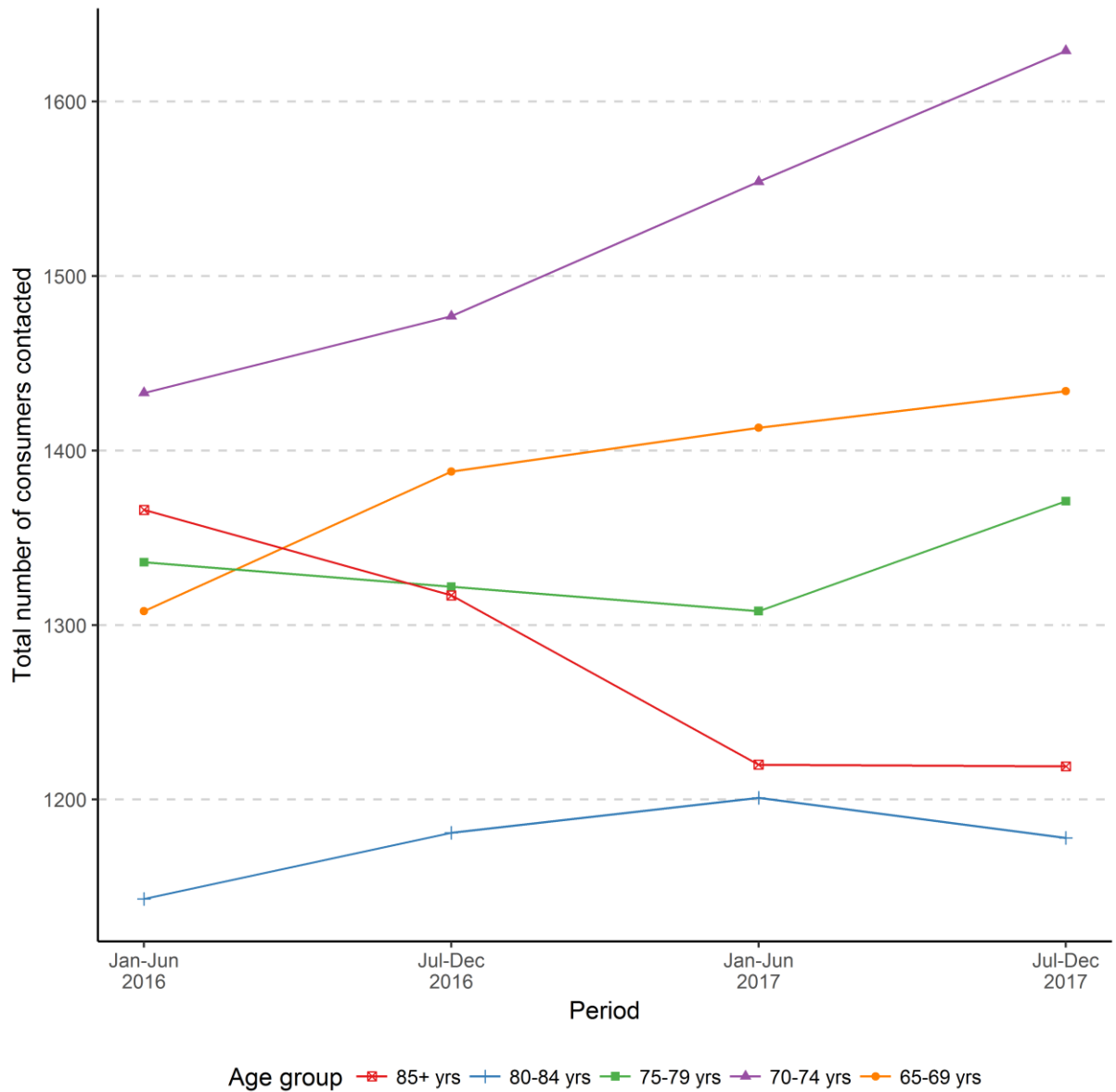
Source: MH-AMB data

Figure 3 – Number of consumers who received an OPMH community service within each six-month period from Jan 2016 to Dec 2017



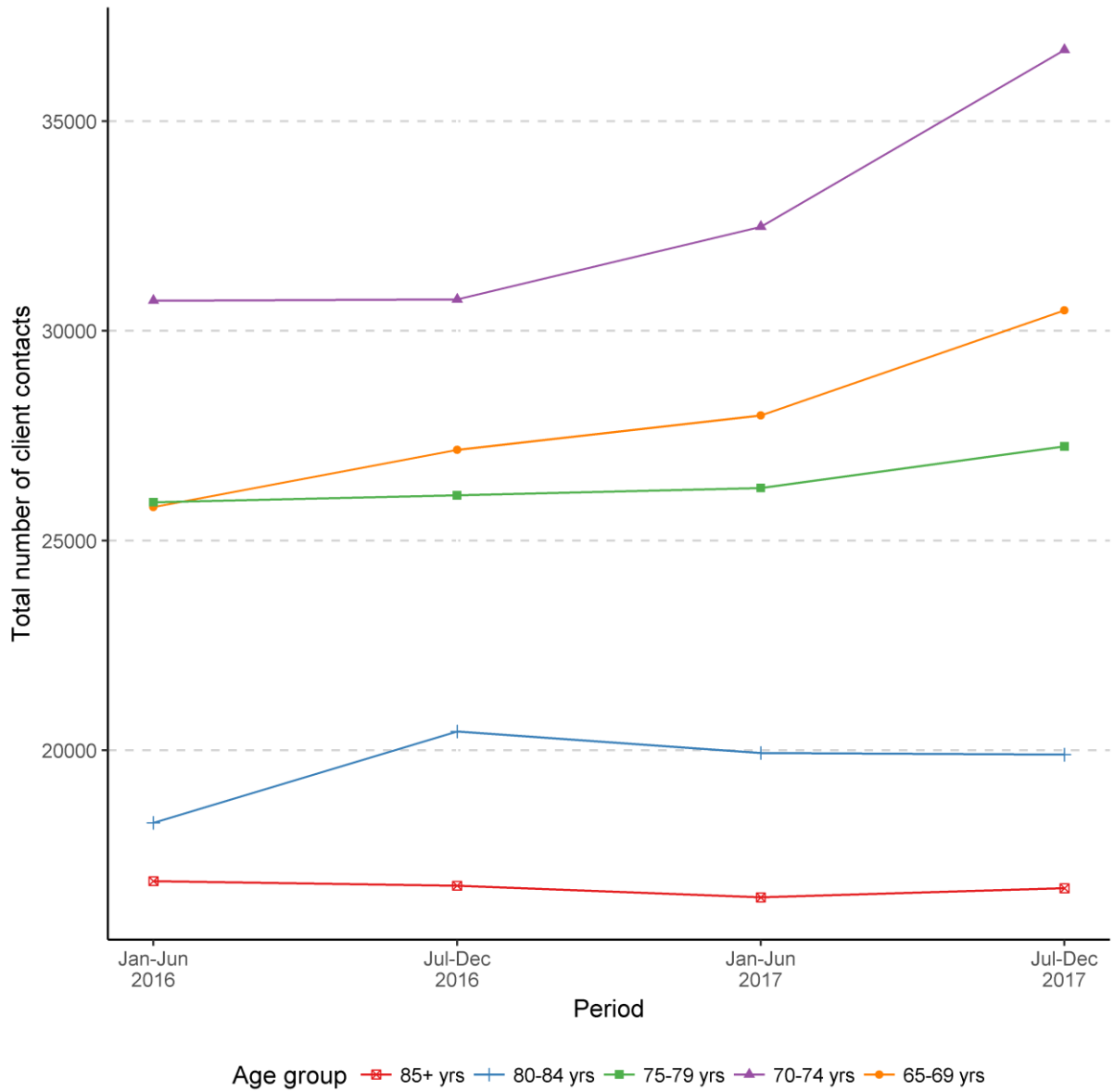
Source: MH-AMB data

Figure 4 – Number of consumers who received an OPMH community service within each six-month period from Jan 2016 to Dec 2017 – by five-year age group



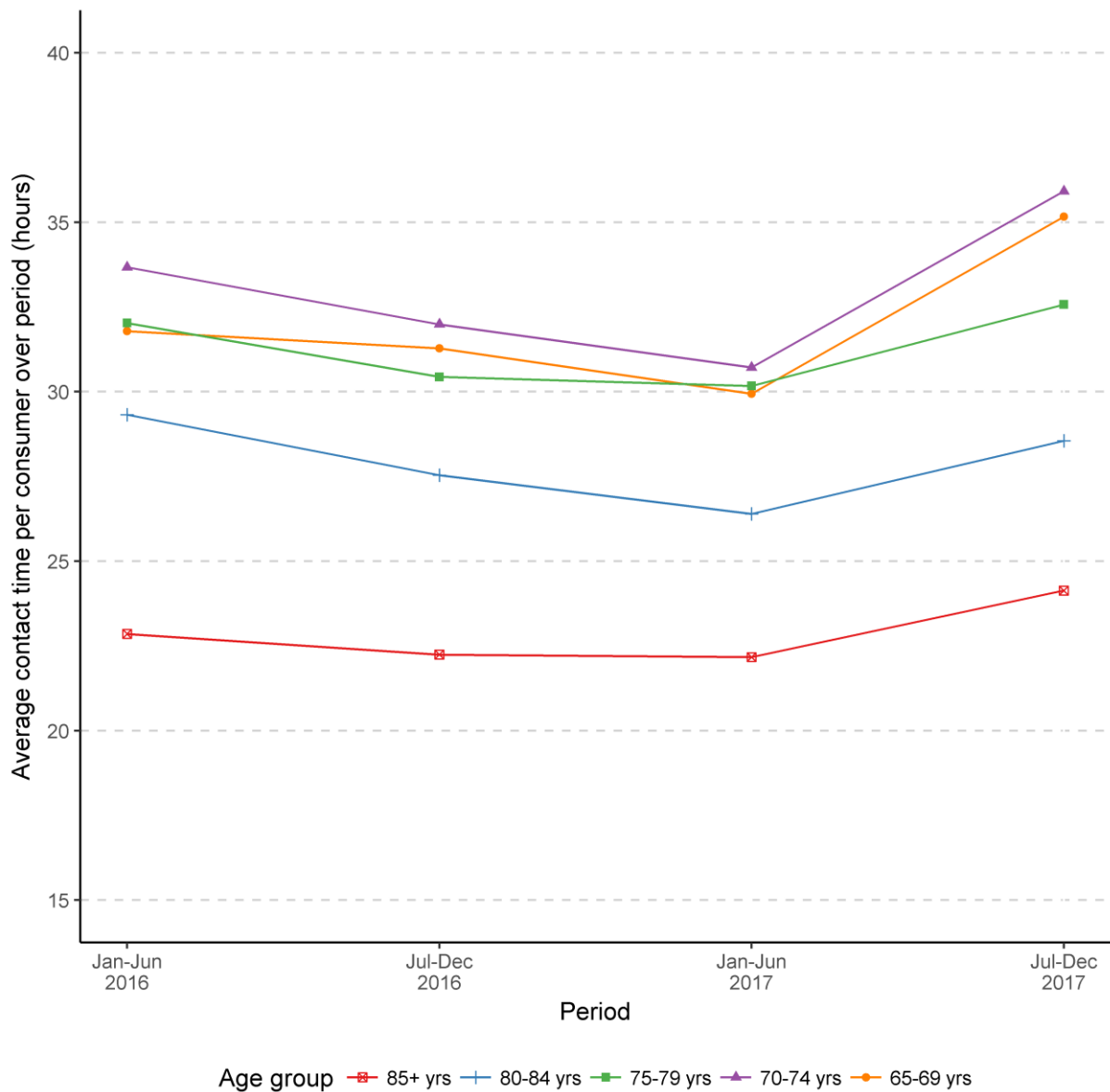
Source: MH-AMB data

Figure 5 – Number of service contacts where the consumer was present



Source: MH-AMB data

Figure 6 – Average time in minutes that each consumer was present at the service contact



Source: MH-AMB data

Challenges and barriers

An overall barrier for the effective operation of the model was resources being tied up in resolving consumers' issues that clinicians and service managers felt are within the domain of other sectors (e.g. aging and disability). This suggests that current strategies and/ or partnerships at a local and statewide level are insufficient to leverage the capacity of these other sectors to complement OPMH community services, to provide the best supports to older people with mental illness. More work could be done in this area.

Another overall barrier was clinicians feeling overstretched in applying the range of policies and assessment tools issued by the Ministry of Health, limiting the time that they have available to provide care according to the OPMH community services model.

Specific barriers were also reported by LHDs with certain features. For example, psychiatrist availability is limited in some parts of the state, and therefore, consumers cannot have ready access to specialist assessment and care.

Challenges and barriers in specific areas referenced by the model are listed below.

Recovery-oriented

- Some clinicians did not perceive that LHDs supported them in undertaking a 'positive risk taking' approach to assessment and planning.
- There has been substantial training in recovery-oriented practices with older people over the last few years and projects to implement ideas. However, some clinicians feel that more work is required to identify effective practices for specific cohorts, such as consumers with severe frailty or severe behavioural and psychological symptoms of dementia (BPSD).
- Some clinicians reported challenges in completing Wellness Plans.
- Some clinicians also reported challenges in developing care plans that are recovery focussed and informed by consumers' Wellness Plans.
- A lack of transport was identified as a barrier for consumers to attend recovery and other therapeutic group activities.
- Some clinicians reported residential care facilities and carers not willing to take risks to allow consumers to engage in activities that align with their recovery goals as a barrier to recovery-oriented care.

Partnerships

- In many LHDs, the OPMH community services criteria have not been adequately communicated to service partners and referral organisations.
- GPs and other organisations referring consumers to OPMH community services mostly reported being unaware of the model and the services, and work is required to raise their awareness.
- Some LHDs reported a reluctance to promote their service to referrers in case of being overwhelmed with referrals, given the level of resources available. This points to the need for clarity around the specialist role of OPMH services, and the need to develop effective partnerships for the ongoing care of consumers.
- OPMH services and other mental health and/ or aged care providers are sometimes unclear about who is responsible for consumers with dementia and BPSD. LHDs have a responsibility to review their local service context to ensure that the needs of these consumers are met, either through direct service provision or partnering with services with a remit to provide BPSD support.
- Strategic partnerships with organisations representing priority groups, such as Aboriginal and Torres Strait Islander people and people of CALD backgrounds, are lacking in some LHDs.

Clinical

- Some services are still struggling with physical assessments or engaging with consumers' GPs for these.
- In many services, falls risk screening is not being done to the level required.
- Some clinicians feel that there is insufficient adaption of assessment and care planning for consumers of culturally and linguistically diverse (CALD) backgrounds.

- There are sometimes tensions between adult and OPMH services about responsibilities for specific groups of consumers (over 65 and with no functional issues or consumers entering residential care). Transitions of care also need work.
- In some services clinicians feel that there is a lack of clarity about the range of biopsychosocial therapies available within the service, and what is available has not been adequately communicated to the local community (including GPs).
- Some clinicians and service managers reported that complexity of accessing services from some organisations, such as *My Aged Care* and the National Disability Insurance Scheme, is impacting access to a wider range of psychosocial therapies for consumers.
- A range of barriers to consumers accessing group activities offering therapy, socialisation and life skills were identified. Sometimes this is to do with transport or other assistance to attend. Other times it is due to the lack of groups that are appropriate for older people and/ or people with a mental illness.
- There is a lack of timely access to psychiatrists in some parts of the state.
- There is a lack of access to clinical supervision in some parts of the state (although alternatives to face-to-face supervision are possible but not yet taken up).
- Peer workers are yet to be employed by some services. Roles are still being defined, and appropriate individuals are not readily available.
- Involvement of consumers and carers in decision making is still at early stages for most services and needs work.
- Some stakeholders do not believe that the YES survey is suitable for some cohorts of older people with mental illness, such as people with dementia.

Outcomes

Consumers' preferences for care align with the person-centred, recovery-oriented, biopsychosocial philosophy of the OPMH community services model of care.

Work is required to raise external health and aged care provider's awareness of OPMH services, which is one of the objectives of the OPMH community services model of care.

Consumers reported that they are seen in the location of their choice, and a variety of options is available.

Consumers tend to remember bad experiences with transition between the community and acute inpatient care, and with their medications. They value continuity of clinicians when transitioning from one service to another and 'easing in' to discharge back home. They also prefer that one person is responsible for making decisions about changes to their medications.

Consumers want to be able to access services when they need them. This includes psychiatrists, who are sometimes unavailable for long periods.

Governance

Many LHDs started out implementing the OPMH community services model of care by establishing a project group. They now all have slightly different governance structures,

which allows them to respond to local circumstances. Leadership was cited as key to achieving the practices articulated in the model.

The OPMH community services model of care is governed by the Mental Health Branch of the NSW Ministry of Health, with advice from the NSW Older People's Mental Health Services Advisory Group. The Advisory Group is well set up to oversee the model given its membership and overview of OPMH services.

Model of care

All stakeholders perceived the OPMH community services model of care as sound. It provides LHDs with a coherent framework for how OPMH community services should act and interact with partners and consumers. Consumers also reported preferences that align with the model. However, some clinicians thought that the demands on them may be too high and were concerned that this may impact the quality of care delivered to their consumers. A few were also concerned about translating the principle of recovery-oriented care into practice for specific cohorts (consumers with severe physical frailty and dementia with severe BPSD). Further practice development and training are needed to effectively work in a recovery-oriented way with these cohorts.

The OPMH community services model of care is a component of the *NSW Older People's Mental Health Services Service Plan 2017-2027* (NSW Ministry of Health, 2017a), which integrates the range of services for older people with mental illness, including acute inpatient care and Transitional Behavioural Assessment and Intervention Service (T-BASIS) units. Some issues with the integration of these services were identified (overall, and in specific areas such as access and intake, clinical review and transitions of care), suggesting that there is room for improvement.

Although the model has features that lead to better staff experiences – such as engaging consumers and carers in service design and recovery-oriented care – staff experience is not mentioned in the model. Implementation of the model could be supported through strategies to promote and maintain positive staff experiences under NSW Mental Health Workforce Plan (forthcoming).

The model could also be simplified in the way that it is presented, as some clinicians found it hard to identify the key messages.

Recommendations

1. That the Ministry of Health work with the LHDs to develop partnerships and strategies at a statewide level to leverage the capacity of other services (including those outside of the health sector) to complement the work of OPMH community services.
2. That the Ministry of Health support the implementation of the OPMH community services model of care through strategies to promote and maintain positive staff experiences under NSW Mental Health Workforce Plan (forthcoming).
3. That the Ministry of Health considers producing summary documents highlighting the principles, features and recommendations of the model of care in a succinct way. This will assist in communicating key messages to busy clinicians to support implementation.
4. That the Ministry of Health work with LHDs to identify and implement effective recovery-oriented practices for specific cohorts of older people, such as those with severe physical frailty and advanced cognitive impairment.
5. That LHDs work at a local level to leverage the capacity of other services (including those outside of the health sector) to complement the work of OPMH community services to provide the best possible supports to older people with mental illness.
6. That LHDs identify and implement strategies to better integrate OPMH community services with other OPMH service elements, including acute inpatient care and T-BASIS units. This could include integration of processes around admission, clinical review and transitions of care.
7. That OPMH community teams and their LHDs identify gaps in recovery-oriented practices and actively work to overcome them. Specific areas of focus might be:
 - ensuring Wellness Plans are completed for consumers
 - providing education to carers about the benefits of recovery-oriented care
 - ensuring all clinicians complete training in the application of recovery-oriented practice to the mental health of older people
 - supporting clinicians in undertaking a 'positive risk taking' approach to assessment and planning
 - using recovery-oriented language in internal communications (e.g. clinical review meetings), and with external partners (e.g. material distributed to GPs and residential care facilities).
8. That OPMH community teams and their LHDs identify gaps in partnerships, and actively work to overcome them. Specific areas of focus might be:
 - distributing criteria for the OPMH community services to service partners and referral organisations
 - identifying appropriate mechanisms to raise the awareness of OPMH community services amongst GPs and other organisations referring consumers
 - clarifying the specialist role of OPMH services amongst staff, and developing effective partnerships with other organisations for the ongoing care of consumers

- identifying and communicating clear service pathways (within OPMH or with partner organisations) for consumers with dementia and BPSD who have specialist mental health care needs
 - developing strategic partnerships with organisations representing priority groups.
9. That OPMH community teams and their LHDs identify gaps in key processes, and actively work to overcome them. Specific areas of focus might be:
- physical assessments
 - falls risk screening
 - adapting assessment and care planning for CALD consumers
 - clarifying the responsibilities of adult and OPMH services in relation to consumers aged over 65 with no functional issues and consumers entering residential care
 - transitions of care.
10. That OPMH community teams and their LHDs identify gaps in techniques and therapies, and actively work to overcome them. Specific areas of focus might be:
- providing guidance to staff on the range of biopsychosocial therapies that may be provided within the service
 - communicating the range of therapies available to the local community (including GPs)
 - creating effective partnerships to assist consumers to access *My Aged Care* and the National Disability Insurance Scheme to make available a wider range of psychosocial therapies
 - investigating opportunities for group activities that are better suited to older people and/ or older people with mental illness.
11. That OPMH community teams and their LHDs identify gaps in capabilities and multi-disciplinary staffing, and actively work to overcome them. Specific areas of focus might be:
- strategies to improve timely access to psychiatrists, for example, through enhanced use of telemedicine (and address barriers to consumers' access to telemedicine)
 - explore alternatives to face-to-face and one-on-one clinical supervision
 - continue to define the role of peer workers and develop strategies to identify and support appropriate individuals in these roles.
12. That OPMH community teams and their LHDs continue with strategies to increase the involvement of consumers and carers in decision making.
13. That OPMH community teams and their LHDs continue to reflect on their service/ practice through benchmarking, self-audit and data gathered through the YES survey, and acting on the information received through these processes.
14. That OPMH community teams and their LHDs continue to implement the OPMH community model of care to ensure that consumers have positive experiences of the service and better health outcomes.

Limitations of the evaluation

This evaluation was undertaken in the early stages of the implementation of the OPMH community services model of care, so it isn't definitive about the outcomes of the model. Some outcomes have been reported, but these are preliminary indications, and a summative evaluation of the model should be undertaken later.

The evaluation used quantitative data collected for assessment and care provision (i.e. the MH-AMB and MH-OAT data). There are known quality issues with these data which InforMH (the information and reporting arm for mental health in NSW) is continuing to address. There was also the roll-out of the electronic medical record from 2014 to 2017, which is likely to have had an impact on the data and also the productivity of staff as they adjusted to the new system. For this report we used the most up-to-date data and reported on trends over time in the number of consumers or number of events of care. These high-level summary statistics are less likely to have been affected by data quality issues, but we acknowledge that the drive to improve the quality of data could have an impact on trends within the data.

Surveys were sent anonymously to staff within LHDs and not all clinicians responded. More importantly we are unable to assess how representative the responders were of all clinical staff. Nonetheless, responses were received from staff in most LHDS, and from a range of staff types and experience. It's possible that the point estimates of the criteria that were presented in this report are biased estimates of the views of the whole staff population, but we do believe they provided valuable information relevant to this evaluation.

Only eight GPs responded to the GP survey and therefore any inference from their responses must be treated with caution. Unfortunately, the low level of response is typical of the involvement of GPs in the review process. We acknowledge that consumers of SMSHOP community service are only a small component of a GPs workload. This is also true for the responses to the surveys of CLS/HASI providers, where again there were only eight respondents.

Five of the 15 LHDs were interviewed for the evaluation. They were selected based on convenience, and therefore the views expressed are not necessarily representative of all LHDs. However, we attempted to obtain a wide range of views by interviewing representatives from rural and metropolitan LHDs and interviewing a wide range of staff in those LHDs. We also supplemented the data from the interviews with the data obtained from the self-audit.

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Appendix 1 – OPMH community services model of care program logic

Inputs	Activities	Outputs	Impacts	Key outcomes
<ul style="list-style-type: none"> • SMHSOP community Services model of care Guideline and consumer/carer/ family resource • Existing funding and staff for SMHSOP • Additional funding for community OPMH teams (2015-16-2017-18) • Australian and international guidance on best practice tools/ approaches for older people with mental illness • Other relevant state-level programs/ service plans (e.g. Mental Health Aged Care Partnership Initiative, NSW Older People's Mental Health Services Service Plan 2017- 	<p>State level</p> <ul style="list-style-type: none"> • Work with SMHSOP Advisory Group and other relevant governance groups • Engagement of other stakeholders • Develop resources for implementing SMHSOP community Services model of care, including implementation checklist and self-audit tool • Develop benchmarking reports and processes for LHDs • Commission and contribute to the evaluation of the implementation of the model of care 	<p>State level</p> <ul style="list-style-type: none"> • Collaboration between key stakeholder groups to monitor the implementation of the model of care and continue to refine it • Ongoing refinement of the model of care, to continue to reflect best practice • Statewide resources for implementing SMHSOP community Services model of care available • Self-assessment tool available • Benchmarking reports and processes for LHDs available • Evaluation report with specific recommendations to improve the model of care and its implementation 	<ul style="list-style-type: none"> • Service delivery to consumers according to model of care, specifically: <ul style="list-style-type: none"> • Partnering with the person and their carer/ family to deliver care • Delivering recovery-oriented care that includes clinical recovery and personal recovery • Improved access (including no 'wrong door' approach) • Improved flexibility in service provision, including care delivered in a range of settings and variety of modalities • Multidisciplinary care • Consideration of biopsychosocial factors in delivering care • Stepped care approach to service provision • Care provided in the location preferred by the consumer • Improved integration of care across settings, sectors (for example, alcohol and 	<ul style="list-style-type: none"> • Improve the lives of older people with mental illness, such as: <ul style="list-style-type: none"> • Lower levels of distress (as measured by K10) • Increased participation in activities of daily living (as measured by LSP16 & RUG-ADL) • Less severe mental health problems (as measured by HONOS65+) • Experience of care delivery (as measured by YES) • Improved consumer, carer and family experiences of services

Inputs	Activities	Outputs	Impacts	Key outcomes
<p>2027, Pathways to Community Living Initiative)</p> <ul style="list-style-type: none"> • National programs/ plans (e.g. MH Commission Living Well in Later Life) • National quality programs/plans/ frameworks (e.g. National Recovery Framework, NSW OPMH Recovery Project, national standards, accreditation) 	<p>LHD level</p> <ul style="list-style-type: none"> • Establish and maintain partnerships with relevant local groups/ individuals • Engage consumers and their carers/ families in the continual improvement of SMHSOP community services • Staff training/ workforce development • Develop local policies and plans for implementing/ delivering the model of care, such as: <ul style="list-style-type: none"> • intake processes/ criteria • assessment • care planning • provision of care • clinical review • transition of care • promotion/ prevention • Develop local resources: <ul style="list-style-type: none"> • for partners referring to the service • for consumers and their carers/ families 	<p>LHD level</p> <ul style="list-style-type: none"> • Recovery-oriented, person-centred, biopsychosocial mindset amongst staff • Appropriate mix of staff delivering SMHSOP community care (i.e. multidisciplinary) • Local protocols/ tools consistent with model of care available to guide staff in service delivery • Greater awareness of SMHSOP community services and the target population for the services amongst professionals likely to refer older people for care (e.g. GPs and other primary care providers, community services), and amongst the community • Local resources available for consumers and their families/ carers on the model of care • Continuous quality improvement of SMHSOP community services, using available resources such as self-audit tool and benchmarking reports 	<p>other drug services, housing, aged care, etc.), and with service providers</p> <ul style="list-style-type: none"> • Improved appropriateness of care delivery to Aboriginal people, and people from culturally linguistically diverse backgrounds 	