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## South Australia's Older Persons Mental Health Services' Model of Service: a country perspective

South Australia has a small population of older people compared to its geographic size. A Model of Service was developed to guide service delivery, with an Older Persons Mental Health Services project team appointed to guide the service. Their brief was to: develop and implement a Model of Service; develop and impart education on topics relating to mental health in late life to the clinicians, mental health teams, and aged care networks; coordinate the education sessions; develop a referral pathways document; develop an orientation package and orientation for clinicians; communicate with mental health teams and the aged care networks on the progress of the project; coordinate recruitment of clinicians; oversee data on the number of assessments undertaken; ensure that the key performance indicators were being met; and order resources for the clinicians (Nicholson and Nowak, 2010).

The aims of the service were to: maximize the mental health services available for people across South Australia; assist older people with a mental illness or at risk of developing a mental illness to remain living and participating in the community or their residential aged care facility; provide access and equity of outcomes for older people with complex and multiple mental health conditions; build and strengthen inter-sectoral partnerships; and contribute to improved measurable health and mental health outcomes for older people and for Aboriginal and Torres Strait Islander people in South Australia (Country Health SA, 2010; Nicholson and Nowak, 2010).

A business case was submitted by Country Health South Australia, Mental Health Services, to fund an Older Persons Mental Health Services for the target population identified. This business case was approved and funding was provided by both Commonwealth and State Governments for a four-year term. The funding was used to: employ Older Persons Mental Health Services clinicians within the local mental health teams; improve staffing and resources; support psychosocial rehabilitation; provide ongoing education of mental illness; provide support to build capacity, decrease stigma, and increase understanding within

the local community; and improve coordination and communication between services within the aged care sector (Country Health SA, 2010; Nicholson and Nowak, 2010). It enabled a full-time equivalent psychogeriatrician to be employed. Even with this funding, it was recognized that older people living in rural South Australia would have limited access to a health service that could adequately respond to all facets of their mental health needs (Country Health SA, 2011). This resulted in a further business case being developed to increase funding for the Older Persons Mental Health Services and psychogeriatricians in South Australia. An Older Persons Mental Health Services Reference Group assisted in developing the Model of Service and guiding the project team in their roles. Educational workshops were to be held annually and this would enable the clinicians to network, with monthly phone meetings taking place to discuss issues and solve problems.

The project team faced many challenges. There were difficulties in attracting and retaining suitable staff to the country positions, possibly due to the positions being part-time and the rural locations of some of the positions. The funding agreement resulted in Older Persons Mental Health Services clinicians being appointed prior to the Model of Service being developed, and this led to some confusion about the roles of the clinicians, service delivery, and differences of opinion within the teams on how the clinicians would operate. These and other issues were slowly being addressed. However, the clinicians were enthusiastic about their roles and took on board the different challenges as they faced them.

The Older Persons Mental Health Services clinician roles included undertaking a specialist clinical mental health assessment and care coordination; undertaking a specialist mental health consultation, i.e. liaising with key services and healthcare providers; joint care planning and coordination between the mental health clinicians, general practitioners, and other key services and healthcare providers; planning for crisis and relapse cases to assist in emergency situations with known consumers and working closely with the Emergency Triage and Liaison Service for out of hours interventions; conducting joint assessments with psychogeriatricians, geriatricians, Aged Care Assessment Team, Geriatric Evaluation and Management Service, and relevant aged care service providers; ensuring assertive care

coordination including specialized psychogeriatric assessment and management plans and a comprehensive consumer risk assessment; being a local point of coordination for transfer of care and for reviews by tele-psychiatry; and forming partnerships with other community services and non-governmental organizations to enhance independence of the consumer (Country Health SA, 2010).

While the project team contracts have now expired, a management group will ensure that the Model of Service is implemented. The future tasks include clinicians developing strong links with their aged care networks including the Aged Care Assessment Team, residential aged care facilities, Geriatric Evaluation and Management Service, Community Health, and other community services to ensure a fully integrated and comprehensive service; ensuring the implementation of the Model of Service; meeting of the Older Persons Mental Health Services clinicians with their general practitioners to network and promote their services; finalizing the development of the referral pathway and accepting all referrals through the local mental health teams; and developing further resources for the Older Persons Mental Health Services (Nicholson and Nowak, 2010).

## **Conflict of interest**

None.

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