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RACF Implementation Guide

Primary Mental Health Care Services in Residential Aged Care Facilities

Version 1.

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Contents

Primary Mental Health Care Services in Residential Aged Care Facilities

1 Introduction

The Adelaide Primary Health Network (Adelaide PHN) commissions services targeting the mental health needs of people living in residential aged care facilities (RACFs). These services are intended to enable residents with mental illness access to primary mental health services similar to those available in the community under the Medicare Better Access Scheme arrangements.

These services are made available through the Commonwealth Government's Psychological Treatment Services for People with Mental Illness Living Residential Aged Care Facilities Budget Measure.

Adelaide PHN commissioned service providers (CSPs) engaged to deliver the Primary Mental Health Care Services in Residential Aged Care Facilities have been selected based on their demonstrated capacity and capability to deliver high quality primary mental health care services. Adelaide PHN has contractual arrangements in place with CSPs to ensure they continue to meet minimum requirements in relation to the provision of high quality, timely and responsive services, including in relation to service and clinical governance, workforce credentialing, accreditation against relevant standards and achievement of Project deliverables. The performance of CSPs is regularly monitored by Adelaide PHN Capacity Building Coordinators, including through regular performance management meetings and formal contractual reporting requirements (against key performance indicators and compliance obligations).

1.1 Purpose of this document

The ***RACF Implementation Guide*** aims to provide RACFs with the necessary details to:

a) Understand the essential service features, resident eligibility and referral processes for primary mental health care services for residents with mental illness
b) Meet the RACF service requirements to become a Registered Site for the delivery of primary mental health care services.

2 What are primary mental health care services for people with mental illness in RACFs?

2.1 Service delivery model

Primary mental health care services will be delivered by Adelaide PHN commissioned service providers (CSPs) through an in-reach model, onsite at RACFs.

The services delivered to RACF residents will be consistent with other primary mental health services commissioned by the Adelaide PHN in that they will be delivered within a broader stepped care framework. Services will be delivered by suitably qualified mental health clinicians, such as psychologists, accredited mental health occupational therapists,

accredited mental health social workers, Aboriginal and Torres Strait Islander health workers and accredited mental health nurses.

Service delivery is based on a stepped-care model which provides a framework that matches interventions to resident's needs. The least intrusive, most effective intervention is provided first. For example, low-Intensity interventions may be individual and support self-management or group based psychoeducational groups. Psychological therapies may be a suitable treatment for people presenting with mild to moderate mental illness, or severe mental illness that is episodic in nature. Psychological therapies will largely be provided face-to-face by qualified mental health clinicians as individual or group therapeutic services.

Key aspects of the service delivery are that:

- Services are delivered within the Adelaide PHN metropolitan region
- Services can only be provided by Adelaide PHN CSPs
- Residents must satisfy the Eligibility Criteria (see Section 2.2) to access services.
- RACFs must be a *Registered RACF* to access services for residents (see section 3)
- All referrals for services will be coordinated through Adelaide PHN's Primary Mental Health Care Services Central Referral Unit (see Section 4.1 for further information on referral processes)

2.2 Resident eligibility criteria

To be eligible to receive services persons must be a resident of a RACF within the Adelaide PHN region, and:

- be "at risk" of mild to moderate mental illness (defined as experiencing early symptoms and assessed as at risk of developing a diagnosable mental illness over the following 12 months)
- have a diagnosed mental illness, with mild to moderate symptoms of a common mental illness
- have a diagnosed mental illness, which is severe and episodic in nature, and will benefit from short-term psychological therapies

Residents with the following conditions and/or presentations are excluded from services:

- dementia with severe cognitive features
- delirium
- severe, persistent and complex mental illness

2.2.1 Delirium, dementia and cognitive decline

For the services, the definition of mental illness is consistent with that applied to MBS Better Access Scheme. This means that dementia and delirium are not regarded as mental illness. This is because these conditions require medical and/or other specialised support which is not within the scope of the services.

A significant proportion of RACF residents will have some degree of cognitive decline. They are not excluded from mental health services if they also have a comorbid mental illness such as depression and anxiety, and if they are able to engage and respond to the mental health services.

2.2.2 Severe and persistent or complex needs

The services will not be able to support residents with significant behavioral issues, or severe and persistent or complex needs that would be better managed by specialised mental health services, such as State Government Older Person's Mental Health Services (OPMHS).

Residents whose behavioral symptoms of dementia (BPSD) are affecting their wellbeing and care should continue to be referred to the Dementia Behaviour Management Advisory Service, delivered through Dementia Support Australia.

2.3 Common presenting issues

There are several sub-groups of residents who have particular needs for whom services are likely to be targeted, including:

- Residents who are having significant transition issues and experiencing adjustment disorders
- Residents with mild to moderate anxiety and/or depression
- Residents with a past history of mental illness for which they received services before being admitted to a RACF which could not be continued
- Residents with co-morbid mental illness and cognitive decline (as outlined in section 2.2.1)

3 RACF service requirements

3.1 Registering a RACF site

To enable residents to receive mental health services each RACF site will need to become a **Registered RACF** by completing the following steps:

Step 1: Complete the Adelaide PHN online form here. This will notify both the Adelaide PHN and CSP of your request for services.

- You will receive a receipt that your request for registration has been received and notification of the CSP who will deliver the services in your region.
- The CSP will contact you within 2 weeks to arrange an initial site visit.

Step 2: In collaboration with the CSP complete the **RACF Checklist** (see section 3.2) in to finalise registration. When both parties are satisfied that all requirements are met, move to step 3.

Step 3: The CSP will notify the Adelaide PHN that the RACF site is now registered.

Referrals for services can now commence.

NOTE: If your organisation has more than one site, you will need to complete an individual registration for each individual RACF site.

3.2 RACF Checklist

The **RACF Checklist** should be used as a guide for the initial appointment between the RACF and the CSP. The CSP will discuss this with you.

Table 1. RACF Checklist for Registration

1	Register your RACF site via the Adelaide PHN online form here	☐
RACF to complete the following steps with the CSP to facilitate access to the site(s) and allow provision of primary mental health services for residents		
2	Arrange ICT access at RACF site for mental health clinicians (including access to resident progress notes).	☐
3	Provide mental health clinicians with access to patient history records; including electronic residents progress notes (e.g. People Point) or paper-based records	☐
4	Arrange organisational induction and orientation for all mental health clinicians (and new staff) as required	☐
5	Manage and coordinate organisational compliance requirements directly with the mental health service provider (e.g. relevant site-specific user agreements, police checks, clearances to work with vulnerable people, statutory declarations; compulsory reporting procedures etc)	☐
6	Provide names of designated clinical leads onsite that will be responsible for coordinating resident appointments; Identify key personal or staff member designated by the RACF site to be contacted in case of mandatory or compulsory reporting requirements	☐
7	Distribute agreed communication to GPs aligned with RACF (e.g. GP Fact Sheet, resident brochure) about the Primary Mental Health Care Services in Residential Aged Care Facilities services	☐
8	Coordinate with the mental health clinician(s) to meet with key RACF staff (e.g. chaplains, nurse practitioners, clinical leads, site managers, ENs, RNs, Leisure and Lifestyle coordinators)	☐
9	Facilitate options for mental health clinicians to promote the service with staff and improve mental health literacy and competency	☐
10	Communicate and promote the services to residents, family members and carers (e.g. at resident meetings, displaying Adelaide PHN Resident Information brochures)	☐
11	Agree to use the standard **Adelaide PHN RACF Referral Form** and **Consent Form** and follow **Referral Processes** (as outlined 4.1). Copies of the current forms can be obtained through the CSP	☐
12	Provide options for private space for the delivery of psychological sessions (e.g. this may be client's private room or a designated clinic room onsite)	☐
13	Provide access to an appropriate space for the delivery of group interventions, as required	☐

14	Other: _____ _____	☐
15	Other: _____ _____	☐

Any RACF site specific requirements (e.g. operational procedures for allied health professionals) should be discussed and agreed to by the RACF site and the CSP during the registration process.

RACFs and CSPs may wish to formalise their working arrangement through a Memorandum of Understanding (MoU) to support co-operation and mutual understanding. A sample MoU is provided as Appendix 1 and can be adapted and/or used as a framework in the establishment of primary mental health care services in RACFs.

4 Collaborative care

To promote mental health outcomes for residents, it will be important for RACF staff and the CSP to establish collaborative working arrangements. For example, communication about the care needs of clients will be important between RACF staff and mental health clinicians. Similarly, documentation by mental health clinicians in resident progress notes to ensure information about the provision of services are relevant and well documented.

In general, RACFs have an overarching responsibility to ensure that residents with mental illness can access mental health services and treatment. As part of implementing primary mental health care services in RACFs, the intention is that the services should not place additional demands on RACF staff beyond their existing responsibilities. The necessary collaboration required from RACFs to support service delivery includes:

- Identifying and referring residents who are eligible for and may benefit from primary mental health care services*;
- Facilitate GP involvement and arrange medical review (if indicated) to exclude physical illness, severe cognitive impairment or other organic causes that may be reversable (e.g. delirium) and not the result of mental illness;
- Assistance with ensuring residents attend appointments;
- Access to information about resident history relevant, to mental health treatment, (including status of medications), subject to clinical governance arrangements;
- Access to consulting rooms and facilities
- Assistance promoting the new services to residents and families.
- Communication with resident's substitute decision makers and/or family

*The Aged Care Funding Instrument (ACFI) recognizes mental illness as a factor influencing the costs to RACFs of providing residential care and may be one way of identifying residents who may be in scope for the services.

4.1 Outcome measures

To support service delivery, RACFs may be asked to share agreed resident clinical outcomes measures (where appropriate) such as Cornell Depression Scale (CSD) and

Psychogeriatric Assessment Scale (PAS) to help inform the mental health clinicians understanding of resident's current needs and situation. As standard practice for all Adelaide PHN Primary Mental Health Care Services, residents will be asked to provide feedback on their experience of services. This information will be collected by the CSP and used to inform service improvement and quality.

5 Referral processes

Referrals for primary mental health care services will only be accepted for Registered RACF sites.

The RACF Referral Form and Consent Form can be accessed on the Adelaide PHN website (adelaidephn.com.au) or directly from the CSP in your region.

As part of the referral process, the RACF key responsibilities include:

- Facilitate GP involvement and arrange medical review (if indicated) to exclude physical illness, severe cognitive impairment or other organic causes that may be reversable (e.g. delirium) and not the result of mental illness
- Fax completed referral to the Adelaide PHN, Central Referral Unit (do not provide the referral directly to CSP).

Completed referrals are faxed to:

Primary Mental Health Care Services - Central Referral Unit

Fax Number: 1300 580 249

6 Escalation pathways

6.1 Risk of harm to self or others

If an escalation in care is required due to increased resident risk of self-harm or risk of harm to others, mental health clinicians will be required to notify the nominated RACF staff (e.g. clinical nursing lead) and the GP of changes in the risk presentation for the resident.

It is acknowledged that in this setting the RACFs are responsible for the overall care of the individual. In clinical risk situations (including risk of harm to self or others) the mental health clinical will ensure the RACFs clinical nursing are alerted directly of the concerns, and that all information pertaining to the resident's situation and risk assessment are documented in the resident's progress notes. In this situation, the responsibility to escalate and coordinate care needs for the resident will be returned to the RACF, such as instigating referral to specialised mental health services (OPMHS), psychiatric assessment or medical review by a GP.

6.2 Reportable assaults

Under the Aged Care Act 1997, RACFs have requirements and procedures for reporting any alleged or suspected incidents of assault on a resident (further information can be found at: www.agedcare.health.gov.au/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportable-assaults).

At RACFs the responsibility to make reports is generally held by the Site Operations Manager (SOM) and/or with the General Manger Residential Care. Before making the report to SAPOL and the Department of Health (DoH) the RACF must be satisfied that the alleged or suspected assault meets the definition of a reportable assault. There are some instances that the RACF may have discretion not to report.

In line with the compulsory reporting requirements for RACFs, CSPs should be aware of these compulsory requirements and relevant RACF specific procedures and report a suspicion or allegation of a reportable assault to the key personal or staff member designated by the RACF site (i.e. Clinical Lead or another person authorised by the RACF to receive reports of this nature).

As a general guide, CSPs working across multiple RACF sites and organizations should:

- Be aware of the RACFs policies and procedures related to responding to resident abuse.
- Report if they see, or suspect, an assault on a resident to the RACF designated staff member as soon as possible after the incident occurs. The designated staff member may be the SOM (or their delegate), the Clinical Care Manager (CCM), the Registered Nurse on duty, or another staff member as indicated by the RACF.
- Some RACFs may require a written staff notification form be completed as soon as possible after the incident occurs. CSPs should request a copy of the notification form and use this as a template and guide for documenting the incident.
- Record Keeping – the CSP should be aware of the requirements for documenting (if any) in the RACF client service record (progress notes) and keep a more detailed summary in their own confidential client record (practitioner notes).

6.3 Critical incidents

CSPs have a responsibility for the formal reporting and management of critical incidents to the Adelaide PHN. All serious incidents or significant client or family/concerns are notified and documented with the Adelaide PHN incident reporting system. As a general guide, if a RACF becomes aware of a critical incident (e.g. injury/harm or a near misses caused to a resident) as a direct result of the mental health service provision, the RACF should share this information with the CSP so they can make a notification to the Adelaide PHN. Information gathered through incident reports will be used to inform learning processes to prevent further resident safety incidents occurring and may assist in system level improvement.

7 Help and assistance

For additional information contact the Adelaide PHN:

Mental Health Enquiry Phone Line – 1300 898 213

9am – 4pm, Monday – Friday (except public holidays)

or Adelaide PHN general enquires:

postal

PO Box 313
Torrensville Plaza SA 5031

office

Level 1/22 Henley Beach Road
Mile End SA 5031

phone

08 8219 5900

email

enquiry@adelaidephn.com.au

8 Complaints or Feedback

For all feedback and complaints, please use the “Contact Us Form” on the Adelaide PHN website (adelaidephn.com.au/contact-us).

9 Appendices

1. Example Memorandum of Understanding (MoU) between RACF site and Adelaide PHN Commissioned Mental Health Service Provider

Appendix 1

Example Memorandum of Understanding (MoU) between RACF site and Adelaide PHN Commissioned Mental Health Service Provider

[*Insert RACF Entity*]

And

[*Insert Commissioned Service Provider*]

Primary Mental Health Care Services in Residential Aged Care Facilities

MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING BETWEEN THE PARTIES:

[Insert Business Name of RACF Site], ABN xxxxxxxxxx, of [insert address]

And

[Insert Business Name of APHN commissioned service provider], ABN xxxxxxxxxx, of [insert address]

1. BACKGROUND

Commonwealth Government's Psychological Treatment Services for people with mental illness in Residential Aged Care Facilities

This Memorandum of Understanding sets out the framework for the delivery of Primary Mental Health Care Services in Residential Aged Care Facilities ("the Project") agreed between [insert RACF entity] and [insert APHN Commissioned Service Provider].

The purpose of the Project is to provide clinical low intensity and psychological therapy mental health services for people residing in residential aged care facilities (RACFs) under the Commonwealth Government's Psychological Treatment Services for People with Mental Illness in Residential Aged Care Facilities Measure ("the Measure").

The Measure aims to address a lack of access to psychological therapies for residents of RACFs experiencing mental illness through the provision of on-site low, medium and/or high intensity primary mental health care services.

The Commonwealth Government has tasked Primary Health Networks (PNHs) to commission psychological treatment services targeting the mental health needs of people living in RACFs under the Measure. Adelaide PHN has commissioned [insert APHN Commissioned Service Provider] to deliver these services in collaboration with [insert RACF entity].

Implementation of the Measure and Primary Mental Health Services Stepped Care Framework

PHNs are engaged by the Commonwealth Government to commission a broad range of primary mental health care services under a stepped care framework. Services delivered under the Measure are to be incorporated within this framework.

The stepped care approach is defined as an evidence-based, staged system comprising a hierarchy of mental health interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions as required. The stepped care framework operates across the severity spectrum of mental health conditions: 'at risk', mild, moderate and severe.

Mutual Benefits and Interests of the Parties

[insert RACF entity] and [insert commissioned service provider] have shared objectives centred around supporting and improving the health and wellbeing of their communities. Through working together, the parties are well positioned to facilitate the delivery of primary mental health services to residents of RACFs at risk or experiencing mild to moderate mental

illness or that have a diagnosed mental illness, which is severe and episodic in nature, and will benefit from short-term psychological therapies

Consistent with these shared objectives, the parties will enable the Project through a coordinated and collaborative approach:

- [insert RACF entity] is well positioned to identify and support eligible RACF residents to participate in the Project and obtain access to clinical low intensity and psychological therapy mental health services;

- [insert commissioned service provider] has been commissioned to provide high quality, evidence-based clinical low intensity and psychological therapy mental health services onsite at RACFs.

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2. PROJECT AIMS AND OVERVIEW

The Project aims to:

- provide residents of RACFs at risk of, or experiencing mild to moderate mental health conditions; or severe mental illness, which is episodic in nature, and will benefit from short-term psychological therapies with access to high quality, timely and responsive clinical low intensity and psychological therapy mental health services;

- evaluate resident experiences and outcomes associated with the provision of clinical low intensity and psychological therapy mental health services;

- assist RACF staff with the promotion and management (including identification of mental health issues) of resident access to clinical low intensity and psychological therapy mental health services.

Under the Project, clinical low intensity and psychological therapy mental health services will be offered onsite to eligible residents living at:

- insert RACF ADDRESS, SA, POSTCODE

Mental health services made available under the Project will comprise individual and/or group clinical low intensity and psychological therapy for eligible residents at risk of, or experiencing, mild to moderate mental health conditions; or severe mental illness, which is episodic in nature, and will benefit from short-term psychological therapies. [insert commissioned service provider] will be funded by Adelaide PHN to provide these services at no cost to eligible residents.

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3. PROJECT OUTCOMES

The expected impacts of the Project are:

- improved mental health and wellbeing outcomes for residents of [insert RACF site].

- improved RACF capacity to identify and manage residents experiencing at risk of, or experiencing, mild to moderate mental health conditions; or severe mental illness, which is episodic in nature, and will benefit from short-term psychological therapies including facilitating access to clinical low intensity and psychological therapy mental health services.

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4. PURPOSE OF THE MEMORANDUM OF UNDERSTANDING

The purpose of this memorandum of understanding is to describe the common understanding about the Project. The memorandum of understanding provides a basis for all parties to achieve the aims and outcomes of the Project as described above.

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5. PRINCIPLES & UNDERSTANDINGS

The principles and understandings underpinning this memorandum of understanding include:

- all parties involved in the Project will work collaboratively together to achieve the stated aims and outcomes for the Project.

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6. RESPONSIBILITIES OF THE PARTIES

All parties to this memorandum of understanding agree:

- to work collaboratively with each other and other key stakeholders (as required) to ensure effective and efficient delivery of the Project, including ensuring appropriate clinical governance and risk management frameworks are in place to ensure the safety of RACF residents, staff, volunteers, contractors and other relevant parties; and
- to contribute to performance monitoring and evaluation of the Project through the provision of qualitative and quantitative data, knowledge and information sharing and expertise.

[insert RACF entity] agrees to:

- contribute to the identification of eligible residents that may benefit from the provision of clinical low intensity and psychological therapy mental health services;
- facilitate referral and consent processes for eligible residents that may wish to access clinical low intensity and psychological therapy mental health services (including notifying the resident's general practitioner and confirming the mental health diagnosis, and consulting with the resident's substitute decision-maker as appropriate);
- facilitate access to information about eligible resident's medical history relevant to the provision of clinical low intensity and psychological therapy mental health services, including the capacity for [commissioned service provider] clinicians to enter information relating to the resident's care into [RACFs] resident information management system;
- work in collaboration with [commissioned service provider] to support residents attend appointments for clinical low intensity and psychological therapy mental health services;
- promote the availability of clinical low intensity and psychological therapy mental health services to residents, their families, carers, staff, general practitioners and other visiting health and related professionals;

- support key RACF staff to assist with the promotion and management (including identification of mental health issues) of resident access to clinical low intensity and psychological therapy mental health services;
- make available suitable resources at [insert RACF site], including provision for the delivery of onsite clinical low intensity and psychological therapy mental health services within the resident's room (as appropriate) by [commissioned serviced provider].

[Commissioned Service Provider] agrees to:

- deliver the clinical low intensity and psychological therapy mental health services for eligible residents in accordance with the requirements set out in this memorandum of understanding and associated contractual arrangements agreed between [commissioned service provider] and Adelaide PHN;
- engage suitably qualified, experienced and credentialed clinicians to deliver the clinical low intensity and psychological therapy mental health services, ensuring each clinician:
  - possesses a current and satisfactory national police check;
  - provides documentary evidence of the above to [RACF site] (if requested); and
  - executes a deed of confidentiality, or similar, in a form acceptable to [RACF site] (if requested);
- deliver the clinical low intensity and psychological therapy mental health services to eligible residents onsite at [RACF site], in accordance with required protocols;
- work with [RACF site] to support residents referred for clinical low intensity and psychological therapy mental health services that may, on clinical triage, be identified as requiring referral to specialised mental health services, and facilitate referral pathways as appropriate; and
- work collaboratively and in consultation with the resident's general practitioner and other key health professionals involved in the resident's care in relation to the provision of clinical low intensity and psychological therapy mental health services;
- support [insert RACF site] to identify/access training to raise the mental health literacy and competency of RACF clinical staff, and to support the promotion and management of mental health services and mental health for residents.

7. MARKETING AND PUBLICITY

Adelaide PHN will handle all marketing and publicity in relation to the Project. Any party to this memorandum of understanding must obtain permission from Adelaide PHN prior to engaging in any marketing or publicity activities in relation to the Project or this memorandum of understanding.

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8. RELATIONSHIP OF THE PARTIES

The relationship of the parties is one of co-operation,and is not intended to imply any arrangement of partnership, or other legally binding relationship other than that explicitly stated in this memorandum of understanding. This memorandum of understanding does not imply any other relationship in respect of employer and employee, principal and agent, or contractors between the parties other than that explicitly stated in this memorandum of understanding.

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9. TERM OF THE MEMORANDUM OF UNDERSTANDING

This memorandum of understanding begins when signed by the parties and is intended to be effective until [insert date]. At the end of the memorandum of understanding, representatives from the parties may meet to assess the relationship and determine the nature of any ongoing relationship.

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10. LEGAL STATUS

This memorandum of understanding is not intended to be legally binding. A party may at any time withdraw its involvement in the Project and this memorandum of understanding by providing notice to the other party.

By signing this memorandum of understanding the parties confirm their commitment to the Project and that the information contained in this memorandum of understanding is complete and correct.

[RACF]
by its authorised representative:

_____
Signature

_____
Name and position

_____
Date

[Adelaide PHN Commissioned Service Provider]
by its authorised representative:

_____
Signature

_____
Name and position

_____
Date