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Psychological Treatment Services for people experiencing mental health challenges in Residential Aged Care Homes

Acknowledgement

This document was developed by the Australian Government Department of Health, Disability and Ageing.

Preferred citation: Australian Government Department of Health, Disability and Ageing. Psychological Treatment Services for people experiencing mental health challenges in Residential Aged Care Homes. Canberra: Australian Government Department of Health, Disability and Ageing; 2026.

Disclaimer

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Introduction

Primary Health Networks (PHNs) are required to commission psychological treatment services targeting the mental health needs of people living in residential aged care homes (RACHs). These services enable residents of these facilities, who are experiencing mental health challenges, to access mental health services similar to those available in the community through the Better Access to Psychologists, Psychiatrists and General Practice through the MBS Initiative (Better Access).

This activity is an extension of the role of PHNs in providing mental health services to underserviced groups within an integrated, stepped care approach. This guidance document should therefore be read in the context of other guidance provided to PHNs on commissioning services through the Mental Health Flexible Funding Stream available on the department's website at www.health.gov.au.

Psychological services for RACH residents will need to be adapted to the needs and environment of this group and commissioned in a way which complements personal care and accommodation services provided by RACHs, dementia services and broader physical health and social support.

As part of their existing grant agreements, PHNs are expected to:

- Commission services for residents experiencing mental health challenges which may trial new service models or build on existing arrangements for commissioning psychological services;

In commissioning these services PHNs are expected to:

- Plan and implement services for residents in collaboration with RACHs, in a way which respects RACH roles, responsibilities and operational issues;
- Develop appropriate referral and assessment processes to ensure services target residents experiencing mental health challenges;
- Commission evidence-based psychological services appropriate to the needs of older people within the stepped care framework;
- Ensure services are efficient, sustainable and equitably distributed;
- Ensure services increase capacity to identify and respond to residents at heightened risk of suicide, particularly older men;
- Promote pathways, linkages and information exchange with broader support services for residents with complex needs, including dementia services and State or Territory Government funded Older Persons' Mental Health Services.

1 What are psychological therapies for people experiencing mental health challenges in RACHs?

1.1 Essential Service Features

The services commissioned by PHNs through this initiative are expected to:

- Offer in-reach services, generally provided on location at RACHs;
- Target residents with a diagnosed mental health condition or who are assessed as at risk if they do not receive services;
- Provide evidence-based, time-limited psychological therapies which are adjusted to be responsive to the needs of older people;
- Be provided within a stepped care framework with a particular focus on supporting older people with mild to moderate mental health needs;
- Be implemented collaboratively, in close communication with RACHs and other key stakeholders, including consumers and family members;
- Be subject to locally developed assessment and referral arrangements which ensure services are matched to need for mental health services; and
- Be equitable and efficient, to enable access to services to be offered across the region to RACH residents over time.

It is expected that:

- Services commissioned may build on existing PHN arrangements for delivering psychological services to communities in need, or may trial new service models for residents of RACHs; and
- Once commissioned, services will gradually seek to offer widespread, equitable access to services.

Unlike other services which PHNs commission, these services may be the only source of psychological services for some RACH residents. Therefore, PHNs must ensure services are fairly distributed, well-targeted and provided through sustainable, cost-effective models.

1.2 What is not in scope?

The initiative is not intended to fund the following, some of which may already be government funded in aged care:

- RACH staff or services – including routine welfare or pastoral care services;
- Services that duplicate the role of State Government Older Persons' Mental Health Services in providing specialist care for residents with high mental health support needs;
- Services that duplicate the role of dementia support services or other aged care services such as the Community Visitors program;
- Services which are remunerable through Medicare such as psychiatry services or GP services;
- Services for family members or carers who are not residents (other than referral to other appropriate mental health services);
- Disability support services; or
- Social support or recreational services.

1.3 Why is this a priority for PHNs?

Mental health services are not routinely available to older people living in RACHs, and are not within scope of the personal care or accommodation services RACHs provide. It is estimated that approximately 58 per cent of people entering residential aged care are recorded with a mental health condition[1]. Experience with other initiatives such as Better Access suggests that up to half of this group of older people diagnosed with mild to moderate depression may wish to receive mental health services if they were available to them. The funding provided to PHNs is intended to address this service gap.

PHNs will be able to use their established partnerships with local stakeholders, including GPs, specialist mental health services and RACHs, to target services to the needs and resources in the region. PHNs will also be well-placed to support local workforce capability to meet the distinct mental health needs of older people.

2 Client Eligibility - who should the services target?

The measure is intended to target people with a diagnosed mental health condition who are residents of residential aged care. The services are expected to primarily target residents with mild to moderate mental health needs. However, residents with high support needs who are not more appropriately managed by a State or Territory Government Older Persons Mental Health Service, and who would benefit from psychological therapy, are not excluded from the measure and may be a target group for some PHNs.

The services provided through the measure may in some instances also target people who are experiencing early symptoms and are assessed as at risk of developing a diagnosable mental health condition over the following 12 months if they do not receive appropriate and timely services. This flexibility is important as mental health needs can be highly changeable in vulnerable older persons and it may not always be possible to obtain an early diagnosis.

2.1 Definition of diagnosed mental health conditions

For this initiative, the definition of a diagnosed mental health condition is consistent with that applied to MBS Better Access items2. This means that dementia and delirium are not within the scope of this initiative because these conditions require medical and/or other specialised support. People with dementia are not excluded from treatment if they also have a comorbid diagnosed mental health condition such as anxiety or depression. Delirium may present with symptoms similar to those associated with diagnosed mental health conditions although it will not respond to psychological therapies and requires urgent medical assessment.

There are a number of sub-groups of residents who have particular needs which services are likely to encounter. This includes:

- Residents who are having significant transition issues and experiencing problems with adjustment or abnormal symptoms of grief and loss, for whom early treatment may prevent them developing a diagnosable mental health condition. This group does need to be differentiated from residents who are exhibiting normal sadness and/or transition issues;

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[1] Australian Institute of Health and Welfare 2024. Mental health in aged care. Web report. Cat. no. AGE 115. Canberra: AIHW.

[2]Patient eligibility for Better Access is defined under Division 2.20, Schedule 2.20.1 of the *Health Insurance (General Medical Services Table) Regulations 2021* as updated time-to-time and published on the Federal Register of Legislation

- Residents who need lower or medium support for their diagnosed anxiety and/or depression– as above, this is expected to be the largest group requiring services through the measure, given almost half of all residents are likely to experience depression;
- Residents who were receiving mental health services prior to admission, where those services are unable to be continued within the relevant RACF. Consideration is required to ensure appropriate continuity of care; and
- Residents who, in addition to experiencing a diagnosed mental health condition, have a level of comorbid cognitive decline and/or dementia. The AIHW reported that 61 per cent of residents with dementia who completed a comprehensive aged care assessment reported experiencing one or more behavioural or psychological symptoms "regularly" or "always"[3] (see section 2.2 below)
- Residents who may be at risk of suicide, noting the average yearly age-standardised suicide rate among people aged 65 years living in permanent residential aged care was 13.0 deaths per 100,000 users[4].

2.2 Provision of mental health services to residents with comorbid dementia

A significant proportion of RACH residents will have some degree of cognitive decline or dementia. They should not be ruled out of receiving mental health services, particularly given many may have comorbid anxiety and depression which may respond to psychological therapies. It is also important that service providers providing psychological therapies in a RACH environment are broadly familiar with dementia, its signs and its management. Resources to support professional training on dementia are identified at the end of this guidance document.

However, caution should be exercised in referring residents with dementia to psychological services without careful assessment for the following reasons:

- Psychological services will not be able to support management of the significant behavioural issues experienced by residents with dementia;
- People with significant cognitive decline associated with dementia may not respond to Cognitive Behaviour Therapy; and
- Referral of individuals with needs relating to their dementia to a mental health service may simply delay them receiving more appropriate support which may help to alleviate their distress and support the RACH with the management of their behaviour.

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

3 Referral and Assessment

Referral arrangements may need to be tailored to the local availability of key clinicians and to broader PHN referral and triage capacity.

In general, referral protocols established by PHNs should:

- Enable requests for services to come from a variety of sources including self-referral, family and friends, Aged Care Assessment Teams (ACAT) or RACH staff;

[3] Australian Institute of Health and Welfare, Dementia in Australia, 2025.

[4] Australian Institute of Health and Welfare, Web Report, Mental health in aged care, 19 July 2024

- Ensure that the patient's GP is advised that they have been referred to mental health services if the GP is not the referring agent;
- Require confirmation that the individual has been assessed for physical causes of symptoms, particularly if the onset of symptoms has been sudden (which could suggest delirium as opposed to mental health challenges); and
- Provide advice on assessments undertaken for cognitive decline or dementia.

GPs will be expected to play a central role in diagnosing mental health conditions and referring residents for psychological services. This is appropriate in view of their broader role in coordinating physical and mental health needs of residents. Importantly, as the MBS item for GP Mental Health Treatment Plans (GP MHTP) is not available in residential care homes, it cannot include a requirement for triggering psychological services. However, within a RACH setting, GPs are generally required to contribute to, and coordinate, the broader care plan for each resident.

A medical diagnosis of mental health conditions by a GP or psychiatrist is important to ensure that symptoms of cognitive decline, dementia or delirium are not mistaken for mental health conditions, and to ensure that physical illness and medication needs are considered in the overall care plan of the individual. However, there may be some circumstances where it is not possible to get a timely medical diagnosis, and provisional referrals to commence service provision in anticipation of a formal diagnosis may be required to enable access to timely care.

Individuals who may benefit from the service can be identified to the referring clinician by any concerned party, be that family members, visitors, personal care staff or through self-referral. Other services such as ACAT or dementia services may also identify individuals as potentially benefiting from the service. Mental health challenges may also be identified as part of the assessment of the resident undertaken for Australian National Aged Care Classification (AN-ACC) purposes although this is will not provide a detailed assessment or diagnosis.

3.1 Considerations in assessing residents for psychological services

Assessment processes for psychological services are important to ensure services are appropriately tailored to individual needs. However, they also need to be efficient and should not inappropriately subsume resources intended for delivering services to clients. For some residents, the referring clinician may have undertaken an assessment, or a brief assessment by the mental health professional at the first appointment which may be sufficient. For patients who may have more intense needs, assessment may require liaison with the GP, with former service providers, or dementia services.

Assessment arrangements for residents formally referred to the service may consider, but are not limited to, the following in matching them to intensity and type of treatment:

- Risk of harm;
- Resident's engagement, motivation, expectations and preferences;
- Impact of symptoms and distress on functioning;
- The severity of symptoms and degree of distress;
- Presence of comorbid conditions that contribute to or are impacted by person's psychological state such as chronic illness or significant pain;
- Cognitive capacity and presence of dementia;
- History of previous mental health diagnoses, treatment and recovery;
- Environmental issues, including transition issues, recent stress, trauma or bereavement. This may include consideration of signs or history of elder abuse, given this can be closely linked to, and an underlying cause of, mental health symptoms; and
- Family support and background, including cultural and resident identity considerations.

Table 1. Referral and Assessment Pathways

Referral and assessment process	By whom	Description
Request for services	By self, relatives, RACH workers, former service providers, ACAT, dementia services or other service.	Resident identified to RN or GP as potentially needing low intensity services or assessment for mental health needs.
Formal referral to trigger the service	Local arrangements developed – may be a GP, psychiatrist, psychologist, RN or other provider who is able to reliably identify residents who would benefit from the service.	Confirms diagnosis or identifies that resident is at risk. Considers physical health needs relevant to mental health. Reviews likelihood of delirium. Identifies whether history of dementia exists.
Assessment/triage to identify level and type of service	By mental health professional (PHN commissioned service).	Assessment aims to identify which treatment is most suitable, and to inform individual approach to services.
Reassessment if necessary after mental health services provided	By mental health professional potentially in partnership with another provider.	If resident's mental health is deteriorating or they are not responding to treatment, they may require referral to a more appropriate service.

4 What services should be provided?

The psychological services delivered to RACH residents will be consistent with other mental health services commissioned by PHNs in that they should be:

- Evidence based, or evidence-informed, short term therapies delivered by mental health professionals or other service providers with training in delivering these therapies;
- Equitably and efficiently provided to ensure optimal access is achieved within the available funding;
- Person-led; and
- Delivered within a quality framework which ensures clear clinical governance, and compliance with national standards.

Some adjustment and tailoring of therapies will be required to meet the specific needs of RACH residents, including the following:

- It may take longer to engage with clients, because of hearing problems or a degree of cognitive decline;
- Cognitive behaviour therapy may need to be adapted to the particular capabilities and needs of the individual, and will not be appropriate for residents with significant cognitive decline;
- Particular types of therapies have proven to be effective with older people, including reminiscence therapies, validation therapy and adjusted cognitive behaviour therapy;
- Language used in talking to older people will need to respect the attitudes of older people towards mental health challenges. For example, use of the term 'mental wellbeing' or 'mental health challenges' may be better received than 'depression', 'mental illness' or 'mental health condition';

- Group sessions may be appropriate for some residents, particularly those with similar needs e.g. significant adjustment problems.

Digital mental health services may be less suitable for many older people but should not be dismissed as a potential option for individuals with lower support needs. Telephone or videoconference-based therapies, particularly for RACHs in rural and remote locations, could play a role in services. Computer-based therapies, including the use of iPads, may help to engage older people and provide a point of focus or to share photos or maps.

In addition, it is important that PHNs require commissioned services to be inclusive, culturally safe and appropriate to the needs of people from diverse backgrounds including Aboriginal and Torres Strait Islander peoples, people who identify as LGBTIQ and people from CALD backgrounds. Partnerships, workforce considerations and cultural governance already established by PHNs for the culturally appropriate commissioning of other mental health services may help inform these approaches. However, it will be important for commissioned services to note that the needs of older people for culturally appropriate care may be even greater than for younger people with mental health challenges, and that lack of such care could present a significant barrier to accessing services for these groups. There is a good evidence base to inform the choice of therapies for older people. Some resources are listed at the end of this guidance.

4.1 A stepped care approach to delivering services to RACH residents

Consistent with other psychological services provided by PHNs, services for RACH residents should be commissioned in the context of the stepped care framework within which services are matched to need. However, PHNs will not be expected to routinely cover the full spectrum of services for older people. Instead, the focus for PHNs should be on addressing the gap in service associated with the lack of availability of Better Access services by providing services which target residents with a diagnosis of a mild to moderate mental health condition.

The provision of low intensity services adjusted to this cohort may be an appropriate and sustainable option for delivery of services for people with mild to moderate needs. These services could be characterized by:

- Quick access to services whilst awaiting a formal diagnosis;
- Fewer and shorter sessions which are less resource intensive than standard psychological care required for this group;
- Provision of services through a broader workforce which includes mental health professionals but also other service providers with training in evidence-based therapies suitable for older people;
- Face to face and/or telephone based/digital mental health services; and/or
- Use of group work where appropriate.

Medium to high intensity services are also in scope and may be the preferred option for some PHNs. These will be characterised by:

- Provision of services by mental health professionals;
- Inclusion of psychological services and behavioural therapies; and
- Provision for liaison with other service providers for those with comorbid physical health issues or dementia which impacts on their mental health.

PHNs are not precluded from provision of more intense services for individuals with high mental health support needs, where these needs are episodic and likely to respond to psychological therapy. Some residents with high mental health support needs may have received and responded to community based psychological services before admission to the RACH. However, PHNs should ensure they do not duplicate the role of State Government Older Persons Mental Health Services in

providing specialist services for older people with very intense and enduring mental health needs which are unlikely to respond to time-limited psychological services.

The below table provides a guide to how the services commissioned by PHNs may fit within the stepped care framework and which services are and are not in scope. The services PHNs commission will be informed by the particular needs of the community, the availability of other services and by considerations of supporting equitable access to services.

Table 2. A stepped care framework for meeting the needs of RACH residents

Field	**Early intervention needs** **Within scope of PHN services**	**Mild to moderate needs** **Key focus of PHN services**	**Severe and episodic needs** **Within scope of PHN services**	**Severe and persistent or complex needs** **Out of scope for PHN services.**
Care need	Low intensity services or routine social support	Primary care – low to medium intensity services	Primary care – high intensity services	Specialist mental health services and dementia services.
Target Groups	Residents who: Present as mildly depressed or anxious but do not have a diagnosis Or, are having trouble adjusting to changes or coping with loss	Residents who: Have a former or new diagnosis of mild to moderate mental health conditions.	Residents who: Have diagnosis of severe mental health conditions, which is episodic in nature. May include pre-existing conditions.	Residents who: Have severe, long term mental health conditions. May also have significant cognitive decline. May have attempted suicide recently and/or are at risk of attempting suicide currently.
Role of PHNs	Flexibility to provide low intensity services for people who do not yet have a diagnosis but are at risk of mental health conditions. Advisory role on resident mental health and wellbeing at facility level	Provision of evidence based psychological and behavioural therapy, including low intensity options if appropriate. Liaison with other service providers as appropriate eg GP, pharmacist.	Flexibility to provide services where there is a service gap Services must not duplicate role of Older Persons Mental Health Service, but may liaise with them on assessment.	In general, this group is likely to require specialist care and may not respond to time-limited psychological services.
Other services	RACH services, and welfare support Community visitors, and family and friends also offer social support	GPs, pharmacists, and RACH services form part of broader team. Dementia support services may also be appropriate	GP and/or psychiatrist diagnosis and medication management vital Private and public psychiatrists, Liaison with former mental health service	Specialist services have lead role in care, supported by GPs and pharmacological management. Dementia Behaviour Management Advisory Service will support specific dementia related needs.

Field	Early intervention needs Within scope of PHN services	Mild to moderate needs Key focus of PHN services	Severe and episodic needs Within scope of PHN services	Severe and persistent or complex needs Out of scope for PHN services.
			providers may be appropriate.	

5 By whom should services be provided?

Services commissioned by PHNs are expected to be provided by the same types of trained mental health professionals who deliver other mental health support services in the community. This would include psychologists and other appropriately qualified allied mental health providers such as accredited mental health occupational therapists, accredited mental health social workers, Aboriginal and Torres Strait Islander health workers, mental health nurses, counsellors and peer support workers (where appropriate).

Low intensity services could be delivered by a broader range of professionals who have specific training in providing evidence based mental health services. PHNs will also have the flexibility to commission supplementary services from peer workers, to support a team approach to meeting the needs of older people. PHNs must be confident that the workforce involved is appropriate and competent to provide the level and type of service required by residents of RACHs. Clearance for working with vulnerable people is essential.

Specialised training credentials in relation to older person's mental health is not required of the workforce delivering services. However, PHNs are expected to ensure that commissioned services are delivered by a workforce which is well-informed on, and sensitive to, the particular vulnerabilities of older people and on approaches to ensuring services meet their needs in a compassionate, supportive and evidence-based way. Information on available online and other training resources is provided at the end of this guidance.

Professionals delivering these services should also be well briefed on the other services which may intersect with the provision of mental health care in the region. These services include personal care and leisure services provided by RACH staff.

Relevant national standards and frameworks should be applied to promote service quality and effectiveness, such as the National Safety and Quality Health Service (NSQHS) Standards (as updated from time-to-time).

6 Collaboration with RACHs

PHNs are likely to already have relationships with regional RACHs as part of their broader activities. RACHs have welcomed the implementation of more accessible psychological services given the role they play in improving resident mental health and wellbeing.

As part of the Aged Care Rules 2025, the Residential Care Service List (service list) sets out the range of care and services which registered providers of residential care (providers) must provide to

permanent and respite residents who need them. Part of the responsibilities of providers of aged care homes is monitoring and enabling the emotional support of all residents. This may involve assisting new residents with their transition, evaluating resident emotional states and providing access to relevant health professionals and services, where required. For more information see the aged care provider guide at: health.gov.au/resources/publications/residential-care-service-list-and-higher-everyday-living-fee-guidance-for-providers.

Where a resident presents with high mental health support needs, providers have a responsibility to ensure that they can access appropriate medical services, including specialised mental health services. Provision of emotional supports should be determined in consultation with the individual, and their registered supporters, as required.

Under the Aged Care Act 2024, the Aged Care Quality Standards (Quality Standards) require RACHs to deliver care that meets older people's needs, goals and preferences and optimises quality of life, reablement and maintenance of function (Outcome 3.2). Clinical care services must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function (Outcome 5.4). An action providers can take to demonstrate meeting this Outcome includes referring and facilitating access to relevant registered health practitioners and medical, rehabilitation, allied health, oral health, specialist nursing and behavioural advisory services to address the individual's clinical needs.

Under the Quality Standards, providers are also required to identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services to ensure the delivery of safe, quality clinical care services and to reduce the risk of harm to older people (Outcome 5.5). Examples of high impact and high prevalence clinical care risks include mental health. An action providers can take to demonstrate meeting the Outcome includes having processes to optimise mental health by actively promoting an older person's mental health and wellbeing, responding to signs of deterioration and responding to distress and symptoms of mental health challenges.

RACHs are also expected to develop an individual therapy and support program designed to manage the needs of care recipients with challenging behaviours effectively. This support program should include details on how to best be able to;

- prevent or manage a particular condition or behaviour; and
- enhance the individual's quality of life; and
- enhance care for the individual; and
- provide ongoing support to motivate or enable the individual to take part in general activities of the residential care home, if appropriate.

However providers are not required to provide clinical mental health support services or to assist with out-of-pocket costs for residents associated with them.

In implementing new mental health services in RACHs, PHNs will need to be particularly mindful of the following key principles:

- The service should not be implemented in a way that results in additional demands on RACH staff beyond their responsibilities;
- Clear communication with RACHs about the overall role of the service and any issues arising with particular residents will be important;
- Up to date RACH resident data systems are important – therefore PHNs should assist RACHs by ensuring information on mental health service provision to residents is included with these records;
- Behavioural Support Plans are an important part of effectively managing the needs of residents with challenging behaviours – therefore PHNs should assist RACHs by ensuring that information on mental health service provision to residents is included with these records; and
- Services need to be respectful of any particular procedures or protocols which RACHs may have for accessing the facility or residents.

The best results for both the resident and the RACH may result where collaborative arrangements between mental health service providers and RACH staff are established to support residents with mental health support needs. These collaborative arrangements should include collaborative care

planning and sharing of information where appropriate. Efforts to increase RACH staff knowledge of mental health challenges also can be effective for residents[5].

PHNs would need to discuss with individual RACHs the extent to which the RACH staff are able to participate in discussions about the progress of individual patients as part of the care team, and/or the extent to which they may wish to have visits from mental health professionals used to help raise the mental health competency of staff. RACH lifestyle directors may also be important points of contact for both identifying individuals at risk, and supporting the engagement of residents, including positive event scheduling.

In general, it is reasonable to expect from RACHs:

- Assistance with ensuring residents attend appointments;
- Assistance organising transport to services if this is required, although the cost of transport would not be the responsibility of the RACH;
- Assistance in identifying residents who may benefit from mental health services;
- Access to information about patient history relevant to mental health support, (including status of medications), subject to clinical governance arrangements;
- Assistance with collaborative care planning and sharing of information where appropriate; and
- Assistance promoting new services to clients and families.

The Australian National Aged Care Classification (AN-ACC) recognises mental health challenges as a factor influencing the costs to RACHs of providing residential care and may be one way of identifying residents who may be in scope for the new services. However, it does not offer funding for mental health therapies to RACHs. For more information on AN-ACC see: health.gov.au/our-work/AN-ACC.

6.1 Innovative collaboration with RACHs to promote mental health and wellbeing

PHNs may also wish to explore flexible and innovative approaches to working with some RACHs and their staff and with other service providers to promote better mental health outcomes of residents. This could include:

- Regular communication and/or knowledge sharing with RACH staff to raise their capacity to support residents who are receiving services;
- Advice on evidence-based activities that might raise the social and emotional wellbeing of all residents;
- Education and information sessions for residents on shared issues of concern such as coping with grief and loss; and/or
- Collaboration with other providers at the RACH, including Dementia Support services and pharmacists involved in medication reviews.

6.2 Other important partnerships in designing and delivering services

Specialist Older Persons Mental Health Services provided by States and Territories, which target the needs of older people with high support needs who require specialist care, will also be an important partner in delivery of services. Older Persons' Mental Health Services deliver services to a

[5] Stargatt, J., Bhar, S., Davison, T. E., Pachana, N. A., Mitchell, L., Koder, D., Helmes, E. (2017). The Availability of Psychological Services for Aged Care Residents in Australia: A Survey of Facility Staff. Australian Psychologist, 52(6), 406-413. DOI: 10.1111/ap.12244

small number of older people within RACHs with high support needs particularly where these individuals may have been receiving services in the community before their admission or where individuals may have displayed suicidal behaviour. These services may also be able to assist with assessment of individuals who experience persistent and severe mental health conditions.

Dementia support services such as Dementia Behaviour Management Advisory Support Service (DBMas) and the Severe Behaviour Response Teams (SBRT), which are available in each state and territory, will be an important partner and may be the source of communication, advice and referrals to and from mental health services where patients have co-occurring needs. These services are funded through the Australian Government and provided by Dementia Support Australia and are available to provide support and advice to health professionals.

Community Visitors programs, which operate in many RACHs, may also be able to provide partnerships by way of ongoing contact and engagement with residents for whom isolation is a factor which contributes to their mental health challenges. Older persons' advocacy groups will also be valuable partners at a local level.

7 How should PHNs implement the services?

Funding for the initiative has been provided since 2018-19 so it is expected that many services are already implemented and entrenched, however, new services can continue to be established by PHNs as relevant. It is envisioned that PHNs will continue to provide services through a stepped care model of service delivery that best meets the need of RACH residents in the region through a process of staged implementation and review. Where relevant, PHNs may wish to commence with pilots that target communities of need. In other cases, PHNs could consider extending existing commissioned services through adjusting the service offer to meet RACH residents' needs. The staged approach provides opportunity to review and if necessary, further upskill the workforce.

PHNs may explore a range of models of care for providing in-reach services. This might include team-based clinic arrangements which rotate across facilities, or commissioning services from private providers for individuals referred to the service. In general, it is expected that PHNs will draw on the stepped care framework, knowledge base, workforce and service delivery models they have developed for commissioning psychological services. Other specific expectations of implementation are that PHNs should:

- Co-design services with RACHs, Local Hospital Networks (preferably with representation from specialist Older Persons Mental Health Services), consumers and carers and other local stakeholders;
- Communicate with regional RACHs about the initiative, its benefits, and issues associated with introducing services into RACHs in the region;
- Ensure clear understanding about the difference between the service offering and existing dementia support services, specialist Older Persons Mental Health Services and broader supports for residents – it should be made clear that services are intended to increase access to mental health treatment services – not replace current services;
- Plan for the workforce needs associated with implementing services, including the upskilling of mental health professionals to support the needs of RACH residents;
- Ensure that funding is allocated primarily to service delivery, and that resources required for establishment and assessment are contained;
- Ensure clear instruction to service providers, to RACHs and to residents and carers on the PHN's policy in relation to co-contributions being charged for services as cost and payment processes can be a significant barrier to services for this group;
- Ensure a clear risk management and clinical governance structure is in place to support the quality of services and provide for clear roles and responsibilities;

- Facilitate the collection and reporting of data via the existing MDS arrangement, and appropriate data sharing with GPs, and RACHs to support service coordination, or evaluation activities;
- Develop an equitable and sustainable service model which can be rolled out at full implementation to support access for RACH residents across the region.

The department will continue to monitor uptake of services in partnership with PHNs, including consideration in the MDS, to assess overall demand among the target group and to inform future program arrangements.

7.1 Tips from the sector

- Ensure logistics such as arranging appointments are discussed in the context of commencing service delivery at RACHs;
- To support the mental health and wellbeing of residents from CALD backgrounds, links with local multicultural groups may be of assistance;
- Community Visitors may be a useful resource to support ongoing contact with residents who are isolated, and could be part of a team approach – local agencies train Community Visitors and they may be willing to partner in some way to improve capacity to support people with mental health challenges;
- Ensure arrangements are in place to clearly delineate between dementia, delirium and mental health challenges, as the symptoms can present in similar ways;
- As a way of engaging RACHs, offer information sessions on coping with situational stress or loss – this can also raise the capacity of staff to support residents;
- Ensure professionals engaged to provide services have personal qualities which lend themselves to this particular environment – this may include patience, personal resilience, and an understanding of older people;
- Commence services with group based information sessions for residents and families – this may help to break down the stigma in relation to mental health for older people and encourage engagement with services.

Useful Resources

Key Reports, Standards and Guides

- Beyond Blue resources, guides and modules focused on promoting emotional wellbeing in older adults www.beyondblue.org.au/mental-health/resource-library
- Position Statement 22 Psychiatry services for older people www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/psychiatry-services-for-older-people
- Psychiatric service delivery for older people with mental disorders and dementia www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/psychiatric-service-delivery-for-older-people-with-mental-disorders-and-dementia
- National Institute for Clinical Excellence, Mental wellbeing of older people in care homes, Quality standard [QS50) www.nice.org.uk/guidance/QS50

Training resources

- Swinburne University – The Wellbeing Clinic for Older Adults provides training programs for practitioners working with older adults. www.swinburne.edu.au/research/centres-groups-clinics/wellbeing-clinic/
- Health Education and Training Institute (HETI) - provides mental health education and training for the NSW Health mental health workforce and for the wider health workforce on mental health related matters, www.heti.nsw.gov.au/education-and-training/our-focus-areas/mental-health
- Australian Psychological Society - APS Institute - Several professional development courses specifically tailored towards supporting Older Adults elearning.psychology.org.au/

Dementia resources

- Dementia Behaviour Management Advisory Service, Dementia Support Australia. 1800 699 799, www.dementia.com.au
- The University of Tasmania's *Understanding Dementia* Massive Open Online Course (MOOC) Enrolment is via the University of Tasmania website mooc.utas.edu.au/course/20223/
- The Dementia Training Program, delivered by Dementia Training Australia (DTA), provides accredited education and continuing professional development for the dementia care workforce in primary, acute and aged care. Further information is at: dta.com.au/

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