Consumers of Mental Health WA
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Curtin University

A PHILOSOPHY OF CARE FOR THE MENTAL HEALTH OF OLDER ADULTS IN WESTERN AUSTRALIA: A RAPID REVIEW

COLLABORATION FOR EVIDENCE, RESEARCH AND IMPACT IN PUBLIC HEALTH

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We acknowledge that this research has taken place on Country in Western Australia and pay our respects to Elders past and present.

CERIPH and CoMHWA are based in Boorloo (Perth) on the lands of the Whadjuk Noongar people, who have been custodians of this boodjar since time immemorial.

We acknowledge all Traditional Custodians and their Elders past and present. We pay our respects to their continuing connection to their culture, community, land, sea and rivers.

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Table of Contents

Table of Contents 3
Background 1
Mental health needs and patterns of service use 1
System-level issues and policy considerations 2
Current service landscape 2
Keeping older adults involved 3
A case for a mental health philosophy of care for older adults 3
The West Australian policy context 3
Purpose of the review 4
A note on terminology 2
How are mental health models of care for older adults described? 2
Service delivery 2
Mode of delivery 2
Setting 2
Theoretical Basis 3
Why mental health models of care for older adults? 3
Policy reform 3
Cost effectiveness 3
Equity and human rights 3
Improving care for consumers 3
Meeting the needs of older people as a unique group 2
How have models of care been used? 5
What are the characteristics of models of care? 3
What are the principles and processes underpinning mental health models of care for older adults? .. 3
What are the factors that influence models of care? 2
What are the specific considerations for priority groups? 3
Aboriginal people 3
LGBTIQA+ people 2
References 2

Background

Australia faces increasing challenges in meeting the mental health needs of its ageing population. Although there have been national mental health reforms in recent decades, the planning and investment targeted at older people have not kept up with an ageing population. For example, the Better Access Initiative was introduced in 2006, increasing Medicare-funded access to mental healthcare, leading to better population access to certain services, but this is not the case for the older population (1). As a result, older Australians have not benefited to the same extent as other population groups from improvements in the broader mental health system (1).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has noted that Australia remains inadequately prepared to respond to the mental health requirements of a growing cohort of older adults and that there is ongoing ambiguity regarding appropriate models of care and service standards for this population (2). The absence of a dedicated national mental health strategy for older adults further contributes to fragmented service responses and limits the development of consistent, evidence-informed approaches (1). Importantly, older adults are not a homogeneous group. Research suggests that those aged 85 and older are more likely to engage with acute and tertiary services, such as public inpatient and emergency services (1). In contrast, those aged 65 to 85 are more likely to utilise Medicare-subsidised primary mental health services, including psychological therapy and GP mental health treatments (3, 4). Recognising and responding to these differing needs across the older adult life stage is critical for effective service planning and delivery.

Mental health needs and patterns of service use

Available population data suggest that the prevalence of reported mental health issues declines with age (5). However, this may also be a result of under-diagnosis, stigma, access issues and generational differences towards mental health, rather than an actual decline in mental health issues in older adults (6-8) (9-11). Older generations may be less likely to disclose symptoms (12), mental health issues may be masked by or attributed to physical illness (13, 14), and surveys may exclude people in aged care or those with cognitive impairment (15). The ways that older adults may express distress can also contribute to under-recognition and lower reported rates of mental health issues (14, 16). Additionally, harmful assumptions about ageing, such as a belief that as people age, they become less capable, less interested in physical activity and social participation, and have less to offer society, can be reflected in the attitudes and behaviours towards older adults (17).

Evidence from aged care settings indicates a substantial burden of mental health conditions among older Australians, which is often not addressed (1, 18-20). Older people living in residential aged care are at heightened risk of poor mental health outcomes, yet access to timely and appropriate psychological, psychiatric, and allied health services within these settings remains inconsistent (21, 22). Barriers to accessing appropriate support include gaps in workforce capability, limited integration of mental health services into routine care, and broader limitations in the quality and provision of care across residential aged care settings (28).

Between 2017 and 2022, 62.5% of people aged 65 years and over entering residential aged care were recorded as having at least mild symptoms of depression (23). As of 30 June 2019, 87% of permanent residents had at least one diagnosed mental or behavioural condition, and 49% had a diagnosis of depression, based on aged care assessment data (18). High levels of depression and psychological distress among residents have been consistently documented (21).

Mental health concerns are also common among older people receiving in-home aged care. A cross-sectional survey of 237 older Australians receiving nationally funded in-home care found high rates of depression and anxiety symptoms (24). Despite this documented issue, service utilisation remains comparatively low. In 2019–20, 241,200 older Australians accessed just over 1 million Medicare-subsidised mental health-specific services, representing substantially lower use than that of younger populations (5). Older adults also remain an important group for suicide prevention. In 2022, 594 people aged 65 and over died by suicide, accounting for 18% of all suicide deaths; men represented 76% of these deaths (5).

Of note, the intersection between pre-existing mental health diagnosis, decision-making capacity, and voluntary assisted dying (VAD) legislation and protocols reflects an emerging and complex challenge (25, 26), made more difficult by the very small amount of evidence in the Australian context (27) and the relative recency of VAD availability across Australian jurisdictions. Consequently, the relationship between VAD access, mental health, and suicide amongst older Australians is an emerging research priority that current data systems may not be equipped to examine systematically.

System-level issues and policy considerations

The Royal Commission into Aged Care Quality and Safety (28) found that the mental health needs of older Australians are not adequately addressed within the aged care system. The Commission identified high rates of depression among residents, limited access to specialist mental health services, and insufficient workforce capability to manage mental health concerns. It further noted that the current service model prioritises acute and severe mental illness, with limited focus on prevention, early intervention, or support for mild to moderate conditions (28). To address these concerns, the Commission recommended that, by 1 January 2022, federal, state and territory governments provide dedicated funding for Older Persons Mental Health Services (OPMHS) to deliver outreach services to residential aged care and home care recipients under the National Health Reform Agreement (NHRA). Although agreed to in principle, implementation has not progressed, with the Australian Government citing ongoing NHRA renegotiations and limited consideration of alternative policy mechanisms (29, 30).

Current service landscape

Mental health care for older Australians is delivered across a mix of primary health care, community mental health, specialist services, hospital-based care, and aged care programs. Service delivery is predominantly community-based, with many older people accessing supports through home support and home care programs (31). Primary Health Networks (PHNs) commission psychological treatment for people living in residential aged care to provide access comparable to community-based services under the Better Access initiative (32). This initiative was established in 2019 in response to the

low uptake of the scheme in residential aged care, reflecting residents' limited access to Medicare-funded psychological services under the Better Access initiative (33).

Most states and territories (excluding the Northern Territory) operate OPMHS to provide specialist care for older people with severe and complex mental illness (28). Hospital services, including inpatient units and emergency departments, also form part of the care pathway. However, concerns have been raised that generalist mental health models, such as those implemented in Medicare Mental Health Centres, may not meet the needs of older adults with co-occurring or cognitive conditions (1). A lack of focus on cognitive impairment within generalist mental health services further limits their suitability (1).

Keeping older adults involved

The literature suggests that while there are guidelines for including older people in health and social care research, such as the INCLUDE Framework (34), older people's perspectives and lived experiences are generally under-represented within mental health research, service design and policy development (10). Within this context, co-design or participatory approaches are increasingly promoted to support the meaningful and equitable involvement of older people in research processes and outcomes (35-37). In addition to a justice and empowerment imperative, there are benefits such as improved understanding of the issues facing older people; more inclusive and responsive policy, practice, and service design; and opportunities to recognise and centre the voices of marginalised groups of older people (38). The literature also highlights that strengthening these approaches may require attention to how participation is structured in practice, including training and support for collaborators, as well as ensuring opportunities for shared ownership of processes and outcomes (38).

A case for a mental health philosophy of care for older adults

Australia's Vision 2030 for Mental Health and Suicide Prevention (39) recognises the need for differentiated approaches to mental health across the lifespan. However, specific national strategic goals to support the mental health and wellbeing of older adults in Australia are limited (40), with calls for integrated models of care that address the range of mental health conditions experienced in later life (40, 41). Current approaches to mental health, while valuable, are insufficient to address the distinct needs of older people. Without a dedicated focus, the mental health needs of this population risk being subsumed within general mental health services (42). This points to a need for states and territories to develop their own guiding frameworks.

The West Australian policy context

The West Australian (WA) policy landscape has increasingly recognised the importance of supporting older adults to thrive across all dimensions of wellbeing. For example, the State Seniors Strategy 2023–2033, *An Age-Friendly WA* (43) represents WA's first dedicated seniors' Strategy. Several elements of the Strategy are particularly relevant to mental health care. These include the emphasis on prevention, health promotion and early intervention; the recognition that social connection and meaningful participation are protective factors against isolation and poor mental health; the commitment to addressing ageism and its harmful effects on help-seeking and access to care; and

the importance of supporting carers as essential partners in the care system. The Strategy also acknowledges the challenges posed by service fragmentation and the need for integrated, coordinated approaches that enable older people to access appropriate support without having to navigate complex systems alone.

Recent developments indicate growing recognition of the need for tailored service planning (44). The Mental Health Commission has funded the creation of the first Older Adult Mental Health Model of Service for Western Australia (WA). Led by the WA Country Health Service, this initiative is grounded in national and international evidence and informed by consultation with consumers, carers, and clinicians. While promising, such initiatives highlight the need for broader national coordination to ensure consistent implementation of best-practice, evidence-informed care for older Australians. A WA mental health philosophy of care for older adults must also be grounded in flexibility and personalisation, recognising the heterogeneity of this population, which includes both those who have managed mental health challenges across the lifespan and those who experience mental ill-health for the first time in later life.

Purpose of the review

This narrative review aims to support Consumers of Mental Health Western Australia (CoMHWA) in advocating for the mental health needs of older adults in WA. It reviews models of mental health care for older adults, focusing on best-practice, evidence-informed approaches.

The review focuses on informing approaches for people aged 65 and over and for Aboriginal and Torres Strait Islander people aged 55 and over. The approaches identified are primarily directed towards people living with mental health issues as they age, and those who may develop a mental health issue associated with ageing, excluding dementia.

Findings will support the development of a philosophy and/or model of care/service for the mental health of older adults. This is in part because services and models are often focused not on mental health but rather cognitive decline, and consequently, there is a lack of focus on social support and/or living well with mental health problems.

A note on terminology

We have sought to use generally recognised terms and definitions regarding health issues, groups and populations. However, we acknowledge the fluidity and contested nature of language and terminology. Future iterations of this document may use different terminology as we continue to hear from people and communities and learn how they want to use and hear words and terms. When referencing the content of specific documents, we generally use the terminology adopted by the author/s. Therefore, it is important to note that we have retained the clinical language used in some of the literature, which may differ from broader, accepted, or preferred contemporary terminology.

Consistent with CoMHWA's strategic direction, we use the terminology people with lived experience (of mental health issues) and consumers (37).

In this review, we use the term older adults to describe people aged 65 and over and Aboriginal and Torres Strait Islander people aged 55 and over. This is consistent with the general terminology used by the Australian Institute of Health and Welfare (45). The literature also often categorises older adults to reflect differences in experience and that mental health symptoms are likely to change over time: Young-old (age 65–74), old-old (age 75–84), and oldest-old (age 85 and over) (46-48).

Recognising the WA context of this work, we use the term Aboriginal in recognition that Aboriginal people are the original inhabitants of WA. No disrespect is intended towards Torres Strait Islander colleagues and community.

The acronym LGBTIQA+ is used to refer to lesbian, gay, bisexual, transgender, intersex, queer, asexual and other people with diverse sexualities and gender expression. This acronym is not intended to be limiting or exclusive of any group; we recognise that not all people will identify with it or use these terms.

Following guidance from People with Disability Australia (49), we acknowledge that both person-first language (people with disability) and identity-first language (disabled people) are used. We also recognise that individuals, their families, communities and those working in services and organisations will prefer particular terms. In this document, we have used person-first language.

In this document, we use the term people from CaLD backgrounds to encompass the diversity of cultural backgrounds, including culture, ethnicity, identity, language, country of birth, national origin, heritage/ancestry, race, and religion. However, we recognise the limits of the selected terms and that other terms may be preferable for specific aspects of identity.

Ageism: the stereotyping, prejudice and discrimination directed towards people based on their age (50). Ageism occurs at an institutional level, such as through laws, policies, and practices; at an interpersonal level, between individuals; and at a self-directed level, where a person internalises ageism. It can be both explicit (conscious) and implicit (unconscious) (50).

Biopsychosocial model: a framework that understands health and wellbeing as shaped by the interaction of biological, psychological and social factors.

Carer: a person who supports someone experiencing mental ill-health, typically within a close personal relationship such

as a family member, friend, neighbour or community member (51).

Consumer: as defined by CoMHWA (2024), a person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed mental illness and/or have received treatment (52).

Intervention: a specific action, strategy or initiative implemented to change behaviours, environments, or social conditions that influence health. Interventions can be educational (e.g., awareness campaigns), structural (e.g., changes to physical environments), policy-related (e.g., regulation), or service-based (e.g., tailored support programs).

Mental ill-health, mental illness or mental health condition: terms used to describe a range of conditions or experiences affecting mental health which may be defined using clinical diagnostic criteria and are commonly described in the literature according to severity, such as mild, moderate or severe (51).

Peer worker: a person with lived experience of mental health challenges who provides support to others through shared understanding, mutual respect and empowerment, drawing on their own experiences to support recovery (53).

Primary care: the entry point to the health system and typically the first place people seek support for their health and wellbeing, encompassing activities from health promotion and prevention through to assessment, early intervention and referral to specialist services (51).

Program: a coordinated set of planned activities designed to improve outcomes for a specific population group. In a health promotion context, programs are evidence-informed, aim to address risk and protective factors, and often involve multi-component strategies such as education, structural change, policy support, and community engagement.

Setting: the place or social context where a program or intervention is delivered. Settings shape people's daily lives and provide natural entry points for influencing action. Common settings include homes, workplaces, schools, aged care facilities, community organisations, recreational spaces, and health services.

Tertiary care: highly specialised or complex health services provided by specialist and allied health professionals, delivered across hospital and community settings (51).

Therapeutic intervention: treatments and supports aimed at improving mental health and wellbeing, including approaches such as cognitive behavioural therapy (CBT), art therapy and individual psychotherapy.

How are mental health models of care for older adults described?

There is no universally accepted definition of a mental health model of care for older adults (54-56), with the term used inconsistently across the literature. Descriptions of models of care range from high-level organisational frameworks to clinical or service delivery approaches, or interventions (54, 56). Generally, a model of care is understood to be a framework that articulates the type of care and how the care is organised and delivered (55).

Models of care are frequently used by governments in policy and service planning to describe how health services are delivered. The models outline best-practice care and services for individuals, population groups, or patient cohorts as they progress through the stages of a condition, injury, or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place (57-61). In the literature, models of care are described across several dimensions: (i) service delivery approach, (ii) mode of delivery, (iii) setting, (iv) underpinning principles or theoretical basis.

Service delivery

Integrated models of care for older adults

There is no standard definition of integrated care for older adults (62). Clinical and service provider descriptions emphasise holistic, coordinated and efficient care within and across services (63-65), with integrated care models addressing both physical and mental health needs (6). From the perspective of older consumers, integrated care emphasises accessibility, relational aspects, such as feeling respected, heard and involved, and smooth care coordination across services (66). A review found evidence that integrated care reduced emergency department presentations and helped stabilise perceived quality of life (67).

An umbrella review synthesised evidence from 19 systematic reviews examining integrated care models (ICMs) that combined health and social services for older people, identifying key elements and mechanisms of change. The findings showed a focus on clinical care delivery (micro), with limited attention to organisational (meso) and broader system (macro) levels of integration, and the main outcomes reported were hospital admission rates, quality of life, and uptake of community services (68).

A systematic review examined the impact of integrated care on patient-related outcomes among older adults ≥ 65 years, synthesising evidence from 12 studies including randomised controlled trials (RCTs) and quasi-experimental designs (69). The findings indicated that integrated care may reduce hospital admission rates and lengths of hospital stay among older people, with some positive effects on patient satisfaction and readmission rates. However, no impact on mortality was observed. However, the authors acknowledged that due to methodological heterogeneity and limited robust evidence, the effectiveness of integrated care on patient-related outcomes in later life remains largely unknown (69).

Stepped models of care

The stepped care model is an evidence-based, staged approach to interventions or services. Care typically begins with low-intensity interventions suitable for most consumers, stepping up to higher-intensity options when clinically indicated (70). Stepped care has been implemented in

several community mental health services for older people, including those in New South Wales (NSW) and the Australian Capital Territory (ACT) (60, 71) and in federally funded Primary Health Networks (72).

Collaborative care models

Collaborative care models are described as multidisciplinary approaches where professionals from different disciplines, such as primary care physicians, behavioural health specialists and mental health professionals, work together to provide integrated care (73, 74). The model is defined in the literature by elements including: accountable care, evidence-based care, measurement-based treatment to target, patient-centred team care, and population-based care (73).

Goodrich and colleagues (2013) suggest that this model supports system-level redesign of health care delivery through coordinated changes across multiple levels of the service system. They include organisational leadership support, provider decision support, clinical information systems, patient self-management support and links to community resources (75). Evidence from more than 80 RCTs has demonstrated its effectiveness across a range of psychiatric conditions (76). Evidence suggests that collaborative care is a cost-effective strategy (75) that improves access to care (76), improves patient outcomes across a range of conditions, populations and settings (75, 76) and reduces stigma associated with seeking mental health treatment (73).

Coordinated care models

Coordinated care models are described in the literature as systematic approaches to improve the continuity and consistency of care, bridging transitions of care across services, often incorporating elements of case management (77). Some authors use the term interchangeably with integrated care (66, 78). Others consider coordination of care as a method for integrating care (79).

Mode of delivery

Models of care can also be defined by their mode of delivery. In virtual models of care, technology enables interaction and treatment through videoconferencing, telephone or smartphone communication, or other digital health platforms such as remote-monitoring devices, apps and web-based tools (80). Blended models combine digital and in-person support (81, 82). Under the National Safety and Quality Digital Mental Health Standards (2023), which set out requirements to ensure digital mental health services are safe, effective and person-centred, models of care must clearly describe how a digital mental health service is organised and delivered (83).

Setting

Models may also be described based on the setting where care is delivered, including inpatient and community models of care (60, 71, 84, 85).

Theoretical Basis

Additionally, models of care are described based on their underpinning principles or theoretical basis (86), such as recovery (87, 88), person-centred (89), family-integrated (90) and participatory models of care (91).

Review of mental health models

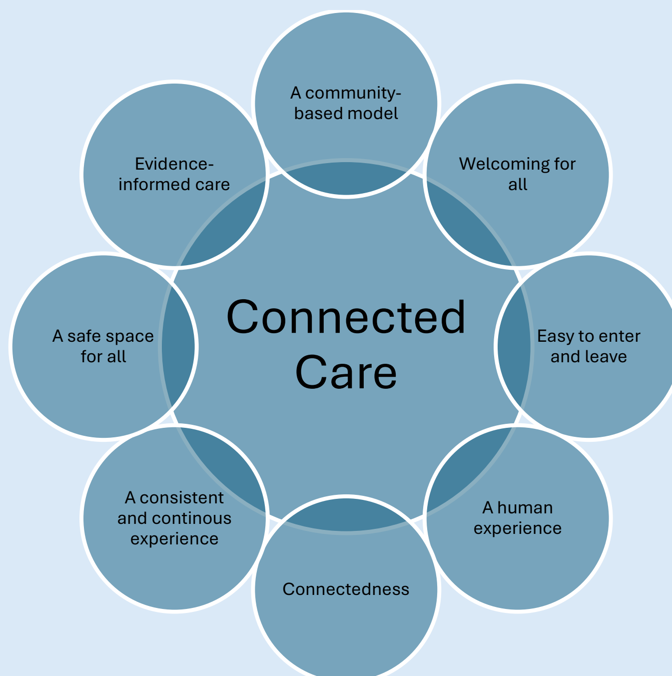
A review of research on different mental health models of care in high-income countries, primarily in Europe and the USA, from 2000 to 2017, identified three broad types of models. Firstly, the *medical-psychiatric model*, which is the most dominant, is a psychosocial intervention commonly time-bound with a focus on the psychological and social causes and manifestations of mental health issues, and the *holistic and integrated model*. The authors suggest that this has strong potential for providing effective mental

health care for older people due to its comprehensive approach to addressing their diverse needs. This model addresses the limitations of the medical-psychiatric model with a focus on holistic strategies that go beyond treating symptoms to include independence, physical functioning, and quality of life, which are critical for older adults and their mental health (92).

A recent narrative review (93) examined models of care across aged care, community care, and health care sectors that support older people (≥65 years) to age in place and delay or avoid entry into residential long-term care. The review found no panacea, but complex, multifactorial care models are consistently reported to contribute to success. In particular, the literature highlights models that are person-centred, that address both the health and social needs of older people in the community. The models typically include comprehensive assessment and care planning and are delivered by a multidisciplinary clinical team (93).

Head to Health Philosophy of Care

A Philosophy of Care was developed for the Launceston Head to Health Centre in 2021, following extensive local consultation with community members. The Philosophy is designed to inform and guide the care provided through the Head to Health adult mental health centres established in Tasmania. The following diagram outlines the principles of the Philosophy which emerged from the consultations:



The Philosophy can be read here.

The following table summarises the models identified in this review.

Models of care	Key features
Aged and community care models	
Complex multifactorial care interventions	• Integrated care at-home addressing social and health needs to support independent and safe living at home • Entry-level support to high-level care for those with complex needs • Targets multiple factors challenging older people to remain at home
Transitional care or restorative care	• Short-term services to support functional independence after hospitalisation or prevent functional decline • Aims to reduce further hospitalisations and delay or prevent residential long-term care • Provided in the home, community or residential care home
Respite care	• Short-term support for individuals and carers • Provided in the home, in the community or in residential care
Home modifications, smart home and wearable devices	• Interventions to enhance an older person's independence and improve quality of life
Housing models	• Community-based arrangements that support older people to stay within communities
Health care models: primary care	
Patient-centred medical home-based model of care (general practitioner-led)	• Coordinated patient-centred care
comprehensive geriatric assessment (general practitioner-led)	• Multidomain assessment of medical, psychological, social and functional needs • Development of a management plan
Community-based complex multifactorial models (health provider-led)	• Providing support for ageing in place (nursing and general practitioners)
Health care models: specialist team care	
Comprehensive geriatric assessment (geriatrician-led)	• Comprehensive assessment and delivery of multidisciplinary, person-centred interventions for clinical and social care needs
Rehabilitation models	• Optimising function and reducing disability following illness or in association with ageing • Focus on specific diagnoses • Short-term, intense interventions after a stay in hospital or in community settings following a decline in independence • Delivered in inpatient or outpatient settings

Why mental health models of care for older adults?

Mental health models of care can provide structured frameworks for delivering coordinated, evidence-based services tailored to the needs of specific populations. Dedicated models for older adults are particularly important given the well-documented inequities in access to mental health care for this group, and the need to address the complex interplay between mental health, physical health, and social circumstances in later life. Key considerations when developing and selecting models of care for older adults include alignment with policy reform, cost-effectiveness, equitable access, improved consumer outcomes, and responsiveness to the unique needs of this population.

Policy reform

Models of care reflect mental health policy. Integrated care is a federal government policy priority for the delivery of mental health services in Australia (51, 67, 78). A stepped care approach to mental health service planning is also a priority of national mental health reforms (94). The National Mental Health and Suicide Prevention Agreement commits governments to jointly drive planning and reform that supports a stepped care model (95).

Cost effectiveness

Models of care are promoted for their cost savings and efficiencies, aimed at reducing demands on the healthcare system (70, 78, 96, 97).

Equity and human rights

There are inequities in access to mental health care and treatment for older people (40, 98-100). This is particularly the case for people aged 75 and over. McKay and colleagues (2025) reviewed trends in access to mental health care for older people since the introduction of the Better Access Initiative in 2006 (101). They found that while overall access improved for the general population, it declined for people aged 75 and older, and even more markedly for those aged 85 and over, with the older age group having an increased reliance on emergency departments and non-specialist care (1).

Access to all types of specialist mental health care declines significantly as people age (1). Services for older people are also fragmented across health, mental health and community services (98). They are unevenly distributed geographically and by care type, with rural areas offering less diversified care (40, 102). There is a need for specialised models of care that support equity of access and provide integrated, coordinated, and age-responsive mental health services across settings and regions (1, 40, 103).

Improving care for consumers

Models of care aim to improve services and outcomes for older people, such as models to address depression and anxiety among older people receiving in-home aged care (24), and emerging approaches that build on the evidence base. For example, a model of care trialled in Victoria called Enhancing the Management of Home-Based Elders with Depression (EMBED) includes training in depression for the aged care workforce and access to psychological treatments for older people experiencing symptoms of depression (104). Other examples include the ‘stepped care’ approach to mental health service delivery, which has been rolled out in primary health care in Australia, building on similar models in the United Kingdom (UK) (105). However, its implementation in Australia has been criticised for diverging from the original intervention-specific model, which emphasised matching individual treatments to need, a principle

applied across the UK mental health system (94). While the evidence on stepped care for older adults is still emerging, stepped care approaches for depression and anxiety have been associated with improved clinical outcomes, although the evidence base remains limited (70).

Experimental studies in other high-income countries have shown that collaborative care models have resulted in significant improvements in depression and anxiety outcomes, compared with usual care (6). Reynolds and colleagues (2022) highlight the importance of multidisciplinary team care for older adults with mental health issues, incorporating comprehensive assessment, clinical management, intensive outreach, and coordination of mental, physical and social health services (6). The authors highlighted the evidence base for integrated care in late-life depression. Interventions included IMPACT, which tested collaborative care management for late-life depression in primary care settings across 18 clinics and 1,801 patients aged 60+ years; PROSPECT, which demonstrated reductions in suicidal ideation and depressive symptoms in depressed older primary care patients; and PRISM-E, which compared integrated care with enhanced specialty referral for improving access to geriatric mental health services (6).

Meeting the needs of older people as a unique group

People with lived experience of managing lifelong severe mental health issues often have a shorter life expectancy than the general population (106). This is primarily due to co-occurring chronic physical health conditions, which may cause them to experience the impacts of ageing earlier (98). Therefore, coordination of mental, physical and social health services needs to be emphasised to address this situation, along with family-centred approaches, which recognise the role of family and of caregivers where such support is available (107). Integrated care is recognised for providing continuity of care, with healthcare teams delivering supportive services that address a range of older people's needs and enable ageing in place (91).

A Pluralistic Framework to Inform Transformative Change across Community and Healthcare Domains

Horgan and colleagues (2024) offer a conceptual tool for understanding and addressing older adult mental health within the context of healthy ageing. The framework resulted from an extensive review of the literature and contextualises the WHO Decade of Healthy Ageing priority areas (ageism, age-friendly environments, integrated care, and long-term care) specifically in relation to mental health. Its multi-level ecological approach provides a robust structure applicable to the WA context (17).

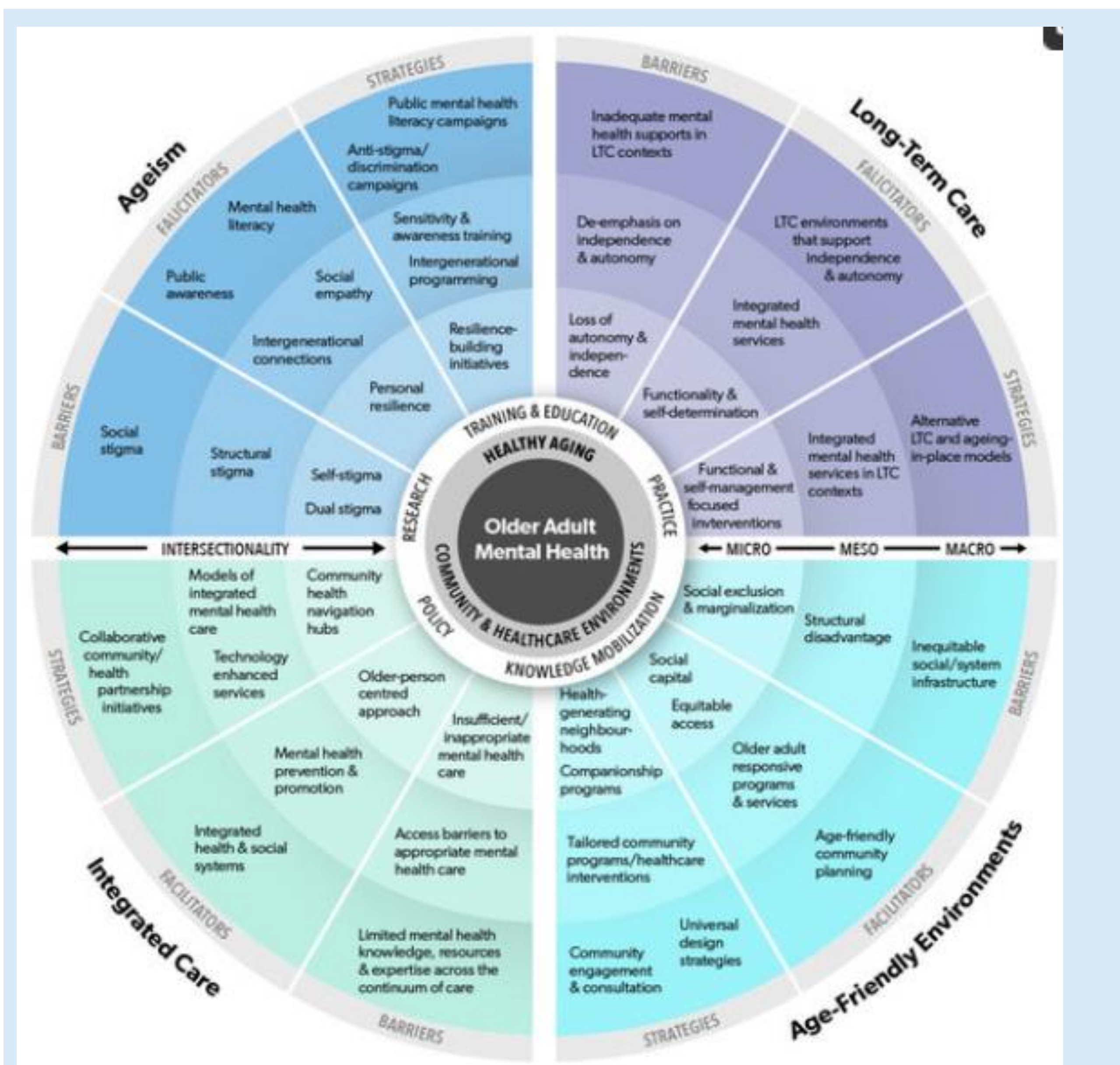
The ecological multi-level approach aligns with the need to address mental health across system, service, and individual levels simultaneously. Macro-level strategies that address ageism and build age-friendly infrastructure complement meso-level service integration and micro-level resilience-building.

The continuum conceptualisation of mental health, from wellness through to mental health concerns and then to illness, supports a population health approach rather than one focused solely on individuals with diagnosed conditions. This aligns with the WA State Seniors Strategy emphasis on proactive support to maintain wellbeing.

The framework's emphasis on shared responsibility across community and healthcare domains aligns with the WA strategy's whole-of-government and whole-of-community approach. It recognises that mental health is not solely a healthcare issue but is also shaped by broader determinants, including housing, transport, social participation, and environmental factors.

Identifying navigation hubs, designed to support individuals in navigating and accessing appropriate community and healthcare services, offers a micro-level strategy to address service fragmentation across multiple sources. It also emphasises the role of integrated mental health care as a model for reducing silos between aged care, primary care, acute care, and specialist mental health services.

The figure presents a pluralistic framework to inform transformative change across the community and healthcare domains to optimise the mental health of older adults and support healthy ageing.



The figure is reproduced from the article: Horgan, S., Prorok, J., Ellis, K., Mullaly, L., Cassidy, K.-L., Seitz, D., & Checkland, C. (2024). Optimizing Older Adult Mental Health in Support of Healthy Ageing: A Pluralistic Framework to Inform Transformative Change across Community and Healthcare Domains. *International Journal of Environmental Research and Public Health,* 21(6), 664.

Read the article here.

The World Report on Ageing and Health: A Policy Framework for Healthy Ageing

This Lancet paper (108) presents key findings and recommendations structured around a redefined concept of healthy ageing. The main areas of recommendation are outlined below.

Aligning health systems to the needs of the older populations they now serve	
Ensure access to older-person-centred and integrated care	Services close to where older people live Comprehensive assessments and service-wide care planning Structures that foster multidisciplinary teams Support self-management
Orient systems around intrinsic capacity	Develop information systems that collect, analyse, and report data for intrinsic capacity Establish performance monitoring, rewards, and financing mechanisms that encourage care that optimises capacity Provide clinical guidelines on trajectories of intrinsic capacity
Develop systems to provide long-term care	
Establish foundations for system of long-term care	Recognise long-term care as an important public good Responsibility for development of a system of long-term care Equitable and sustainable mechanisms to finance care Roles of government and develop services that will be necessary to fulfil them
Ensure quality of long-term care	Care protocols or guidelines to address key issues Mechanisms for care coordination (including between long-term care and health-care services) Quality management systems focused on functional ability
Ensure everyone can grow old in an age-friendly environment	
Combat ageism	Campaign to increase understanding of the ageing process Legislate against age-based discrimination Ensure a balanced view of ageing in the media
Support healthy ageing in all policies at all levels of government	Enable older people to age in a place right for them through housing options and assistance with home modifications Introduce measures to protect older people from poverty Provide opportunities for social participation and for having meaningful social roles
Improve measurement, monitoring, and understanding	
Improve understanding of the health status and needs of older populations	Include older people in population surveys and disaggregate by age and sex and important social characteristics Establish regular population surveys of older people
Increase understanding of healthy ageing trajectories and what can be done to improve them	Assess effect of health care, long-term care, and environmental interventions on trajectories of healthy ageing Quantify the economic contribution of older people and costs of providing the services they need and have the right to

How have models of care been used?

Models of care provide structured frameworks for delivering mental health services to older adults. They outline the philosophy of care, partnership approaches, service components, staffing requirements, therapeutic interventions, and performance measures. They serve multiple functions: guiding care within larger mental health services, informing the implementation of system reforms, and designing post-crisis services. Several emerging Australian models demonstrate innovation across different care contexts. Virtual delivery modalities, including telehealth, are increasingly used to improve access, though evidence suggests older adults often prefer blended or face-to-face approaches that allow for relationship-building.

Guiding care as part of a larger mental health service

Models of Care guide how care is delivered through state and territory-funded Older People's Mental Health (OPMH) services (28). Some states and territories have developed models of care documents for OPMH services (60, 109), which outline the philosophy of care, ways of working, including the role of partnerships, components of care, staffing, key processes, techniques and therapies and key performance measures.

Models of care have also been used as implementation frameworks for reform within state and territory OPMH services. For example, the Pathways to Community Living Initiative (PCLI) has been implemented within NSW OPMH services to support transitions from long-stay hospital care to community or residential aged care settings. Within the PCLI framework, a coordinated model of care has been developed to help older people with severe and persistent mental illness and complex needs who are, or risk becoming, long-stay inpatients. The model integrates hospital and community services through multidisciplinary rehabilitation and specialist living-support programs (110).

Models of care are also used to guide the design of post-crisis services for older people. In an NSW Ministry of Health-funded study, Wand and colleagues (2023) conducted interviews with older adults with lived experience, clinicians, general practitioners, and researchers (n=22) to inform the development of guiding principles for an Older Persons' Aftercare model following self-harm. The study found that aftercare should be a systemic, coordinated, and person-centred, integrating health and social supports across settings, while keeping the individual central within interconnected systems of care (111).

Clinical treatment contexts

Models of care are used in clinical settings to organise and coordinate the delivery of therapeutic interventions for older adults with mental health issues (70, 97, 112).

Aged care and community service contexts

There are emerging models of mental health care for older adults in Australia; however, there are limited data on their effectiveness (1). Examples from aged care and community contexts are discussed below:

- **The Healthy Ageing Service (HAS):** a free early intervention and prevention program, established in 2020, that provides support for older adults residing in Melbourne, Victoria (113). Designed as a holistic, multidisciplinary psychosocial care model with a

stepped approach, it aims to reach people with mild to moderate mental health challenges that are not eligible for tertiary mental health services but require more than primary mental health support, described as the 'missing middle' (114). The service is a response to recommendations from the Australian Royal Commission into Aged Care and the Royal Commission into Victoria's Mental Health System (113, 115, 116).

- **Enhanced Management of Home-Based Elders with Depression Model of Care (EMBED)** (104): has been developed by in-home care provider Silverchain, working in collaboration with several universities, to improve the identification and treatment of depression among people receiving care at home (117). Developed through co-design with staff and consumers, the model of care includes staff training, routine mental health screening, assessment and treatment tailored to the needs of the older person (118). It also includes telehealth access to mental health clinicians and the option to use a digital platform to access resources, communicate with clinicians, and track progress and activities (119). EMBED was piloted in Victoria in 2024 and demonstrated positive outcomes, with significant reductions in depression and anxiety symptoms among participants. There were high levels of client program satisfaction and endorsement from staff who reported greater confidence in identifying and supporting clients with depression (120). A planned larger clinical trial will be undertaken in WA and South Australia (SA) to assess long-term outcomes and cost-effectiveness (120).

- **The BEFRIENding for Depression, Anxiety and Social support in older adults living in Australian residential aged care facilities (BEFRIENDAS):** this randomised controlled trial evaluated the effectiveness of a befriending intervention for older people with depressive symptoms living in residential aged care across multiple Australian states (121). The trial compared two groups: one receiving weekly befriending from a trained volunteer for four months, and the other receiving usual treatment. Results from the completed trial indicate that befriending led to small improvements in depressive symptoms and loneliness, with no significant effects observed for anxiety or perceived social support. While the improvements in depression were modest, the findings suggest that befriending may be a useful adjunct to existing supports and may inform future models of care in residential aged care settings.

- **ELders AT Ease (ELATE):** a model of psychological care developed to deliver Cognitive Behaviour Therapy (CBT) for depression in residential aged care settings. The model brings together aged-care staff, family members, and mental health trainees under the supervision of clinical psychologists, providing a structured and systems-wide approach to improving access to evidence-based therapy (20). A cluster RCT conducted in Melbourne, Victoria, is evaluating ELATE's effectiveness in reducing depressive symptoms among residents, with findings expected to inform the implementation of structured psychological care models in aged-care settings (112).

- **Household Model of Care:** an Australian residential aged-care facility for older people with long-term mental health conditions implemented a person-centred Household Model of

Care to replace a traditional institutional approach (89). The applied model of care integrates health and social care within small household-style settings, using the built environment (e.g. a specially designed home-like environment) to support autonomy, recovery, and strong relationships between residents and staff. The model examined how the built environment influenced experiences at different levels (e.g., bathrooms and bedrooms, site layout, and the neighbourhood). A qualitative post-occupancy evaluation involving four focus groups with 16 staff members found that the facility's physical design, together with changes to organisational culture, enabled more person-centred and recovery-oriented practice for residents (89).

- **Stepped Care for Older Adults** is a free service, funded by North Western Melbourne Primary Health Network (PHN), and offered in selected areas of Melbourne and regional Victoria for adults aged 65+ (50+ for people who identify as Aboriginal and/or Torres Strait Islander). Older people with mild to moderate mental health issues or those at risk of developing such issues can self-refer or be referred through their GP or other service provider. The model aims to reduce loneliness and psychological distress, strengthen social connections, build capacity for self-management and health awareness, enhance confidence through goal achievement, and increase engagement with appropriate services and supports (122). The program provides access to a multidisciplinary team that offers mental health assessment, group support, and referrals to other services (123).

Virtual delivery contexts

Emerging evidence suggests that digital approaches are effective and acceptable, particularly as the uptake of technologies, such as smartphones and iPads, increases among older people (104). Telehealth and other virtual modalities are used to deliver psychological interventions and support (80, 114, 124), helping to overcome physical barriers to accessing care (111). However, digital models are not suitable for all consumers. In a qualitative study with 29 older adults experiencing symptoms of depression and/or anxiety and receiving in-home aged care, Kelly and colleagues (2025) found that while participants appreciated the convenience of telehealth, many preferred face-to-face or blended approaches that fostered trust and familiarity. These findings highlight the need for digital approaches to be personalised, flexible, and aligned with individual consumer preferences (125).

Philosophy of Care for Adelaide's Urgent Mental Health Care Centre

The Philosophy of Care for Adelaide's Urgent Mental Health Care Centre was co-created through a partnership between the Office of the Chief Psychiatrist, South Australia's (SA) Lived Experience Leadership and Advocacy Network, and The Australian Centre for Social Innovation. People from South Australia with lived experience of mental health distress, emergency department admissions, or experience as family members and carers participated in conversations to shape guiding principles for the centre.

The Philosophy is organised around six core themes: Who We Are (culture, roles and people); Our Heart (lived experience); Feeling Safe (safety, not surveillance); What We Say (care-full language); Our Values in Action (values-driven practice); and Every Stage Counts (leaving as a crucial step).

Key features include the centrality of lived-experience leadership, with the Philosophy emphasising genuine connection, non-judgmental and compassionate care, cultural safety, autonomy, the dignity of risk, and the importance of transitions (including warm referrals and follow-up after leaving).

Read more here.

What are the characteristics of models of care?

Models of care are evidence-based and can support a whole-of-service approach to mental healthcare (109, 126) for consumers (60, 71, 83).

Part of guiding service frameworks

Models of care can sit within broader service plans and frameworks that guide how services are structured and delivered (71, 127). For example, the NSW OPMH Services Service Plan 2017–2027 outlines service delivery for older people over ten years, incorporating three models of care: community services, an acute inpatient unit, and the Transitional Behaviour Assessment and Intervention Service (T-BASIS). This model of care provides specialised support for older people who have challenging behaviour associated with dementia and/or mental illness that requires care in an inpatient unit (71).

Multidisciplinary

Models emphasise the provision of multidisciplinary care delivered by coordinated teams (84, 107, 109, 126). Models of care for older people may integrate mental health and physical health care within a single service (74, 128). Community models may also incorporate physical health intervention teams as part of a holistic approach to care (60). These models are characterised by inclusiveness, addressing the diverse needs of consumers with a range of diagnoses and comorbidities (84).

Collaboration and partnerships

Collaboration across sectors and disciplines is a defining feature of mental health models of care for older people. Models implemented within particular settings, such as community or inpatient services, operate as part of a broader system of care (126). Effective care requires strong partnerships between mental health, aged care, primary care and community services to ensure continuity and holistic support.

Specialised residential aged care services delivered in partnership with mental health teams are positioned as a key part of the care continuum (84). Integrated models emphasise the importance of aligning care and health or mental health services to address coexisting physical and mental health needs (104, 129). They also recognise the important role of general practitioners, who often provide a trusted, ongoing relationship that supports coordination and continuity of care across services (60, 109, 125, 130). These partnerships also extend to carers and family members, who can play a key role in supporting care delivery (60, 109, 112, 126).

Programmatic components

A model of care may incorporate programs that sit within or align with the broader care framework. These can include group-based recovery/wellness programs, which have been found to be highly valued by older consumers (131). For example, the Older People's Mental Health Service within NSW Health provides a holistic, community-based intervention, known as the Wellness Group program, developed to align with the community and acute inpatient model of care guidelines (96). The program is designed for older people living with mental health issues, experiencing complex biopsychosocial circumstances, but with reasonable cognitive capacity and the motivation to participate in the program. Referrals come through hospitals, community health centres, GPs, and other public or private providers. The program comprises weekly social worker- and occupational therapist-led group sessions that incorporate peer

engagement, exercise, self-reflection, sharing, and education on mental and physical well-being. Although the findings are descriptive, the authors suggest that the program enabled recovery in the community, reduced relapse, improved continuity of care, and promoted more efficient use of acute services, drawing on evidence from participants' medical records, clinical outcomes, and consumer feedback (96).

Psychological and psychosocial therapies

Psychological interventions are components of several models of care. For example, CBT is delivered within stepped care models (97), and behavioural activation (a brief psychotherapeutic approach that seeks to change the way a person interacts with their environment) (132), has been used for the treatment and prevention of depression in later life as part of a collaborative care model in rural WA (124). A Cochrane systematic review of psychological therapies for depression among older adults living in long-term care facilities, such as nursing homes, residential homes or assisted-living facilities, found that therapies may reduce depressive symptoms and improve quality of life compared with usual care, although the certainty of the evidence is low (19). The authors stressed the need for high-quality clinical trials on the effectiveness of treatments for depression in long-term care (19).

Group-based psychosocial programs

Although group-based therapy approaches are used in some models of care, there is limited evidence of their effectiveness among older adults (114). Perin and colleagues (2025) reported on a wellbeing skills group program in Victoria as part of an early intervention and prevention model for increased access to mental health support (Healthy Ageing Service). The program consisted of six weekly sessions, facilitated by mental health clinicians alongside a peer support worker, focused on evidence-based psychological skills to promote emotional wellbeing (114). Outcome data from 40 participants showed improvements in psychiatric, social, and occupational functioning. However, there were no significant changes in depression and anxiety symptoms. It was recommended that further research be undertaken to assess the efficacy of programs using this approach (114).

Emphasis on supporting relationships and connections

The literature highlights the relationship between mental health and social connectedness in later life, and the importance of interventions to address loneliness and isolation (53, 84, 121, 130, 133-135). Models of care can also support older people to maintain friendships, social connections and established roles, all of which are important for supporting wellbeing and recovery in later life (84). They should also recognise the diversity of older people and the strategies that are appropriate for the target population (130). Peer support approaches can also strengthen connectedness. For example, peer workers supporting consumers experiencing isolation and loneliness reported that sharing their recovery stories was beneficial for both consumers and themselves (53). However, although there is strong evidence linking low social participation to poorer mental health, empirical evidence on the mental health benefits of purpose-designed, social connection interventions for older people is still emerging (133).

WHO Comprehensive Mental Health Action Plan 2013–2030

The WHO has developed a global mental health action plan (41) guided by the following objectives:

1. Strengthen effective leadership and governance for mental health.
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
3. Implement strategies for promotion and prevention in mental health.
4. Strengthen information systems, evidence and research for mental health.

There are several key components of this WHO plan that are relevant to developing a Philosophy of Care for Older Adults' Mental Health in WA. For example, key elements include: rights-based principles emphasising dignity, autonomy, empowerment and non-discrimination; a person-centred approach (rather than disease-centred); universal coverage and life course approach; comprehensive assessment across physical and mental domains; evidence-based psychological interventions (particularly CBT, problem-solving therapy, and behavioural activation); strong emphasis on social connection and reducing isolation; multidisciplinary action including team care with clear care pathways; caregiver support as integral to the model; and community engagement throughout implementation.

Read the Plan here.

What are the principles and processes underpinning mental health models of care for older adults?

The design and delivery of mental health services for older adults is guided by foundational principles that shape how care is conceptualised, organised and experienced. These principles reflect contemporary understandings of what constitutes quality mental health care, while also recognising the distinct needs, preferences, and circumstances of older people. They draw on broader frameworks for person-centred care that are relevant to older people's circumstances. and recovery-oriented practice, while attending to the particular considerations that arise in later life, including the intersection of mental and physical health, the impact of life transitions and loss, and the risk of ageist assumptions limiting access to effective treatment and support. Importantly, they increasingly focus on adding life to years.

Principles have practical implications for how services are structured, how services engage with older adults and their families, and how systems are designed to facilitate rather than impede access to appropriate care. They also reflect the growing recognition that older people themselves, alongside carers and families, must be active partners in shaping the services they receive, rather than being passive recipients of care.

The following section examines the key principles identified in the literature, recognised as foundational to effective models of care for older adults' mental health. These include a focus on recovery; person-centred and person-led approaches; attention to diversity and equity; meaningful participation and co-design; addressing ageism; health promotion and prevention; and the need for cross-sector collaboration to reduce fragmentation and improve outcomes.

United Nations Principles for Older Persons (1991)

The Principles guide countries in developing policies and programs that recognise the diversity of older people, the impact of ageing, and consider actions that focus on their independence, participation, care, self-fulfilment, and dignity. These include:

- Adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
- Environments that are safe and adaptable to personal preferences and changing capacities.
- The ability to reside at home for as long as possible.
- Integration in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
- Family and community care and protection in accordance with each society's system of cultural values.
- Health care to help them maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
- Social and legal services to enhance their autonomy, protection and care.
- Appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
- Human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
- Educational, cultural, spiritual and recreational resources of society.
- Live in dignity and security and be free of exploitation and physical or mental abuse.
- Be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Read the Principles here.

Focusing on recovery

Recovery is a key principle underpinning models of care for older adults. Personal recovery is described as a unique journey that may have a different meaning for people in later life compared with other age groups (131, 136, 137). A UK study into recovery among older people is frequently cited in Australian research (53, 84, 131). It identified three components of recovery that are important for older adults. The components included: i) maintaining an established and enduring sense of identity; ii) using coping strategies to support continuity and reinforce identity; and iii) managing the impact of physical illness. However, determining how recovery-oriented care can most effectively be implemented for older people remains underexplored (131, 138).

Ensuring a person-centred orientation

Addressing the needs of older people must recognise their inherent worth, respect their dignity, and provide care that is equitable, fair, and accessible (139). Consumers have identified person-centred, trauma-informed and holistic care as foundational principles of integrated care, emphasising that health systems should adapt their models of care to meet consumer needs, rather than requiring consumers to coordinate and integrate care themselves (62, 111). This requires recognition that there is no 'one size fits all'; rather, models must meet the unique needs, preferences, and values of clients and their support networks (140). Advocates have also emphasised the preference for person-led (109), rather than person-centred care, to ensure older people remain central to all decision-making regarding their care (141). Current guidelines recommend a holistic approach to therapeutic interventions, encompassing psychological, social, and biological aspects of care (142).

Yan and Geng (2024) provide several insights relevant to the development of a philosophy of care for older adults' mental health. Their analysis of healing spaces for older adults found that care based on the biopsychosocial model has become the dominant direction in mental health services for older adults, and that creating comfortable, safe therapeutic spaces incorporating natural elements and artistic atmosphere can help alleviate anxiety and promote mental health (143).

Attending to diversity and difference

In accordance with the principles of A Vision for Change (139), a critical principle in service provision for older people is that they should have access to the services most appropriate to their needs. Existing silos within the health system and between relevant support systems make it harder for those most in need to identify and access services critical to the effective management of their conditions (144). For example, a review of models for older people's health in New Zealand found significant gaps in service responsiveness for cultural safety and equity approaches (145). Equity, diversity and inclusion must be embedded in all mental health treatment, care and supports for older adults (146). Effective services consider and support consumers' preferences for the setting and modality of care, including using telemedicine as an adjunct to face-to-face services (109).

Fostering participation and meaningful involvement

The literature demonstrates the need to prioritise 'doing with' rather than 'doing to' in reforms to support older adults and their mental health. Robust models for consumer and carer participation should include older people (98).

The European experience

The Mona Lisa project in France is a national commitment to suicide prevention in older persons, using empowerment of older persons and solidarity with civil and public stakeholder engagement to seek meaningful inclusion and integration in society (https://www.monalisa-asso.fr/). Participation by older adults can drive reform and improve mental health services, benefitting both organisations, individuals and their support networks (147). Older people must have a public voice (100). Initiatives such as AGE Platform Europe promote the voices of older persons and the realisation of their human rights (https://www.age-platform.eu/).

A key consideration is that mental health services for older people should promote self-determination (139) to enable active participation in their recovery, where possible, and to support social connections and meaningful activity. For example, reports suggest that consumer and carer participation among people from CaLD backgrounds lags behind mainstream levels. Accordingly, culturally inclusive participation opportunities can extend the benefits of participation, producing more equitable outcomes (147). Strong evidence supporting the value of consumer and carer participation has become a central tenet of policies and plans, including the National Standards for Mental Health Services (148, 149).

Co-design underpins the development of models of care (84, 111, 130, 150-153). Co-design is recognised as essential for inclusive and person-centred care (84, 103, 111).

The INCLUDE Framework

Goodwin and colleagues (2023) have developed practical recommendations to address the continuing underrepresentation of older people in health and social care research, drawing on the INCLUDE (Innovations in Clinical Trials Design and Delivery for the Underserved) framework. This work was undertaken within the UK health and care research context (34).

The INCLUDE framework was developed to address barriers to the inclusion of under-represented groups in health care research and acknowledges that under-representation is shaped by multiple, intersecting factors, including demographics (age, ethnicity, gender), health status (health conditions and impairments), socioeconomic conditions(digitally excluded, language barriers, no supports), and living circumstances (e.g. rural locations, care homes, homeless and prison populations). Through stakeholder consultation and a rapid review of the literature, the authors identified barriers and solutions across multiple levels of a social-ecological model: individual, interpersonal, organisational, community, and policy.

This informs 14 practical recommendations, such as removing arbitrary age-related exclusion criteria, designing studies that are inclusive of cognitive impairment and multiple health conditions, and involving older people, carers, and professionals with expertise in ageing in the research design. The framework also emphasises flexible and accessible approaches to participation, such as home visits for data collection and alternatives to digital-only methods.

Program example: Talking Mental Health

Talking Mental Health is a co-designed, research partnership program to strengthen home care staff responses to the mental health needs of people in community aged care (154). The program was implemented at a Melbourne (Victoria) based aged care provider, Uniting AgeWell. It involved three phases: co-design to create new and modified care protocols; staff training on the new processes; and piloting of the protocols over ten weeks (151). A process evaluation found that the co-design approach implemented across the three phases was valued, there was improved staff commitment to mental health and well-being, increased uptake of evidence to better identify older clients within the community who have mental health concerns, and improved access to support for their wellbeing (151).

Tackling ageism

Images and language used to describe older people can present negative stereotypes and generalisations (98). Diverse perspectives on ageing, shaped by social determinants such as income, education, and social support, highlight how these factors impact mental health (155). Protection from ageism is critical, including addressing therapeutic nihilism (155), where assumptions that older people are less likely to benefit from treatment can limit their access to treatment. Combating ageism is one of the four action areas of the Decade of Healthy Ageing (2021-2030), with recommended interventions, including anti-discrimination policies and laws, education initiatives and intergenerational activities (50, 156). Evidence suggests that positive attitudes and behaviours towards older people can improve with education and greater understanding (98), alongside equitable access to mental health care and support.

Aging and Mental Health Policy Framework

The Canadian Centre for Addiction and Mental Health has established a framework incorporating five principles, with recommendations, to guide the development of comprehensive policy.

The five principles are:

- Older adults must have access to evidence-informed mental health treatment.
- Older adults with mental illness and dementia, and their caregivers, should receive the care and supports needed to live safely and with dignity in settings of their choosing.
- Equity, diversity and inclusion must be embedded in all mental health and dementia treatment, care and supports for older adults.
- Policy, programs and practices should support mentally healthy aging.
- Governments at all levels must prioritise and invest in seniors' mental health and wellness.

The Framework can be found here.

Healthy ageing: prevention, health promotion and early intervention

Models may have a prevention and health promotion component or focus (68, 103, 113, 126). Promotion, prevention and early intervention are key components of contemporary mental health policy and plans (149). The WHO suggests that mental health promotion and prevention strategies for older adults can support positive and healthy ageing and strength-focused approaches. Such initiatives could focus on physical and social environments that support wellbeing, participation and capacity (11). Ensuring a health promotion focus is also important as part of a multi-pronged approach to supporting the physical and mental health needs of older people (138). Mental health promotion among older adults should preserve respect for older people's potential to grow and flourish in later life and counter negative myths of ageing that can become self-fulfilling prophecies. Health promotion programs and initiatives that have been shown to benefit older adults should be implemented.

UN Decade of Healthy Ageing: Plan of Action 2021–2030

The United Nations (UN) Decade of Healthy Ageing (2021–2030) is a global collaboration to improve the lives of older people, their families and communities. It builds on the WHO Global Strategy and Action Plan on Ageing and Health (2016–2030) and the Madrid International Plan of Action on Ageing (2002), and is aligned with the UN 2030 Agenda for Sustainable Development. The Plan defines healthy ageing as *"developing and maintaining the functional ability that enables well-being in older age."*

Guiding Principles

Principle	*Description*
Interconnected and indivisible	All implementing stakeholders address all the Sustainable Development Goals together, rather than selecting from a list
Inclusive	Involves all segments of society, irrespective of age, gender, ethnicity, ability, location or other social category
Multistakeholder partnerships	Mobilises partnerships to share knowledge, expertise, technology and resources
Universal	Commits all countries, irrespective of income level and development status, to comprehensive work for sustainable development
Leaving no one behind	Applies to all people, whoever and wherever they are, targeting their specific challenges and vulnerability
Equity	Champions equal, just opportunities to enjoy the determinants and enablers of healthy ageing. May require unequal attention to some population groups to ensure the greatest benefit to the least advantaged, most vulnerable or marginalised members of society
Intergenerational solidarity	Enables social cohesion and interactive exchange among generations to support health and wellbeing for all people
Commitment	Sustains work over the 10 years and into the longer term
Do no harm	Commits countries to protect the wellbeing of all stakeholders and minimise any foreseeable harm to other age groups

Read the document here.

Reducing silos and working in partnership across portfolios

Care for older people is often fragmented, making it difficult to navigate and access appropriate services, partly due to current funding arrangements and care models. (109). In addition, the degree of integration, alignment and collaboration between services varies, resulting in service duplication and a lack of access to healthcare and support services (157). The more stakeholders are brought together across sectors and disciplines, the greater the possibility for leveraging resources, sharing learnings and experience, supporting diffusion of policy and concrete action (41, 146, 156). Collaboration is needed across government departments to identify and trial alternative service and care models for older people, to enhance integration and responsiveness (146).

Living well in later life: a statement of principles

The Mental Health Commission of NSW (158) issued principles to support older people's mental health and wellbeing. The statement was developed with input from a range of stakeholders (consumers and carers, peak advocacy bodies, professional associations, service providers and government agencies). The principles serve as a call to action for government, the private sector, and the community to embed them in their practices and programs.

Several principles are directly relevant to models of care, including the need for prevention and early intervention, person-centred and recovery-oriented practice, and the active involvement of older people and carers in decision-making. The principles also emphasise ageing-friendly, culturally informed and accessible services, the development of peer work models, and the reduction of fragmentation through integrated care across the health, aged care and community sectors.

The statement can be found here.

What are the factors that influence models of care?

The delivery of effective mental health care for older adults is influenced by factors operating at multiple levels. At the system and structural level, workforce capacity, funding arrangements, dominant models of care, and structural ageism shape the broader environment in which services operate. At the service level, practices relating to communication, workforce attitudes, relationships with consumers and other services, and the implementation of recovery-oriented approaches directly influence quality of care. Underpinning both is the need to understand and respond to the experiences and perspectives of older consumers and their carers, whose attitudes, circumstances and support needs are central to designing accessible, person-centred models of care.

Consumer experiences and perspectives

The lived experiences and perspectives must inform effective mental health models of care for older adult consumers and their carers. Older people bring diverse attitudes, beliefs and life experiences that shape how they understand mental health, whether they recognise symptoms, and their willingness to seek support. Many older adults value self-sufficiency, yet they may face financial, practical or attitudinal barriers to accessing care. Research emphasises the importance of holistic, whole-of-person approaches that integrate physical and mental health care, and the critical role that family members and carers play in supporting older people to navigate services. However, carer involvement is often inconsistent, and services do not always facilitate meaningful partnerships with families. Listening to and acting on consumer and carer perspectives is essential to delivering truly person-centred care.

- Attitudes and knowledge: attitudes and knowledge about mental health among older adults are important considerations when designing models of care. Many older adults have an ethic of self-sufficiency, a belief in managing emotional and personal problems independently (125, 159, 160). Additionally, they may have difficulty recognising symptoms as being related to their mental health and may not perceive that they need mental health support (98, 159, 160). Efforts should focus on empowering older people to recognise when they may be experiencing mental health issues and the appropriate threshold for seeking help (159). This can be achieved through prevention and early intervention strategies that are person-centred and tailored to people's needs, which may differ according to their stage of life (98).

- Financial and practical barriers: wait times, travel times, transport, travel, the cost of managing multiple conditions, knowledge of costs, financial supports and financial status have been identified as barriers to accessing appropriate services and timely care (129, 159, 161). In an Australian national survey (n=6000), many older people reported going without one or more forms of health care because of cost, including mental health care (e.g., access to psychologists and counsellors) (162). Other financial issues included the risk of financial abuse by carers, such as misappropriation of funds or property, coercion to change legal documents, and control over personal finances (161).

- Importance of whole-of-person supports: older consumers have reported concerns about managing their physical and mental health conditions, highlighting the need for care that adequately integrates both aspects of health (62, 125, 129). Older consumers receiving aftercare following self-harm have described the need for holistic, person-centred care that addresses the physical, psychological, and social dimensions of wellbeing (111).

- Social support and help-seeking: social support and attitudes toward help-seeking may also influence engagement with care, with evidence suggesting that when social networks normalise help-seeking and view mental health support positively, older people are more likely to access services (160).

- The role of family and carers: family members and carers are essential partners in mental health care and service navigation (60, 90, 98, 109, 112, 163). Informal carers provide the majority of support for older people (164); however, their involvement and recognition within services are often inconsistent.

- A systematic review of 14 international studies from high-income countries found that family-integrated care is associated with improved outcomes for older adults with neurodegenerative and mental health conditions. The positive outcomes included reduced depressive symptoms, improved functioning, and lower caregiver burden (90). The effectiveness of such an intervention is influenced by the extent and quality of carer involvement, communication between carers and clinicians, the availability of training and respite for carers, and the adaptability of services to support both the individual and their family's needs (90).

- An Australian study with eleven carers of older people with mental health issues living in rural SA, identified several barriers to positive health outcomes. These included limited mental health literacy and service-readiness; misinterpretation among service workers of confidentiality and privacy provisions that restricted information sharing; inconsistent feedback and communication from services; and fragmented, poorly coordinated care that left carers to act as primary navigators of care, contributing to carer stress (163).

- Family members and carers should be part of the decision-making process in the mental health and aged care settings (88, 98, 112, 161, 163, 165). Services should ensure that staff receive appropriate training to build an appropriate understanding of confidentiality and privacy provisions, support sustained two-way communication, and identify a clear point of contact to enable cross-sector (health, aged and social care) coordination (163). However, further research is needed to determine how carers can be better involved in models of care (54).

Service level factors

The effectiveness of mental health services for older adults depends not only on system-wide structures and policies, but also on the practices and cultures that operate at the service level. How services communicate and share information, the attitudes of the workforce, the quality of relationships between providers and consumers, connections with other services, and the extent to which recovery-oriented approaches are embedded in practice all influence the care that older people receive. Evidence indicates several service-level factors are critical to delivering integrated, person-centred mental health care for this population.

- Communication and information sharing: good communication and information sharing are vital, both among service providers to support integrated care, and between providers, consumers and carers (62, 90, 128, 166).

- Ageist attitudes: ageism among providers is a barrier to care and recovery (84, 111, 130). Research suggests that healthcare and aged care professionals can view depression as a normal consequence of ageing. This view can limit treatment and have adverse impacts (100, 167), such as an increased risk of suicide, particularly among older men (165). Education packages for healthcare professionals that address ageism should be based on empirical evidence derived from the experiences of older people (100).

- Relationships with consumers: the quality of relationships between care providers and older people is central to adequate, person-centred support. Relational approaches that foster genuine connections enable people with mental health issues to feel more engaged in their care and better understood (89, 91, 125). An example of such an approach is the Staying Active – Staying Independent (SASI) program, a participatory care model developed by a nursing service in Hobart, Tasmania. The program aimed to reduce functional decline among community-dwelling older adults by addressing mobility, nutrition, continence and mental health (91, 168). Community support workers (CSWs) were trained to provide care and support, using care plans developed with the integrated care team and the older person. A qualitative evaluation of the SASI program, which involved interviews and focus groups with CSWs, found that the relationship-focused approach and CSWs' skills were crucial to its success (91). Participants reported improved functioning and quality of life, whereas CSWs reported increased role satisfaction and professional growth (91).

- Relationships with other services: strong relationships and partnerships across services are needed for coordinated care (79). An evaluation of the OPMHS in NSW found that staff faced challenges when they were required to respond to consumers' needs perceived as outside the service's scope, thereby diverting the service's limited resources. The evaluation highlighted the need for better cross-sector collaboration to address these gaps (126).

- Recovery-oriented practice: strengthening recovery-oriented approaches is an ongoing priority, particularly when ensuring that care is tailored to people's needs, including for people with physical frailty and dementia (126). Evidence highlights gaps in the implementation of recovery-

oriented practice. For example, an audit of care plans in rural NSW community mental health services for older people found that the documentation was inconsistent and only about half of the care plans were person-centred (88). Ongoing staff training and support are consistently emphasised to ensure recovery-oriented care (88, 126, 131). In residential aged care settings, recovery-oriented practice can also be enabled through supportive environments and organisational cultures that promote autonomy and social connection (89).

System and structural level issues

While service-level factors directly influence consumers' experiences of care, they operate within a broader context of system and structural conditions that can either enable or constrain effective mental health support for older adults. Workforce shortages, fragmented funding arrangements, governance structures, and the dominance of biomedical approaches all shape how services are designed and delivered. Underpinning many of these issues is institutional ageism, which includes the rules, norms, practices and policies that systematically disadvantage older people and restrict their opportunities for optimal health and wellbeing. Addressing these system-level factors is critical to achieving equitable access to quality mental health care for older Australians.

- Mental health workforce: workforce shortages are a key issue impacting care (1, 99, 104, 169, 170), alongside the need for a skilled workforce with specialist knowledge of older people's mental health (100, 151, 166). This includes the capacity of aged care workers to identify depression and provide effective support, with role and setting training to strengthen these actions (104, 151). Building mental health workforce capability is essential for implementing recovery-orientated models of care for older adults (110, 111), encompassing skills in identifying and responding to both depression and cognitive impairment, which may go undetected among older people accessing mental health services (171).

- The importance of peer workers: building the peer support workforce within aged care services strengthens a recovery orientation (53, 56, 98, 131, 161).

- Funding and governance: fragmented funding across different types of services negatively impacts access to mental health care for older people by contributing to inflexible and poorly integrated services (62, 99, 111). Beyond improved funding mechanisms, investment in governance that enables strong local leadership is also needed to support recovery-oriented practice (85, 136, 151).

- The biomedical model: this approach influences the care of older adults, framing ageing as the onset of disease and decline in health (92, 172). The biomedical perspective has shaped services for older people, reinforcing assumptions that professionals know best and limiting older people's agency in care decisions (92, 98). For example, consumer and carer representatives have critiqued the stepped care model as clinician-driven, reducing consumer choice in accessing supports and services (141). Similarly, integrated care has emphasised micro-level integration, with a focus on clinical mechanisms over community-level capacity building and responses (68).

- Ageism: As a social determinant of health, ageism can contribute to the

deterioration of older people's physical and mental health by denying them their human rights due to its impact on care practices (50). The adoption of an international charter for the rights of older people is recommended as a structural strategy to address ageism, create a more equal environment and improve health and wellbeing outcomes (100). In Australia, the Aged Care Act 2024 (the new Act) introduces a Statement of Rights that sets out the rights of older persons when accessing aged care services funded by the Australian Government. This replaced the former Charter of Aged Care rights (115, 116, 173).

Place-based systems of care: a way forward for the NHS in England

This National Health System paper outlines a rationale for place-based 'systems of care' suggested as organisations collaborating to manage common available resources (174). Place-based systems are an alternative approach to situations where organisations adopt a 'fortress mentality' (only acting to secure their own future). The benefits of systems of care are outlined as a means for local health services to work together to tackle universal, immediate financial and service pressures, and as a platform to implement radically new models of care across local areas.

The following principles were produced to guide the development of systems of care:

1. Define the population group served and the boundaries of the system.
2. Identify the right partners and services that need to be involved.
3. Ensure a shared vision and objectives reflecting local context and the public's needs.
4. Appropriate governance structure for the system of care.
5. The right leaders to manage the system and develop a new system leadership.
6. Agree on how conflicts will be resolved, the process, and the consequences for breaches.
7. Sustainable financing model for the system
8. Dedicated team to manage the work of the system.
9. 'Systems within systems' to focus on different objectives.
10. Set of measures to understand progress and use for improvement.

Read more here.

Peer work models in improving support and outcomes for older people

While there is substantial evidence on peer support for other population groups, research on peer work models and their benefits for older adults in mental health services is still emerging in Australia (137). However, recent models of care for OPMH services in Australia highlight the growing role of peer work and signal future peer workforce expansion (60, 71, 109).

Coates and colleagues describe a peer support model implemented for consumers and carers in a specialist mental health service for older people in the Central Coast of NSW from 2016 to 2017. Developed and implemented in partnership with a non-government organisation, peer workers were employed to provide individual support to consumers and carers, co-facilitate group programs, and deliver mental health promotion activities (53).

An action research approach was used to implement and evaluate the model, with all participants considered partners in the design. Data collection included focus groups, consumer and carer surveys, field notes, and a review of project documents to assess acceptability, barriers, and solutions.

Peer workers reported that they found the role rewarding, particularly valuing the friendships formed with other peer workers and the opportunity to support consumers and carers. Consumers also reported positive experiences, describing the model as supporting them in their recovery.

The evaluation found that while the model was acceptable to consumers, carers and clinicians, several implementation challenges emerged. Initial resistance by some staff was addressed by involving clinicians in the model's development and providing training on peer work roles. A further challenge related to governance, whereby the non-government organisation employed peer workers but was based in a specialist mental health service, creating confusion around reporting lines and responsibilities. The researchers recommended that models of care include clear policy and procedural responsibilities to be developed before implementation (53).

Program feedback indicates that consumers and carers value the program, and it has enhanced the capacity of staff and other aged care services to support recovery-oriented practice (175). Clinicians report valuing the skills and insight of peer support workers to assist people in their recovery (175).

What are the specific considerations for priority groups?

Working with priority populations requires specific considerations and adaptations to ensure meaningful and safe engagement, which leads to positive health outcomes.

Aboriginal people

Older Aboriginal people have essential roles within their families and communities as cultural knowledge holders, caregivers and teachers (176, 177). Ageing well is inseparable from family, community, and Country, reflecting the interdependence of generations and the centrality of cultural continuity (178). Older Aboriginal people contend with the ongoing impacts of colonisation, oppressive policies and systemic racism, which continue to impact health outcomes (179). Many are Stolen Generation survivors and are often under-represented in data relating to psychological distress, mental health, and social and emotional wellbeing (152). Self-determination, and the social and emotional wellbeing model, which is an Aboriginal holistic understanding of health encompassing social, emotional, spiritual and cultural health and wellbeing (180), must underpin the design of models of mental health care (181, 182).

Positive mental health outcomes for older Aboriginal people require supporting strong relationships with community and Country (181). Elders and older Aboriginal people advocate for social and emotional wellbeing services that coordinate primary care, mental health care and broader human services (183). Culturally informed, locally based governance is critical (152) as is Aboriginal-led design and treatment models (184). Community-led approaches recognise culture as central to health and wellbeing across the lifespan (178). A human rights-based approach, informed by the United Nations Declaration on the Rights of Indigenous Peoples (185), outlines the key principles of practice for service providers in supporting the social and emotional wellbeing of older Aboriginal people (183). Examples from the literature highlight the importance of Aboriginal self-determination and embedding ways of knowing, being, and doing for developing effective models of care:

- Farah Nasir and colleagues (2021) describe the development of a community-led Indigenous Model of Mental Health Care for depression in South West Queensland. Using a community-based participatory research approach, focus groups and interviews were conducted with community members, psychologists, mental health workers, Aboriginal Medical Services staff, and Elders who were spiritual healers. Participants emphasised the need for autonomy over funding decisions, the centrality of Aboriginal understandings of social and emotional wellbeing, and the importance of maintaining strong connections to culture, community and Country. The findings highlight that a model of care for depression must be holistic and culturally appropriate (186).

- Mackell and colleagues (2023) described an intergenerational model of care, embedded within three Aboriginal community-controlled art centres in geographically remote communities, where Elders played central roles in governance, knowledge-keeping, and intergenerational teaching. Drawing on interviews and field notes collected as part of a larger Participatory Action Research study involving the art centres and two aged care providers, the findings highlighted the Elders' central role in governance, knowledge-keeping and intergenerational

teaching. Person-centred care was enacted through caring for and being with Country. Elders and older people both received care and support and provided it to younger generations, staff, and communities, in contrast to mainstream transactional approaches that position older people solely as service users. The art centres were described as places of healing that foster social and emotional wellbeing, cultural safety, and ongoing connection to Country (187).

The United Nations Declaration on the Rights of Indigenous Peoples

The UNDRIP provides a universal framework of minimum standards for the survival, dignity and well-being of the Indigenous peoples and elaborates fundamental issues as they apply to the specific situation of Indigenous Peoples. The Declaration has implications for the development of a mental health philosophy of care for older adults.

1. Recognition of Indigenous Elders as a Priority Group: Articles 21 and 22 explicitly require that "particular attention shall be paid to the rights and special needs of indigenous elders" in improving economic and social conditions, including health. A philosophy of care must address the mental health needs of Aboriginal and Torres Strait Islander older people as a distinct priority population.

2. Right to Culturally Safe Mental Health Services: Article 24 affirms Indigenous peoples' right to traditional medicines and health practices, alongside equal access to the highest attainable standard of mental health. This supports the integration of traditional healing approaches within mental health service delivery, and the provision of culturally safe, responsive services that respect Indigenous worldviews of health and wellbeing. A philosophy of care should ensure that older people's dignity, autonomy and right to health are central to service design and delivery.

3. Self-Determination in Service Design and Delivery: Articles 3, 18, 19 and 23 establish the right of Indigenous peoples to self-determination and to be actively involved in developing and determining health programs affecting them, including administering such programs through their own institutions. A philosophy of care should therefore be co-designed with Aboriginal and Torres Strait Islander people and support Indigenous-led models of mental health care for older people.

4. Free, Prior and Informed Consent: Article 19 requires states to consult and cooperate in good faith with Indigenous peoples to obtain free, prior and informed consent before implementing measures that may affect them. This principle should underpin all policy development, service planning, and research involving Aboriginal and Torres Strait Islander older people.

5. Holistic Understanding of Wellbeing: The Declaration's recognition of spiritual, cultural, and connection-to-Country dimensions (Articles 12, 25, 31) aligns with Indigenous holistic concepts of social and emotional wellbeing, which extend beyond Western clinical definitions of mental health. A philosophy of care should embrace this broader understanding.

6. Addressing Historical Injustice and Intergenerational Trauma: The Preamble's acknowledgment of historic injustices through colonisation is directly relevant to understanding the mental health impacts of intergenerational trauma on Aboriginal and Torres Strait Islander older people, including Aboriginal people and their family members impacted by forcible removal.

7. Addressing Stigma and Discrimination: Experiences of stigma and discrimination related to mental illness may be compounded by racism and the ongoing impacts of colonisation and intergenerational trauma. Article 2 affirms that "Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity." A philosophy of care must actively address stigma to identify and counter ageist and racist attitudes among clinicians, culturally safe service design, and community-level interventions that promote positive perceptions of ageing and mental health help-seeking.

Read the Declaration here.

LGBTIQA+ people

Little research has been published on mental health models of care for older LGBTIQA+ consumers in Australia. The limited data on older LGBTIQA+ people indicate that the population experiences mental health disparities and higher rates of isolation and loneliness compared with heterosexual people in Australia (5, 134, 135). Research also shows that older LGBTIQA+ people often fear discrimination in accessing aged care. These concerns include expectations that services may not understand or be able to respond to their needs, and that staff may lack the skills and training to support them (135, 188). These concerns are often situated within the context of lifelong experiences of discrimination and stigma (60), where individuals' identities and relationships were pathologised or criminalised.

Settings that are often used by older people, such as retirement villages, aged care facilities and community centres, have also developed within heteronormative frameworks that can marginalise non-heterosexual lives and relationships (189). While high-level strategies to support LGBTIQA+ consumers tend to adopt a more generalist approach, they contain considerations that can guide models of mental health care for older LGBTIQA+ people:

- The *National LGBTIQ+ Mental Health and Suicide Prevention Strategy 2021–2026*, developed by LGBTIQ+ Health Australia, identifies that mainstream service providers have made limited progress in adapting their models of care to be genuinely LGBTIQ+ inclusive, with significant variation in workforce capability and commitment to inclusive practices (190). Co-designed with LGBTIQA+ communities, peak organisations, clinicians and advisory groups, the Strategy calls for government investment in alternative models of care that may be more effective for LGBTIQA+ communities. It also emphasises the need for models grounded in a human rights framework that address the specific needs of people with variations in sex characteristics, including bodily integrity, physical autonomy and self-determination.

- The Australian Government's *National Action Plan for the Health and*

Wellbeing of LGBTIQA+ People 2025 – 2035 (191), developed in consultation with LGBTIQA+ people, community-controlled organisations and other sector stakeholders, outlines several priorities relevant to mental health models of care for older LGBTIQA+ consumers (192). These include strengthening the capacity of mainstream services to deliver culturally safe and person-centred mental health care, while building LGBTIQA+ community-controlled services in mental health and supporting peer-led services. The Action Plan emphasises trauma-informed approaches and tailored suicide prevention, recognising the lifelong impact of stigma and discrimination. It also identifies the importance of reducing social isolation through peer networks and community connection, with specific attention to older people, and acknowledges the role of inclusive aged care initiatives such as Silver Rainbow training (193), to strengthen the ability of service providers, policy makers and the community on how to meet the needs of older LGBTIQA+ people (194). These priorities point to models of care that are integrated, safe and responsive to the distinct needs of older LGBTIQA+ people.

- The Australian Government's *Actions to support Lesbian, Gay, Bisexual, Trans and Gender Diverse and Intersex elders: A guide for aged care providers* was developed to assist service providers to advocate for and support LGBTI elders and older people. It highlights the need for tailored responses. The need for culturally safe and inclusive services was highlighted (195).

GRAI Older Persons' Blueprint

GRAI (GLBTI Rights in Ageing Inc.) provided a submission to the consultation around the development of the WA LGBTIQA+ Inclusion Strategy (196). It draws on the voices of nearly 200 older LGBTI Western Australians around five themes: social isolation, discrimination and safety concerns, lack of inclusive services, housing and financial insecurity, and the ongoing impacts of historical trauma. The result is a blueprint for change which prioritises areas for action, relevant to the mental health needs of older adults in WA and an underpinning philosophy of care.

- Peer-Led Social Networks
- Intergenerational LGBTIQA+ Community Hubs
- Inclusive Government Programs and Services
- 'Rainbow Standard' for Legislation and Policy
- Public Education Campaign on LGBTI Ageing
- Complaint Pathways and Accountability
- Co-Design in Policy and Program Development
- Reporting and Quality Standards
- LGBTI Inclusion Navigators
- Regional Outreach Models
- Prioritise Older LGBTI People in Housing Strategies
- Inclusive Housing Options

- Employment Pathways for Older LGBTI People
- Financial Literacy and Planning Programs
- Safeguards Against Financial Abuse
- Formal Acknowledgement of Past Injustices
- Expungement of Historical Offences

Read more here.

People from culturally and linguistically diverse (CaLD) backgrounds

There is a lack of research specifically on models of mental health care for people from culturally and linguistically diverse (CaLD) backgrounds. The most recent Australian Census data (2016), which includes a breakdown by age and country of birth, show that one in five people aged 65 and over were born in non-English-speaking countries (5). It is projected that this demographic will continue to grow substantially over the coming decades (197), highlighting the need for more evidence -informed models of mental health care for older people from CaLD backgrounds.

Existing literature highlights that older people from CaLD backgrounds underuse mental health services and face significant barriers to accessing them, indicating the need for culturally safe, person-centred models of care (126, 172, 198, 199).

Research with eight service providers examining mental health services for Croatian and Bosnian-born migrants in Australia found that older consumers were perceived as more difficult to engage, which was attributed to heightened stigma around mental illness and a cultural tendency towards being emotionally reserved (198). The study highlighted the need for improved service coordination and referral pathways across health, social and community services, as well as strengthening cultural competency and cross-cultural training within the workforce (198).

A formative evaluation of the NSW OPMH Community Services model of care found that while consumer interactions with the service increased from 2016 to 2017 following implementation of the model, there was no corresponding increase in access by people from CaLD backgrounds (126). Clinicians reported inadequate adaptation of assessment and care-planning processes for consumers from CaLD backgrounds, and the evaluation highlighted a lack of strategic partnerships with multicultural community organisations across local health districts. Recommendations focused on targeted adaptation of assessment tools and strengthened partnerships with multicultural community organisations to improve service responsiveness and inclusion (126).

An earlier report by the Federation of Ethnic Communities Councils of Australia (2015) concluded that older people from CaLD backgrounds were at higher risk of mental health issues than other Australians, yet consistently underused mental health services. The report stressed the need for culturally sensitive information and services, diagnostic tools, and acknowledged that there was limited evidence on effective care for older people from CaLD backgrounds following a mental health diagnosis.

The Victorian Government Inquiry into support for older Victorians from migrant and refugee backgrounds reinforced the importance of culturally safe care (172). The Inquiry emphasised the need for holistic, person-centred care delivered through coordinated, culturally informed systems that recognised the central role of family, culture, community and the social determinants of health (172). Further research is needed that centres the perspective of older people from CaLD backgrounds, including those living in regional and remote areas (102).

Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery

The Framework, developed by Mental Health in Multicultural Australia (MHiMA), is a tool for mental health services operating in all sectors. The Framework enables mental health services to evaluate their cultural responsiveness, enhance service delivery, and work in partnership with people from CALD backgrounds. The key theoretical underpinnings of the Framework are:

- Cultural responsiveness
- Risk and protective factors
- Culturally responsive practice
- Consumer and carer participation
- Recovery and cultural diversity

Read about the framework here.

People in regional and remote communities

Over one-third of older people aged 65 and over live in rural or remote communities in Australia (5), where access to mental health services is much less than that of those living in metropolitan areas (40, 85, 102, 124). Key barriers include the limited availability of mental health and specialist services (78, 85, 88, 102, 129), workforce shortages (85, 103, 200), and difficulties navigating the mental health system (129, 163). Stigma can also prevent older people in rural communities from disclosing any mental health concerns (129)

Models of care, therefore, need to be adapted to the local context (78, 85, 200). For example, evidence from research in three rural South Australian communities (78) showed that norms of community connectedness, self-reliance, and informal networking supported flexible and creative responses to gaps in mental health services. However, these local practices were undermined by systemic fragmentation between state and federal responsibilities, insecure short-term funding, and the bureaucratisation and centralisation of service delivery. Their study concluded that an integrated model of care for older adults, based on top-down policy understandings, cannot be easily transplanted into rural communities without adaptation to local conditions (78).

Similarly, Jackson and Roberts (2019) (85) described the development and implementation of OPMH services in rural New South Wales over 15 years, highlighting the importance of long-term commitment, investment in local clinical leadership, and innovative service models as essential for improving access to older people’s mental health services in rural and remote communities. The statewide model of care was adapted to local contexts, including hub-and-spoke

networks linking smaller rural teams with regional hubs, telepsychiatry and fly-in/fly-out psychiatric support, step-up/step-down inpatient units attached to rural hospitals to support people with severe or complex needs, and specialist partnerships with residential aged care facilities as a service innovation within the broader OPMH model. The literature also suggests that the need for flexibility in funding models is an important enabler of effective regional care, supporting local services to manage challenges such as transient populations (144).

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