Government of **Western Australia**
Department of **Health**

Older Adult Mental Health Sub Network Establishment Report

Including outcomes of the Older Adult Mental Health Sub Network Inaugural Open Meeting

12 August 2016

better health • better care • better value

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Contents

Executive Summary 3
Introduction 5
Mental Health Network 5
Mental Health Sub Networks 5
Older Adult Mental Health Sub Network Open Meeting 6
Open meeting process 6
Panel discussion 7
Workshop outcomes 8
Issues rated highly by participants 12
Next steps 13
Appendix A: Open Meeting program 14
Appendix B: Detailed participant input 15
Appendix C: Inaugural Older Adult Mental Health Sub Network Steering Group 29
Appendix D: Acronyms 30

Executive Summary

Older Adult Mental Health Sub Network

The Mental Health Sub Networks were established to support the Mental Health Network (MHN) in engaging with and delivering outcomes for specific cohorts of mental health service users.

This report outlines the process of establishment of the Older Adult Mental Health Sub Network Steering Group, with a focus on the outcomes of the Open Meeting that will inform the Group's work.

This report was endorsed by the Mental Health Unit, Clinical Support Directorate at the WA Department of Health on 19 December 2016.

Open Meeting

The MHN in conjunction with the Mental Health Commission (MHC) hosted the Older Adult Mental Health Sub Network Open Meeting on 12 August 2016.

The Open Meeting was attended by 106 people, including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The Open Meeting program is available in Appendix A.

The panel members spoke to a number of issues and possible solutions, highlighting the following:

- Sub-optimal integration and co-ordination of services for the elderly with mental health issues.
- Need to engage families in care planning.
- Lack of training in mental health for staff working with the elderly.
- Lack of services for those aged <65 with cognitive impairment and co-morbid mental health issues.
- Lack of appropriate accommodation options for the elderly with mental health issues.

The workshop session captured the common issues raised by participants, as identified by the Open Meeting facilitator:

- Lack of clear pathways for health professionals to enable efficient resolution of issues, including information breakdowns between GPs and health services and no agreed model of care for transition and handover between services.
- Carers and family often excluded from the planning and evaluation of care, plus require greater support and capacity building to continue care after discharge.
- More appropriately trained staff are required, particularly Community Mental Health Nurses and Registered Nurses in residential facilities.
- Greater and more consistent skills development and training is needed across the sector, particularly for General Practitioners and staff in aged care facilities.
- Limited budgets and poor coordination / understanding of available funding and resources between the different stakeholders.
- Lack of knowledge in the sector and community about the range of available mental health service options, resources and providers.
- Inadequate or inflexible accommodation options and service gaps, particularly for clients under 65 with cognitive impairment and associated behaviours, or for patients with complex physical comorbidities.

- Lack of high dependency unit beds.
- Service gaps created by geographic boundaries, and a lack of available services in rural and remote areas.
- Lack of 24 hour support processes resulting in an over reliance on ED.
- Confidentiality of medical records results in information gaps and the existence of different sets of medical records.

The workshop included an opportunity for the participants to nominate which issues and gaps they considered to be highly important. The two most highly rated items were:

- Lack of family inclusion.
- Lack of knowledge in the community about mental health service options.

The themed outcomes from the workshop session are outlined under Workshop outcomes, with the detailed participant input, including the rating, available in Appendix B.

Steering Group

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN Executive Advisory Group for final approval. A list of the Inaugural Steering Group representatives for the Older Adult Mental Health Sub Network is available in Appendix C.

The information collected from the Open Meeting workshop will be used to guide the Older Adult Mental Health Sub Network Steering Group in the development of their work plan and to inform and support the MHC in the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Older Adult Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health on the planning of health services.

Introduction

Mental Health Network

The establishment of the Mental Health Network (MHN) was undertaken by the Department of Health with the support of Professor Bryant Stokes, Acting Director General, Department of Health, in partnership with Mr Timothy Marney, Mental Health Commissioner, Mental Health Commission (MHC).

The MHN was launched during Mental Health Week in October 2014. The MHN is led by Co-Leads Dr Helen McGowan and Ms Alison Xamon.

The MHN Executive Advisory Group (EAG) membership includes consumer and carer representatives as well as representatives from the Department of Health, MHC, Office of Mental Health, Primary Care, Mental Health Clinician Reference Group, Office of the Chief Psychiatrist, Western Australian Primary Health Alliance (WAPHA) and the Western Australian Association of Mental Health.

The objective of the MHN EAG is to support and guide the MHN to undertake the following:

- Contribute to improving the mental health and wellbeing of Western Australians.
- Draw upon a community of practice approach to share information, engage with the sector and community, foster collaboration and develop partnerships.
- Engage with organisations and individuals to support innovation and change.
- Develop an agreed set of strategic priorities across the mental health sector.
- Promote system change including continued development of a person-centred and recovery orientated culture, with better integrated and connected services.
- Promote adoption of recognised best practice across the sector.

The Mental Health Sub Networks structure was created to support the MHN to meet these objectives.

Mental Health Sub Networks

The Sub Networks are intended to focus on the needs of a particular cohort, be task orientated and to deliver products by bringing together the right people, from the community sector, Health, consumers, carers and other interested parties. A structured approach was taken to engagement and the establishment of each of the Sub Networks.

A prerequisite to the establishment of each Sub Network included confirmed sponsorship from a health service, identified co-ordinators and support of key stakeholders within the sector prior to progressing the development of the Sub Networks.

The MHN Co-Leads took a leadership role in networking with individuals and organisations to identify and establish the Sub Networks.

An Implementation Group of key stakeholders was then formed to assist in the organisation of an Open Meeting, including the selection of appropriate panellists to provide snapshots of key sector issues. The aim of the Open Meeting was to give the broad community the opportunity to actively participate in the formation of the Sub Network and provide critical input to shape its priorities moving forward.

At the conclusion of the Open Meeting, expressions of interest were called for from individuals to join a Steering Group to drive the work of the Sub Network.

Each Mental Health Sub Network Steering Group is required to have representation from:

- consumers
- carers or family members
- community managed organisations
- public community mental health services
- inpatient public mental health services
- inpatient and community private mental health services
- primary health services
- agencies delivering prevention and promotion programs and initiatives
- MHC
- mental health professionals from a range of disciplines including:
  - peer workers
  - allied health
  - nursing
  - medical
  - psychology
  - psychiatry
- individuals and agencies working in regions across the state including:
  - rural and remote and metropolitan districts/regions (particularly relevant for cross-sectoral working groups)
- individuals and agencies working with different age cohorts (relevant for cross-age cohort working groups)
- the sponsoring organisation.

All nominations were considered by the Implementation Group and the names of the successful applicants presented to the MHN EAG for final approval. In order to keep the Steering Groups at workable sizes, applicants were selected on the basis of their ability and willingness to represent the concerns of multiple cohorts.

A list of the Inaugural Steering Group representatives for the Older Adult Mental Health Sub Network is available in Appendix C.

Older Adult Mental Health Sub Network Open Meeting

Stakeholders for Older Adult mental health services in Western Australia met for the inaugural open meeting of the Older Adult Mental Health Sub Network at the Bendat Community Centre, Wembley on 12 August 2016.

A total of 106 people attended the Open Meeting including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations.

- 95 people registered to attend the Open Meeting.
- 106 people attended the Open Meeting (11.6% more than registered).
- 60 organisations were recorded as having representatives at the meeting.

Open meeting process

The energy and good-will demonstrated throughout the establishment of the Older Adult Mental Health Sub Network continued to develop momentum throughout the Open Meeting.

The Open Meeting program is available in Appendix A.

Following the acknowledgement to country given by Mental Health Co-lead, Ms Alison Xamon, the Open Meeting heard overviews from Dr Helen McGowan regarding the MHN; A/Assistant

Mental Health Commissioner, Mr David Axworthy, presented Mental Health – The Big Picture; and Consultant Psychiatrist, Dr Angela McAleer, gave an overview of the Older Adult Mental Health Sub Network.

Panellists recommended by the Older Adult Mental Health Sub Network Implementation group then shared snapshots of key issues and perspectives in the older adult mental health sector.

The outcomes of the panel discussion and workshop session as captured by the facilitator are themed and summarised below.

Panel discussion

The Panel consisted of representation from the following perspectives:

- Carer — Mr Colin Edwards
- Geriatrician — Dr Nick Spendier
- Aged Care Nurse Practitioner for Residential Care Line — Ms Carol Douglas
- Primary Health — Dr Cathy Parsons
- Brightwater — Ms Carol Bartlett

The following points were captured by the facilitator during the panel session:

- Increased access to open air ground floor spaces for patients is required.
- The ability for recently admitted patients to make telephone contact with a delegated carer is therapeutic in a distressing and unfamiliar environment.
- If possible, avoid assisted showering by opposite gender nurses.
- There are a vast range of services and options available and it becomes difficult to know who the best person is to suit a patient, especially for carers and loved ones but also for health care providers without the in-depth knowledge.
- Siloed services exist and it can lead to a lot of duplication of services and options.
- Some more overarching governance from the service providers is needed to avoid duplication in a resource finite area.
- We're all aiming for best outcomes for the client but done in isolation it's not the best outcome.
- Aged care facilities aren't always sure of who's the best or who's accountable for outcomes and they end up sending patients to the Emergency Department (ED);
  - We need a pathway to support aged care facilities to intervene and evaluate outcomes rather than just submitting reports.
  - The key stakeholders and referral sources aren't accountable, with reports often just 'submitted' without any consultation between the service and the aged care facility.
- A General Practitioner (GP) can offer advocacy in this situation, as elderly people with mental and physical health problems are often in no position to advocate for themselves in the tertiary setting.
- Need for increased communication in handovers as it often falls down when the GP is involved, six weeks later you get a letter from the service; we need more timely handovers in the form of a phone call.
- Residential aged care services cover a real diversity of patients and we're a very regular user of the WA mental health services; so when we're supported by older adult mental health services in long term care situations it works really well and there are some great specialists in the field.
- Acute episodes, escalating behaviour or very disinhibited (physically aggressive or suicidal) patients are hard to get support for and often the only option is ED, which is really

dependent on the location and services available, so you get a yoyo effect if the services don't exist in the hospital.
- Patients under 65 years can be difficult to get support for in a timely fashion, which can lead to more acute conditions by the time people are cared for.
- Providing acute care without security providers on site is challenging if people do become aggressive.
- Would like to see a more seamless service without so much emphasis on location and age brackets.
- A 24 hour liaison mental health service would be well received.
- Continually looking at more holistic care than solely medical model and pharmaceutical measures is needed.

Following a networking break, the meeting resumed with a workshop session facilitated by an external provider.

Workshop outcomes

Participants were asked to consider the panel presentations and take into account their own knowledge and experience of the sector to answer the following questions:

- What do you see as key issues, challenges and gaps in service delivery that are still to be resolved in the older adult mental health space?
- For this issue, what potential solutions would you propose?

Responses were shared in real time via GroupMap - allowing cross pollination of ideas from all participants. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The following points were captured during the workshop session by the facilitator, summarised and themed:

Lack of clear pathways for health professionals to enable efficient resolution of issues, including information breakdowns between GPs and health services and no agreed model of care for transition and handover between services:

- GPs not getting communication from clinicians when patients have been in hospital.
- GP not getting to talk to the psychiatrist or geriatrician.
- Information is stilted between GP and health services.
- No Model of Care that articulates a clear pathway for GP liaison and referral.
- Lack of timely reports after referrals.
- Unclear handover boundaries between services.
- Need for a Memorandum of Understanding (MOU) for clients discharging to sub-acute care of transitional care to ensure shared and ongoing responsibility whilst the client is recovering from acute episode.
- Lack of clear models on smooth handover or transition.
- Models of care about transition between services.
- Lack of efficient handover and effective transition procedures.
- Coordination between stakeholders is difficult.
- Lack of clear pathway for health professionals to enable efficient resolution of issues.
- Lack of communication between service providers.
- Better pathways for communication between clinical team, carers and other stakeholders.
- Poor communication between services and community team.
- Lack continuity of care with ongoing support from mental health services for individuals, families and carers for people.

- Need for better shared care of consumers accessing both mental health and aged care services and ensuring continuity of care and coordination of services.
- Complexity of navigation of services.
- Lack of coordination for an individualised response.
- No clarity on the appropriate placement according to the needs of clients.
- Need to recognise that prioritising the development of relationships between service providers beyond silos positively impacts responses and is reliant on initiative.
- Service provision based on relationships rather than sustainable process independent of personalities.
- Services are driven by their own agendas not patient needs.
- In-reach to community resources is needed.
- Lack of acceptance of referral from facility based Nurse Practitioner to Older Adult Mental Health (OAMH).
- Get clear guidelines regarding the early indicators of deterioration and how to get a response early.
- Inconsistent provision of service models of care, culture of service, historical ways of providing service.
- Missing Care Pathways for Behavioural and Psychological Symptoms of Dementia (BPSD).
- System guidance is needed, especially for younger people with dementia and Alcohol and Other Drugs (AOD) clients, and also people with Down syndrome develop dementia as part of the condition.
- Lack of clear pathways to support the person and the facility in management of challenging behaviours associated with dementia.
- More transparency regarding good clinical outcomes and service evaluation.
- Clinical evaluation of services and patient outcomes needed.
- Need for more evidence based practice.
- Over emphasis on the dementia experience.

Carers and family often excluded from the planning and evaluation of care, plus require greater support and capacity building to continue care after discharge:

- Lack of family inclusion.
- Need for investment in Aboriginal aged care specially targeted at the needs of family kinship.
- Family and friend carers often feel excluded from the planning and evaluation of care.
- Also feel uncomfortable to take patients home without the knowledge of the support available or the training to be confident.
- I have been told to back off from supporting family because I'm deemed to be able to do it and they won't give family the support they should have.
- A lot of this stems from funding.
- Carers feel left out.
- Experience of carers is sometimes greater than incoming staff working for service providers.
- Need carer allowance to support older adults.
- Communication with carers and consumers needs lay language.
- Review employed carer education and skill levels related to pay and sense of value across all sectors.
- As a carer we should be able to advocate and not be relied on instead of professional support.
- Lack of access to respite care.
- Need better health literacy in carers.

More appropriately trained staff are required, particularly Community Mental Health Nurses and Registered Nurses in residential facilities:

- Nurses have been removed from the Aged Care Standard of Practice and the care has diminished significantly.
- Ratios of trained staff have deteriorated in the context of privatised residential care facilities, with resultant absence of therapies and late referral of co-occurring morbidities.
- Lack of appropriately trained staff to provide the level of care required.
- Need for increased Community Mental Health Nurses.
- Not enough mental health Registered Nurses (RNs) in residential facilities.

Greater and more consistent skills development and training is needed across the sector, particularly for GPs and staff in aged care facilities:

- Need for more training in suicide prevention in aged care facilities.
- Greater skills development and training of all staff involved across the sector is needed.
- Lack of consistency in staff education in residential facilities.
- Staff education for clinicians regarding communication skills.
- Need GP education and training regarding older adult issues and needs.
- Better trained GPs to send referrals to the right residential care or service.
- Older adult mental health service referral lacks specialist bipolar knowledge.
- Staff education about modifying risk factors.
- Some GPs, even those who work in Residential Aged Care Facilities (RACFs), are not aware of appropriate tests or organic screening.
- Not enough GPs who are aged care friendly and who will visit RACFs.
- Avoid use of locums that don't understand OAMH.
- Employees of service providers need to have passion, rather than 'just a job'.
- Continuous education and problem with non-English speaking clients.
- Staff build frustration when behaviours are not managed well.
- More person centred management is needed and if not, then a lot of dopey, over sedated people will be walking around.

Limited budgets and poor coordination / understanding of available funding and resources between the different stakeholders:

- Limited budgets.
- Lack of funding across the OAMH arena.
- The complexity of care is not matched with staff numbers and available resources.
- Poor coordination of resources and funding between different stakeholders.
- Appropriate funding levels are required to enable needs to be met for the individual; no more one size fits all.
- Costing issues and cost cutting driving evidence based clinical care.
- Lack of clear responsibility / resources for budget delivery resulting in hands on care to non-government organisations (NGOs) from the MHC.
- Consolidate resources.
- Understanding the constraints and individual resources of each service provider to build credibility.
- Poor liaison between services.
- Underutilisation or lack of understanding of business rules of funded services (e.g. home medication review and residential medication management review); therefore, possibility of eligible people missing out.
- Conflict of being a coordination service and a service provider.

Lack of knowledge in the sector and community about the range of available mental health service options, resources and providers:

- Lack of knowledge in the community about mental health service options.
- There is so much great work already being done and nobody knows what is going on.
- Need to educate the community about what dementia is, about dying and reducing stigma, and about providing support.
- Need for better awareness of what other service providers provide.
- Not knowing what services are available particularly when a loved one is becoming unwell.
- Better awareness of the supports and services that are available to consumers and where to refer people for support.
- Lack of knowledge of available resources.
- Raise the profile of older adult mental health.
- This meeting is part of the solution!
- Lack of education in the community but also those working in the area.
- Absence of diversional therapy meaning a loss of quality of life and the negative impact of therapeutic milieu.
- Duplication of services.

Inadequate or inflexible accommodation options and service gaps, particularly for clients under 65 with cognitive impairment and associated behaviours, or for patients with complex physical comorbidities:

- Transitional Care Packages (TCP) - lack of supported accommodation for patients who do not fit the standard for aged care accommodation.
- Mentally ill people that are better housed in alternatives (e.g. 50 - 60 year old men with co-morbidities that do not fit residential aged care).
- Lack of home care packages and available packages aren't flexible enough.
- Services for younger adults, especially accommodation and inpatient beds.
- The gap is who is responsible for accommodation (Commonwealth or the State?).
- Lack of facilities to meet demand.
- Lack of psychogeriatric residential care for more complex individuals needing ongoing accommodation options rather than hospital services.
- The stigma of mental health reduces placement opportunities into aged facilities or other services.
- When people mention Aged Care and Mental Health other people don't want to know (a bit like you're contagious!).
- Gap in service provision for clients under 65 with cognitive impairment and associated behaviours.
- Older adults being 65+ doesn't recognise Aboriginal people who often age earlier.
- Those under the age of 65 and those with complex co-morbidities.
- Residential care with mixed physical health problems and complex mental health issues.
- Lack of services for patients with physical comorbidity.
- Gaps in service with boundaries created by age limits.
- Complex needs.
- Exchange of school children into older adult facilities.

Lack of High Dependency Unit (HDU) beds:

- Lack of HDU beds but great that another 10 are being added.
- Lack of beds specific for unremitting BPSDs.
- Not enough extended care mental health beds.

- Pressure of services to clear beds and no follow up.
- Lack of HDU beds.
- More HDU beds to be made available in rural and remote areas.
- Lack of authorised beds across the sector and the geographical distribution of them.
- Underutilisation of Transitional Care beds.

Service gaps created by geographic boundaries, and a lack of available services in rural and remote areas:

- Boundaries created by geographic location.
- Location of services and mismatch with location of older populations.
- Lack of co-location with other services.
- Lack of available services in rural and remote areas.
- Lack of statewide services.
- Rural and remote areas are poorly served, with very few visits per year.

Lack of 24 hour support processes resulting in an over reliance on ED:

- Lack of specialist older adult mental health telephone services after hours.
- Lack of 24 hour support processes resulting in over reliance on ED.
- Lack of a 24/7 liaison service or one stop shop.
- ED should not be an option.

Confidentiality of medical records results in information gaps and the existence of different sets of medical records:

- Barriers to sharing information due to privacy issues.
- Assessment information not shared.
- Medical notes not accessible to community services.
- Confidentiality of medical records means different sets of medical records exist.
- Medical notes only accessible to some community services.

Other issues:

- Lack of consumer representatives on sub network groups.
- Promote the use of compassionate person centred advanced care directives.
- Patients don't get many 'visitors'.
- Ageing population.
- Expect increase in alcohol and other drugs (AOD) in the future.
- Eden alternative.

Issues rated highly by participants

Participants were invited to identify the issues they believed were important by using the ‘like’ indicator in GroupMap. The points below are the issues and gaps identified by the wider group of participants as highly important.

- Lack of family inclusion.
- Lack of knowledge in the community about mental health service options.
- Nurses have been removed from the Aged Care Standard of Practice and the care has diminished significantly.
- Ratios of trained staff have deteriorated in the context of privatised residential care facilities, with resultant absence of therapies and late referral of co-occurring morbidities.

- Need for investment in Aboriginal aged care specially targeted at the needs of their family kinship.
- Limited budgets.
- There is so much great work already being done and nobody knows what is going on.
- Absence of diversional therapy meaning a loss of quality of life and the negative impact of therapeutic milieu.
- Need for more training in suicide prevention in aged care facilities.

Next steps

The information collected from the Open Meeting workshop will be used to guide the Older Adult Mental Health Sub Network Steering Group in the development of their work plan and inform the MHC to support the delivery of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (Plan). The Older Adult Mental Health Sub Network will also be engaged to support consultation undertaken by the Department of Health to advise on the planning of health services.

In addition to working on identified projects, the Steering Group will work to foster engagement and communication in the older adult mental health sector.

Developments, issues for broader discussion and achievements will be reported back to the broader Older Adult Mental Health Sub Network membership via the Older Adult Mental Health Sub Network Steering Group.

Appendix A: Open Meeting program

Department of **Health**

Mental Health Commission

Older Adult Mental Health Sub Network Inaugural Open Meeting

9.30am Friday 12 August 2016

The Bendat Parent and Community Centre, 36 Dodd St, Wembley

Time	Program	
9.00am	Registration	
9.30am	Introduction Acknowledgement of Country	Ms Alison Xamon
9.35am	Mental Health-The Big Picture	Mr David Axworthy
9.45am	Overview of Mental Health Network	Dr Helen McGowan
9.55am	Overview of Older Adult Mental Health Sub Network	Dr Angela McAleer
10.05am	Panel discussion – identifying issues and possible solutions in the older adult mental health sector	Mr Colin Edwards - Carer Dr Nick Spendier - Geriatrician Ms Carol Douglas - Aged Care Nurse Practitioner for Residential Care Line Dr Cathy Parsons - Primary Health Ms Carol Bartlett - Brightwater
10.25am	Networking break	All
10.50am	Reflect and build on themes	Mr Will Bessen
11.45am	Joining the Older Adult Mental Health Sub Network and Steering Committee	Ms Alison Xamon
11.55am	Concluding remarks and acknowledgements	Ms Sarah Sprague
12.00pm	Close and Networking	

Appendix B: Detailed participant input

The table below captures the individual issues and respective solutions raised by participants in the workshop session using the iPad technology.

The 'liked' indicator was used as a method to ensure the feedback component of the session was targeted to key areas within the available time frame and is also displayed.

Issue	Proposed solutions	Likes
• Lack of family inclusion.	• Families as part of the acute management of agitation, particularly through telephone and technology. • In hospital and ED situations the relatives of patients with dementia are not allowed to stay overnight - the solution in the UK is *Johns Campaign.* • Culturally and Linguistically Diverse families need to be included.	12
• Lack of knowledge in the community about mental health service options.	• Strengthening GP networks and peak bodies to distribute information more broadly. • Still stigmatised, even with publicity and the available services, as people won't seek help themselves. • We think that maybe less providers so that the funding is more effective, which in turn would mean that it would be easier to collate the list so that people knew what was available.	12
• Nurses have been removed from the Aged Care Standard of Practice and the care has diminished significantly. • Ratios of trained staff have deteriorated in the context of privatised residential care facilities, with resultant absence of therapies and late referral of co-occurring morbidities.		11
• Need for investment in Aboriginal aged care specially targeted at the needs of their family kinship.		9
• Limited budgets.	• Better agreement between funding sources to determine the allocation of funding and resources.	8

Issue	Proposed solutions	Likes
• There is so much great work already being done and nobody knows what is going on.	• Build skills registers and opportunities to share and network.	8
• Absence of diversional therapy meaning a loss of quality of life and the negative impact of therapeutic milieu.	• Problematic in residential care in particular. • Therapeutic approach is most effective but not prepared and able to invest in Occupational Therapy.	7
• Need for more training in suicide prevention in aged care facilities.		7
• Need to educate the community about what dementia is, about dying and reducing stigma, and about providing support.		6
• Poor liaison between services.	• In-reach positions have been very helpful. • Liaison positions whose responsibilities are to make that transition.	6
• Residential care with mixed physical health problems and complex mental health issues.		6
• TCP - lack of supported accommodation for patients who do not fit the standard for aged care accommodation. • Mentally ill people that are better housed in alternatives (e.g. 50 - 60 year old men with co-morbidities that do not fit residential aged care).	• Need more age appropriate residential care.	6
• Lack of appropriately trained staff to provide the level of care required.	• Specific mental health training.	5
• Poor coordination of resources and funding between different stakeholders.		5
• GPs not getting communication from clinicians when patients have been in hospital.	• Better training and advocacy on what is needed to the people that have that area of influence. • Ensure timely information both ways to speed up the process.	5

Issue	Proposed solutions	Likes
• Greater skills development and training of all staff involved across the sector is needed.	• Allocate funding for training and skills development.	5
• Need for increased Community Mental Health Nurses.	• Immediate response from Community Mental Health Nurses diffuses situation, feel supported and improves capacity of the service provider. • Actually coming to the facility rather than a phone call adds value. Efficient use of time, especially in context of physically frail and complex patients.	5
• Rural and remote areas are poorly served, with very few visits per year.		5
• Lack of consistency in staff education in residential facilities.	• Collaborative training model. • Consider psychological skills of staff as equally as important as physical skills (e.g. manual handing skills). • Quality and consistency training which is competency based and contemporary to include independent living in the community.	5
• Need for better awareness of what other service providers provide.		4
• The complexity of care is not matched with staff numbers and available resources.		4
• Complexity of navigation of services.	• Service mapping and referral pathways. • WAPHA developing the Mental Health Atlas.	4
• Eden alternative.	• Central point of access.	4
• Employees of service providers need to have passion, rather than 'just a job'.		4
• Lack HDU beds but great that another 10 are being added.		4

Issue	Proposed solutions	Likes
• Need for an MOU for clients discharging to sub-acute care of TC to ensure shared and ongoing responsibility whilst the client is recovering from acute episode.	• Discharge of clients from acute services when client is still subacute and still requires some element of specialist services means higher risk of readmission. • Shared care during this period would reduce admissions. • Very important to have a comprehensive discharge plan which is timely and includes the person within a person centred framework.	4
• Not enough mental health RN's in residential facilities.	• Need for more accessible training for staff as it is currently cost prohibitive for organisations. • Also a recruitment issue. • Cert IV Mental Health is available through Australian Medical Association but people are not aware as an industry (not publicised). • Stipulate awareness or mental health experience as a requirement for recruitment?	4
• Some GPs, even those who work in RACFs, are not aware of appropriate tests or organic screening.	• Greater role for the Primary Care Network to better train GPs. • More timely referrals by GPs to Geriatricians. • Better liaison required to avoid delays created when delayed medical screening occurs.	3
• Family and friend carers often feel excluded from the planning and evaluation of care. • Also feel uncomfortable to take patients home without the knowledge of the support available or the training to be confident.	• Inform and skill carers when patient is in an inpatient setting and involve them in the discharge planning process in line with standards. • Should be treating patients in a holistic service model, not a medical model, and need to include carers • Better information about carer supports in the community (e.g. Carers WA).	3
• Lack of home care packages and available packages aren't flexible enough.		3
• Lack of specialist older adult mental health telephone services after hours.		3

Issue	Proposed solutions	Likes
• Lack of clear pathways to support the person and the facility in management of challenging behaviours associated with dementia. • No clarity on the appropriate placement according to the needs of clients. • Lack of beds specific for unremitting BPSDs.		3
• Not enough extended care mental health beds.	• Make more beds available! • Someone needs to stick their hand up and actually provide extra beds that are clearly identified. • Co-location of extra beds with hospitals with OAMH services.	3
• Not knowing what services are available particularly when a loved one is becoming unwell.		3
• Staff education for clinicians regarding communication skills.	• Peer clinician sessions as time to reflect.	3
• Lack of access to respite care.		2
• Need for better shared care of consumers accessing both mental health and aged care services and ensuring continuity of care and coordination of services.	• Yearly meeting for service providers to allow them the opportunity to interact with other professionals and share ideas. • More holistic service responses required.	2
• Need for more evidence based practice.		2
• GP not getting to talk to the psychiatrist or geriatrician.	• Prioritisation of telephone access to psychiatrists and geriatricians. • Timely discussion between GP and specialist is core business, not an add on.	2

Issue	Proposed solutions	Likes
	• Amsterdam Dementia Village where university students move in with older people. • More user friendly, community based services. • Staff are 'around' to enable cycling, shops etc. • Facilities within for those whose dementia has deteriorated.	2
• Lack of co-location with other services.		2
• Lack of consumer representatives on sub network groups.	• Extend membership to ensure individuals with lived experience are directly involved.	2
• Pressure of services to clear beds and no follow up.		2
• Lack of available services in rural and remote areas.	• Dedicated funding to source rural and remote services. • Ability of the sub network to video conference into future meetings. • Expand the tele-health network.	2
• Lack of statewide services.	• Telepsychiatry via technology.	2
• Ageing population.	• Invite retirement population in to WA, increase flow of capital into the state and create critical mass for services.	1
• Appropriate funding levels are required to enable needs to be met for the individual; no more one size fits all.		1
• As a carer we should be able to advocate and not be relied on instead of professional support. • I have been told to back off from supporting family because I'm deemed to be able to do it and they won't give family the support they should have. • A lot of this stems from funding.	• More funding would be helpful. • More collaboration with family to see where their needs are not being met, firstly as the family but also the unwell family member. • Individuals may also want an independent advocate and/or carer as they may not want to burden family members.	1

Issue	Proposed solutions	Likes
• Barriers to sharing information due to privacy issues.	• Individuals advised of consent to opt out of information sharing across services.	1
• Better awareness of the supports and services that are available to consumers and where to refer people for support.		1
• Better pathways for communication between clinical team, carers and other stakeholders.		1
• Better trained GPs to send referrals to the right residential care or service.		1
• Carers feel left out.		1
• Clinical evaluation of services and patient outcomes needed.		1
• Conflict of being a coordination service and a service provider.		1
• Costing issues and cost cutting driving evidence based clinical care.		1
• Assessment information not shared.	• Services need to share assessments and not have excuses of why they can't. • Need to develop tools that are patient centred and used by all disciplines. • Be proactive with information sharing (e.g. wellbeing mapping with all able to see the care plan). • Care plans that carers can identify with. • More focused on sensory modulation.	1
• Duplication of services.		1
• Lack of efficient handover and effective transition procedures.		1
• Exchange of school children into older adult facilities.		1
• Experience of carers is sometimes greater than incoming staff working for service providers.		1

Issue	Proposed solutions	Likes
• Gap in service provision for clients under 65 with cognitive impairment and associated behaviours.	• Increased staffing levels required to meet the needs of the clients, and appropriate skills. • Currently operationally insufficient.	1
• Get clear guidelines regarding on the early indicators of deterioration and how to get a response early.	• Access to toolbox education. • Balance between medical and person centred care. What do you know about that person to help make their life better. • Knowing who to contact, clear pathway to a 'hotline' when an issue arises to avoid the shuffle around. • Role of specialist service providers to provide toolbox education to providers regarding responding to and recognising early deterioration.	1
• Lack of HDU beds.		1
• Over emphasis on the dementia experience.	• Broader understanding of the complexity of mental health issues.	1
• Inconsistent provision of service models of care, culture of service, historical ways of providing service.	• Consumer driven service development to better reflect need. • Promote quality and choices. • More flexibility around 'the guidelines'. • Dignity of risk! (However - do consumers realise the value of better clinical care versus a better physical facility?)	1
• Lack continuity of care with ongoing support from mental health services for individuals, families and carers for people.		1
• Lack of 24 hour support processes resulting in over reliance on ED.	• Broadening the 24 hours support line currently available to residential aged care facilities.	1
• Lack of a 24/7 liaison service or one stop shop.		1
• Lack of clear models on smooth handover or transition.		1

Issue	Proposed solutions	Likes
• Lack of clear pathway for health professionals to enable efficient resolution of issues.	• Bring the sub network level of expertise together to plan the development of a one stop shop (24 hr hotline with risk assessment tool and standardisation across organisations). • Contact with the hotline would be your reference (they decide on where the referral goes).	1
• Lack of clear responsibility / resources for budget delivery resulting in hands on care to NGOs from the MHC.	• 24 hours access and support to mental health service to enable seamless care.	1
• Lack of communication between service providers.	• Standardised documents for sharing information. • Agreed confidentiality agreements.	1
• Lack of knowledge of available resources.	• Develop a mental health pathway within the Residential Care Line Triage and Advice line.	1
• Lack of psychogeriatric residential care for more complex individuals needing ongoing accommodation options rather than hospital services.		1
• Medical notes not accessible to community services.		1
• Missing Care Pathways for BPSD.	• Shared referral pathways. • Severe Behavioural Response Team and other groups shared referral meeting and shared documentation. • 24 hour helpline.	1
• Model of care that articulates a clear pathway for GP liaison and referral.		1
• Models of care about transition between services.		1
• More HDU beds to be made available in rural and remote areas.	• Use of Royalties for Regions to fund HDU beds in rural and remote areas.	1
• More transparency regarding good clinical outcomes and service evaluation.		1

Issue	Proposed solutions	Likes
• Need carer allowance to support older adults.	• 'Oldy bonus' instead of 'baby bonus'.	1
• Need GP education and training regarding older adult issues and needs.		1
• Older adult mental health service referral lacks specialist bipolar knowledge.	• Lack of choice around referral options and models of service. • Assumption was all older adults need an in-home consulting service. • Stereotyping of older adults means services are highly medicalised services and 'done to' rather 'done with' individuals.	1
• Older adults being 65+ doesn't recognise Aboriginal people who often age earlier.	• Need for culturally competent service responses. • More communication about the referral criteria to OAMH.	1
• Need to recognise that prioritising the development of relationships between service providers beyond silos positively impacts responses and is reliant on initiative.		1
• Raise the profile of older adult mental health.		1
• Services are driven by their own agendas not patient needs.	• Case conference data needs to be measured by patient outcomes not referral numbers.	1
• Lack services for patients with physical comorbidity.	• Co-location of inpatient mental health beds with general hospital. • Combined geriatric / mental health service.	1
• Services for younger adults, especially accommodation and inpatient beds.	• Need dedicated services and accommodation options. • Reconfiguration of services to bring equivalent patient cohorts together. • Closure of Graylands and Selby is an unmissable opportunity to do this!	1
• Staff build frustration when behaviours are not managed well.	• Sensory modulation focused assessment tools – standardisation.	1

Issue	Proposed solutions	Likes
• System guidance is needed, especially for younger people with dementia and AOD clients, and also people with Down syndrome develop dementia as part of condition. • Expect increase in AOD in the future.	• Person on phone rather than queueing devices for older people (call waiting). • Model of care to be described better as access is difficult.	1
• The stigma of mental health reduces placement opportunities into aged facilities or other services.	• Need better education. • If a facility knows they can get good support then they are more likely to take the client / resident in. • A key person from residential facilities better trained and supported by OAMH services which will also assist admissions that are not appropriate. • Better training of inpatient staff so they better understand the impact of moving patients to RACFs, including understanding the limited resources that will then be available. • The link person could also involve a GP.	1
• This meeting is part of the solution! • Consolidate resources.		1
• Understanding the constraints and individual resources of each service provider to build credibility.	• Understanding limitations and finding creative solutions that can be undertaken.	1
• Under-utilisation or lack of understanding of business rules of funded services (e.g. home medication review and residential medication management review); therefore, possibility of eligible people missing out.		1
• When people mention Aged Care and Mental Health other people don't want to know (a bit like you're contagious!). • Patients don't get many 'visitors'.	• Establish a community group to visit residents.	1

Issue	Proposed solutions	Likes
• Need better health literacy in carers.		0
• Unclear handover boundaries between services.		0
• Boundaries created by geographic location.		0
• Poor communication between services and community team.	• Clinical practitioner position or Consultant-Liaison (CL) position who ensures better communication between services.	0
• Communication with carers and consumers needs lay language.		0
• Complex needs.		0
• Confidentiality of medical records means different sets of medical records exist.		0
• Continuous education and problem with non-English speaking clients.		0
• Coordination between stakeholders is difficult.	• Need better pathways for discharge and general communication.	0
• ED should not be an option.	• OAMH triage as an acute assessment area co-located with ED.	0
• Review employed carer education and skill levels related to pay and sense of value across all sectors.	• Subsidy for TAFE fees and increased educational opportunities for front line carers.	0
• Gaps in service with boundaries created by age limits. • Those under the age of 65 and those with complex co-morbidities. • The gap is who is responsible for accommodation (Commonwealth or the State?)	• Needs to be clear direction regarding governance. • Development of clear guidelines regarding responsibility and accountability. • Partnerships between Government and providers using the private sector to help support this, especially needed in WA.	0
• Information is stilted between GP and health services.		0
• In-reach to community resources is needed.	• CL and clinicians attached to particular services.	0

Issue	Proposed solutions	Likes
• Lack of clear pathways for health professionals to enable efficient resolution of issues.		0
• Lack of acceptance of referral from facility based Nurse Practitioner to OAMH.	• Referral criteria needs to be broader.	0
• Lack of authorised beds across the sector and the geographical distribution of them.	• Unnecessary transfer of care to other units.	0
• Lack of coordination for an individualised response.	• Identifying the most appropriate person / role to coordinate the support (e.g. Health Navigator).	0
• Lack of education in the community but also those working in the area. • Staff education about modifying risk factors.		0
• Lack of facilities to meet demand.		0
• Lack of funding across the OAMH arena.	• Need more allied health.	0
• Lack of timely reports after referrals.	• Communication protocols to be developed between referring and receiving services. • Address barriers to communication (may be time poor). • Centralised online communications system may assist.	0
• Location of services and mismatch with location of older populations.	• Mapping of population and services.	0
• Medical notes only accessible to some community services.		0
• No Model of Care that articulates a clear pathway for GP liaison and referral.	• The older adult steering group to develop current models of care to reflect contemporary practices.	0

Issue	Proposed solutions	Likes
• More person centred management is needed and if not, then a lot of dopey, over sedated people will be walking around.		0
• Not enough GPs who are aged care friendly and who will visit RACFs.	• Add to this problem "in a timely manner.	0
• Avoid use of locums that don't understand OAMH.		0
• Promote the use of compassionate person centred advanced care directives.	• Ensure the family GP is involved in care.	0
• Service provision based on relationships rather than sustainable process independent of personalities.	• Service provider managers prioritising needs of residents and families vs needs of staff. Seek a better balance.	0
• Under-utilisation of Transitional Care beds.	• Not under-utilisation, it’s over or wrong utilisation of TCP beds.	0

Appendix C: Inaugural Older Adult Mental Health Sub Network Steering Group

At the conclusion of the Older Adult Mental Health Sub Network Open Meeting, expressions of interest in joining the Steering Group of the Sub Network were called for. The Sub Network Implementation Group selected the following representatives to form the inaugural Older Adult Mental Health Sub Network Steering Group:

- Anna Richards
- Angela McAleer (co-chair)
- Clare Bestow
- Paul Swales
- Carol Douglas
- Shirley Glasgow (co-chair)
- Sarah Sprague
- Carol Bartlett
- Tim Nayton
- Merinda March
- Nick Spendier
- Rob Willday (Permanent Proxy Luke Hayes and Asta Mendis).
- Tim Wallace (Permanent Proxy Katie Howard)
- Caroline Luke
- Terry Preston

Appendix D: Acronyms

Acronym	Definition
AOD	Alcohol and Other Drugs
BPSD	Behavioural and Psychological Symptoms of Dementia
CL	Consultant-Liaison
EAG	Executive Advisory Group
ED	Emergency Department
GP	General Practitioner
HDU	High Dependency Unit
MHC	Mental Health Commission
MHN	Mental Health Network
MOU	Memorandum of Understanding
NGOs	Non-Government Organisations
OAMH	Older Adult Mental Health
RACFs	Residential Aged Care Facilities
RNs	Registered Nurses
TC	Transitional Care
TCP	Transitional Care Packages
WAPHA	WA Primary Health Alliance

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