SANTO + WILLIAMS
MAKING IT WORK AT WORK

Eastern Melbourne Primary Health Network
Rapid Improvement Workshop – Older Persons Mental Health Agenda November 2018
Draft Summary Report

Introduction

Eastern Melbourne PHN held a half-day workshop with stakeholders in the older persons sector on 14th November 2018. The workshop's purpose was to bring relevant stakeholders from Residential Aged Care facilities, community service organisations and hospitals together to explore the mental health, alcohol and other drug issues for older people, and consider how to better respond to this vulnerable and high needs population.

Workshop presentations provided an overview of the policy context, EMPHN catchment data, and the known gaps and challenges for older people with mental health issues receiving support from the primary health sector. Presenters included:

- Anne Lyon, Executive Director, Mental Health and Alcohol and Other Drugs (AOD), EMPHN
- Dr Kelly Shaw, Director KP Health
- Professor Kuruvilla George, Director Medical Services, Peter James Centre and Wantirna Health, Clinical Director of Aged Persons Mental Health and ECT for Eastern Health
- Nina Cook, Carer Consultant Aged Persons Mental Health and Senior Post Discharge Carer Peer Worker, Eastern Health
- Emma Newton, Manager, System Redesign & Service Transition, Mental Health & AOD, EMPHN

Participants provided their insights and mapped what they see as the gaps and issues for older people experiencing mental health and AOD issues at both the service and system levels. Associate Professor Alex Cockram, consultant for the Integrated Regional Mental Health, AOD and Suicide Prevention Plan provided some summary comments based on her observations of the participant discussions.

Opportunities for improvement were identified and will inform both a specific budget release from the Commonwealth and the broader planning agenda for Eastern Melbourne.

This report summarises the workshop findings and identifies a broad range of rich possibilities for strengthening responses.

Identification of the Gaps and Issues at the Service and System Levels

Residential Aged Care Facilities (RACFs), hospitals and community services identified what they perceive to be the gaps and issues for older people experiencing mental health and AOD issues and the priority areas to be addressed. The findings from the perspective of each part of the service system are set out below. Strong and consistent themes were evident across the data. These themes included issues relating to service integration and continuity of care across services and sectors; pathways and system navigation for older persons; funding barriers; and education and capacity building, particularly for GPs and RACFs.

The Residential Aged Care Facility (RACF) Perspective

Service level	System level	Priorities
• Engaging doctors in holistic physical and mental health care and a lack of mental health support from GPs in giving advice, education, how to navigate the system; GPs have gaps in their knowledge and experience in managing challenging behaviours and need support • The best method currently for rapid diagnosis is via Emergency Departments e.g. delirium screening and general admission, which is less than ideal • RACFs staff lack experience and education in recognising and managing severe and enduring illness; RN involvement is usually late and PCAs try to manage but this causes staff stress; lack of or limited inhouse psychologists e.g. when need to access an acute health service • Depression is not recognised or is seen as an "adjustment disorder" or the grief and loss when first moving into aged care. • Residents don't see RACFs as their home and have insufficient opportunities to go out into the community • Families' can be disconnected or have limited ability to manage mental health needs, behaviours and substance abuse • There are younger client cohorts in RACFs with mental health issues • Duplication of services • Privacy issues	• Silos re. delirium, depression, dementia, delusion and boundaries between mental health, acute health and aged care systems; overlaps in needs and presentations; lack of system integration and navigation; unclear referral pathways with limited resources to manage them and no entity is accepting care responsibility • Aged care funding models and appropriate funding for wellbeing and positive lifestyle • Financial barriers with private organisations • Mental health issues are not addressed in TCP and some services are not available in TCP • Northern Region is particularly fragmented	1. Engaging doctors in holistic physical and mental health care 2. Supporting GP'S to be able to give advice, provide education and information on how to navigate the system 3. Addressing gaps in RACFs staff education and experience in recognising and managing severe and enduring mental illness

The Hospital Perspective

Service level	System level	Priorities
• Increasing numbers of older people with mental health issues • Competing demand for GP's • Getting mental health "into the conversation" with GPs when an older person presents for other reasons; a reluctance of older people to talk about mental health issues when they present for other reasons • There is an underlying cohort of patients who do not go to GPs but need help • Accessibility and timeliness of services outside of the primary health setting • Continuity of care from tertiary to primary without confusing people with too many clinicians • Physical frailty of older people, mobility issues and difficulties with transport • Increasing homelessness of elders and services to refer them to • Bereavement support • Gaps in information	• Poor preparedness for people living longer and with increased disabilities • Erosion of social connection and lack of community connectedness • Increased intake numbers from the "middle" band • Poor service integration • Inadequate funding for services addressing psychosocial needs has led to increased Emergency Department presentations • Neuropsychological assessments are not covered by Medicare • Inadequate financial support to address mobility and physical frailty issues • Productivity-based policy has restricted investment as there is no financial gain– more money is going to under 65s as they are seen to have the greater potential to contribute to society • Discharge plans are fragmented due to lack of social workers or case managers	1. Improving service integration and pathways to manage the system. 2. Clinician care planning to ensure continuity of care and clarity as to where responsibility ends when transitioning from hospital to primary care 3. Social workers to assist with discharge plans 4. Embedding mental health in conversations about physical health 5. Increasing service accessibility for older persons to address insufficient psychosocial service funding or community groups for social connectedness 6. Access to transport to and from services 7. Addressing the productivity-based policy barrier

The Community Services Perspective

Service level

- **Diagnosis is difficult, and GPs are busy**
- **Continuity of holistic care, service integration and coordination between GPs, pharmacies, RACFs, early intervention and community service providers**
- **Lack of coordination to support transition from hospitals to community**
- **Inadequate support for housing and mental health**
- **Insufficient evidence base and education for treatments in older people including medications and effectiveness**
- **Barriers to seeking help - mental health is a stigma and older people tend to be stoic; "choice" can overwhelm older people and change is frightening**
- **Older people experience social isolation and need community connection**
- **Impacts on the partners of people experiencing mental health issues - especially difficult when average age of first presentation is 82 years**
- **Transport (especially public) is difficult**
- **Older people do not have a knowledge of the service sector or how to seek help**
- **Care needs to be culturally appropriate: older people are isolated with language barriers, they may be without family or with family who are already 'overstretched'; inability to access to culturally responsive staff**
- **Peer workers need to be properly trained and supported**
- **Service offerings are only weekdays 9am – 5pm and no home visits**

System level

- GPs most likely to undertake mental health assessments but there are no integrated 'GP guidelines'
- Councils' Aged Assessments are based on self-reports, lack depth and do not include mental health and AOD assessments
- Case managers do a service level assessment and may miss mental health assessments
- Lack of a holistic model of care including: GPs, Practice Nurses, Mental Health, generalist staff with knowledge of mental health services, defined pathways and navigation to other parts of the sector, medication oversight, suicide prevention, and post-discharge staff creating informed discharge summaries as people can have multiple care plans
- Lack of mechanisms to support 'Graduates' and manage deinstitutionalisation impacts
- Inability to use MBS teams in residential care
- RACFs need early identification and a mechanism for integrated / team care. The embedded clinical function (MHN / Clinician in Aged Care) can be utilised more effectively, especially as part of a care team
- Private aged care facilities are a particular gap
- Funding e.g. the 65 year- old age limit.
- Need additional mental health funding, especially block funding for community providers
- My Aged Care Reform has created confusion and people do not know what it is; packages are low level and disadvantage people accessing services; people do not understand the limitations of their package
- Assessments for Carers Pension take too long
- Need training for in-home workers and carers
- Carers accessing family members' records raises privacy consent issues e.g. for people with dementia
- Privacy and confidentiality issues
- Community development and connectedness
- Addressing awareness and stigma; Dementia Australia needs to be linked to a "whole of community" awareness

Priorities

1. Reforming services and addressing funding confusion to deliver to 'whole of person': improving responsiveness through service integration, creating linkages and connections to appropriate providers and developing care plans for assessment, coordination and thorough follow-through
2. Increasing health literacy for consumers re. what is available, what they should get and how to navigate the system
3. Developing adequate packaged care with an MBS Claim number and funding quantum to reduce the burden
4. Developing a shared understanding of mental health in the system and increasing identification and diagnosis of older people with mental health issues
5. Upskilling for all aged care workforces, including cultural awareness
6. Addressing social isolation issues and increasing connectedness
7. Strengthening carers' involvement and support

Possible Solutions

Participants brainstormed scores of rich potential solutions to the current challenges. These ideas are summarised below and have been clustered into themes. The possible solutions will be further analysed and prioritised by EMPHN to inform the Commonwealth budget release and broader catchment planning. As a starting point for prioritisation, participants nominated their four 'big ideas' for consideration.

1.Service system reform

1.1 Identification of those at risk and early intervention

- Early intervention / targeted funding
- Adopt the UK 'Take 10' template – takes 10 minutes and provides a natural way to start a conversation and people do not have to be psych trained to deliver it. Five hundred GPs in London participated in a pilot with the tool and thought it was beneficial. It is on paper at present but it could be done online, at home, at GP anywhere and would mean anyone can deliver it
- Consider using the Delirium score tool as a flag for depression that can trigger a referral to a psychologist
- Upskill community allied health to understand and detect mental health to be able to navigate the system and ensure people get access to the system straight away
- Create a checklist e.g. ACAs for clinicians, ward nurses and aged care facility nurses to use
- Strengthen early intervention through a focus on personal wellbeing e.g. social work
- Develop a common language for non-mental health staff and community members and ability to identify mental health issues and refer on
- Create targeted funding support to immediately link early-identified or at-risk people, prior to them entering a RACF, with access to case management and a package to keep the person living at home for longer
- Create a funding incentive to give to all 65+ people, like the baby bonus. It could be a card that they can use to purchase approved mental health services. Or clinicians could send an invitation to 65+ year-olds to come in for an assessment, or a birthday card at 65 years to prompt people
- Revisit the label 'Aged Persons Mental Health' and refer to it as wellbeing or some reference to the whole person

1.2 Service model design and integration

- Create a central contact number for assessment support, psychogeriatric triage, mobile assessment team and help with navigation
- Develop a multi-disciplinary team-based model including counselling, nurses, psychologists, GPs, reminiscence therapy, peers and social relationships, pharmacists and social activities and psychosocial supports. Current Lifestyle Coordinators in RACFs are unfunded roles - should be a social work coordinator; be based at RACFs or be home-based care or community hubs using aged care facilities, RSLs or where aged people congregate; it could be similar to the community visitor scheme and include education and be culturally responsive
- Look at social services and develop clear rules around what makes a good referral, including vulnerability criteria
- Address service gaps for those not accessing services
- Strengthen navigation:
    - Make it easy for people to navigate the system through simplifying the referral system, knowing who is eligible for what programs and services and capacity building through parallel conversations and simple language
    - Design a navigation system led through My Aged Care
    - Create a service directory to improve navigation

    - Create a community directorate
    - PHN to take up the navigation role – put ads on TV, flyers in hospitals
    - Create an online telehealth site or App
- Strengthen the role of GPs:
    - EMPHN and GPs to work collaboratively to improve on a current project to increase capacity and capability of GPs
    - Enable longer GP consultations for Aged Care Mental Health
    - Create secondary consultations for GPs
- Develop other existing roles:
    - Strengthen community supports
    - Strengthen social work / care coordination
    - Increase peer workers
    - Empower CALD communities to respond to their own needs
    - Pay hospitals to provide support
- Create new roles:
    - MHSCM (as EMPHN has) with outreach to homes and residential services
    - Create a mobile psychiatric team for aged care services
    - Create Out of Hours support e.g. Nurse on Call for mental health
- Strengthen funding packages:
    - Develop home packages and tweak the funding (it currently only addresses 'direct service care') and consider logistics for people accessing services
    - Create individualised packages with community-based services
    - Package funding and services for integration purposes
    - Target funding for those with complex and existing mental health diagnosis to enable case management for Home Care, early intervention and to keep those living at home there longer
- Develop hubs / one-stop shops:
    - Increase community support through group programs (one stop shops), meals, social inclusion
    - Create a café run for older people to provide navigation to services, peer support, care collaboration
    - RACFs offer good opportunities for integration and could become hubs for the surrounding community, similar to a day hospital model. It may be a good business opportunity for RACFs
- Address transport as a major issue: people living at home may have a taxi card but cannot go out alone and need to be connected with local government community buses; those in RACFs may need staff to go with them to access the community
- Leverage Royal Commission findings and funding opportunities

2. Further research and consultation

- The Commonwealth should directly involve consumers and carers, GPs, community services providers and frontline stakeholders in solution design before any changes are made
- Examine service types – who will consumers want to talk to, who will listen and have the time, and what is 'culturally appropriate' care
- Analyse the number of HARP referrals that are currently made and consider if there is scope to consider another arm of HARP

3.Workforce development and capacity building

- Targeted online learning sessions rolled out to GP's and nurses would be quick and effective
- Create an online course similar to the dementia online course that is available. For many staff English is not their first language, so it needs to be easy and practical Technology such as an App can be used to create a rapid response and recovery-oriented approach and include scenarios to upskill workers
- Explore technological responses e.g. a recovery-oriented approach. Resources could include a phone app for workforce including multiple choice scenarios and comparison; upskilling for non-mental health professionals; embedding and layering
- Upskill all workforces in hospitals, and community allied health, nursers, general support services
- Make RACF owners accountable for educating their staff; include programs in place and requirement to be accountable and provide evidence
- Use the existing mental health workforce to upskill others
- Provide education and professional connectedness to enhance current support, especially around cultural issues
- Make it everyone's role to be aware of mental health through embedding knowledge into the culture and conversations of everyday and increasing the capacity of aged care staff and other clinicians
- Create cross-sector workforce development and capacity building opportunities
  - Design a collaborative approach to upskilling
  - Cross- sector education with mental health, aged care, community health, GPs
  - More frequent sessions such as this workshop to share learnings, workshop ideas and develop solutions
  - Bring stakeholders together regularly e.g. quarterly on a network basis to get to know each other and other local services, hear research and policy updates, share learnings, to discuss issues, pull together human and financial resources, workshop solutions, have a collective 'call to action' to address the identified issues, and to review progress
- Include mental health in aged care in higher education and PCA education

4. Community capacity building

- Create a community directorate with promotional activities, pamphlets / booklets exploring ideas / considerations to stay at home, how to transition into RACF etc.
- Increase grassroots knowledge and education about Mental Health
- Increase pre-education / community awareness for consumer education prior to mental health issues emerging
- Raise community awareness / promotion via multiple channels including YouTube and marketing to those in the community who are not yet in need of services
- Create a "What can I do to stay home" campaign
- Build communities for better resilience for carers
- Develop pop-up stands in areas where people go and gather e.g. libraries, supermarkets, football grounds, pharmacies
- Create a café run by older people to learn skills and build social connectedness
- Enhance community activities
- Improve people's personal wellbeing and access to regular activity

5. The Initial Four 'Big Ideas'

1. Create a care coordination or 'whole of person' health advocate - a consistent professional who moves with the person, coordinates and navigates for them across all the sectors, fostering whole-of-person clinical, psychosocial and physical care, and engages family members or carers
2. Develop a funding incentive for all 65+ people to have three mental health contacts
3. Partner with or seek sponsorship from supermarket chains for pop-up stands targeting older people and carers with celebrity endorsement, catch phrases such as "R U OK'; introducing the 'Take 10' template and providing clear direction as to where to refer people
4. Create a community awareness campaign with promotion via multiple channels (including YouTube, social media) that is targeted to both providers and consumers and strengthens the PHN role and the role of peer workers