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# **Together for the mental health care of older people (TMOP)**

Improving the network  
planning and management of  
integrated primary mental  
health care for older people  
in rural regions

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# Background

## INTRODUCTION

There is significant unmet need for mental health care for older people (aged 65 and over) in Australia, with those living in rural communities particularly disadvantaged in terms of availability and access to services. Collaboration between health and social services has been advocated in national policies, yet integrated primary mental health care for older people in the Australian context remains problematic. Tested methods for developing and managing more integrated servicing are required.

## OLDER PEOPLE'S MENTAL HEALTH IN RURAL AUSTRALIA

Population ageing is common worldwide. In Australia the population aged 65 years and over is projected to increase rapidly in regards to both total numbers and proportion of the total population.<sup>1</sup> It is reported that mental illness affects up to up to 50% of older people living in residential aged care, up to 48% in hospital settings and 20% in community dwellings.<sup>2</sup> In addition to diagnosable mental illness, social isolation and loneliness are also associated with increased health problems and mortality for older people.<sup>3</sup> Many individuals over 65 years will experience multiple chronic mental and physical health conditions, making health care delivery more complex.<sup>4,5</sup>

In Australia 36% of the population aged 65 and over live outside major cities, with reported poorer health outcomes and unmet needs for mental health care.<sup>2,6</sup> People aged over 65 are less likely to access general practitioner mental health services and mental health professionals,<sup>7,8</sup> and are further disadvantaged by a lack of available local mental health professionals and services.<sup>2,9</sup> Consequences of a lack of adequate primary mental health care for older people include frequent and longer acute hospitalisation, deterioration of physical and mental health, and earlier admission to residential care.<sup>10,11</sup>

## INTEGRATED CARE AS A POLICY SOLUTION

An older person with a mental health problem may require input from a range of services across sectors. In Australia, health, aged care and social services have varied funding (public and private), governing structures (split across Commonwealth and state/territory governments) and service scope and boundaries. These services will also have different institutional and professional cultures<sup>12</sup>. This context can be challenging for both health and social care professionals and consumers to navigate.

Due to the complexity of mental health and general health problems experienced by older people, there is widespread support internationally for the provision of a more integrated approach to care, with a growing evidence base for the effectiveness of this approach.<sup>13-17</sup> Governments and professional groups have prioritised mental health service delivery based in primary care, with the need for integrative approaches that include the provision of the 'right service' at the 'right time' and the transition of care between various service sectors.<sup>7,18-21</sup>

Delivery of integrated care is recognised to be complex, although generally there is consensus that integration needs to occur at different levels,<sup>12,22,23</sup> is organised around the needs of individuals,<sup>12,24</sup> and is focused on being consumer-centred rather than on organisational processes.<sup>25</sup> Integrated care requires the use of specific strategies that are known to help primary mental health care services work together (linkages),<sup>13</sup> as well as the factors that enable the development of these strategies (enablers).<sup>26</sup> Benefits of a more integrated approach to care can include: better outcomes for the consumer and carer; improved access to and experience of services; and better use of existing resources.<sup>12,27</sup>

To achieve better service integration, the Australian Government established 61 regional primary health care organisations between 2012-2013. Called Medicare Locals, one of the objectives was to work with State Local Health Networks and other services to improve the patient journey through developing more integrated services. After a change in the Australian Government in 2013, it was announced in 2014 that a smaller number of Primary Health Networks would replace the Medicare Locals, but with a similar objective to improve the coordination of patient care. Primary Health Networks are due to commence on the 1<sup>st</sup> July 2015 and at the time of writing the Medicare Locals were in “wind down”.

## A NETWORK APPROACH TO PROMOTE MORE INTEGRATED SERVICING

The complexity of mental health care for older people in a rural region requires locally tailored and flexible services in order to respond to health and social care needs. Networks are an optimal service form for this flexibility because they are characterised by the collective use of information (feedback), organisational learning (iterative problem solving) and distributed leadership (maximising stakeholder connection).<sup>28</sup> These benefits mean that inter-organisational networks, as an organisational structure, are able to be more flexible and responsive than individual services.<sup>29</sup> While there are multiple types of networks with different purposes and origins, in this study we are concerned with purposive networks that are goal directed in order to better meet the needs of older people with mental health problems. A goal directed network is defined as follows:

...a joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organizational structures or processes to plan and implement a joint program, as well as sharing relevant information, risks and rewards.<sup>30, p.310</sup>

We draw upon three aspects of network theory to do two things; first to understand the context in which mental health services are provided to older people in a rural region, and second to understand how organisations can work together as a network to problem-solve community mental healthcare for older people. These three aspects are:

1. Network governance and management.
2. Linkage strategies and enablers.
3. Facilitated reflection.

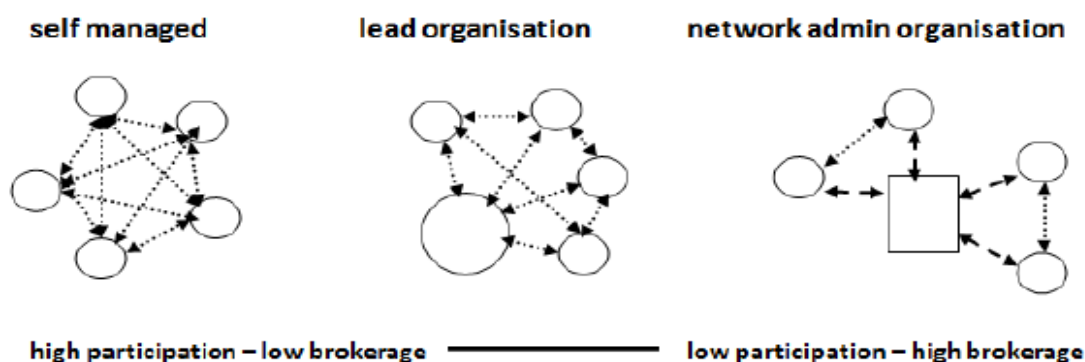
### Network governance and management

Networks pose different governance and management challenges to more traditional forms of service organisation such as bureaucratic hierarchies and markets.<sup>31,32</sup> A key role for network managers and leaders is to “establish a foundation upon which network participants can operate”<sup>29, p.40</sup> Modes of leadership that rely on the role of facilitator/broker are necessary, with the overarching management role being to “increase the stock of trust and reciprocity in the network”.<sup>29, p.46</sup> Milward and Provan<sup>33</sup> have identified five tasks that lead to effective network management, namely the management of accountability, legitimacy, conflict, commitment and design (governance structure).

Exploring the type of network governance operating in a network, and determining which is the ideal structure to meet the changing needs of a network, is an important task for network management.<sup>29</sup> Kenis and Provan<sup>34</sup> have described two dimensions of brokerage and participation against which they place three models of network governance. At one extreme a self-governing network will have all members equally sharing governance tasks. At the other extreme one agent governs the network. In terms of participation, governance may occur through members, either collectively (shared) or through one lead member, or without any member participation, where governance occurs through an outside agent, called a network administrative organisation. Variants between these two extremes of participation

and brokerage would involve the division of governance activities between all or some of the members.

The three models are illustrated in Figure 1 below.



**Figure 1. Typology of network governance**

*Adapted from Kenis & Provan 2009, p 447*

Governance structures often evolve over time, and in practice governance models are frequently a hybrid of one more of these three types<sup>29</sup>. The effectiveness of different governance structures is dependent on the distribution of trust, the number of participants, goal consensus and the need for network level competencies (e.g. quality monitoring, building legitimacy, bridging, negotiation, advocating). Kenis and Provan suggest that brokered forms of governance are more effective where there is a moderate level of trust, higher participant numbers, lower goal consensus and increased need for network level competencies<sup>34,35</sup>.

### Linkage strategies and enablers

A further element of network theory is the linkage strategies and enablers that support network functioning. Linkage strategies and enablers were identified in a previous narrative review by one of the authors. Ten linkage strategies were identified<sup>13</sup> (Appendix 1) as well as the factors that enable the development of these strategies (Appendix 2).<sup>26</sup> An exploration of the extent to which linkage strategies and enablers are present in a network provides a description of network function, capacity and areas for improvement.

### Facilitated Reflection

Networks are built on the collaborative relationships between individuals and organisations, with trust and mutual exchange core to their success.<sup>35</sup> Facilitated reflection, based on inter-organisational relations theory, is proposed as a method that can help participating organisations improve network functioning. Facilitated reflection is the process that Hibbert and colleagues<sup>36</sup> identify as the generalisable feature of network management. Because collaborative relationships are idiosyncratic, Hibbert et al see the generalisable feature of network management as the development of “handles for reflective practice”<sup>36, p.405</sup> in which partners formulate their actions in light of their own circumstances and competencies. Network management therefore involves learning through reflective practice by problem solving in situ.<sup>26,31</sup>

The use of these three aspects of network theory is further described in the methods section below.

## AIMS AND OBJECTIVES

Despite the promotion of integrated servicing in policy, there remains a paucity of real-world testing of practical governance and management models to achieve this.<sup>26</sup> The TMOP (Together for the Mental Health of Older People) project sought to better understand the

processes through which a network of organisations can work together to meet the mental health care needs of older people. A case study of older people's mental health servicing in a rural location was undertaken.

Our specific objectives were to:

1. Explore the extent to which services are operating as a network in the provision of older people's mental health servicing.
2. Describe the barriers and enablers to the provision of more integrated servicing for older people with mental health problems in one rural region.
3. Determine the effectiveness of facilitated reflection in promoting multiple rural services to work together as a network in order to problem-solve community mental healthcare for older people.

Expected outcomes were to:

1. Strengthen partnerships and establish network commitment for older people's mental health care in the region.
2. Develop agreed protocols.
3. Improve service co-ordination.



## Methods

We conducted a case study using mixed methods to determine the effectiveness of a network planning model.

## FRAMEWORK FOR NETWORK PLANNING

The following assumptions underpinned the framework for network planning:

- > The implementation of change in a network would be driven by collective reflection on feedback about the network.
- > The extent to which information feedback was used by the services would be influenced by their level of commitment to working together (conducive context).
- > A conducive context would be created if there were linkage enablers.<sup>37-39</sup>

The research design that was used to promote collective reflection is shown in Figure 2. The figure shows the research project as the first cycle in what would ideally be a continuous cycle of network reflection.

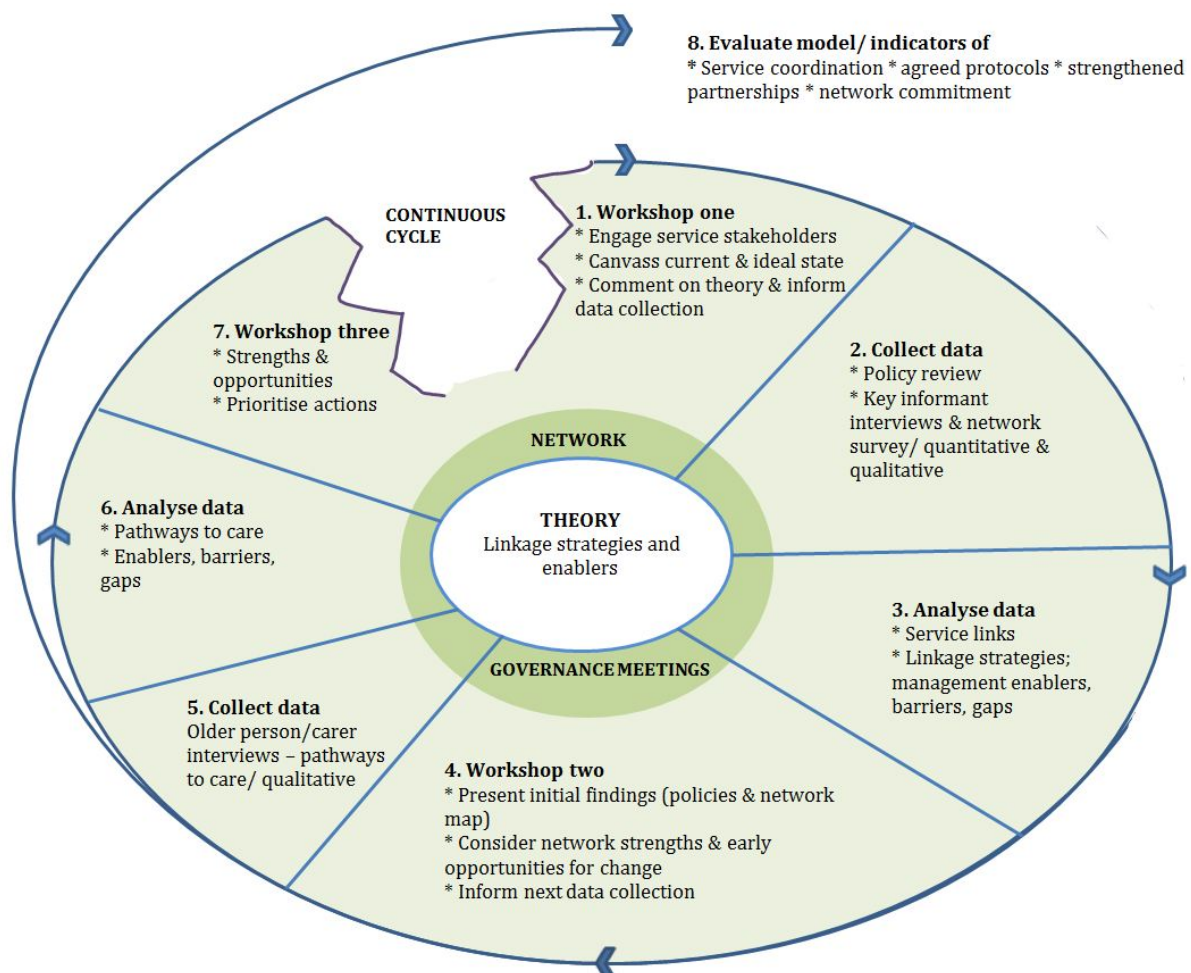


Figure 2. Framework for network planning

The process brought together stakeholders from different organisations in a rural region to start to identify issues in service provision for older people with mental health problems and establish early goals. The facilitated reflection involved the collective use of feedback on data obtained from a network survey, service provider key informant interviews and care

seeking journeys described by consumers or their carer. This reflection was facilitated to enable problem solving in three one-day workshops with service provider key informants, and throughout the project at seven governance meetings with key stakeholder partners.

## SETTING

The setting of the case study was the southern part of the Adelaide Hills, Fleurieu and Kangaroo Island rural region in South Australia. This region has a growing older population with a 52% increase in those aged 65 years and over from 2001 to 2011.<sup>40</sup> The region is typical of many Australian rural locations that are within 100km of metropolitan centres, but which still face difficulties in service access, coordination and follow-up because of differences in funding criteria and boundaries between services.

Specialist mental health services are delivered to older people living in the region by the local community-based mental health team with a consultation liaison service available at the large mental health hospital 80kms away in Adelaide. A range of other mental health related services are provided from public sector psychologists, social workers and nurses. Acute inpatient units providing psychiatric inpatient treatment for people over 65 years are also located in Adelaide, but these are run by metropolitan networks of the South Australian Government health system.

There are some anomalies specific to the region. For instance the region has greater reliance upon private service provision for older people than other rural areas in South Australia. People in the Hills sub-region and Fleurieu South Coast sub-region have access to a wide range of non-government organisations (NGOs), with residential aged care services primarily provided by NGOs, rather than by the state as tends to occur elsewhere in South Australia through aged care beds in local rural hospitals. Kangaroo Island, as a smaller and isolated sub-region, has less NGOs to draw upon, has one general medical practice and a state funded residential aged care facility.

## DATA COLLECTION

In order to explore older people's mental health servicing in the region, and generate data for facilitated reflection, we conducted the following:

1. An organisational network analysis.
2. Interviews with service provider key informants and consumers/carers.
3. Policy document analysis.

The exploration of the effectiveness of facilitated reflection occurred through:

1. Minutes of meetings of the governance group.
2. Participant feedback and observations about the process to arrive at agreed actions from three workshops with service provider key informants.
3. End of project interviews with members of the governance group.

## PARTICIPANTS AND PROCESS

### Governance Group

A governance group was established comprising three key senior staff with management responsibilities in rural mental health, regional primary health care planning and social care related to older people's mental health in the region. This was a small decision-making group that included the project chief investigators and research associate. The group met throughout the project to establish research governance and inform network planning. Meetings occurred before and following each of three workshops, and also at the conclusion of the project in order to review the effectiveness of the framework for network planning for broader application. Seven meetings occurred over the course of the project with minutes taken from these meetings.

## Service provider key informant interviews

Participants for service provider key informant interviews were recruited via purposive snowball sampling starting first from the governance group. Key organisations and staff providing mental health and related services to older people in the region were identified across mental health, primary care, aged care and social care services. We conducted individual and group interviews with 32 key informants from 26 organisations (see Appendix 3 for a Summary of Organisations Interviewed). The interviews were conducted using organisational network analysis<sup>41,42</sup> to explore the regional service network structure and to gain perspectives on the linkage barriers and enablers between services (see Appendix 4 for the Key Informant Survey and Interview Guide). In addition, six leadership interviews were conducted with senior managers (n=12) from major service providers after the second workshop in order to gain a management perspective on the servicing and network issues (see Appendix 3: Summary of Organisations Interviewed, and Appendix 5: Senior Leader Interview Schedule).

## Consumer/carer interviews: care seeking journeys

We conducted ten interviews with consumer/carers (nine were with the carer) aged 65 years and older who had sought mental health care in the region to explore their journeys to care<sup>a</sup>. These participants were purposively recruited with the assistance of the service providers in the key informant interviews and stakeholder workshops. Consumers/carers were interviewed using the Pathways Interview Schedule,<sup>43</sup> a semi-structured instrument designed for the systematic gathering of information on routes to and sources of care (see Appendix 7 for the Survey and Interview Guide). Two participant types were purposively selected with the assistance of the service provider key informants: those who had successfully negotiated a care journey and those who had not. Although we sought to interview both consumers and carers, fewer consumers were suggested by service key informants. Limited consumer participants may have been in part a result of service 'gatekeeping' as well as due to the nature of this client group; for example, two consumer interviews were not used due to the consumers' limited understanding of the project and interview process.

## Policy review

Policy documents at the Commonwealth, South Australian and the local operational levels were examined for their relevance to the development of integrated mental health care for older people in the region. The Commonwealth (n = 15) and state (n = 7) level policies were identified through online searches and advice from the governance group (see Appendix 8 for the list of policy documents). Operational policies (e.g. service plans, local guidelines and protocols etc.; n = 24) were identified through the service provider key informant interviews (see Appendix 9 for the list of operational policy documents).

## Workshops

Participants for three workshops were recruited initially from the governance group and then from participants in the service provider key informant interviews. Participants included workers and senior leaders from mental health, primary care, aged care, social care and consumer organisations across the region (see Appendix 10 for the Summary of Organisations represented at each workshop). Findings from the project were presented to the participants progressively at each workshop, where facilitated group reflection was used to identify issues regarding older people's mental health servicing and potential solutions (see Appendix 11 for a detailed description of the workshops). In Workshop 1 participants (n = 12) were asked to reflect on three case scenarios (see Appendix 11a) and consider the scenarios in relation to; a) the linkages strategies already in place in their region, and b)

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<sup>a</sup> See Appendix 6 for a Summary of Participants; note: we use the term 'consumer/carer' throughout, except when referencing direct quotations from participants.

ideal linkage strategies to address the problems presented in the scenarios. Workshop 2 (n = 18) involved reflecting on the findings from the service provider key informant interviews, focusing on current service links, enablers and barriers to effective linkages, and early opportunities for change. In the final workshop, findings from the consumer/carer interviews were presented, and participants (n = 17) were asked to identify opportunities for change, assign a value analysis to the opportunities and develop a plan of action for high-value opportunities (see Appendix 12 for Workshop 3 Tools).

### Knowledge exchange

A range of knowledge exchange activities were undertaken to facilitate ongoing engagement and ownership (see Appendix 11). These included engaging the research users in the planning and ongoing implementation of the research project through the governance group, distributing summary reports to project participants, presentation of the mid-project report at various forums and meetings in the region and maintaining a project blog on the Flinders University website.

### End of project Interviews

Further interviews were conducted with five senior leaders and members of the governance group at the end of the project to explicitly explore whether they had found the network planning framework useful or not (see Appendix 13 for the Interview Guide).

## DATA ANALYSIS

Measures of organisational network analysis were used to provide information about which organisations were linked, the number of links in the network, and the types of interactions between organisations (e.g. exchanging information, referrals and planning).<sup>41,42</sup> Maps displaying the patterns of connections between organisations were generated using the UCINET software.<sup>44</sup>

Interviews with service provider key informants and consumers/carers were analysed using framework analysis<sup>45</sup> to explore the present linkage strategies and management barriers and enablers between mental health, primary care, aged care and social care services, and how these affected people's help seeking experience and journey. Our coding framework was informed by the research questions. In addition, the interviews with consumers/carers were presented as care seeking journeys depicting the participants' journeys to care, including the people involved, key actions, consumers' experience/critical issues and suggested improvements (see Appendix 14: Care Seeking Journey Examples; Carer Journey 8 is an example of an unsuccessful care journey, Carer Journey 1 a successful journey). Quotations from participants relating to barriers and enablers are presented in Appendix 15, with only a limited number of quotations presented in the text.

National and state level policy documents were examined to explore how the issue of mental health and older people is discussed and addressed, and the implications of this for the development of linked care for older people in a rural region. The local operational policies were examined for congruence, direction and resource opportunities.

To evaluate the utility of the "framework for network planning" for an informal network to develop a more integrated approach to mental health care for older people, we analysed the minutes of the governance group, the record on the service provider stakeholder workshops and the end of project interviews.

## ETHICS

The Human Research Ethics Committees of the South Australian Health Department (HREC/13/SAH/126) and Flinders University (notification10/2014) granted ethics approval.

## Results

The case study results are presented in two sections. The first describes the case study of the network of older people's mental health servicing in the region. The second describes the effectiveness of facilitated reflection in promoting multiple rural services to work together as a network to problem-solve community mental healthcare for older people.

### THE NETWORK OF OLDER PEOPLE'S MENTAL HEALTH SERVICING IN A RURAL LOCATION

#### The network of older people's mental health servicing

Services were identified in the workshop discussions to be operating in separately clustered self-managed networks within health, aged and social care. There was no single formal purposive network that covered older people's mental health servicing. Instead there were various groupings of services that linked for different purposes and functions that could be viewed as separate networks with their own leadership:

*I think there's a severe lack of coordination and communication at all levels. We've got too many organisations trying to provide the same services ...there's nobody coordinating or getting all these groups together to see if we can coordinate things ... We're all working individually and we're not talking to each other and there's duplication of service and it's just so frustrating. (GP)*

To explore the extent that services were operating as a network we conducted an organisational network analysis of data collected from service provider key informant interviews. Across the region the 24 surveyed organisations nominated 117 agencies with whom they link to either exchange information about client care, make or receive referrals, or communicate about the management, planning and operation of services. As Table 1 shows, there were fewer links on the management, planning and operation of services than for information exchange about client care and referrals. This communication pattern would be expected because the linking of management activities across organisations tends to involve more complex relationships than simply information exchange and referrals.<sup>32</sup>

**Table 1. Link types**

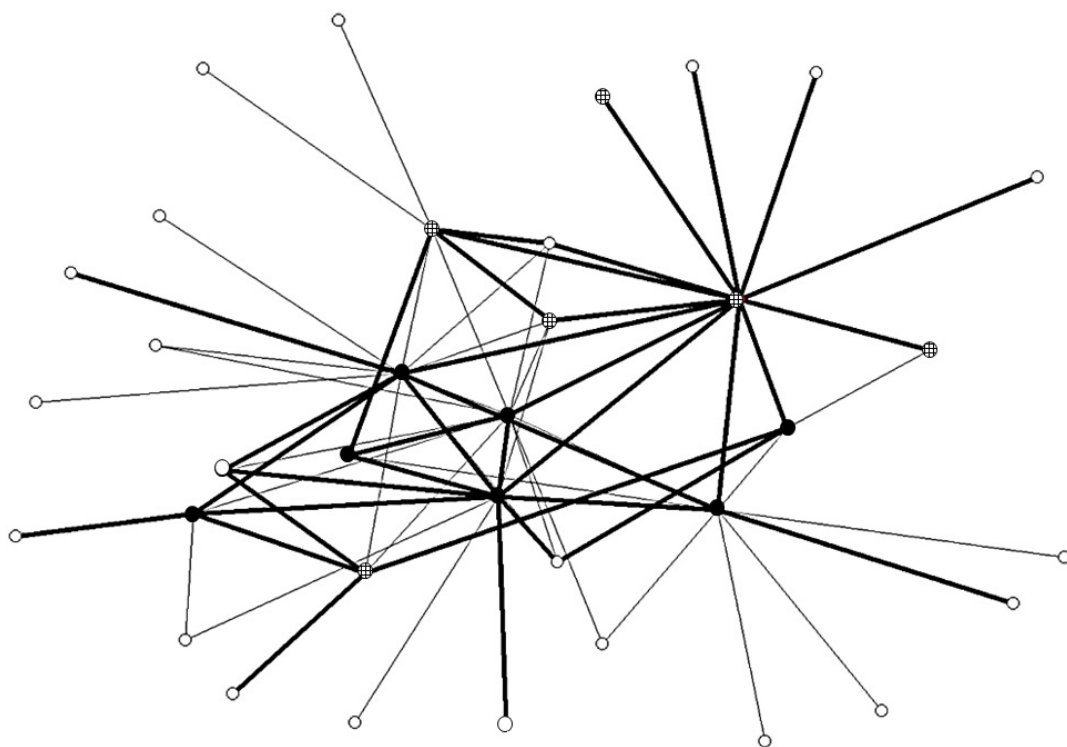
	Number of Links (Mean)	Centralisation*
Information exchange	502 (4.42)	25.05%
Referrals	506 (4.48)	25.02%
Management, planning & operations of health services	304 (2.69)	14.82%

\*The extent to which the links are directed to one/more members in a network.

These links were represented as maps displaying the patterns of connections between organisations, which were fed back to participants at the workshops. The maps indicated that health services were more linked to other health services, with less cross-sector linking between health services and aged and social care services. The pattern of links did not identify a clear organisation with a mandate to take on overall governance and management functions for a network of older people's mental health servicing, nor one that covered the broader range of health and social care.

Figure 3 is a network map demonstrating how organisations link more frequently with other organisations within their sector than they do between sectors. Black nodes represent health care organisations, hashed nodes are aged and social care organisations and white nodes are other nominated linked organisations. Note: nodes with similar patterns of links are placed in closer proximity (clustered); thicker lines indicate more frequent linking.





**Figure 3. Network services reporting links to do with service management, planning & operations of service (main sub-regional location)**

The data in Tables 2-4 show a finer analysis at the main sub-regional location. The majority of the links were to a health service (61%), suggesting a more clinical focus to the network. The tendency of links to be clustered by sector is evident in health sector to health sector links across communication about client care (71%), referrals (64%) and management, planning and operation of services (73%). There was some clustering of aged and social care services together, but this was not as strong as for health service clustering and was not so for referrals.

**Table 2. Links for communication about client care (main sub-regional location)**

	Services reporting links	To Health Service Links	To Aged & Social Care Links	Total (%)
From Health Service	10	91 (71%)	38 (29%)	129 (67%)
From Aged & Social Care	6	26 (41%)	37 (59%)	63 (33%)
Total	16	117 (61%)	75 (39%)	192 (100%)

**Table 3. Links for referrals (main sub-regional location)**

	Services reporting links	To Health Service Links	To Aged & Social Care Links	Total (%)
From Health Service	10	94 (64%)	53 (36%)	147 (73%)
From Aged & Social Care	6	29 (54%)	25 (46%)	54 (27%)
Total	16	123 (61%)	78 (39%)	201 (100%)

**Table 4. Links for management, planning & operation of services (main sub-regional location)**

	Services reporting links	To Health Service Links	To Aged & Social Care Links	Total (%)
From Health Service	7	45 (73%)	17 (27%)	62 (54%)
From Aged & Social Care	7	25 (48%)	27 (52%)	52 (46%)
Total	14	70 (61%)	44 (39%)	114 (100%)

For referrals, health services were disproportionately more linked in the network, comprising 63% of the services reporting links yet making 73% of these links. For communication about client care and the management, planning and operation of services the link activity tended to be more even, with the health services comprising 63% and 50% of the services reporting links and making 67% and 54% of these links respectively.

Table 5 shows the main services to which other services link regarding the management, planning and operation of services, which again highlights the focus on health issues, with no highly linked social care agencies evident. The regional community-based structure in the Positive Ageing Task Force (PATF)<sup>b</sup>, which was established to facilitate service development, planning and collaboration between services, was not as highly linked into by health agencies to deal with older people's mental health. This was highlighted in the network reflections, which led to discussion about ways to change this.

**Table 5. Main organisations to which others report linkages**

Service	# organisations that report links to this service
Medicare Local	8
Mental Health Service (sub region 1)	8
Aged Care Assessment Team	7
Dementia Care Service	5
Mental Health Service (sub region 2)	5
Medical Practice (town 1)	5
Medical Practice (town 2)	5
District Hospital (sub region 1)	5

We drew on the service provider key informant interviews, leader interviews and workshop data to describe the linkage strategies that were present in the region against the list of effective linkage strategies reported in the literature (see Appendix 1) and assessed using three criteria (see Table 6). We identified that services were connected through a range of meetings, as follows:

- > Clinical: There were several meetings in the region bringing different services together with a clinical focus, such as the weekly Multi-Disciplinary team meeting held at the Multi-Purpose Health Service on Kangaroo Island, and the Multi-Disciplinary team meeting held at the Community Health Services in the regional city facilitated by the Aged Care Assessment Team (ACAT).
- > Information sharing and planning: Several meetings had this function including the Medication Advisory Committee (MAC) facilitated by Southern Adelaide Fleurieu Kangaroo Island (SAFKI) Medicare Local; the Southern Fleurieu and Kangaroo Island Positive Ageing Taskforce (PATF) facilitated by the regional city Council.
- > Educational: The Mental Health Professionals Network and the Southern Fleurieu Provider network were both facilitated by SAFKI Medicare Local.

All of these meetings were informal with variable service commitment; for instance, the Multi-Disciplinary team meeting in the regional city was discontinued during the project timeframe. The various smaller networks were typically clustered by same service type; for instance the PATF was predominantly attended by aged care, social care and generalist community health services but not specialist health care services. There were no active cross sector meetings specific to older people's mental health servicing.

While many linkage strategies were present these seemed to be localised to particular service groupings rather than across the health and social care sectors as a whole.

<sup>b</sup> The Positive Ageing Taskforce is a Home and Community Care (HACC) funded regional structure that aims to support and develop capacity in the aged & community care sectors in order to improve the wellbeing of older people.

Strategies appeared more to do with direct collaborative activities, the various use of guidelines and some communication systems rather than formal agreements (see Table 6)

**Table 6: Linkage Strategies**

Category	Strategy	Present	Comments
Direct collaborative activities	Link working	✓✓	Predominantly informal links and localised, some OPMH specific
	Co-location	✓✓	Various services collocated across the region mainly health and some aged care services
	Consultation liaison	✓✓	OPMHS role (local) and psychiatric & geriatrician review (visiting) but GPs & social care services looking for support
	Care management	✓✓	Good within and across services, some gaps when the consumer has needs that cross health & social care – no overarching cross sector coordination
Agreed guidelines	Protocols	✓	Protocols for general mental health – none OPMH specific that cross health & social care
	Stepped care	✓✓	Predominantly between health and aged care
Communication systems	Enhanced communication	✓✓	Various meetings in the region but no overarching formal mechanism with commitment from health & social care. Informal mechanism working well in small sub region (see below)
	Enhanced referral	✓✓	Range of formal and informal process in place but some lack of knowledge about these across services in the region
	Electronic communication system	✓	Limited to health services
Service agreement	Service agreement	✓	No specific agreements for OPMH other than more general MOU between police, SAAS and mental health.

**Criteria:** Older people's mental health (OPMH) specific; regional as compared to localised; and formal and regular compared to ad hoc. No criteria evident (X) through to all three criteria evident (✓✓✓)

## Enablers & barriers to networked servicing and to mental health services for older people

The enablers and barriers were identified in relation to; (1) services operating as a network and (2) the provision of mental health services for older people in the region.

### *Enablers supporting service working as a network*

As with the linkage strategies, we drew on service provider key informant interviews, leader interviews, consumer/carer interviews and workshop data to describe the enablers to organisations linking in the region against the list of effective linkage enablers reported in the literature (see Appendix 2), and assessed this using three criteria (see Table 7). The enablers appeared to be more related to partnership formation activities undertaken by workers engaged in service delivery by workers who were committed to doing this. There did not appear to be higher level government policy or program support related to older people's mental health, or cross sector authorisation or resources for networking (see Table 7).



**Table 7: Linkage Enablers**

Category	Enabler	Present	Comments
Government Policy & Program Support		x	Integration advocated but lack of implementation strategy. No detail regarding older people's mental health.
Organisational Level: Leadership	Authorise / Encourage Team Work	✓	Authorisation around specific issues but limited meetings to enable teamwork
	Resources & Strategies	✓	Limited resources and formal strategy. Dedicated staff in OPMHS clinician, PATF project officer, SAFKI rural coordinator
	Recruitment & Staff Development	✓✓	As above recruitment into staff positions - MHFA training
Worker Level Partnership Formation Activities	Joint development through active communication; Share information, plan & problem-solve	✓✓	As above (table 6) various meetings – works well informally in small sub region with long term workers embedded in the community. Larger subregion needing more formalised processes.
Worker Attribute Enabler	Commitment to collaboration; Skills in primary care & mental health; Primary care focused & flexible work style; Ability to fit into teams	✓✓	As above – committed workers discussed in service provider and consumer/carer interviews – expressed limits on participation in meetings.
Evaluation & Feedback		✓	Limited but with some via the PATF communicating out to members
Proximate location	Interaction capacity	✓✓	Evidence of this working well in the small subregion and in some centres

**Criteria:** Older people's mental health (OPMH) specific; regional as compared to localised; and formal and regular compared to ad hoc. No criteria evident (X) through to all three criteria evident (✓✓✓)

The following enablers were described as supporting networked servicing: collaboration between services and with consumers; worker approach and attributes; small and proximate location.

### 1. Collaboration between services and with consumers

Service provider key informant and consumer/carer interviews highlighted the importance of direct collaborative strategies between services in enhancing links. Specific enablers included:

- > Referrals, case conferences and multidisciplinary meetings.
  - o Service provider key informants used both formal and informal processes when making referrals.
  - o Various multidisciplinary meetings in the region facilitated links.
  - o For consumers/carers, being included in case conferences and receiving regular information and feedback helped them to know what was going on.
  - o Service provider key informants described the benefits of feedback from the other service providers they were linking with.

*...we have a good relationship with lots of the GPs in that they refer and we can feed back. When it feels good is when you see a problem or an issue and you have access to the people ...you've got a direct contact and you know that they will then feed back to you what's happened. (NGO)*

- > The importance of a named care coordinator – consumers/carers stated they were often dependent on a care coordinator for identifying the best support options and referral to other services, which requires a worker (as a coordinator) to have a good knowledge of service options.
- > Trust and belief in services – service provider key informants identified that positive experiences with other services led them to link more frequently with these services, with quick responses, positive professional relationships and feedback promoting trust. Longevity of services also promoted linkages, with stakeholders reluctant to refer to 'untested' services or services with tenuous funding.

*...we build relationships over time ... if I have a positive experience ...in terms of the person is well looked after and there's communication ...you tend to keep using that referral pathway. (GP)*

## 2. Worker approach and attributes

The following aspects of worker approach and attributes were identified as enablers:

- > Personalised approach to care delivery.
  - o For consumers/carers, approaches that demonstrated a flexible and consumer-centred focus were appreciated, with contacts that had a social focus highly valued.
  - o For service provider key informants, positive approaches included being flexible, creative and pro-active.
- > Workers' personal attributes (such as being passionate, a 'people person', and easy to talk to) were described across different interviews as facilitating links by helping to establish relationships at both the service level and with consumers/carers.

## 3. Small and proximate location

Service provider key informants considered informal links to be useful in a rural setting, particularly in small and contained regions where people are known. The following aspects of location were identified as enablers:

- > Relationships - Informal networking facilitated information sharing and referral between agencies. Knowing the person and being connected and part of the community was viewed as beneficial for both service providers and consumers/carers.
- > Community - Informal networking facilitated awareness of what other services provided, allowing service providers to plug any gaps in service provision. This was particularly evident in smaller communities that had fewer service options:
 

*...a lot of informal networking, [in the] local community you tend to know everybody and you often ring up for advice or a chat or whatever ...so there's a fair bit of that. (Aged Care Service)*
- > Service location, type and philosophy:
  - o Co-location of services facilitated linking, with business being done in corridor conversations.
  - o Stakeholders also identified service models (e.g. a community development approach) as impacting positively upon linkages.

### *Barriers to services operating as a network*

The barriers to services operating as a network were identified as the following: the lack of a network administration organisation; service fragmentation; and funding.

#### 1. Lack of a network administration organisation

The enablers described above indicate the need for local level linkages in supporting organisations to operate as a network. However, the analysis of the network maps and interview data during Workshop 2 identified there were fewer connections at the level of management and planning and there was not clear and strong support for workers to allocate the time to maintain such linkages. The workshop discussion revealed that the region lacked a clear organisation with the mandate or resources to take on network management functions across health and social care. A network administration organisation would function to monitor the network and foster network commitment amongst services. At the outset of the project the Medicare Local was the body auspiced by the Australian Government to manage regional community health planning; however at the time of the project Medicare Locals were being closed, with uncertainty regarding the role of the yet to commence Primary Health Networks that will have some of these functions but were yet to be initiated:

*... there needs to be a lead organisation for coordination of care and maybe down the track the Primary Health Network would be that. At the moment I suspect [the network is] self-managed because everybody's trying to look after their client the best way they can... [B]ecause of the uncertainties around Medicare Locals, ...the funding withdrawn for the over 65 mental health service with Country Health and also with the Positive Ageing Taskforce ...the three main organisational partners in this research [have only got funding till the end of June] ...the ideal, looking forward would be to have a lead organisation. (Primary Care)*

#### 2. Service fragmentation

Rather than operating as a single network that covered older people's mental health with a clear network administration organisation and with formally engaged members, the services in the region were identified as operating as various smaller self-managed networks within health, aged and social care. Different service types did not appear to have shared goals, with different client profiles and service priorities. Service providers and consumers/carers identified the fragmentation between service sectors, with consumers/carers often required to engage with multiple workers, within the same organisation or across organisations (see Appendix 14, Care Journey 1). When care needed to cross the mental health and social care sectors, managing the person's care became more complicated because there was no organisation with an over-arching coordinating role that bridged the two sectors.

Interviews with some consumers/carers indicated that they were the main navigators in seeking help. The fragmentation between service sectors meant it was they who had to find appropriate services, which was often dependent on their knowledge and ability to navigate the system. Service providers were aware of the challenges consumers/carers faced in identifying which service to approach, but aside from providing them with information about other service options (e.g. aged care providers), there were limited processes to facilitate this process for consumers/carers.

*I think working together with the clinical side and the social side has proved to be really good but I wouldn't say there was a lot of connection... I don't know when ... she [last] saw a psycho-geriatrician or mental health team. (Aged Care Service)*

*You need to have a coordinator who will say I've got this person who's been recommended from the doctor or ...wherever it might be, who needs somebody to stand by them to fuddle all these points through. (Carer)*

### 3. Funding

Two aspects of funding were described, namely 'funding direct care only' and 'funding uncertainty'.

#### > Funding direct care.

Some service provider informants indicated that tight budgets and performance indicators, in which funding was tied to direct care tasks, led organisations to retract to direct care as core business, and some workers stated being told that networking meetings were not "core business". Hence there did not appear to be the funding environment to support networking:

*...activity based funding measures disability; it measures services provided ...it doesn't recognise the relationships between services as being valuable. (Health Service)*

#### > Funding uncertainty.

Funding uncertainty from the Commonwealth and State governments for regional community health planning, older people's mental health services and contracts with non-government social care providers had an impact upon staff recruitment and referral, as the following service stakeholder described:

*Recruiting into positions if there's a vacancy, that's a huge problem. People are insecure in their positions because they don't know whether the funding is going to go on after certain dates. (Health Service)*

A consequence of funding insecurity was described by one informant who stated that GPs would not refer to local services that only "*get funded from year to year, they might be there one time and don't exist the next so they'd rather deal with Government services that they know or big services that they know are going to be there*" (NGO).

Particularly relevant to the regional network was the cessation of funding of both the PATF and Medicare Local, which were best placed for network management. As one participant stated:

*At the beginning of the study there were a number of organisations that were keen, willing and cooperative and in good faith wanted to be involved. Many of those already have, or will disappear by the 31st of December [2014] and more again by the 30th of June [2015]. (Health Service)*

### *Barriers to the provision of mental health services for older people*

In addition to identifying barriers to networked servicing in the region, we also explored the barriers to the provision of mental health services for older people. These were identified through analysis of the consumer/carers and service provider key informant interviews and the policy analysis. The barriers identified fall under three categories: lack of policy support; service accessibility; service feedback.

#### 1. Lack of policy support

The policy analysis identified a number of barriers to the provision of mental health services for older people. These included:

#### > Lack of Commonwealth policy support for mental health care for older people.

The analysis revealed that older people with mental health problems are generally excluded from Commonwealth policy, with the focus being on early intervention

strategies for younger people. Older people are absent from policy solutions and priority actions. There are no preliminary performance indicators related to older people's mental health, with people aged 65 or older explicitly excluded from measurements of success in The Roadmap for National Mental Health Reform 2012-2022.<sup>6,46,47</sup>

*Reform and funding of mental health services for older people continues to be neglected, with older people at significant risk of ongoing decline in mental health care.*<sup>47, p. 4</sup>

- > Disconnect between aged care and mental health policy.

There is a disconnect between mental health and aged care policies (e.g. the portfolio of Ageing was excluded from the Expert Reference Group of the Working Group on Mental Health Reform).<sup>46,48</sup>

- > Lack of policy emphasis on mental health promotion and prevention.

There is a greater focus on older people's mental health in South Australian policy (e.g. the Older Persons Mental Health Future Service Model 2009-2016), possibly reflecting the division of health care policy and service provision between Commonwealth and State governments. However, the policy emphasis is on structural factors (e.g. beds and service location) and the provision of acute and continuing psychiatric care, with little attention to the need for mental health promotion and prevention.

- > Lack of policy strategies, actions or funding to support integrated care.

The concept of integration is frequently referenced in Commonwealth and South Australian mental health and aged care policy (see Appendix 8). However, there is a lack of specific strategies, actions or funding to support organisations from health, aged and social care to work together.

## 2. Service accessibility

The case study identified that there was a range of service options in the region for older people's mental health, although there were some difficulties accessing specific services. GPs reported delays in accessing tele-psychiatry for assessment and advice, and there were reported delays for consumers to access geriatrician assessment. Gaps in service access were identified for several 'client groups': people living in residential facilities had limited or no access to counselling services; and it was reported that people with a severe mental illness were not linked into social care or community services during periods of stability where they may benefit from increased participation in social activities.

Barriers with accessing available services related to:

- > Mental health literacy and competency:

Mental health literacy (including recognition of a mental health problem, its causes and treatment options) operated as both a barrier and enabler to service access. Where service providers and/or consumers/carers had low mental health literacy, access was impeded. By contrast, good mental health literacy acted as an enabler to service access.

Delayed help seeking occurred when consumers/carers misinterpreted symptoms of decline in function as normal ageing. As one carer stated:

*It was hard for us to know what was wrong with her because as I said she'd fluctuate ...she'd come good and then she'd go back again ...but there were just a few odd things that she'd say, the people next door were spying on her, it was really quite bizarre. (Carer)*

During this time consumers/carers stated they sought advice from GPs, who themselves had varying levels of mental health literacy and competency. Mental health problems cover the spectrum, from those with a diagnosable mental illness to those experiencing psychological distress. It was identified that some of the social care and aged care

services had limited knowledge about mental illness. Lack of mental health literacy and competency meant that workers were not always sure which service was the most appropriate to address consumers' needs:

*I think workforce competency around understanding and working with clients with both mental health issues and with dementias and other issues, where there just isn't that really competent, high levels of competency for the workforce... (Health Service)*

> Service knowledge:

Lack of knowledge about what services are available, the client groups they serve and how to access services was a barrier to service access. For consumers/carers who were lacking this knowledge, there was no clear starting point for service access, leaving them reliant on service providers to give information and refer them to additional services, if appropriate. The care seeking journeys revealed that this led to multiple missed opportunities and subsequent delays in service access (see Appendix 14). In addition to knowing what services exist and what they can provide, prior experience helped mitigate frustration, such as when dealing with waiting times for services. Knowledge of services also assisted people to act as an advocate for the person they were caring for, because they knew how the system worked. For those without this knowledge it took a crisis to facilitate referral from emergency services or primary care, and hence access to other clinical services.

Service providers also had difficulty in identifying service options. Reliance upon informal networks in particular created difficulties for service providers who were new to the region in terms of knowing what service options were available:

*I think sometimes, because I've been doing this job for two and a half years, it takes a long time to understand the informal processes because a lot of people just know how it happens. So when you're new [to the area] there's a lot of unwritten rules, so I think my role at the moment is mentoring C in a new role. I find some of it is so much in your head and what you do every day and not documented, that I think if someone new came into the area they would have a lot of problems trying to work out what was going on. (Primary Care)*

> Service location:

Service provider key informants reported that if a clinical service was not locally based (e.g. an Adelaide-based service providing outreach), then another local service might receive the referral in order to provide quicker assessment. It was viewed that local clinical services were thereby "plugging the gap" for required services (e.g. geriatrician assessment and review) which impacted upon already stretched local mental health services.

### 3. Service feedback

Consumers/carers described experiencing confusion and a lack of clarity regarding care provision after accessing services, if health professionals did not keep them informed on a regular basis. They described being left feeling "quite bewildered" when they were not given details of decisions made about care. Service provider key informants also highlighted lack of feedback as an issue, when the priority was to maintain client confidentiality, but that resulted in delays in referrals and a reluctance to discuss issues with the consumer's family.

*...there's confidentiality issues where people can't talk to each other and that creates a barrier, so that ...can be from a range of things where the organisation says you can't liaise with someone, or ...the client has said you can't... (Health Service)*

# EFFECTIVENESS OF FACILITATED NETWORK REFLECTION

Promoting change within inter-organisational relations requires substantial time.<sup>49-51</sup> TMOP involved one major cycle of facilitated inter-organisational network reflection over ten-months. Two reflective processes were occurring. The first was at the larger level, which was to consider the need for a network, and the second at a smaller more immediate level to work on specific tasks.

The larger reflective process was to bring organisations together and consider the need for a network, and then consider what was required to develop this network that covered older people's mental health servicing. This process occurred in a context where there was no existing overall network that dealt with this, but rather groupings of services and without a clear organisation to take on the network governance and management role. Hence the reflective process needed to establish what service links already existed (organisational network analysis), what was the potential for networking (stakeholder interviews), what were the needs (consumer/carer interviews) and to galvanise commitment (workshops and knowledge exchange). Such a process in the first cycle would be expected to take considerable time.

At the second level, facilitated reflective activities occurred in the workshops (three to four months apart) and at governance group meetings (before and after each workshop) to consider what and how to collect data about existing service linkages and care seeking journeys, what service issues needed addressing and how to act on these issues. Changes were made during the ten months at the smaller level, which would be expected to have an impact upon the larger level development of the network over time.<sup>52</sup>

*I think the workshops have actually brought social linkages in absolutely, but it's the mechanism, it's still not concrete in communication with that, despite some of the outcomes of the research. I think we still need to make that link stronger. (Primary Care)*

The TMOP project brought together a broad range of services from those involved in older people's mental health servicing in the region, including mental health, primary health, aged and social care. When bringing together a range of services, sensitivities and conflicts are likely to become evident.<sup>31</sup> Governance meetings were therefore scheduled prior to and following each of the stakeholder workshops to manage issues that arose during the course of the project. Two such sensitivities did arise about whether older people's mental health service signposting was occurring and the management connectivity of one organisation; both issues were successfully resolved through the governance group process.

The purpose of TMOP was to ascertain if a network planning model (using facilitated reflection) could engage a range of services to plan and manage the development of integrated primary mental health care for older people. Expected outcomes were: to strengthen partnerships and establish network commitment for older people's mental health care, develop agreed protocols and improve service co-ordination.

## Strengthening of partnerships and establish network commitment

The processes used to strengthen partnership included workshops and knowledge exchange. The partner stakeholders all highlighted, in the end of project interviews, the value of the three workshops in strengthening partnerships and establishing network commitment. In particular:

- > Commitment to the network was demonstrated by the ongoing participation and engagement of service stakeholders throughout the project. Eleven of the twelve participants attending the first workshop remained engaged throughout the duration of the project, participating in all workshops, service stakeholder interviews and

recruitment of consumers/carers for the care seeking journey interviews. Additional participants at the second workshop, recruited via snowball sampling for the interviews, also remained engaged for the remaining project duration.

- > The three workshops helped local services to identify as a network and begin problem-solving interagency communication and referral links:

*I think that it's been really useful getting everyone together ...that's increased the understanding of everyone that was there of all ...services that are available and so obviously better communication, and the feedback plus the opportunities and learning about referrals and things. And I think just the excitement that things can be improved and what possibilities there were.*  
(Health Service)

Face to face contact at the workshops gave participants from different services the opportunity to gain a broader understanding of older people's mental health servicing in the region and to clarify issues that were important across services. At the third workshop participants established priority actions about care pathways, cross sector training and referral, the need for a service agreement and inclusion of older people's mental health in local public health plans (see Appendix 16).

- > Commitment to the network from management was demonstrated by an agreement at the conclusion of the final workshop for the three partner stakeholder organisations to meet and more formally work together on the plan of network actions. This was despite the funding that was to cease for the Medicare Local and the PATF during 2015.

### Development of agreed protocols

- > The reflective process led to some direct actions being taken within the network to solve identified problems. In Workshop 2, the analysis of service linkages identified gaps in communication between GPs and aged and social care providers, which resulted in the development of a referral template. The worker who facilitated this presented the template to participants at Workshop 3 (see Appendix 17).
- > Lack of knowledge of service options (highlighted in service provider key informant interviews) led to plans to develop a directory of social care services to be 'housed' on the local council website. Each of the actions involved workers from different services collaborating, thereby further developing links within the network.

### Improved service coordination

Despite the achievements discussed above, improved service coordination was not realised within the ten months between workshop one and three. This was due to the length of time required for inter-organisational change that was compounded by the current funding uncertainty for services in older people's mental health, the uncertainty in service contracts to non-government organisations and also in the transition from Medicare Locals to Primary Health Networks. Service providers noted that the unstable and changing service landscape impacted upon linking in the region. Furthermore, this uncertainty created a leadership hiatus when it was evident that a network administration organisation was required to facilitate and maintain the process of network reflection.



## Discussion

In order to best meet the complex care needs of older people with mental health problems, there needs to be coordination at both the level of client care and service planning. To achieve these levels of coordination, mental health workers and services would benefit from considering themselves as part of a network. Benefits of inter-organisational networks include better use of resources, more coordinated care and capacity building in the workforce and in the broader community.<sup>29</sup> The aim of this study was to better understand the processes through which a range of organisations can work together as a network to meet the mental health care needs of older people. To explore this we conducted a case study of older people's mental health servicing in a rural location, and used a "model for network integration" drawing on aspects of network theory.

The case study provided valuable information about the effectiveness of a network approach in the context of rural mental health care for older people. The findings from this study are applicable to other contexts where inter-organisational networks are established to address complex care needs. The case study identified that for a network planning approach to be effective the following points need to be considered:

- > The need for a network administration organisation;
- > The need to have linkage strategies and enablers at micro (service delivery) through to macro (system) levels;
- > The process of facilitated reflection takes resources and time, and will invariably raise some sensitive/ uncomfortable issues.

## NETWORK GOVERNANCE AND MANAGEMENT

Exploring the current and ideal type and structure of network governance is an important starting point for problem-solving around networked care provision in a particular context.<sup>29</sup> Kenis and Provan's<sup>34,35</sup> three models of network governance – self-managed, lead organisation and network administration organisation – provided the basis on which we explored these issues.

There was not one formal and clear network of services dealing with older people's mental health, but rather a range of organisations with different goals, ways of working together and clustering of links. While some of these organisations were more highly linked with some leadership functions (e.g. the regional city council auspicing the Positive Ageing Taskforce), older people's mental health servicing overall across the various networks of services was seen to be self-governing, in that there was no overarching network administration organisation.

While a self-governing network was effective in the smaller rural locations in this study, it was not seen to be effective in larger areas in the region with more service options and, hence, increased complexity. Instead greater formality in structures and processes is required to manage the network as it grows in size and task complexity.<sup>34, 35,53</sup> This is particularly important in overcoming the lack of connection between clinical and social care services, identified in this and in previous research.<sup>22</sup> Thus we identified the need for an organisation with a mandate to take on overall governance and management functions for a network of older people's mental health servicing, covering the range of health and social care services. Furthermore identification of sensitivities that arose during the project supports the need for a neutral network administrative organisation, with management and leadership oriented towards building trust and reciprocity through facilitation/brokerage<sup>31</sup> being an important function of that organisation. Unobtrusive (or 'soft relational') leadership is also important so that network partners do not see the network administrative organisation as interfering<sup>31</sup>.

In rural locations where there are fewer resources, it may be unrealistic to have a network administration organisation dealing specifically with older people's mental health servicing, but rather one that addresses older people's health needs generally. The network administration organisation would need to have the mandate to coordinate services with the relevant expertise to address specific issues (e.g. those related to older people's mental health servicing). How members participate in the network would vary and be responsive to specific needs at specific times.

The tasks of the network administration organisation are as follows:

- > Gain commitment from service stakeholders.

When there is no current network then the starting point for the network administration organisation is to bring services together to identify as a network and begin to establish commitment. TMOP had to: (1) establish the range of services, their current linkages and the enablers and barriers to network formation; (2) describe servicing issues; and (3) seek agreement on what actions could be collectively undertaken to address these issues. This process took ten months. In the future and once having established the network, the network management focus would then be more immediately orientated on already agreed goals and on the specific tasks (as identified in the priority actions - Appendix 16); thus future cycles of facilitated reflection would likely be much quicker.

- > Gain agreement on goals and working together on smaller tasks.

Conflict can emerge from differing goals among network organisations, and managing the tension between congruent and diverse goals is a key network management task.<sup>31,33</sup> Getting agreement to work together on smaller tasks helps to develop a network identity, as services form links and get to know each other. Small, "do-able" tasks provide the opportunity to develop a trust history<sup>32,52</sup> whereby success creates the confidence to work together on larger tasks.

- > Secure resources to support the network.

Network administration organisations require resources to facilitate network problem solving<sup>29</sup>. This problem solving becomes increasingly difficult when there is ongoing and significant system instability, particularly funding uncertainty, as was the case over the course of the TMOP project. Instability impacts on services' ability to commit to the network and also on the sustainability of any agreed actions.

In addition to these tasks that are a priority for this older person's mental health network, Milward and Provan<sup>33</sup> identify other tasks that include the need to manage accountability (establishing who is responsible for what) and legitimacy (continuously ensuring that members view their work with other organisations as valuable and worthwhile) in the network.

## NETWORK LINKAGE STRATEGIES AND ENABLERS

The second aspect of network theory drawn on in this study were the linkage strategies and enablers supporting networked care, identified in a previous review of the literature.<sup>13,26</sup> Strategies and enablers supporting more networked servicing operate at micro (service delivery), meso (professional/ organisational) and macro (system) levels.<sup>22</sup> 'Functional integration' is achieved when there is linking at all three levels.<sup>22</sup>

Linkage strategies and enablers were present in the region, particularly at the micro level through direct collaborative activities and worker level partnership formation, both as a result

of the attributes of workers and their commitment to networking. However, much of the linking appeared to be localised, sector-based and informal, rather than formalised and regional, across mental health, aged and social care. More formal processes leading to the authorising of support and resources from the meso (organisational) and macro levels (policy) were needed in order to build on the identified localised strengths.

Collaboration at the local level may lead to change from the bottom up,<sup>52</sup> as services come together for activities such as joint care planning, and in the process identify servicing issues that can be followed up at a higher level. In order for this to occur, however, there needs to be the support from management at a meso level, as workers need the authorisation to spend time in this way.<sup>35,53</sup> There also needs to be funding and policy support at a macro level, which in this case study did not appear conducive. Rather, activity funding was tied to direct client care leading to a retreat to core services rather than collaboration, thus hindering opportunities for linking.<sup>26</sup> At the macro level there was also the policy silence on older people's mental health care, the disconnect between mental health and aged care policy, and the lack of focus on prevention and promotion for older people's mental health.

Mental health care provision for older people is complex, and as our care seeking journeys illustrated, often involving multiple services across health and social care. Where care planning does not accommodate the multiple needs of older people and with good feedback communication, then the result can be a chaotic experience for the consumer with missed or delayed servicing opportunities.<sup>24,54</sup>

## FACILITATED NETWORK REFLECTION

Facilitated network reflection involved the collective use of feedback on data obtained from the case study, bringing together stakeholders from different organisations in the region to identify issues in service provision for older people with mental health problems and establish some priority actions.

Facilitated reflection through workshops and governance group meetings started to build connections. However with the lack of a network administration organisation and the end of funding for both the Medicare Local and Positive Ageing Taskforce in 2015, both of whom had some network management functions, then the network development and momentum remained fragile. It was clear that the ten months' reflective process used in TMOP was insufficient time to cement service commitment to the network and to achieve change, as the literature on inter-organisational networks and change indicates.<sup>49-51</sup>

For the network to be developed and sustained there needs to be a network administration organisation driving the process,<sup>35,54</sup> and for network facilitation to be effective a network administration organisation needs the following.<sup>29</sup>

- > The skills to facilitate the reflective process, including the ability to manage potential conflicts between different services. Management of conflict is an important task and network managers should reinforce 'trust' as a critical enabler in effective networks.<sup>31</sup>
- > The negotiation skills to ascertain and then work with the key staff in organisations that may comprise the network, so as to gain the commitment from these organisations. These key staff should include individuals with appropriate status, power and commitment to champion the network within their home organisation.
- > Links with services from both health and social care sectors for the credibility needed to facilitate linkages and engagement between sectors.
- > To engage with consumers/carers in the design of mental health services for older people.

### Changes to & limitations of facilitated reflection in the TMOP project

Part way through the project it was recognised that increased engagement from the regional service leaders was needed to support any organisational change. To achieve this, additional interviews were conducted with senior leaders from organisations across sectors (n = 6). The purpose was to get their perspective on whether services in the region were working together in a networked way or not, and to explore the role of leadership in developing this. These regional leaders were also invited to the workshops, particularly the final workshop where decisions were to be made about priority actions.

In order to develop a more consumer-focussed approach to the facilitated reflective process, as recommended in recent research on integrated care,<sup>24,25</sup> the TMOP method could be refined in the following ways:

- (1) First undertaking the mapping of consumer care seeking journeys and using the findings as the basis to list the range of services for the organisational network analysis. In TMOP we did this the other way around, which meant that the organisational network analysis revealed the network that has bounded more from the service perspective than the consumer/carer perspective.
- (2) Having a consumer/carer or consumer/carer organisation included on the governance group.

The ten-month timeframe for the facilitated reflection aspect of the study was determined by the funding of TMOP; however, to be effective over a cycle whereby there can be reflection on the outcome of actions taken by the network, then a much longer period would be required. At the end of TMOP, participants acknowledged that although the process had identified a number of issues, it had not gone to the next stage of working out how those issues could be resolved.

## Policy Options

The main issues impacting upon the function and sustainability of the network in our case study were:

1. The lack of a broad network of connections between mental health and social care services.
2. Lack of a clear organisation with a mandate to take on overall network management and functions.
3. Negative impact of policy and funding models on service networking in older people's mental health.

These issues can be addressed by the following policy options at the micro, meso and macro levels.

## MICRO LEVEL OPTIONS

### Supporting coordination at the level of service delivery

Service providers (from all sectors) should provide a basic level of care coordination to facilitate consumers linking to and between services. This means that 'any door is the right door', where support is provided to the consumer to access the most appropriate service. This may be through providing information, suggesting the consumer see their GP for further assessment and referral, or direct referral to specific services. The aim would be to improve consumer experience and outcomes. To facilitate this, the following strategies could be considered:

1. Health, aged and social care service managers establish mechanisms for joint care planning between different service sectors that in addition to coordination of consumer care would build network relationships, particularly when these are conducted face to face.
2. Service providers to involve the consumer/carer in care planning so that networks develop that are consumer-focused, more seamless and avoid duplication.
3. The processes of network management should include the development of protocols and tools (e.g. referral templates, decision supports) for local organisations involved in older people's mental health. Through the joint development of these tools, workers across these organisations would then discuss and negotiate in situ their roles, communication processes and care pathways.
4. Information sharing between services about consumer care be promoted by clarifying and educating workers on the current authority and processes (e.g. agreements) that enable services to share information about consumers within the parameters of confidentiality and privacy.

### Supporting development of the network

5. Managers across the health and social care sectors identify link workers within their organisation who have authorisation and commitment to linking with other services in the network. This role should be detailed in position descriptions and recognised so that the link worker has the authority and becomes a resource person within the network.
6. Consumer/carer involvement to be incorporated into the development of older people's mental health networks, particularly related to building mental health literacy in the wider community and for building mental health capacity in community support workers.

## MESO LEVEL OPTIONS

7. The development of an inter-organisational, inter-sectoral network supported by a network administrative organisation will lead to better and more coordinated care for older people living with mental health problems and their caregivers. A dedicated and 'neutral' network administrative organisation is best placed to address issues resulting from a complex service landscape (e.g. varying service ideologies, funding and governance) to facilitate timely access to and transition between the range of health and social care services. The development of such a network would also facilitate the engagement of carers/consumers in designing a responsive service system. In rural locations, where there are fewer resources, it is suggested that the network administration organisation have the mandate for older people's health servicing in general, with the remit to form smaller as needed sub-networks specific to the servicing needs of different groups (such as mental health).

Three options are proposed regarding the organisations that could take on the network governance and management function in older people's health:

Option 1: The new Primary Health Networks (PHNs). This would be the ideal option given that an objective of the PHNs is to facilitate integration between services to achieve improved access and coordination of health care. PHNs should have the authority from national level policy for primary health care network management to be a part of their role. They would therefore have the legitimacy to engage the various services in mental health, primary health, aged and social care and community groups in an older people's health network.

Option 2: State Health either through community health or mental health services. This option would ensure commitment to a network from a wide range of specialist and generalist health care providers, and ensure the needed expertise was available for both clinical services and training of aged care and social care staff about mental health. This option is limited, however, given the pressure on state run community and mental health services to focus on the provision of clinical services, and less so on community health development.

Option 3: Local government within the policy framework of local public health plans. This option could be operationalised by local partnership arrangements, such as was the case in this study through the Positive Ageing Taskforce. This option would provide a particularly local genesis and orientation to network development and management given the connections that local government has with community groups and services. This option could be limited, however, if there were disconnects between the specialist clinical health and social service sectors as was found in this case study. If local government were to auspice network management through such a "taskforce" it would need to be resourced for this and with a level of formal agreement to ensure that it had the network management legitimacy to secure commitment from the various service sectors.

8. Through their authority, managers from health and social care services validate the network by legitimising the time and effort required to establish and maintain local relationships and networking activities that are needed to enhance collaboration. This may involve supporting staff to attend meetings for joint care planning or targeted service development activities.

## MACRO LEVEL OPTIONS

Older people's mental health policy:

9. Include older people as a distinct and vulnerable group in Commonwealth mental health policy, with solutions and priority actions for addressing older people's mental health. Details of how best to address the mental health care needs of older people are

discussed by Royal Australian & New Zealand College of Psychiatrists in various position statements.<sup>6,46</sup> Older people should also be included in indicators and targets in mental health reform.

10. Include the mental health care needs of older people in local government public health plans.
11. Include the portfolio of Ageing in future mental health reform so that there is better integrated aged care and mental health policy.
12. Increase policy focus on mental health promotion and prevention for older people by including actions for mental health promotion and prevention in Commonwealth and State level mental health policy, with a greater emphasis on providing recovery-oriented care.

Policy relating to integration:

13. Policy to include funding models and implementation strategies to support integrated care; integrated care is a key objective in Australian health policy related to older people and mental health, yet specific strategies to support integration are not presented.

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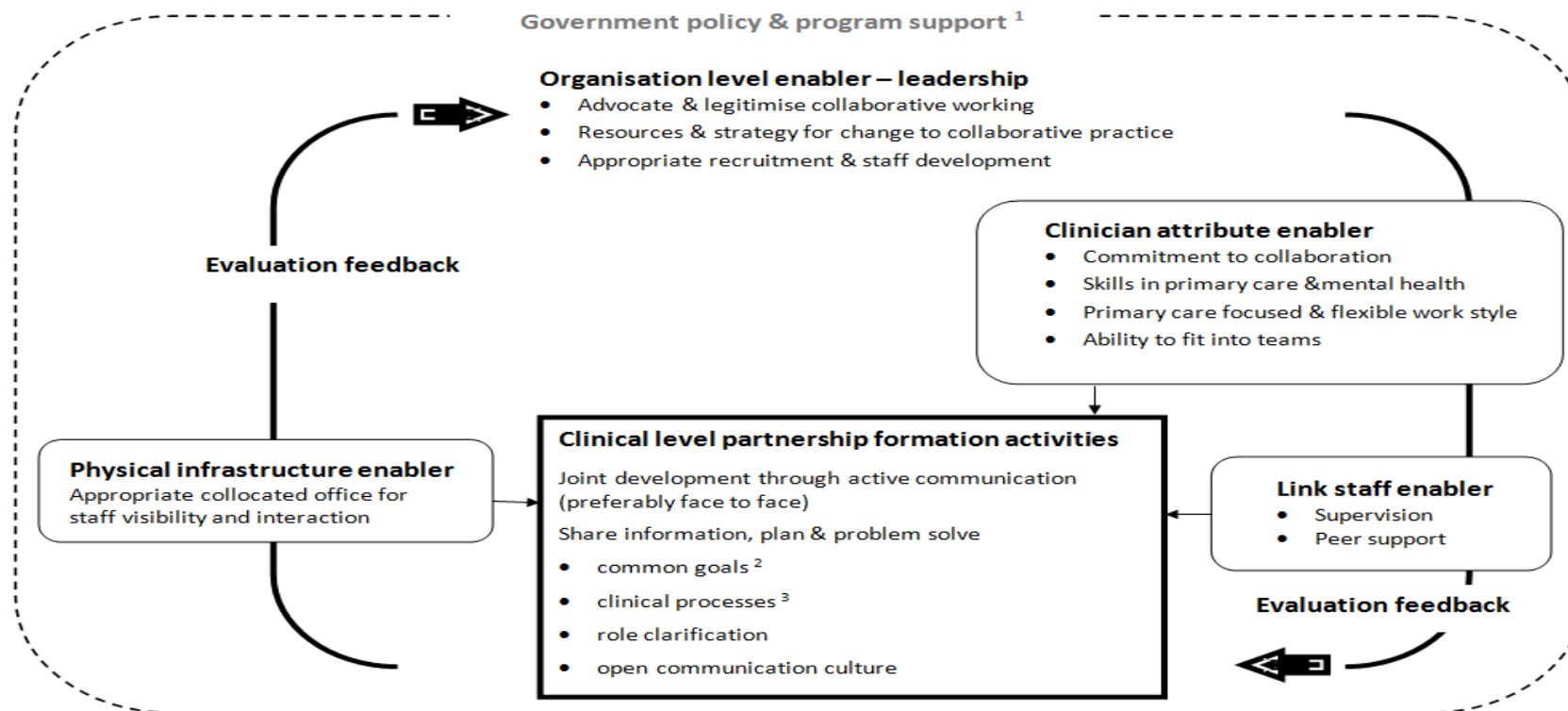
## APPENDIX 1: LINKAGE STRATEGIES

Category	Linkage	Definition
Direct collaborative strategies	Link working	Organisational tasks connecting 2+ services - may involve limited clinical intervention but not expert clinical advice or structured liaison- does not include the work of an existing employed practice nurse undertaking extended tasks if there is no linkage work outside current general practice. Includes a process to clarify role between LW and others.
	Co-location	Face-to-face not virtual co-location- could lead to improved practitioner communication. Also includes MH worker (nurse, psychologist) located in primary care practice. Must be providing treatment, not simply an administrative arrangement
	Consultation liaison	A practitioner connection where P1 has an explicit arrangement to provide expert level advice about ongoing care to P2 that is apart from the usual referral relationship - it may involve P1 receiving referral letters, making an assessment & providing some treatment and ongoing expert support to P2.  Includes the specialists' advice to the primary care practitioner regarding treatment and monitoring (either directly or via another worker e.g., through link working) and may include educative roles. It does not involve the transfer of the patient from primary care.
	Care management	The coordination of care - it can include assessment, review and follow-up and a care management plan - linking with other services, or defined care pathway.
Agreed Guidelines	Specific treatment protocol	An agreed process that is structured and documented about a specific patient treatment including evidence based algorithms such as in pharmacotherapy or Problem Solving Therapy in Primary Care (PST-PC). Does not include referral, stepped care or care management plan that are coded elsewhere.
	Stepped Care	A treatment trajectory based on patient response or outcome. Involves a formal treatment escalation or de-escalation procedure to involve other providers based on specified patient outcomes.
Communication system	Enhanced communication	A formal process with feedback -includes meetings, shared medical records, patient held records, consistent process for notifications, standardised letters, referrals and reports. May includes a worker from outside the practice attending the practice - e.g. to attend meetings.
	Enhanced referral	Expedited access, explicit referral criteria &/or process, which can include process for emergencies.
	Electronic	Telephone or video communication between 2+ people with at least 2 practitioners not in same room -

	communication system	may or may not include patients. Includes 'telemedicine'.
Service agreement	Service or formal work agreement	Formalised contract or funding mechanism about how services will work together.

Fuller JD, Perkins D, Parker S, Holdsworth L, Kelly B, Roberts R, Martinez L, Fragar L. Effectiveness of service linkages in primary mental health care: a narrative review part 1. BMC Health Serv Res. 2011;11:72

## APPENDIX 2: LINKAGE ENABLERS



Fuller JD, Perkins D, Parker S, Holdsworth L, Kelly B, Roberts R, Martinez L, Fragar L. Building effective service linkages in primary mental health care: a narrative review part 2. BMC Health Serv Res. 2011;11:66

## APPENDIX 3: SUMMARY OF ORGANISATIONS INTERVIEWED

Sector	Number of Interviews (number of people)		
	Service Provider Key Informant Interviews	Senior Leader Interviews	End of Project Interviews
Mental Health	3 (5)	1 (1)	2 (2)
NGO	3 (3)		
Social care	3 (3)		
Aged care	1 (1)	1 (2)	
Primary care	8 (9)	1 (5)	1 (1)
Community health	6 (9)	2 (2)	
Hospital	1 (1)		
Local government	1 (1)	1 (2)	1 (2)
<b>Total</b>	<b>26 (32)</b>	<b>6 (12)</b>	<b>4 (5)</b>

# APPENDIX 4: SERVICE PROVIDER KEY INFORMANT SURVEY AND INTERVIEW GUIDE

## Together for the Mental Health of Older People (T-MOP)

### Key informant & service network survey

We are interested in the communication links that you have with other services that enables you and your organisation to provide care and support for people aged >65 with a mental health issue.

We are interested in:

- (a) Communication about the provision of client care.
- (b) Communication about the management, planning and operation of services for mental health care in the region.

### ABOUT YOU AND YOUR ORGANISATION

1. First we want to know who you are, so that we have a record of who has participated and if we need to clarify anything with you. Your name will not be included in any report that is produced.
  - 1.1. Your name:.....
  - 1.2. Job title:.....
  - 1.3. Organisation & Department .....
  - 1.4. Location of organisation (Town): .....
  - 1.5. How many years/months have you been working at the organisation? .....
  - 1.6. Email: .....
  - 1.7. Phone number: .....
2. About the organisation that you work for. Can you tell me what is your organisation's role in the provision of services for older people?

### NETWORK SURVEY

3. Can you list on the survey sheet that I will give you up to 15 other services with whom you and others in your organisation (to the best of your knowledge) have communicated over the past 3 months. List those services that you consider are the most important for your organisation in providing care and support for older people with mental health issues. They could be important to you because you communicate with them frequently; alternatively they could be important to you as a resource, even though communication is less frequent.



We are interested in:

(a) Communication about the provision of client care. There are two parts to this:

**a1 Information about client care**

This includes giving or receiving information about mental health care for clients, such as case conferences, sharing client information and/or case notes, corridor conversations, meetings and/or correspondence about client care. The information can be about specific clients or clients in general.

**a2 Referrals**

This is where you send or receive a client referral. This can occur informally (such as recommending to a client that they see a particular service) or more formally by making a phone call or sending a referral letter to a service.

(b) Communication about the management, planning and operation of services for mental health care in the region. The communication can occur formally (e.g. in meetings) or informally (e.g. in the corridor or 1:1).

## SURVEY SHEET

<p>LIST THE SERVICES HERE</p> <p>YOU DO NOT HAVE TO LIST 15, BUT 15 IS THE MAXIMUM</p>		<p>Score only those activities you do with each other service</p> <p>(on average <u>over the past 3 months</u> how often did you communicate with them)</p> <p>1 = less than once per week;</p> <p>2 = about once per week</p> <p>3= more than once per week</p>			
		(a) Client care			(b) Management, planning, operation
Name of service	Location of service (town)	a1 Information	a2. Referral		
			Send	Receive	
<i>Example: Community Health Centre</i>	<i>Smithtown</i>	<i>3</i>	<i>1</i>	<i>–</i>	<i>2</i>
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

## EXPERIENCE OF WORKING TOGETHER

4. I now want to ask you if there are any formal or informal processes that support your communication links with these other services.

*(for prompt of links show the list of link strategies discussed at the workshop)*

*For example, how would you make and receive referrals? (standard letter, phone, face to: face)*

5. Are there any operational or procedural policies that inform how you work with other services in the provision of mental health care to older people?

*Can you tell me how useful these policies are in informing how you work with other services? (ask for copies if available)*

6. Are there examples where you consider that services in the region work together well to provide services to older people with mental health issues?

*Please describe these examples – and why you think these work well*

7. Are there examples where you consider that services in the region DO NOT work together well to provide services to older people with mental health issues?

*Please describe these examples – and why you think these DO NOT work well*

8. Are there things that you would like to see changed in the way that services work together to meet the needs of older people with mental health issues?

*Are there things you would not like to see changed and can you give any examples?*

9. Is there anything else that you would like to say about how services in the region work together to provide services to older people with mental health issues?

If there is anything else you would like to say in follow up to this interview please feel free to contact me by phone or email.

Are you happy for me to contact you by phone or email if I want to clarify anything from today's interview?

THANK YOU

# APPENDIX 5: SENIOR LEADERS INTERVIEW SCHEDULE

## Together for the Mental Health of Older People (T-MOP)

### Senior leaders interview schedule

In relation to older peoples mental health we are interested in your perspective as a person in leadership in how you see mental health, general health, aged care and social care (community care) services working together in an integrated way or not on the Southern Fleurieu and Kangaroo Island region, and what role leadership has to play.

1. Are there things you would like to see changed in the way that services work together to meet the needs of older people with mental health issues on the Southern Fleurieu and Kangaroo Island region?

*Can you give any examples?*

2. Regarding the structure and processes to support services working together.

- What is currently in place and working well?
- What should be in place?

*You might like to use two attached sheets showing a list of service linking strategies (attachment 1) and the enablers to linking (attachment 2) as a prompt.*

3. What leadership and management strategies are needed for working together across services and who should be involved in these?

- Should there be a lead organisation or can this be shared?
- How formal do you think the structures and processes for working together should be?

*For example, GP's report having to manage clients with 'low level' mental health issues. Additionally those with a serious and enduring mental illness (when stable) may only see a GP. Whilst these clients may not meet the criteria for or require ongoing case management by specialist MHS, they may benefit from engagement with services that provide social activities or social support.*

*What do you think would be needed to sort out this issue?*

4. Attached are the key points with the suggested opportunities for change as documented in the mid-project report (attachment 3).

- Do you have any comment to make about these suggestions?
- What would you like to happen post Workshop 3, who should be involved and what will be needed to make it happen? *(For example the development of pathway to care protocols for different client profiles has been suggested post project)*

5. Is there anything else that you would like to say about what is needed for services in the region working together to provide services to older people with mental health issues?

Please feel free to contact me by phone or email if you want to follow up on this interview.

Are you happy for me to contact you by phone or email if I want to clarify anything from today's interview?

THANK YOU

## APPENDIX 6: SUMMARY OF CONSUMER/CARER PARTICIPANTS (CARE SEEKING JOURNEYS)

Participant	Carer Age	Carer Gender	Relationship to client	Mental Health Issue	Consumer Age	Consumer Gender
Carer 1	71	Male	Friend	Depression and Dementia	79	Male
	68	Female	Friend			
Carer 2	70's	Female	Daughter-in-law	Acute confusion	94	Female
Carer 3	60's	Female	Wife	Alzheimers	74	Male
Carer 4	55	Female	Daughter-in-law	Alzheimers	86	Female
Carer 5	70	Male	Husband	Neurocognitive Disorder	67	Female
Carer 6	60's	Female	Daughter	Schizophrenia and Dementia	85	Female
Carer 7	75	Female	Wife	Dementia	88	Male
Carer 8	81	Male	Husband	Untreated mental illness and Alzheimers	79	Female
		Female	Daughter			
Carer 9	91	Male	Husband	Severe Depression and Dementia.	92	Female
Consumer 1	N/A	N/A	N/A	Anxiety/Depression	74	Female

# APPENDIX 7: CONSUMER/CARER SURVEY & INTERVIEW GUIDE

Improving the network planning and management of integrated primary mental health care for older people in rural regions

## Pathways Encounter Form

### 1. Basic Information

1.1 Name of facility (care point) of the person recruited: \_\_\_\_\_ ☐☐ 1-2

\_\_\_\_\_

1.2 Is the person a client or carer?

1 = Client

☐ 3

2 = Carer

1.3 Date: \_\_\_\_\_ ☐☐☐☐☐☐ 4-9  
day month year

1.4 Client's/Carer's identifying code: \_\_\_\_\_ Number: ☐☐☐ 10-12

1.5 Age: \_\_\_\_\_ ☐☐ 13-14  
Years

1.6 Gender: \_\_\_\_\_ ☐ 15

1.7 Martial status or living situation:

1 = Lives alone

☐ 16

2 = Cohabiting with spouse

3 = Cohabiting with children

4 = Other (specify): \_\_\_\_\_

1.8 Does the person live in a town or outside of a town (such as on a farm)?

1 = In a town

☐☐ 17-18

2 = Outside of a town

What is the name of the town (or nearest town)? \_\_\_\_\_

\_\_\_\_\_

☐☐ 19-20

## 2. The Decision to First Seek Help

We understand that you/the person you care for has sought help for emotional, mental or stress problems.

2.1 Looking back, when do you/ the person you care for think this problem began?

\_\_\_\_\_

☐☐☐☐ 21-24

years months

2.2 Before seeking help from someone, did you/ the person you care for try any self-help methods?

1 = Yes

☐ 25

2 = No

2.3 If so what?

1 = Book

☐ 26

2 = Internet

3 = Self help group

4 = Other (specify): \_\_\_\_\_

2.4 Who did you/ the person you care for first talk to or see to get help about this problem?

1 = Family member/friend

☐ 27

2 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known

2.5 How long ago? \_\_\_\_\_

☐☐☐☐ 28-31

years months

2.6 Who suggested that you/ the person you care for seek this help?

1 = Self

☐ 32

2 = Family member/friend

3 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known



2.7 What was the main problem that made you/ the person you care for seek this help? \_\_\_\_\_

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---

2.8 What was the main assistance that they provided? \_\_\_\_\_

---

---

---

2.9 Did they suggest that you/ the person you care for talk to or see someone else?

1 = Yes

☐ 33

2 = No

2.10 If so who?

1 = Family member/friend

☐ 34

2 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known

### 3. Next Decision to Seek Help

3.1 Who did you/ the person you care for then talk to or see to get help about this problem?

1 = Family member/friend

☐ 35

2 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known

3.2 How long ago? \_\_\_\_\_  
\_\_\_\_\_

☐☐☐☐ 36-39  
years months

3.3 Who suggested that you/ the person you care for seek this help?

- 1 = Self ☐ 40  
2 = Family member/friend  
3 = GP  
4 = Nurse  
5 = Social or community worker  
6 = Mental health service  
7 = Other (specify): \_\_\_\_\_  
8 = Not known

3.4 What was the main problem that made you/ the person you care for seek this help? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3.5 What was the main assistance that they provided? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3.6 Did they suggest that you/ the person you care for talk to or see someone else?

- 1 = Yes ☐ 41  
2 = No

3.7 If so who?

- 1 = Family member/friend ☐ 42  
2 = GP  
3 = Nurse  
4 = Social or community worker  
5 = Mental health service  
6 = Other (specify): \_\_\_\_\_  
7 = Not known

#### 4. Next Decision to Seek Help

4.1 Who did you/ the person you care for then talk to or see to get help about this problem?

1 = Family member/friend ☐ 43

2 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known

4.2 How long ago? \_\_\_\_\_

☐☐☐☐ 44-47

years months

4.3 Who suggested that you/ the person you care for seek this help?

1 = Self ☐ 48

2 = Family member/friend

3 = GP

4 = Nurse

5 = Social or community worker

6 = Mental health service

7 = Other (specify): \_\_\_\_\_

8 = Not known

4.4 What was the main problem that made you/ the person you care for seek this help? \_\_\_\_\_

---

---

---

4.5 What was the main assistance that they provided? \_\_\_\_\_

---

---

---

4.6 Did they suggest that you/ the person you care for talk to or see someone else?

1 = Yes

☐ 49

2 = No

4.7 If so who?

1 = Family member/friend

☐ 50

2 = GP

3 = Nurse

4 = Social or community worker

5 = Mental health service

6 = Other (specify): \_\_\_\_\_

7 = Not known

## 5. Experiences of access to and transition through care

Thinking about the processes we've just discussed, I'd like to explore in a bit more detail what the experience of accessing help and support was like for you/the person you care for.

5.1 How easy or difficult was it for you/the person you care for to access help?

5.2 How much did you have to be 'the navigator' in the process of getting help?

5.3 Were there any barriers that you/the person you care for encountered when accessing help?

These could be difficulties for you/the person you care for personally or in relation to the services themselves?

5.4 If you had to access more than one service, what was the referral process like for you/the person you care for?

5.5 Was the assistance provided by the service(s) effective or useful for you/the person you care for? In what way?

5.6 Looking back, is there anything you know now that would have made your journey to seeking support more straightforward/easier?

Is there anything you would do differently?

5.7 How do you think mental health services for older people in the area could be improved?

## APPENDIX 8: POLICY DOCUMENTS INCLUDED IN THE ANALYSIS

Year	Policy documents	Representation of mental health and older people	Policy solutions
<b>Commonwealth Policy</b>			
<i>Mental Health</i>			
2009	National Mental Health Policy	At-risk	None
2009	The Fourth National Mental Health Plan	At-risk, lack of access, need for services, co-morbidity	None
2009	A Mentally Healthy Future for all Australians (National Advisory Council on Mental Health)	Absent	None
2011	Budget: National Mental Health Reform	Absent	None
2012	The Roadmap for National Mental Health Reform	Absent	None
2013	National Report Card on Mental Health	Absent	None
<i>Aged Care</i>			
2008	Ageing and Aged Care in Australia	Absent	None
2012	Living Longer Living Better	Ageing as decline, focus on Dementia & Veterans	Home and Community Care Service Supplements
<i>Health Care</i>			
2010	A National Health and Hospitals Network for Australia's Future	Absent	None
2011	National Health Reform 'Progress and Delivery'	Absent	None
2014	National Health Reform Agreement	Absent	None
<i>Primary Health Care</i>			
2010	Australia's First National Primary Health Care Strategy	Absent	None
2013	National Primary Health Care Strategic Framework	Absent	None
<i>Rural and Remote Health</i>			
2012	National Strategic Framework for Rural and Remote Health	Absent	None
<i>Productivity Commission</i>			
2011	Caring for Older Australians	At-risk (particularly	Expand use of in-

	(Productivity Commission)	veterans, socially disadvantaged)	reach services to residential aged care facilities;  Visiting multi-disciplinary health care teams
<b>South Australian Policy</b>			
<i>Mental Health</i>			
2010	South Australia's Mental Health and Wellbeing Policy	At-risk, focus on positive ageing, lack of access to services	Integration and co-ordination of services;  Healthy ageing strategies, illness prevention and early intervention, including helping older people reduce or manage risk factors
2009-2016	Older Persons Mental Health Future Service Model	Lack of access to services	Location of care – community, general hospitals, residential aged care;  Type of care – community, transitional, acute
<i>Aged Care</i>			
2009	Health Service Framework for Older People	At-risk, lack of access, ageing population, older people with mental illness a high risk priority group, co-morbidity	Integration with a focus on GP Plus Health Care Centres;  Support & reinforce a wellness and self-management approach;  Access to psychogeriatric advice;  Co-location of services
2010	Health Policy for Older People	Lack of access, recovery	Reduce or manage risk factors;  Integrate and coordinate mental health services
2014	South Australia's Ageing Plan	At-risk	None
<i>Health Care</i>			
2013	State Public Health Plan	Absent	None
<i>Rural and Remote Health</i>			
2009	Country Health SA Mental Health Services: Model of Care	Absent	None

## APPENDIX 9: OPERATIONAL POLICY DOCUMENTS

### SA Health

#### Country Health SA Local Health Networks:

- South Coast (Service Plan).
- Adelaide Hills (Service Plan).
- Kangaroo Island (Service Plan).

#### CHSA Mental Health Teams

- Country Health SA Mental Health Service Model of Care, August 2009.
- CHSA Local Health Network, Mental Health Procedure: Access and Entry, 6 Dec 2010.
- CHSA Local Health Network, Mental Health Procedure: Assessment and Review, 1 Nov 2010.
- CHSA Local Health Network, Mental Health Procedure: Older Persons Mental Health Services Referral Process, 2 May 2011.
- CHSA Local Health Network, Mental Health Procedure: Role of medical practitioners in Country Health SA, Older Persons Mental Health Service, 14 March 2011.
- CHSA Local Health Network, Mental Health Procedure: Admission pathway for CHSA Older Persons Mental Health Service consumers under an inpatient treatment order, 1 January 2012.
- CHSA Local Health Network, Mental Health Procedure: Older Persons Mental Health Service clinical handover ISBAR procedure, April 2012.
- CHSA Local Health Network, Mental Health Procedure: Mentoring procedure for Older Persons Mental Health Services, 2 April 2012.
- CHSA Local Health Network, Mental Health Procedure: Older Persons Mental Health Services transfer of care at time of discharge from an inpatient mental health unit, 11 April 2012.
- Memorandum of Understanding Between the Minister for Social Housing (on behalf of Housing SA) and Minister for Mental Health and Substance Abuse (on behalf of SA Health, Mental Health and Substance Abuse) 2013-2014.
- Mental Health and Emergency Services Memorandum of Understanding 2010 SA Health, SA Ambulance Service, Royal Flying Doctor Service, South Australian Police.
- SA Health Mental Health Services Pathways to Care Policy Guidelines 13 May 2014.

#### Community Health Service

- Department of Health and Ageing, HACC, Community Care Common Standards.

#### Aged Care Assessment Team (ACAT)

- Aged Care Assessment Teams, Australian Privacy Principles for Aged Care Assessment Teams, March 2014.

### Local Council

#### Positive Ageing Taskforce

- Positive Ageing Taskforce, Strategic Plan 2010- 2019, April 7, 2010.

#### Alexandrina Centre for Positive Ageing

- Department of Health and Ageing, HACC, Community Care Common Standards.

#### Caring Neighbourhood Program City of VH

- Department of Health and Ageing, HACC, Community Care Common Standards.

### **National Organisations**

#### SAFKI Medicare Local Plans & Procedures:

- Annual Plan 2013-2014.
- Strategic Plan, 2011-2014.
- Service Coordination and Integration Policy, October 2013.
- Mental Health Escalation Pathway Procedure, October 2013.
- Clinical Case Review within REACH Aged Care, May2013.
- Mental Health Rapid Access Service Guidelines, REACH Aged Care, July 2013.

### **NGOs**

#### Aged Care Services

- Department of Health and Ageing, HACC, Community Care Common Standards.



## APPENDIX 10: SUMMARY OF ORGANISATIONS REPRESENTED IN WORKSHOPS

	<b>Aged &amp; Social Care</b>	<b>Health Service</b>	<b>Total*</b>
<b>Workshop 1</b>	5	7	12
<b>Workshop 2</b>	7	11	18
<b>Workshop 3</b>	4	13	17

\*Each organisation was represented by one person

# APPENDIX 11: DESCRIPTION OF WORKSHOPS & KNOWLEDGE EXCHANGE

## Workshops

Workshop 1: The primary aim was to begin the process of engaging participants (n=12) in the research and get them to start to consider themselves as a network with regards to older persons servicing. Participants were provided with information about the project which included an introduction to the networking model, in particular the linkages model detailing strategies that best facilitate collaborative working. Case scenarios were developed based on previous research in the region, and participants were asked to reflect on three case scenarios (see Appendix 11a) and consider the scenarios in relation to a) the linkages strategies already in place in their region, and b) ideal linkage strategies to address the problems presented in the scenarios. Feedback regarding the usefulness and relevance of the linkages model in the region was sought, as well as input into the development of a list of regional organisations involved in providing services for older persons with mental health issues (used to identify which service stakeholders to interview). Prior to the workshop, feedback about the case scenarios had been sought from several participants from different services.

Workshop 2: Initial findings were presented to participants (n= 18). This included network maps, data on network links<sup>42</sup> and early policy analysis. The aim of this workshop was to allow participants to consider network strengths and early opportunities for change.

Workshop 3: Data from the consumer/carer interviews were presented to participants (n=17). Participants were then asked to identify the opportunities for change, assign a value analysis to the opportunities and develop a plan of action for high-value opportunities.

## Knowledge exchange

Knowledge exchange activities were a priority to facilitate ongoing engagement and ownership.

- > A summary report was distributed to all participants following Workshop 1. This detailed the linkage strategies that services were using to work together (as informed by case scenarios), identification of issues raised in discussion relating to servicing for older person's with mental health problems in the region, and how participants would ideally see service provision in the area.
- > A mid-project report was compiled and sent to all the stakeholders, including those who participated in the interviews, following Workshop 2. The focus was to summarise the findings to date and the suggested opportunities for change in the network (as identified at Workshop 2).
- > The research team attended various relevant forums/meetings to present the mid-project report and generate discussion and feedback regarding the issues and opportunities for change. This included initiations to present at the Positive Ageing Taskforce meeting (August); the Mental Health Professionals Network meeting (September) and the Older Persons' Team for Country Mental Health SA meeting (October).
- > Detailed minutes of each of the governance meetings were distributed to all governance members to promote ongoing engagement, participation and decision making from the partner stakeholders.

- > Regular updates summarising TMOP at different stages throughout the 10 month period were housed on Flinders University website.

## APPENDIX 11A: CASE STUDIES

### James

78 year old man lives with his wife, Mary, moved to Encounter Bay 11 years ago following retirement. Family reside in Adelaide.

**Situation:** Mary is contacting the GP surgery on a regular basis expressing concerns about her husband's ability to drive. The GP requested an appointment with James for assessment following Mary's repeated contacts though James himself was very reluctant to attend. At the assessment Mary reported that James had been getting lost whilst driving and that he had had one minor car accident and several near misses. During the consultation with James, he became very defensive, denied any near misses and stated confidently that he was a safe driver. The GP conducted the Mini-Mental State Examination on which James scored 23/30. The remainder of the examination was unremarkable. At the end of the consultation the GP recommended that James only drive locally.

James's wife is becoming increasingly distressed by her husband's behaviour. She reports that he is very irritated and blaming her for the restrictions to his driving though so far he has been adhering to the GP's recommendations. Mary and James no longer participate in joint pastimes they previously enjoyed, e.g. going out for lunch and attending the cinema, and are now more isolated from family and friends subsequent to James being unable to drive to Adelaide. Mary has noticed that if she goes out James is unlikely to have anything to eat or drink all day, even if she leaves food prepared. As a result Mary has gradually restricted her own activities as she feels she needs to be at home at all times to support her husband.

**Background:** Prior to retiring James owned a successful business in Adelaide. They own their own home and are financially stable. James and his wife retired to VH following discussions with their son who planned to visit them during every school holiday period. As the grandchildren have become older, the family, though supportive, usually visit briefly once or twice a year. James and his wife enjoyed going for drives and James would drive to Adelaide once a fortnight so they could see family and friends.

### Questions to guide the small group discussion:

Which health professional might initiate/assist in help-seeking after the problem has been identified?

Where will the referral go? How will the referral be made? E.g. letter, face to face meeting, phone call, formal referral process

Which services may get involved?

What linkage strategies are already in place?

Fill in the table on the butchers' paper details of the linkages already in place.

## **Christine**

86 year old woman, lives alone, her sister whom she was residing with for many years died 2 years ago. Long term resident of Yankalilla.

Situation: Christine attended the podiatrist with the support of her care worker to treat an ulcer that had developed on her foot. The care worker had noticed this as Christine was refusing to go shopping saying her shoes were uncomfortable and needing replacing. An appointment was arranged for a review the following day at the GP surgery, which the care worker again supported Christine to attend. When seeing the GP Christine admitted to having recently ceased all medications for her Depression and Diabetes. She stated she was aware of the consequences to her health and was "happy to die". The care worker informed the GP that recently, on occasion, she was prompting Christine to change her clothing as her dress would be inside out or soiled. She also reported that Christine would occasionally accuse her of having stolen something. These items would then sometimes be located in unusual places around the home. At the GP assessment Christine was unable to say what the month and year was. She became very irritated by the question saying "What does this have to do with my foot ulcer?"

Background: Christine had been admitted to the local community hospital a year ago for treatment of leg ulcers. Following this an OT home assessment was conducted. At the time of this assessment Christine's home was found to be in a state of squalor. The OT arranged for an industrial clean and a care package of 2 hours a week was obtained for support with shopping and cleaning. Christine had been very difficult for the care worker to engage from the outset and a reasonable relationship had been developed. Christine often presented as quite irritable and argumentative and the care worker was finding it increasingly difficult to manage the requested support in the allocated time. The care worker found she would often have to do the various tasks herself in order for the job to get done.

Christine has a long history of Depression and diabetes type II which has historically been managed well by herself and the GP. Christine was previously very reliant on her sister in getting 'out and about' and her sister took on a primary role in managing household tasks. Christine and her sister were never well linked into the local community and Christine is estranged from her one son, whom lives locally.

### **Questions to guide the small group discussion:**

Which health professional might initiate/assist in help-seeking after the problem has been identified?

Where will the referral go? How will the referral be made? E.g. letter, face to face meeting, phone call, formal referral process

Which services may get involved?

What linkage strategies are already in place?

Fill in the table on the butchers' paper details of the linkages already in place.

## Ed

73 year old man, living in a residential facility in Goolwa. Classed as requiring 'low level care.'

Situation: Ed had recently "dropped off" participating in various activities he used to enjoy including gym with the physio once a week and attending a lunch club at a local community centre. Furthermore he has stopped showering, even with prompts from the residential staff, and has been upsetting other residents with his constant requests for cigarettes. Other residents are saying they are frightened to say no to these requests and are complaining about his poor hygiene. Ed appears to be experiencing psychotic symptoms in the form of auditory hallucinations on a daily basis. He reports believing he has a micro-chip implanted in his head that causes him to hear abusive voices however states he is usually able to ignore them. Staff report that over the past few days Ed has become increasingly distracted and is responding to the voices by shouting out at them. The residential care staff assist Ed in managing his regular medication and provide PRN medication if required. They describe Ed as "being happy to do very little" though have managed to get Ed to take responsibility for his personal care and care of his room with minimal prompting. Staff recognise he requires increased support at this time though are concerned this may negatively impact on his independence in the long run.

Residential staff feel inadequately trained to deal with Ed's health issues and are struggling to manage his behaviour in an appropriate manner resulting in Ed becoming frustrated and volatile on a few occasions.

Background: Ed has a long history of enduring mental illness after being diagnosed with Schizophrenia in his early twenties. He has been itinerant at various times and moved between different states. Ed's family eventually located him and facilitated his move into a residential facility in Adelaide. He had settled well into this home but was required to move following its closure. Ed subsequently relocated to Goolwa four years ago to be closer to family. Ed's sister visits once a week and is very good at detecting any changes in his mental state. She has recently reported to staff she is concerned Ed was becoming unwell again after observing some of his behaviour. Ed has had various levels of contact and support from mental health services over the years. He has had multiple admissions in the past to various psychiatric wards however has not required an admission for more than 10 years. He has also been seen by community mental health teams at different times for long periods.

Ed has diabetes type I and ischaemic heart disease. His management of this is variable. Ed's finances are managed by Public Trustee.

### Questions to guide the small group discussion:

Which health professional might initiate/assist in help-seeking after the problem has been identified?

Where will the referral go? How will the referral be made? E.g. letter, face to face meeting, phone call, formal referral process

Which services may get involved?

What linkage strategies are already in place?

Fill in the table on the butchers' paper details of the linkages already in place.

## APPENDIX 12: WORKSHOP 3 TOOLS

### Enablers and Barriers (Organisational Level)

Enablers	Barriers
Collaboration between services (trust, service response time)	Questions about service provided & client profile for service
Collaboration with the client (having a named contact person)	Lack of feedback (between services & to clients)
Services with the same focus (social care or clinical care)	Lack of knowledge of service options (stakeholders & clients)
Workers' personal attributes (caring, approachable)	Carer Issues (mental health literacy, the competent carer)
Personalised approach to care (flexible, forward planning)	Client issues (resistance & autonomy)
Relationships- knowing the person (workers & clients);	
Knowledge of service options	
Crisis as a facilitator	
Carer as the advocate & navigator of care seeking	
Connections viewed as being dependent on key individuals	

### Ideas for Change (Local Level)

Suggested opportunities for change	Value Analysis
Formalising a feedback mechanism between Aged Care providers & GPs	
Provision of an educational program facilitated by Nurse Practitioners or CPCs to educate agencies on importance of feedback	
Setting up a virtual meeting space to share resources & local knowledge	
Increased awareness of services and easier referrals between GPs and mental health services (broadly defined)	
Easier referral between clinical and non-clinical services (what is needed to bridge the gap between health and social care?)	

## Enablers and Barriers (Organisational Level)

Enablers	Barriers
Collaboration between services (trust, service response time)	No clear organisation across sectors providing overall coordination of client care (stakeholder & client)
Services with the same focus (social care or clinical care)	No clear inter-organisational leadership process to cross boundaries between sectors Limited evidence of planning between services
Service location e.g. co-location	Few connections between physical health & mental health care services (stakeholder & client)
Informal links can be used easily in small contained regions	Social inclusion activities & programs were not well represented & the potential for increased participation in social activities for people with severe mental illness (during periods of stability) was raised
Relationships- knowing the person (workers & clients)	Confidentiality issues (stakeholders & client)
Knowledge of service options (& community organisations)	[Some] workers told meetings are 'not core business'
Multiple meetings in the region bringing different services together	Location- travel time & costs; if services are less accessible (e.g. city based services), local services may be requested to 'plug the gap'
	Waiting times for specialist assessments e.g. access to tele-psychiatry & geriatrician assessments
	Lack of service options e.g. the older person with a 'lower level' mental health problem & respite places
	Connections viewed as being dependent on key individuals
	GPs reported difficulties managing clients in local hospitals



	The impact of funding may threaten current links & service planning and management (SAFKI ML & PATF funded until 2015)
	Funding issues- impact on staff retention & changes in services (stakeholder & client)
Policies & Protocols: There is generally support for integration, collaboration, coordination and networking	Policies & Protocols: There is a lack of strategies for connecting clinical and social services, and mental health and aged care

## Ideas for Change (Organisational Level)

Suggested opportunities for change	Value Analysis
Up-skilling support workers to identify & report decline in older persons' function & mental state	
Capacity building for support workers	
Engage leadership at higher levels to support workers participation in networking activities	
Shared electronic case notes	
Increased access to psycho-geriatricians & geriatricians	
Consider the roles, current resources & organisations appropriate to provide assessment & sign-posting of referrals for older people across a range of mental health and related problems (dealt with by RFs & GPs)	
Acknowledge those staff with important local network leadership functions by recognising this in their role	
Pathways to care protocols- to be inclusive for GPs and community members	

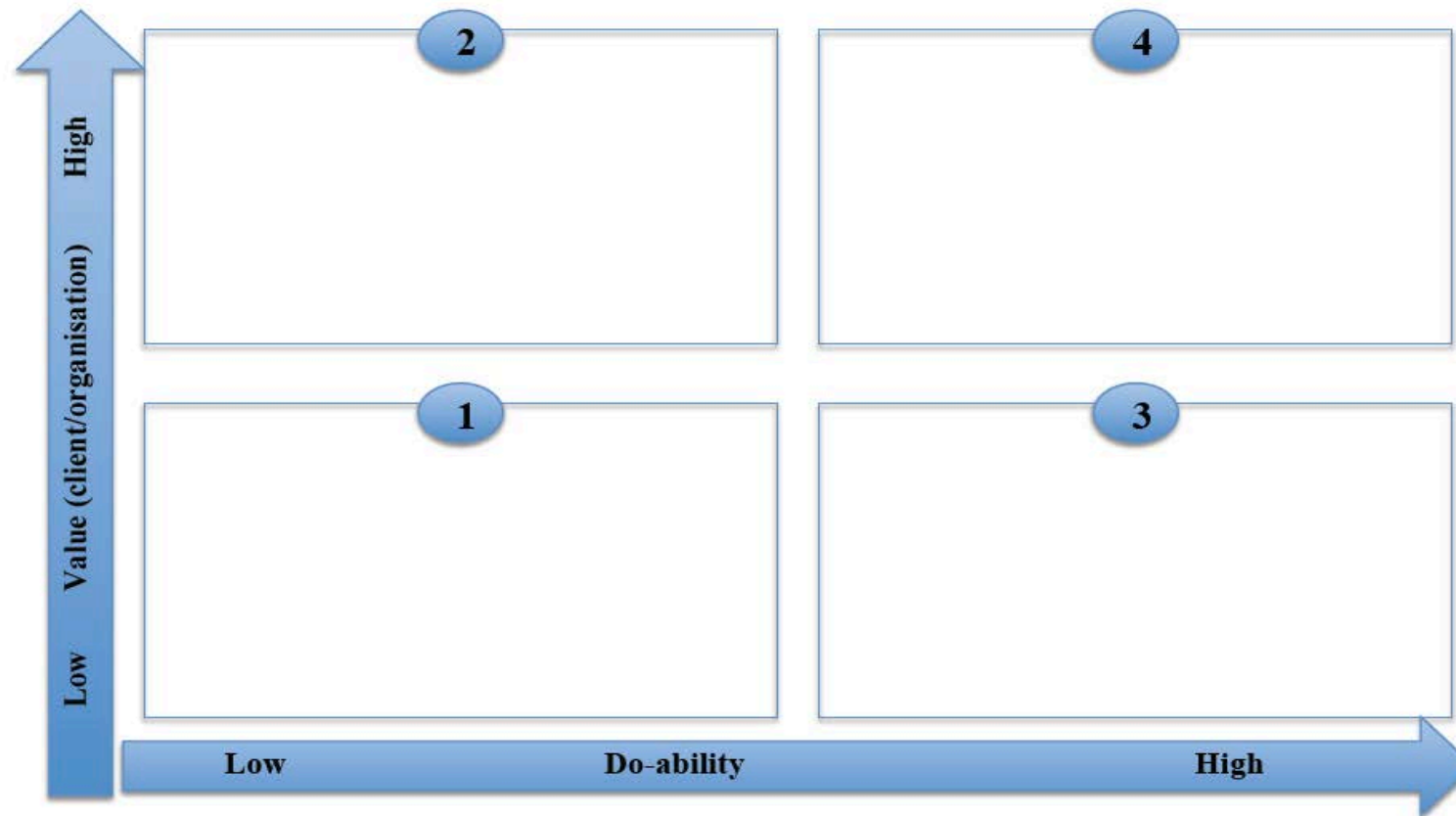
### Enablers and Barriers (Policy Level)

Enablers	Barriers
State Policy: <ul style="list-style-type: none"> <li>• Specific policy around the needs of older people with mental health problems.</li> </ul>	Fragmented policy and funding environment
State Policy: <ul style="list-style-type: none"> <li>• Stepped care approach.</li> </ul>	Older people are generally absent from national policy
State Policy: <ul style="list-style-type: none"> <li>• Attention to structural factors (e.g. beds and service location) to address the needs of older people with mental health problems</li> </ul>	State policy: <ul style="list-style-type: none"> <li>• Little attention to the need for mental health promotion, prevention and early intervention for older people</li> </ul>
National Policy: <ul style="list-style-type: none"> <li>• My Aged Care &amp; Regional Assessment Service (CHSP)</li> </ul>	

### Ideas for Change (Policy Level)

Suggested opportunities for change	Value Analysis

## Value Analysis



## Plan of Actions

Issue	Improvement Tasks	Value Analysis	Who will be involved	Process for feeding back outcomes
01. e.g. <i>Lack of feedback between Aged care providers and GPs</i>	<i>Development of a feedback tool template</i>	4	Medicare Local Aged Care (NGO) General Practice	
02.				
03.				
04.				
05.				

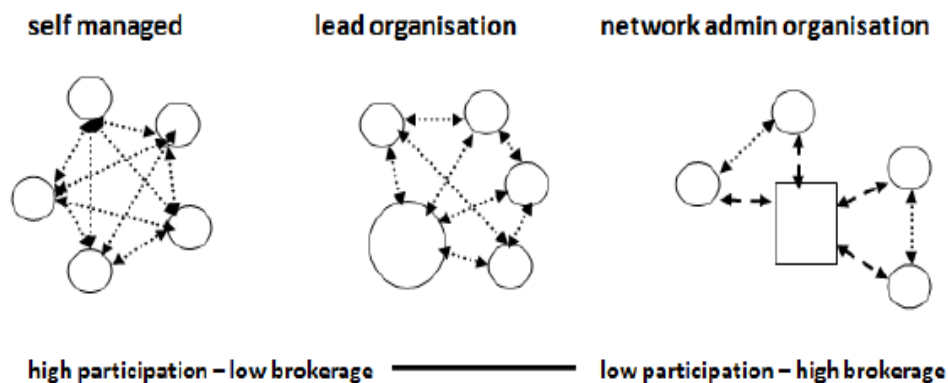
## APPENDIX 13: END OF PROJECT INTERVIEW GUIDE

### Together for the Mental Health of Older People (T-MOP)

#### Senior leaders project evaluation interview schedule

In relation to older peoples mental health we are interested in your perspective, as a person in leadership, on how you think this project has informed the capacity for services to jointly problem solve issues related to older persons mental health on the Southern Fleurieu and Kangaroo Island region.

For this project we have utilised Network theory to understand the health care context and suggest management strategies that suit the network type. The following diagrams are 3 different network types.



*For example:*

*1. The MHS could be seen as the lead organisation amongst NGO's where there are brokered support packages.*

*2. Had the funding for ML's continued, they would have been viewed as the central organisation in the network administration organisation.*

1. Prior to the inception of the project, would you have considered the service/s you represent to have been part of a network?
2. Do you think this has changed over the course of the project and if so how?

*i.e. if you thought there was a network, do you think it has changed, and how?*

*Or if you did not think of the services as forming a network, has your perception of whether there is a network changed, and how?*

3. If you agree a network exists – now at the completion of the project- which network do you consider best describes the services dealing with older people's mental health on the Fleurieu region?

*You can consider the different geographical locations.*

4. Which network type do you think would be the most ideal to address the issues of older people with mental health issues?
5. Do you think there would need to be a clear organisation to lead and facilitate this or would a group of organisations be better able to facilitate the process?
6. As a result of the project do you consider there have been any changes in the way that services work together to meet the needs of older people with mental health issues on the Southern Fleurieu and Kangaroo Island region?

*Can you give any examples?*

7. Some of the indicators of positive change (as described on the model-attachment 1) include:
  - service coordination
  - agreed protocols
  - strengthened partnerships
  - network commitment

Can you comment on if you think there have been any changes in relation to any of these indicators?

8. Can you describe how you found the facilitated reflective process (workshops, survey, interviews) as a way to manage the range of services as a network, in terms of the following:
  - acceptability of the process
  - ability to identify and act on issues
9. What components of the project do you think have been the most helpful, and in what way have they been helpful?

*Can you give specific examples?*

*You might like to use model (attachment 1) showing the 8 stages of the project as a prompt.*

10. What components of the project do you think have been the least helpful and in what way have they been unhelpful?

*Can you give specific examples?*

11. Did the project achieve what you expected?

12. Would you use this process again – would you change anything?

13. Could you see the process of group reflective feedback being useful as a means to bring services together as a network on other issues to identify and problem solve around the issues?

Are there practical issues (such as resources, skills, time etc) that would need to be considered for this process to work effectively?

14. Is there anything else that you would like to say about the impact of this project on organisations in the region working together to provide services to older people with mental health issues?

Please feel free to contact me by phone or email if you want to follow up on this interview.

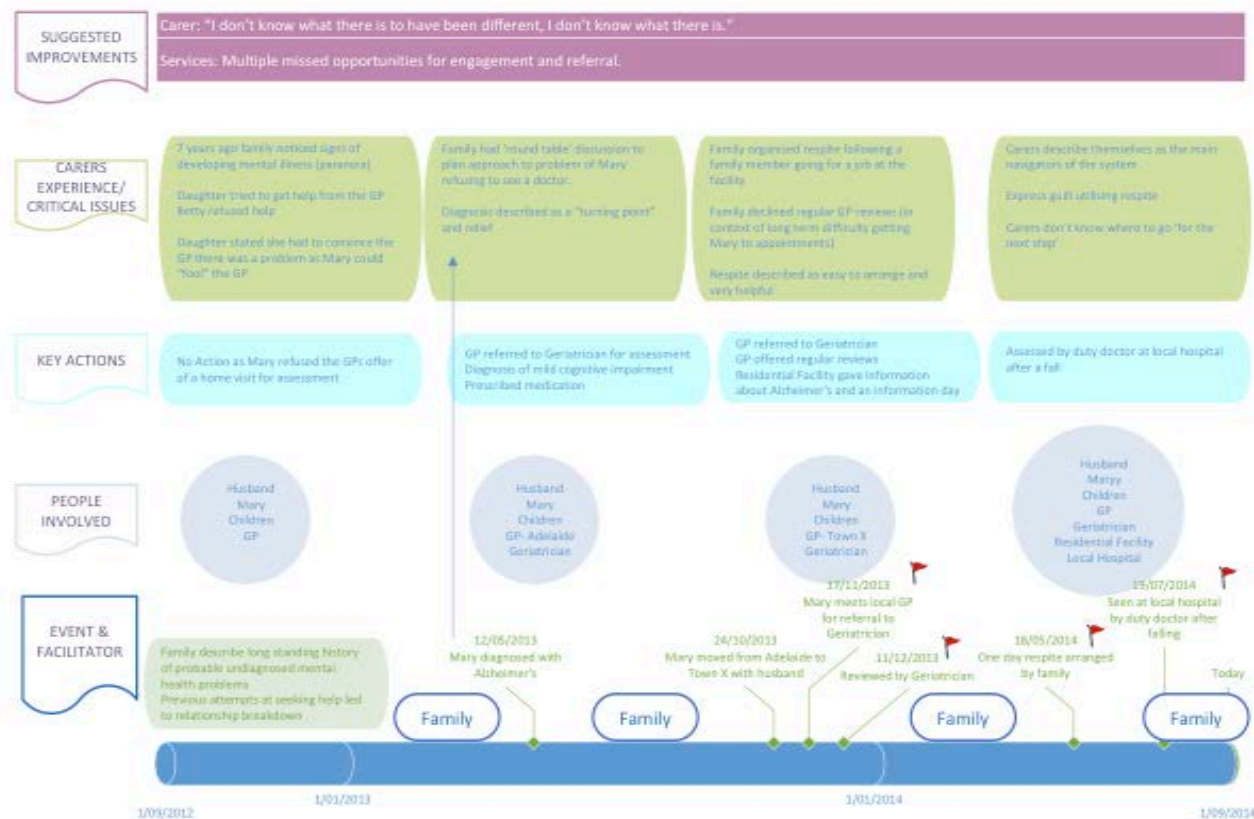
Are you happy for me to contact you by phone or email if I want to clarify anything from today's interview?

THANK YOU

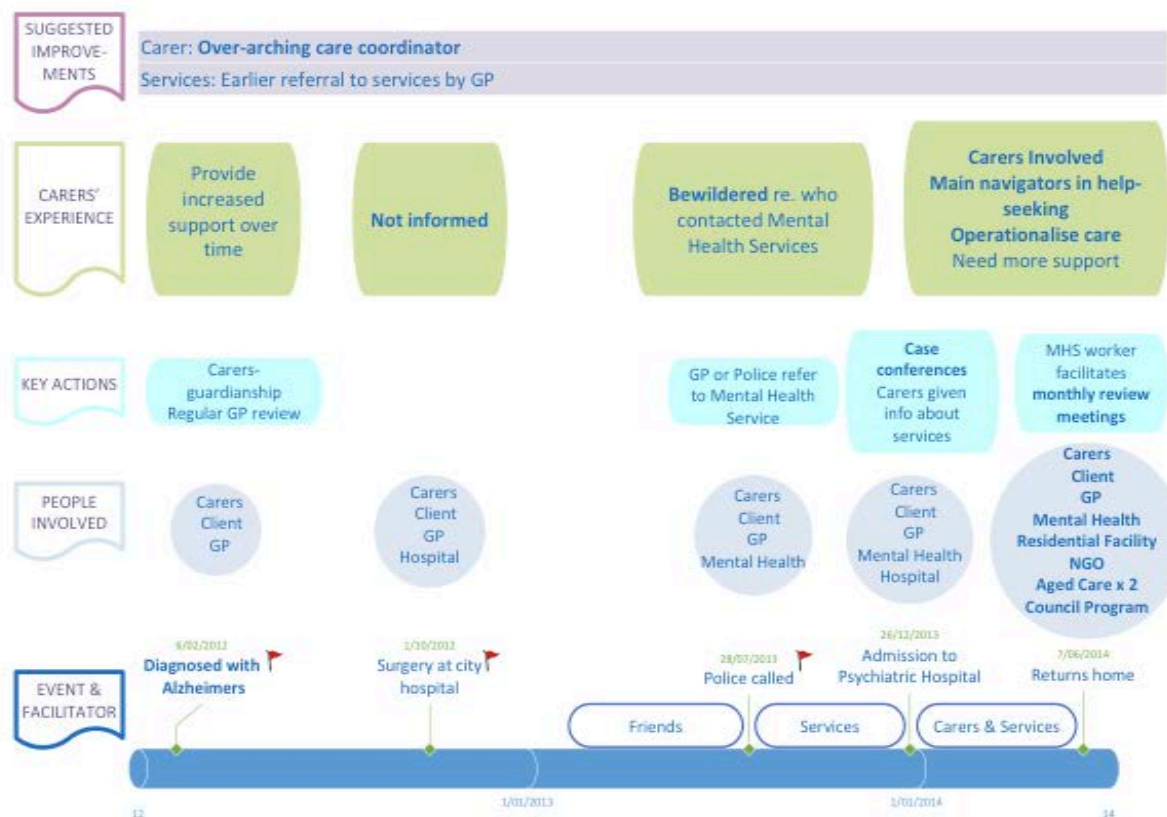


## APPENDIX 14: CARE SEEKING JOURNEY EXAMPLES

### Care Seeking Journey 8 (with detail)



## Care Seeking Journey 1 (summarised)



## APPENDIX 15: EXAMPLE QUOTES OF ENABLERS & BARRIERS

Enablers supporting networked services		<i>Example</i>
<b>Collaboration (between services and with consumers)</b>	Referrals, case conferences & multidisciplinary meetings	<p><i>I think it's very good for everyone to see what page we're all on... she's sort of keeping us a step ahead... talking about the next step we need to take. (Carer)</i></p> <p><i>...we have a good relationship with lots of the GPs in that they refer and we can feed back. When it feels good is when you see a problem or an issue and you have access to the people... you've got a direct contact and you know that they will then feed back to you what's happened. (Community Therapy Service)</i></p>
	Named care coordinator	<p><i>...we try to do [reviews] with the same GP that's looking after them for a while, that's very important, we try and convince people when they come down here to choose a GP that they will see regularly. (GP)</i></p> <p><i>...they all know her history here but I try to just deal with one doctor. (Carer)</i></p>
	Trust & belief in services	<p><i>...we build relationships over time... if I have a positive experience... in terms of the person is well looked after and there's communication... you tend to keep using that referral pathway. (GP)</i></p>
<b>Worker approach and attributes</b>	Personalised approach to care delivery	<p><i>He said 'look if we get your mum on a good day bring her in'... that was ongoing for a year, it didn't happen overnight so he was very flexible, he just said just ring and I'll make myself available, which is incredible because I mean I know social workers have schedules as well. (Carer)</i></p>

		<i>[The mental health worker] has actually taken him out a couple of times, her husband's a mechanic and that's what my husband was for years and years, so a couple of times she's taken him there just to hang around in the workshop...so that's been nice...it's almost a social occasion for him to get out which has been very, very good. (Carer)</i>
	Workers' personal attributes	<i>...most of the... workers are passionate, keen, vital, they really love working with people, easy to talk to... (Mental Health Service)</i>
<b>Location</b>	Relationships	<p><i>...a lot of informal networking, local community you tend to know everybody and you often ring up for advice or a chat or whatever so there's a fair bit of that. (Aged Care)</i></p> <p><i>Having the same people and working the same position for many years does make life easier because you get to know them and you know that there's no obstacles in ringing them up and talking to them, so that does help a lot. (GP)</i></p>
	Community	<p><i>...because they're a small community [smaller towns] they tend to take care of their own, so you know neighbours and friends will support each other, they set -up their own bowling clubs or social clubs so they're quite contained. (NGO)</i></p> <p><i>In country communities you tend to know your neighbours a bit more than in metro areas and I think that the neighbourhood circle is larger in country communities than in metro communities, and I think therefore there is that opportunity for earlier intervention to actually be promoted by community members. And so when we're looking at mental health and well-being there is a real role for community to provide psycho-social support to one another that perhaps doesn't present itself in metro areas. And you know there's a whole heap of networks in country that the Government would not even recognise but are actually filling up</i></p>

		<p><i>the gaps. (Mental Health Service)</i></p> <p><i>I think it's been pretty easy [to get help], everybody's been so supportive... part of that is ... because I have personal friendships and that, but I think that that's true for most people in the community on the Island. That community feeling of 'we see you down the street, we know who you are, let us know how we can help'. (Carer)</i></p>
	Service location, type and philosophy	<p><i>...with the aged care being next door it's very easy to get feedback from them in regards to what's happening with a patient and it's also easy and accessible if there's any problems, we can visit almost immediately over the day itself. (GP)</i></p> <p><i>...if we're running our programmes from a community development model you can't provide that type of service without those partnerships and networking, so it's definitely part of what we do. (Social Care Service)</i></p> <p><i>I've been exposed to working with psychologists in our business for more than ten years and the psychologists and the patients all love that relationship because we can communicate face-to-face, they can see the client, they can see me at morning tea and have a chat about the patient... [the visiting psychiatrist] has been coming to our practise for more than fifteen years, she's very busy but again because she consults in our surgery we're able to have informal over morning tea conversations, she'll knock on our door and have a chat to us if we need to about somebody she's worried about, it's a great working relationship. (GP)</i></p>
<b>Barriers to networked services</b>		<b>Example</b>

<b>Lack of a lead organisation</b>		<p><i>I think there's a severe lack of coordination and communication at all levels. We've got too many organisations trying to provide the same services... there's nobody coordinating or getting all these groups together to see if we can coordinate things... We're all working individually and we're not talking to each other and there's duplication of service and it's just so frustrating. (GP)</i></p> <p><i>... how [do you] keep [the] linkages viable... because you're going to end up with a map that is huge... does the GP need to know about that? Is he the key person? Is the practice nurse? Is it the mental health clinician? So who needs to know about the service for the referral, because the GP can't keep track of all that, that's not possible. (Primary Care)</i></p>
<b>Service Fragmentation</b>	Separately clustered networks	<p><i>It appears to be working well when the same service types are working together; in this instance community services. (NGO)</i></p> <p><i>...before the project there were, there appeared to be some clinical networks and there appeared to be some non-clinical networks with not a lot of communication between them. (Local government; End of Project Interview)</i></p>
	Lack of shared goals	<p><i>There is no lead organisation, there is no specific structure and certainly those organisations within... those, not common goals because that's the problem there's not a common goal, those organisations with cross overs of service provision... there are individuals and those informal links are still valuable... (Mental Health; End of Project Interview)</i></p>
	Engaging with multiple workers	<p><i>... I feel you need to have a coordinator who will say I've got this person who's been recommended from the doctor... or wherever it might be, who needs somebody to stand by them to fuddle all these points through... like [Aged care provider] and the [Social support service], all of those are very good but how do you coordinate all those with that one person? So if you could have somewhere, one person that says I'm going to pick up X's case and find out all the services available for him and I've been involved with that so I</i></p>

		<p><i>know... what's applicable for this person. (Carer)</i></p> <p><i>...there are so many different professions that could come in and deal with mental wellbeing... (Primary Care)</i></p>
	Difficulty navigating help-seeking	<p><i>It takes a long time to understand the informal processes because a lot of people just know how it happens, so when you're new to a practice... there's a lot of unwritten rules. (Practice Nurse)</i></p> <p><i>I went to the GP but [they] said to me that it's taken her a long time to form rapport with my mother to trust her and she was refusing to be seen by [a psychiatrist], she wouldn't even let the GP ring and discuss her management... (Carer)</i></p>
<b>Funding issues &amp; implications</b>	Funding direct client care	<p><i>...activity based funding measures disability; it measures services provided... it doesn't recognise the relationships between services as being valuable. (Mental Health Service)</i></p> <p><i>...every time you get a change of management you then have to re-justify any time outside of face-to-face client contact because that's what we're getting paid for. (Aged Care Provider)</i></p> <p><i>...for community health KPIs now have been set about how much direct contact client time versus non-direct time. So what I'm saying is that we're working in the opposite direction. (Community Health)</i></p> <p><i>...we aren't being paid... for our work in health promotion, we're being scrutinised on our</i></p>

		<p><i>one to one clinical service and that's what we are increasingly pressured to do. I mean that's where we've kind of been carved off community health a bit, we used to be able to be involved more in those broader community wellness type stuff, we're just not now. (Mental Health Services)</i></p> <p><i>But all of that comes at the expense of having the opportunity to go to that community meeting, to meet those people and to link with those agencies, to build that network and to build those good solid relationships that are grounded in trust based on knowing a face and knowing that that person is someone I can talk to and I always get valuable information from that person. (Mental Health Service)</i></p> <p><i>...in a very tightened, constrained financial climate everyone pulls back to their discreet funding buckets and the lines of demarcation and the goodwill tends to evaporate... I think there's been a lot of in-kind support and goodwill that operates locally but as managers are under more pressure about their budgets what you see is probably a retreat to a much more rigid interpretation of what services can be provided or not, and I'm sure in those environments capacity for liaising and networking possibly becomes somewhat strained. (Community Health)</i></p>
	Inconsistent funding	<p><i>...recruiting into positions if there's a vacancy, that's a huge problem. People are insecure in their positions because they don't know whether the funding is going to go on after certain dates. (Community Health)</i></p> <p><i>...it took about two months to actually get an appointment and I had a wonderful psychologist... then last year... they all thought they were going to lose their jobs, so [the Psychologist] went and got a job elsewhere and I just didn't go anymore. (Consumer)</i></p>



		<i>...particularly challenging at the moment is the uncertainty. We know the current HACC funding we all have agreements that end in June [2014], but we don't know what's going to be funded on July the 1st yet, so that's a particularly challenging point. (Community Health)</i>
	Impact of centralising governance and administration of services	<i>...the governance for Community Health on Kangaroo Island has gone off the Island... I think it's disconnected things... so the leadership locally in that area has changed dramatically and so it's difficult... trying to work out where to go... (Mental Health Service)</i>
<b>Barriers to mental health servicing for older people</b>		<b>Example</b>
<b>Lack of policy support</b>	Mental health care for older people neglected	<i>Reform and funding of mental health services for older people continues to be neglected, with older people at significant risk of ongoing decline in mental health care. (RANZCP 2014, p. 4)</i>
	Disconnect between aged care & mental health	<i>... working with the extensive aged care sector to provide better mental health service [is] a baffling omission [in the Fourth National Mental Health Plan]. (Roberts 2011, p. 229)</i>
	Lack of emphasis on promotion and prevention	
<b>Service accessibility</b>	Availability of	<i>When you're looking for it is when you really want it, you can't say in nine months' time I</i>

	services	<p><i>want to get some teeth done or I want to do something, you can't work it that way, it doesn't work... Entitlement [to respite] is fine but you've got to find somewhere you can get it. (Carer)</i></p> <p><i>...for those... needing a differential diagnosis of depression, dementia or drug interaction who are bumbling along at home... it might be several months. (GP)</i></p>
	Mental health literacy	<p><i>It was hard for us to know what was wrong with her because as I said she'd fluctuate... she'd come good and then she'd go back again... but there were just a few odd things that she'd say, the people next door were spying on her, it was really quite bizarre. (Carer)</i></p> <p><i>I think workforce competency around understanding and working with clients with both mental health issues and with dementias and other issues where there just isn't that really competent, high levels of competency for the workforce... (Community Health)</i></p>
	Service knowledge	<p><i>... when the referrer does the shotgun referral each of those individual services... may or may [not] be the right service. (Mental Health Service)</i></p> <p><i>I think it's just the amount of programmes and acronyms and... where do you need to go for this particular person and what would support them the best, and I think it's people not quite knowing, especially with mental health because you might not need the full blown bouquet, you might just need one piece of the system. And I think that's where people, maybe they don't refer because they just look at it and just go I'm not even sure where to go here, you know. (NGO)</i></p> <p><i>I think services are there, there are a lot of services there but everybody doesn't know about</i></p>

		<p><i>all the services that are there. And the fact is it's hard for everybody to know about those services because they change, the programmes come and go. (Primary Care)</i></p> <p><i>Where does that [information about services] come from? Where would that come from...? (Carer)</i></p>
	Service location	<p><i>...there's a very good understanding of roles and responsibilities and sharing of those roles and responsibilities where there's a gap. It doesn't work quite as well in larger communities. (Mental Health).</i></p> <p><i>...we have an excellent service in the... [visiting] Older Person's Assessment Service and it is highly in demand, we now have two geriatricians that come... there's a long waiting time, it would be really great to see that service even further enhanced so that psychiatric services don't get the basic diagnosis of dementia business that... comes to us because of the level of risk not because of psychiatric acuity... (Mental Health)</i></p>
<b>Service feedback</b>	Lack of feedback	<p><i>It seemed to us that somebody came and took him away [to hospital]. We understood that because of the silly things that he'd done they would do that, but we didn't know who had [arranged the admission]. (Carer)</i></p> <p><i>[From] the services... that are doing home visits... we will often do the referrals and all too frequently get no communication at all... This is frequently for the people who've got chronic problems you get no information at all. (GP)</i></p>
	Confidentiality	<p><i>At what time do you say to somebody 'I am really concerned about your husband... are you considering that there's some things that are happening that probably aren't just normal ageing?'... there really is a fine line between the rights of the patient to confidentiality and then to my right to know if it's something that's going to affect either his safety or my</i></p>

		<p><i>wellbeing and the rest of my family's wellbeing. (Carer)</i></p> <p><i>...there's confidentiality issues where people can't talk to each other and that creates a barrier, so that...can be from a range of things where the organisation says you can't liaise with someone, or... the client has said you can't.. (Community Health)</i></p>
	Lack of connection between services	<p><i>I think working together with the clinical side and the social side has proved to be really good but I wouldn't say there was a lot of connection... I don't know when ... she [last] saw a psycho-geriatrician or mental health team. (NGO)</i></p>

## APPENDIX 16: PRIORITY ACTIONS

Issue	Improvement Tasks	Value Analysis	Who will be involved	Process for feeding back outcomes
01.  Lack of feedback between Aged care providers and GPs	1.1 Development of a feedback tool template	4	1.1 Medicare Local  Aged Care (NGO)  General Practice	1.1 Medicare Local to work with one GP practice to trial the implementation process.  Medicare Local to canvass which local community organisations want to use the tool.  Each community organisation will be responsible for implementing their own work instructions.

<p>02.</p> <p>Lack of knowledge of services</p> <ul style="list-style-type: none"> <li>• GPs</li> <li>• Local council</li> <li>• Health services</li> <li>• Community services</li> </ul>	<p>2.1 An electronic map of local services/resources is currently being developed by SAFKI ML</p>	<p>4</p>	<p>2.1 Medicare Local</p>	
	<p>2.2 A local service provider network electronic directory (detailing services and key contacts in area) is currently being managed by SAFKI ML</p> <p>This could be made available more broadly, including to local council</p>	<p>4</p> <p>2</p>	<p>2.2 Medicare Local</p> <p>Local government</p>	<p>2.2 Medicare Local to continue to take carriage of the directory for the next 6 months. The Network provider group meets 6 monthly.</p> <p>Medicare Local and the PATF to 'hold' the network provider directory for the next 6 months.</p> <p>There was acknowledgement that there is lack of clarity post June 2015 regarding ongoing responsibility of updating the network provider directory.</p> <p>Ongoing management could possibly be facilitated by: the Aged Care Regional Assessment Service; the PATF or the PHN.</p>

02. cont.  Lack of knowledge of services	2.3 A service provider directory is currently being developed for KI	4	2.3 NGO with support from Medicare Local	
	2.4 Organisations to ensure their details on the 'My Aged Care' website are relevant and up-to-date	4	2.4 Medicare Local	

03.				
Need for mental health literacy upskilling	3.1. Mental Health First Aid training to be provided	4	3.1 Medicare Local	
Recognising decline ('at risk' individuals) e.g. Community Services, Carers Forum, MOW's	3.2 AWACCS tool to be offered for use to community staff from different organisations to support staff to identify and report decline (requires 1 hour training)	4	3.2 Medicare Local and Community health (for information)  PATF  Social care organisation	3.2 PATF to take carriage of introducing the tool to different organisations. PATF to liaise with Medicare Local and Community health re accessing the tool and implementation.  Social care organisation- to trial the tool with volunteers.



04.  Need for increased collaboration between services  Services are funded for outputs rather than networking	4.1 There is a need to consider formalising partnerships (developing a 'low level' MOU) to enhance collaboration  A formalised partnership would validate the need for local relationships and networking and allow people to develop local protocols	4	4.1 Mental Health  Medicare Local  PATF	Managers from mental health, Medicare Local and PATF to meet for a discussion regarding formalising collaboration.
	4.2 Re-invigorate PATF MH working group and focus on specific objectives	4	4.2 PATF	
05.  Policy	5.1 The local government regional public health plan is due to come out in February	4	5.1 PATF to distribute the document widely for review and	5.1 Draft plan to be distributed by the PATF in February 2015 for comment.

	2015 for consultation		comments	
	All organisations should review and comment on the plan		Medicare Local to have input and support the council	
			Mental Health to contribute to the plan	

# APPENDIX 17: REFERRAL TEMPLATE & POWERPOINT PRESENTATION

## Southern Fleurieu Services

### GP Referral

Date:

To: Medical Practice & fax number	<input type="text" value="select practice"/>
Attention Dr	<input type="text"/>

From / Fax:	<input type="text" value="list care providers"/>
-------------	--

Patient / Client Details			
Patient/client name:	<input type="text"/>		
Date of birth:	<input type="text"/>	Date of referral:	<input type="text"/>
Patient/client aware of referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

*NB: Please attach client consent to share information*

Health Service Request
<input type="checkbox"/> <input type="text" value="select appropriate response"/>
Details: <input type="text"/>

Signature:	Name: <input type="text"/>
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*NB: GPs please attach details of care or a printed summary note and fax to referrer.*

Adapted from documents developed collaboratively from South Adelaide Health Service (SAHS) and General Practice Network South (gpns) 2009.



## Why

### Workshop 2

- Table top discussions revealed an issue around referral into General Practice from Community based services and clients they cared for.
- Sometimes instructions around follow ups and appointments were lost as clients didn't know how to deal with them, and carers (including community based services) were not part of the consult.

## What

### Referral and feedback template proposed

- A small working group was formed consisting of a GP, Practice Nurse and NGO worker
- Communication was done via email



## How

- An initial template for referral and response was developed and circulated
- The template was tabled at a GP Network meeting. It was suggested to simplify the system and not proceed with the response template.
- Changes were made to the referral template and an example circulated to 3 GPs involved, and a wider group of community services.

## Next Steps

- Following the workshop today, this template will be available for use by Community Services for referral into general practice
- Services that are not in the list of care providers can be added
- Service organisations can add their logo to the top of the form

# Annie Jones

**Southern Pluralis Services**  
**GP Referral**



Date: 20/11/2014

To: Medical Practice & fax number	Goodwin Medical Centre: 85551002
Attention: Dr	Byrne

From / Fax:	Cabery Community Care - 8555588
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## Patient / Client Details

Patient/Client name:	Annie Jones		
Date of birth:	22/11/1928	Date of referral:	20/11/2014
Patient/Client aware of referral?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	

Nil: Please attach patient consent to share information

## Health Service Request

**Re:** Decline in wellbeing

**Details:** Dear Steve,

Annie has been a client of ours for home services now for over 12 months, but over the past 3 months we have noticed that she has become more withdrawn and fearful of anyone entering the house. It is difficult to engage her in conversation and seems to be losing weight. I feel that she needs assessment of her mental health state.

Signature:	Nicole Deb Sparke
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Nil: GPs please attach details of care or a printed summary note and fax to referer.

# Thankyou

Dr Steve Byrne  
Michelle Pearce  
Gwyn Eason