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

# Joondalup Wanneroo Region Mental Health Sub Network Establishment Report

**Including outcomes of the Joondalup Wanneroo Region Mental Health Sub Network inaugural Open Meeting**

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# Contents


Executive Summary 2
Introduction 4
- Mental Health Network 4
- Mental Health Sub Networks 4

Joondalup Wanneroo Region Mental Health Sub Network Open Meeting 5
- Open meeting process 6
- Panel discussion 6
- Workshop outcomes 8

Next steps 12
Appendix A: Open Meeting program 13
Appendix B: Detailed participant input 14
Appendix C: Inaugural Joondalup Wanneroo Region Mental Health Sub Network Steering Group 21
Appendix D: Acronyms 22

# Executive Summary

## Joondalup Wanneroo Region Mental Health Sub Network

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

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

### Open Meeting

The MHN in conjunction with the Mental Health Commission (MHC) hosted the Joondalup Wanneroo Region Mental Health Sub Network Open Meeting on 25 February 2016.

The Open Meeting was attended by 60 people, including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations. The participants were highly engaged and motivated throughout the meeting and actively contributed to information collected.

The Open Meeting program is available in Appendix A.

The points below capture the common issues raised during the plenary and in the workshop, as identified by the Open Meeting facilitator:

- Lack of comprehensive navigation support and mapping through and across the system, leaving consumers and service providers unaware of available services and guided by inadequate tools (e.g. simple lists of phone numbers).
- A need to address the social determinants to mental health, particularly shortages of housing and appropriate emergency accommodation.
- A need for improved General Practitioner engagement, including clear referral pathways and communication and feedback with community based service providers.
- Poor discharge planning, options and ongoing support during a critical recovery phase, including discharge treatment plans not shared with all stakeholders and a lack of continuity of treating psychiatrist.
- Information and Communication Technologies inconsistencies between Emergency Department (ED) and other services resulting in breakdowns between services and in the continuity of care.
- Duplicated and fragmented services without agreed standardised pathways (including non-health related agencies).
- Restrictive entry criteria preventing people from accessing the services and support they need (i.e. non severe crises and people who have 'burned bridges').
- Unsustainable level of presentations to the ED resulting in long waiting times and added stigma.
- Funding targets and structural changes (e.g. National Disability Insurance Scheme) affect the provision of key services.
- Lack of resourcing for specific services required, including youth mental health, long term psychotherapy, eating disorders and culturally and linguistically diverse requirements.
- Shortage of qualified and experienced mental health practitioners in the region.

- Need to better incorporate the priorities of consumers and carers into service delivery and development (include the ‘learned’ and the ‘lived’ expertise).
- The reality of population growth demands.
- A need to better integrate treatment and support for comorbidities and social issues.

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

## Steering Group

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

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

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

# Introduction

## Mental Health Network

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

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

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

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

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

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

## Mental Health Sub Networks

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

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

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

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

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

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

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

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

A list of the Inaugural Steering Group for the Joondalup Wanneroo Region Mental Health Sub Network is available in Appendix C.

# Joondalup Wanneroo Region Mental Health Sub Network Open Meeting

Stakeholders for Joondalup Wanneroo region mental health services in Western Australia met for the inaugural open meeting of the Joondalup Wanneroo Region Mental Health Sub Network at HBF Arena Joondalup on 25 February 2016.

A total of 60 people attended the Open Meeting including mental health service consumers, families, carers, mental health advocates, health professionals, university academics, service providers and organisations.

- 80 people registered to attend the Open Meeting.
- 60 people attended the Open Meeting (75% of those that registered).
- 37 organisations were recorded as having representatives at the meeting.

## Open meeting process

The energy and good will demonstrated throughout the establishment of the Joondalup Wanneroo Region Mental Health Sub Network continued to develop momentum throughout the Open Meeting.

The Open Meeting program is available in Appendix A.

Following the acknowledgement to country given by Mental Health Co-lead Alison Xamon, the Open Meeting heard overviews from Dr Helen McGowan, regarding the MHN; Ms Louise Southalan regarding Mental Health – The Big Picture, and Mr Kempton Cowan and Associate Professor Alastair Vickery regarding the Joondalup Wanneroo region mental health sector.

Panellists recommended by the Joondalup Wanneroo Region Mental Health Sub Network Implementation group then shared snapshots of key issues and perspectives in the Joondalup Wanneroo Region mental health sector.

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

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

## Panel discussion

The panel consisted of representation from the following perspectives:

- Consumer — Mr Alan Alford
- Carer — Ms Diane Mouritz
- Primary Care — Dr Sharon Vasey
- Clinician — Dr Raj Tanna.

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

- This is a positive advancement in agencies coming together which is really encouraging.
- I was required during my treatment phase to attend a government health service and provide information. I went there, the woman drew up my file and read some details, and made a sympathy comment ‘oh you poor thing’. That really affected me as sympathy was the last thing I needed. It destroyed 6 months of clinical work and took me another 6 months to regain my confidence again. The personal cost to my mental health, the clinical resourcing cost to the community and the opportunity cost for another consumer from that single event was huge.
- This sub network is really important to build a unified approach around language and solutions for service providers and consumers.
- Delighted to see so many people here to share, listen and build on ideas.

- We need to build a whole community approach of true multi-sectorial collaboration across the full continuum of care, no isolated agency alone can do provide the full service.
- Accessibility to, and responsiveness of, a range of services is needed.
- We need to heavily and authentically involve consumers and carers in our service delivery. Navigation through the services is an issue and we really need a map of the services currently on offer, then we need the road works in terms of some standardisation of the care (i.e. standard pathways of care).
- I believe the region needs a distributed agreement for services that say 'this is how people can get to services, get through and get out of services'. We've come a long way and we all try to work together but the reality is that we still have a fractured approach and we need a really simple path through those services.
- We need to be quite innovative in our distributed understanding and agreement of these issues.
- A consortium, governance board or group may be a mechanism to enshrine certain values and minimum standards that could be measured.
- We need that distributed understanding across services to improve the flow of consumers without the need for reassessment and barriers.
- We also need to take into account the social determinants of mental health in terms of truly collaborating on homelessness, poverty the like.
- Improvements that could be made to the care of patients with mental health problems from a primary care perspective:
  - primary care being central in the care of patients with mental health problems
  - General Practitioners (GP) responsible for management, follow up and monitoring
  - GPs coordinating referrals to allied health / secondary care and non-government organisations (NGOs)
  - GPs working closely with community mental health teams.
- Currently the links between GPs and organisations such as Headspace, Anglicare and NEAMI are poor, which can lead to fragmented and disjointed care.
- Primary care needs clarification on referral pathways for patients with complex psychosocial problems. Currently GPs are frequently unaware of services available (e.g. NEAMI crisis services and referral pathways are confusing).
- Primary care seeing more of the patients with stable complex mental health problems to relieve pressure on outpatient waiting lists.
- GPs are very capable of looking after patients with complex mental health problems with adequate support from the community mental health team.
- The aim would be for shorter waiting times for patients who require access to a community mental health team; current waiting times are a minimum of four weeks unless an emergency.
- Continuity of care needs improvement. Patients should see the same members of the community mental health team, particularly the psychiatrists. Currently there are frequent changes of psychiatrist.
- Community psychiatric nurses could be attached to a local GP practice to improve communication with secondary care and enable patients to be seen at their local clinic; advantages would be the multi-disciplinary care and continuity of care. Patients with mental health problems often smoke, drink excess alcohol and / or use illicit drugs, have poor diets and are on medications that increase cardiovascular risk; attention would be paid to lifestyle factors such as smoking cessation and dietary advice to improve cardiovascular and mental health.

- With the government moving towards community focused care, there are a range of difficulties with discharge from hospital services to GPs:
  - discharge summaries are not always detailed enough or accurate
  - GP expertise is not always adequate
  - some consumers that lack insight will not always attend GP visits and this affects the consumer - carer relationship
  - more involvement of carers and families would be ideal but not all consumers want carer involvement and it is their choice
  - including advance health directives with discharge summaries would be an improvement.
- Partners in Recovery programs are available for support and navigation.
- Navigation is frustrating at times so always ringing when there has been a change in clinician is really helpful for consumers.
- There are some fantastic resources in Joondalup, so keep up the good work.

## Workshop outcomes

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

  - What do you see as key issues that are still to be resolved?
  - For this issue, what potential solutions would you propose?

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

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

**Lack of comprehensive navigation support and mapping through and across the system, leaving consumers and service providers unaware of available services and guided by inadequate tools (e.g. simple lists of phone numbers):**

- We need a map of services to actually work and the information sharing to not just be another list of numbers to contact or forms to fill in.
- Need to continuing to identify the services and processes that work well.
- Difficult to navigate through and across the system.
- Do we need to look at a centralised resource and communication opportunity to advise health professionals and patients on the available local and timely services and how to access them?
- Mental health patients need a central point (medical home) to have continuous care.
- Making us do a lot of the work or navigate systems ourselves is going to cause more distress than recovery.
- Need to do the mapping analysis to look at the region and see collectively where the gaps are and build vertical integration across funders and horizontal integration across services.
- Unaware of services available for consumers and workers.

**A need to address the social determinants to mental health, particularly shortages of housing and appropriate emergency accommodation:**

- Many of the problems are social.

- Lack of accommodation, housing and support options for mental health patients.
- Lack of affordable accommodation.
- Minimal accommodation, particularly crisis accommodation.
- People coming to mental health services due to lack of resources in other areas (e.g. housing).
- Solutions need to be focused on basic needs first (i.e. housing, food and transport).
- High rates of domestic violence.
- Unemployment issues compound mental health conditions.

**A need for improved GP engagement, including clear referral pathways and communication and feedback with community based service providers:**

- Clear pathways for GP referral is required for various levels of care.
- GPs are unaware of the community based mental health services that are out there.
- Lack of engagement of GPs in the whole care of people.
- Lack of mental health expertise at the GP level that could be alleviated by the introduction of mental health nurses and nurse practitioners.
- Poor communication and lack of feedback between GPs and Headspace.

**Poor discharge planning, options and ongoing support during a critical recovery phase, including discharge treatment plans not shared with all stakeholders and a lack of continuity in psychiatric allocation:**

- Discharge treatment plans upon release from hospital being available for community, government and non-government services, including Corrective Services.
- Lack of support for people at the time of discharge from mental health units and ED, which is a critical point of time up to approximately six weeks post discharge.
- Limited discharge options from hospital.
- Need to improve continuity of care in the community mental team, as patients often see different psychiatrists.
- Need for community psychiatric allocation upon discharge.
- Poor communication and discharge planning.
- Other services or treatment teams need to be aware discharge is going to happen prior to discharge (e.g. housing, financial and other social determinants).

**Information and Communication Technologies inconsistencies between ED and other services resulting in breakdowns between services and in the continuity of care:**

- Computer systems not talking to each other between ED and mental health clinics.
- Links between public and private health system and services are not consistent (e.g. clinical entry data system at the Joondalup ED not linked into the Health system, therefore if a child attends the Joondalup ED, Child and Adolescent Mental Health Service (CAMHS) don't always know about it).
- Sometimes families don't tell and sometimes faxes don't go through.

**Duplicated and fragmented services without agreed standardised pathways (including agencies that aren’t health-related):**

- Need for broad standards to be agreed across the sector.
- Catchment area restrictions mean that if clients are more transient or mobile, they lack continuing and collaborative care across public health regions and different lead agencies (i.e. Partners in Recovery (PIR) and community mental health).

- Duplication and fragmentation of services.
- Gap between services provided by Disability Services Commission (DSC) and mental health.
- Even though there are Memorandums of Understanding (MOUs) in place, they are not always practiced.
- Department of Housing disconnect due to a lack of training in mental health.
- A majority of clients in Department of Housing homes have comorbidity and mental health issues that are not readily seen, and therefore not addressed or taken into consideration, and if visible, usually ignored.
- Challenge of working together well for the consumer.
- Require much more substantial inter-sectorial collaborative partnerships and Models of Care across the continuum of care.
- No wrong door approach needed.
- Commitment and resources dedicated by each service to respond, being clear about their business and the business of others, connecting people to get the right service and being funded for this activity.
- Poor coordination of primary mental health services.
- Private or public health not partnering adequately with NGOs to provide continuity of care.
- Standardised pathways to care need to be developed across integrated services.
- Multiple assessments experienced by individuals.

**Restrictive entry criteria preventing people from accessing the services and support they need (i.e. non severe crises and people who have 'burned bridges'):**

- Need for consideration of appropriate services and supports for consumers who have 'burned bridges' with a number of services.
- How do we support people with communication difficulties in the mental health sector to receive relevant, skilled services (e.g. counsellor, psychiatrists and psychologists, mental health nurses etc.)?
- Address the needs of people that do not qualify for community clinics because of 'severity or situational crisis' and are given a list of numbers.
- Services for consumers who don't meet specific intake criteria for specialist mental health services.
- Some services are underutilised because of restrictive entry criteria (e.g. NEAMI).
- Where do the people that do not meet requirements go if they are in crisis, or do we leave them to fend for themselves or possibly suicide?
- GPs are not seeing those with moderate mental illness.

**Unsustainable level of presentations to the ED resulting in long waiting times and added stigma:**

- Crises shouldn't need to go to community or ED services.
- Many people who are currently in inpatient beds can be better supported at home.
- Stigma attached to mental health access via the ED.
- Suggest more trauma informed care in ED, particularly for mental health.
- Require timely and appropriate responses on presentation at EDs.
- Long waiting times in ED.

**Funding targets and structural changes (e.g.** National Disability Insurance Scheme (**NDIS) affect the provision of key services:**

- The contradiction between person-based services and meeting key performance indicators (KPIs), as services are more likely to support people that help them meet their targets.
- Lack of openness and transparency around the resource management of services.
- Fragmented funding.
- PIR are available to assist and support people to navigate the mental health system, but this is likely to change with the transition to the NDIS.

**Lack of resourcing for specific services required, including youth mental health, long term psychotherapy, eating disorders and** culturally and linguistically diverse **(CaLD) requirements:**

- Insufficient services available to provide long term psychotherapy.
- Lack of assertive in-reach across service delivery.
- Lack of eating disorder services in the northern suburbs.
- Lack of Psychiatric Liaison Nurses.
- Lack of services appropriate to CaLD experiences.
- Lack of psychological services available within community and hospital settings.
- Lack of specialist care in child mental health and adolescent mental health.
- Lack of mentor services.
- No older adult specialist mental health inpatient beds.
- Poor youth mental health services.
- Gap in the transition to adult services.
- Specialist interpreter services (i.e. Auslan) needed for individuals who are doubly isolated due to depression and communication problems for profound deafness.

**Shortage of qualified and experienced mental health practitioners in the region:**

- Need driven and mental health focused staff that keep momentum in working towards recovery; this is not just another job.
- There is a serious shortage of qualified and experienced mental health practitioners, and we need to improve the mental health workforce.
- Social workers working alongside the psychiatric nurse and GP to address psychosocial issues within one location.
- Some community support services have inadequate quality of clinical care provision.
- Utilise the allied health resources and their skills (e.g. occupational therapy, mental health clinicians, social workers, physiotherapists and psychologists) as there are many comorbidities besides a mental health issue.

**Need to better incorporate the priorities of consumers and carers into service delivery and development (include the 'learned' and the 'lived' expertise):**

- Joining up the 'learned' and the 'lived' expertise in the management and support provided to individuals.
- Recovery becoming medicalised and something you 'do' to people.
- Services need to reflect the priorities of consumers and carers.
- Supporting people with disabilities and mental health issues and giving them a voice.

**The reality of population growth demands:**

- Matching the number of mental health beds to Wanneroo's population growth.
- Population growth demands.

**A need to better integrate treatment and support for comorbidities and social issues:**

- Service system needs to respond and integrate treatment and support for co-occurring post discharge (e.g. drug and alcohol, offending behaviours, homelessness etc.).
- There are difficulties navigating and understanding co-morbidity of disability and mental health.
- More specialised services often have more restrictive selection criteria that exclude comorbidity, which is correlated with higher complexity.

**Other issues:**

- Not enough preventative interventions, both prior to diagnosis and at the critical point requiring tertiary level services.
- Social isolation.
- Perception by families that they will be sent away if they are already linked to another service, even if they need immediate assistance.

The detailed participant responses are available in Appendix B.

# Next steps

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

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

Developments, issues for broader discussion and achievements will be reported back to the broader Joondalup Wanneroo Region Mental Health Sub Network membership via the Health Networks.

# Appendix A: Open Meeting program

Department of Health
Mental Health Commission
GOVERNMENT OF WESTERN AUSTRALIA

# Joondalup Wanneroo Region Mental Health Sub Network Inaugural Open Meeting

## Thursday 25 February, 2016

Venue – Medallist Room, HBF Areana, Kennedya Drive, Joondalup

Registrants of this event will have the opportunity to find out how they can actively participate in the Joondalup Wanneroo Region Mental Health Sub Network and help shape its priorities.

| Time | Program | |
|---|---|---|
| 1.00pm | Registration | All |
| 1.30pm | Introduction<br>Acknowledgement to Country | MC – Ms Alison Xamon |
| 1.35pm | Mental Health-The Big Picture | Mental Health Commission |
| 1.45pm | Overview of Mental Health Network | Dr Helen McGowan |
| 1.55pm | Overview of the Joondalup Region Mental Health Services | Mr Kempton Cowan<br>Assoc Prof Alistair Vickery |
| 2.05pm | Identifying issues and possible solutions to navigating the local mental health system. Perspectives from: | Consumer: Mr Alan Alford<br>Clinician: Dr Raj Tanna<br>NGO: tba<br>Primary Care: Dr Sharon Vasey<br>Police: Snr Sgt Scott Arnold |
| 2.35pm | Networking break | |
| 3.00pm | Feedback and ideas for future | Mr Will Bessen |
| 3.45pm | Joining the Joondalup Wanneroo Region Mental Health Sub Network and Steering Group | Ms Alison Xamon |
| 3.55pm | Concluding remarks and acknowledgements | Ms Linda Locke |
| **4.00pm** | **Close and Networking 4.00pm** | |

# Appendix B: Detailed participant input

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

| Issue | Proposed Solutions |
|---|---|
| • We need a map of services to actually work and the information sharing to not just be another list of numbers to contact or forms to fill in.<br>• Or we are going back to a printed sheet of helpline style information given at the ED level? | • Continued information sharing and education for all service providers, consumers and carers. |
| • Lack of accommodation, housing and support options for mental health patients. | • Explore creative solutions and opportunities for people that require supported living options.<br>• Work with developers and planning authorities to partner different organisations (e.g. Vive development in Craigie).<br>• There are cross pollination opportunities for inter-sectorial collaboration. |
| • Lack of affordable accommodation. | |
| • Need for consideration of appropriate services and supports for consumers who have "burned bridges with a number of services". | • Specific program or service for consumers who find emotional regulation hard. |
| • Need for broad standards to be agreed across the sector. | • A consortium governance model to be developed with distributed agreement over broad clinical governance issues. |
| • Catchment area restrictions mean that if clients are more transient or mobile, they lack continuing and collaborative care across public health regions and different lead agencies (i.e. PIR and community mental health). | • Transient referral pathways and utilisation of state-wide e-medical records for clear and consistent communication, which reduces the need for reassessment, risk management and lack of inter-service collaboration with shared clients.<br>• Federal level legislation consistent across jurisdictions rather than local and State level. |
| • Challenge of working together well for the consumer. | • Provide more collaborative in-reach and outreach work across the service sectors. |

| Issue | Proposed Solutions |
|---|---|
| • Clear pathways for GP referral is required for various levels of care. | • Provide accessible early care by ensuring these services are solutions focused.<br>• Keep GPs informed about the options available to them. |
| • Need for community psychiatric allocation upon discharge. | |
| • Computer systems not talking to each other between ED and mental health clinics. | |
| • Need to continuing to identify the services and processes that work well. | |
| • Crises shouldn't need to go to community or ED services. | • Need to develop Chief Medical Officer led crisis centres as opposed to specialist mental health services. |
| • Department of Housing disconnect due to a lack of training in mental health.<br>• A majority of clients in Department of Housing homes have comorbidity and mental health issues that are not readily seen, and therefore not addressed or taken into consideration, and if visible, usually ignored. | • Mental health training or staff affiliation, and continued contact to make it easier for the client and also for the Department of Housing to lessen the issues arising. |
| • Difficult to navigate through and across the system. | • Investment in a peer support workforce to target specific entry and exit points (e.g. EDs, inpatient units, community services and primary care).<br>• These workers would be conceptualised as "mental health connectors" as a discharge summary can take months to complete. |
| • Discharge treatment plans upon release from hospital being available for community, Government and non-government services, including Corrective Services. | • Consent to release to be completed by hospitals prior to discharge to allow services in the sector to access upon request.<br>• Prevents delays in accessing community treatment and reduces the client risk to self and / or the community. |
| • Do we need to look at a centralised resource and communication opportunity to advise health professionals and patients on the available local and timely services and how to access them? | • Develop a one stop information shop via a gateway portal or resource, that includes information for service providers, carers and individuals. |

| Issue | Proposed Solutions |
|---|---|
| • Duplication and fragmentation of services. | • Political solution needed. |
| • Unemployment issues compound mental health conditions. | • Individual Placement and Support providers need to provide flexibility of access, not just business hours. |
| • Fragmented funding. | • NGOs and mental health teams should be under the same administrative umbrella. |
| • Gap between services provided by DSC and mental health.<br>• Even though there are MOUs in place, they are not always practiced. | |
| • GPs are unaware of the community based mental health services that are out there. | • Some form of service directory coupled with presentations to any existing GP networks. |
| • GPs are not seeing those with moderate mental illness. | • Significant investment, training and support for primary care. |
| • High rates of domestic violence. | • Establish joined up services to address this issue systemically. |
| • Lack of housing and emergency accommodation. | |
| • How do we support people with communication difficulties in the mental health sector to receive relevant, skilled services (e.g. counsellor, psychologists, psychiatrists, mental health nurses etc.)? | |
| • Mental health patients need a central point (medical home) to have continuous care. | • Providing mental health patients with a medical home that can be a reference point, help with medical and mental health, and provide access to support services such as housing. |
| • Insufficient services available to provide long term psychotherapy. | |
| • PIR are available to assist and support people to navigate the mental health system, but this is likely to change with the transition to the NDIS. | • Ongoing support and funding for PIR is needed outside of the NDIS process.<br>• Leave as a tier two service. |
| • Need driven and mental health focused staff that keep momentum in working towards recovery; this is not just another job. | |

| Issue | Proposed Solutions |
|---|---|
| • Joining up the ‘learned’ and the ‘lived’ expertise in the management and support provided to individuals. | • Include family members in the coproduction of recovery or care plans.<br>• Build the capacity of carers to enable them to share leadership in the care plan development and the recovery process of the individual.<br>• Embed peer support workers in all service provision and support them with independent supervision to recognise and value their input. |
| • Keep It Simple Stupid system - let's not make a bunch of policies, forms and information that goes nowhere, as consumers have a hard enough time trying to deal with MH on a daily and nightly basis 24/7, 365 days a year.<br>• Making us do a lot of the work or navigate systems ourselves is going to cause more distress than recovery. | • Too many recovery plans for each organisation, too many processes to complete KPIs that do not ultimately help the consumer or carer. |
| • Lack of assertive inreach across service delivery. | • Need lower threshold for access to inreach and outreach services.<br>• Currently access is best achieved through ED but it’s not appropriate for distressed unwell people to be waiting in ED for hours on end.<br>• Need immediate access to support and assessment to prevent crisis and admission. |
| • Consumers unaware of how to navigate across systems and services. | • Provide ‘advocates’ that track clients across services and providers to assist in navigation along the continuum of care, through child, adolescent, adult and older adult life stages. |
| • Lack of eating disorder services in the northern suburbs. | |
| • Lack of engagement of GPs in the whole care of people. | • Fully integrated and flexible funding to reduce competitiveness.<br>• Tendering funded for outcomes not activity based to support quality of care not quantity.<br>• Shift from politically driven to public health focus. |

| Issue | Proposed Solutions |
|---|---|
| • Lack of meaningful system navigation. | • Systemic collaboration between all service providers, whether public, private or NGO to map the services actually delivered.<br>• Engage 'Peer Navigators' (whether consumer or carer lived experience) to assist in the identification of relevant services, thus coproducing a 'best solution'. |
| • Lack of mental health expertise at the GP level that could be alleviated by the introduction of mental health nurses and nurse practitioners. | • Source funding for general practice to provide mental health nurses.<br>• Review workforce demographics to ascertain the projected need for mental health specialists currently and into the future.<br>• Provide professional development opportunities for generalist nurses that are contemporary, relevant and meaningful.<br>• Implement systems to recognise talent and encourage or incentivise the uptake of mental health qualifications. |
| • Lack of openness and transparency around the resource management of services. | • Require a way of communicating across services in a real time context. |
| • Lack of Psychiatric Liaison Nurses. | |
| • Lack of resources. | • Need a voice that can advocate for more services. |
| • Lack of services appropriate to CaLD experiences. | • Focus on community based solutions and interventions like family group conferencing models for family and domestic violence in New Zealand and Canada. |
| • Lack of psychological services available within community and hospital settings. | |
| • Lack of specialist care in child mental health and adolescent mental health. | |
| • Lack of support for people at the time of discharge from mental health units and ED, which is a critical point of time up to approximately six weeks post discharge. | • Six week peer support program or link in with existing peer support program such as Personal Helpers and Mentors Program.<br>• Improved linkage between patients, hospitals and existing programs. |

| Issue | Proposed Solutions |
|---|---|
| • Limited discharge options from hospital. | • Increased inpatient bed options, supported community accommodation, subacute beds and acute inpatient beds, and agreed entry and exit criteria.<br>• Synchronised optimised services.<br>• Wrap around community services with easily agreed entry criteria and connection with acute services.<br>• Hospital in the home services in the Joondalup region.<br>• Activity from decommissioning Selby and Graylands acute beds to be transferred to Joondalup Health Campus and then Hospital in the Home (HitH), and the physical beds utilised in the region. |
| • Links between public and private health system and services are not consistent (e.g. clinical entry data system at the Joondalup ED not linked into the Health system, therefore if a child attends the Joondalup ED, CAMHS don't always know about it).<br>• Sometimes families don't tell and sometimes faxes don't go through. | • Provide a key liaison person to transfer appropriate information to relevant other services to ensure that links are made and there is a continuity of care across the spectrum.<br>• Make it mandatory that links are made (e.g. back to GP and other identified services).<br>• Case management approach to follow up the next day and connect with GPs follow up. |
| • Many of the problems are social. | • Improved community supports are needed. |
| • Many people who are currently in inpatient beds can be better supported at home. | • Develop home treatment teams and utilise HiTH. |
| • Matching the number of mental health beds to Wanneroo's population growth. | • Better population projections at sufficient resolution to identify population growth regions.<br>• Interim mental health observation area to address the overflow and sufficient time needed to turn around, plus provide referral to community support and services. |
| • Stigma attached to mental health access via the ED. | • Poor waiting area facilities need improvement; provide a specific area to improve access and a 24 hour walk-in mental health service. |

| Issue | Proposed Solutions |
|---|---|
| • Lack of mentor services. | |
| • Minimal accommodation, particularly crisis accommodation. | • Build requirements into the planning process to attract providers to the northern suburbs. |
| • More specialised services often have more restrictive selection criteria that excludes comorbidity, which is correlated with higher complexity. | • Increased wrap around holistic tertiary level services. |
| • Require much more substantial inter-sectorial collaborative partnerships and Models of Care across the continuum of care. | • Increased partnerships and models should be commissioned and evaluated. |

# Appendix C: Inaugural Joondalup Wanneroo Region Mental Health Sub Network Steering Group

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

- Alan Alford
- Alistair Vickery (co-chair)
- Debbie Childs
- Fiona Reid
- Glen James
- Greg Gordon
- Jason Ellis
- Lauren Breen
- Linda Locke (co-chair)
- Maggie Spence
- Margaret Bates
- Mark Anderson
- Rachel Dixon
- Raj Tanna
- Amatal Uzma.

# Appendix D: Acronyms

| Acronym | Definition |
|---|---|
| **CaLD** | Culturally and linguistically diverse |
| **CAMHS** | Child and Adolescent Mental Health Service |
| **DSC** | Disability Services Commission |
| **EAG** | Executive Advisory Group |
| **ED** | Emergency Department |
| **GP** | General Practitioner |
| **HitH** | Hospital in the Home |
| **KPI** | Key Performance Indicators |
| **MHC** | Mental Health Commission |
| **MHN** | Mental Health Network |
| **MOU** | Memorandum of Understanding |
| **NDIS** | National Disability Insurance Scheme |
| **NGO** | Non-Government Organisation |
| **PIR** | Partners in Recovery |
| **WAPHA** | WA Primary Health Alliance |

**This document can be made available in alternative formats on request for a person with a disability.**