Mental Health Network

Dementia Support Australia and Older Adult Mental Health

Referral and Collaborative Care Guidelines

October 2018

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Background

This document was developed in response to concerns raised in the Older Adult Mental Health Sub-Network (OAMHSN) that there was lack of clarity regarding referral pathways for patients with Behavioural and Psychological Symptoms of Dementia (BPSD). Both Dementia Support Australia (DSA) and specialist Older Adult Mental Health Services (OAMHS) are currently funded to provide services for people with severe BPSD living in residential aged care and their families and carers, with the consequent risk of overlapping, fragmented and inefficient care pathways. The OAMHS also provide services for people with severe BPSD living in the community, admitted to general hospitals or requiring specialist mental health inpatient care. DSA and OAMHSN agree that a collaborative, person-centred approach would optimally support consumers and their families and carers and best utilise the skills and resources of the service providers.

Key principles underpinning guidelines

i. **No wrong door approach** – Given that both services deliver services to support people living with Behavioural and Psychological Symptoms of Dementia (BPSD), whichever service the referrer contacts first should generally accept the referral unless it does not meet their intake criteria (see below).

ii. **Working collaboratively** – Each service should seek advice/involvement of the other service in cases where it is felt that this could improve the outcome for the client. This can be achieved at any point of involvement (triage or assessment/monitoring/transitioning).

'No wrong door' approach

In addition to above (i); either service can:

- Triage and refer straight to other service
    - *For example;* DSA receives a referral where there is no diagnosis of dementia.

- *For example;* DSA receives a referral with active suicidal ideations/ psychosis as the main, obvious concern and there is an appropriate OAMH service to refer to.
- *For example;* OAMH receives a referral for a low risk behaviour (such as wandering or vocalising).

- Triage, assess and forward to other service
  - *For example;* DSA accepts a referral at triage and following F2F assessment, determines that the underlying issues relate to mental health (psychiatric symptoms/conditions; paranoia, severe depression) as opposed to dementia.

With the above, DSA or OAMH will have discussion with the referrer about preferred methods for referring/forwarding to other service. This prompt process could be service to service, or referrer to service. Information from triage process should be shared between services to avoid duplication for referrer.

- **Triage, assess and develop shared care approach**
  - *For example;* either service, having accepted a referral, feels that co-management of the case would improve outcomes for the client. OAMH may look at medication management and DSA may look at capacity building sessions/mentoring with a combined approach to both providing non-pharmacological strategies with possible joint visits.

Overview of services

	Dementia Support Australia		Older Adult Mental Health
	DBMAS	**SBRT**	
Specialty	BPSD	BPSD	All Older Adult Mental Health including BPSD
BPSD Tiers	3,4,5,	5,6,7	3,4,5,6,7
Co-morbidity	yes	yes	yes
Referral	Anyone	Anyone	GP and specialist medical referral only *(DSA able to refer onwards post triage if GP is involved and aware) GP involvement required except in exceptional circumstances.*
Method:	Email, fax, phone, face to face. Short term case management (12 weeks)	Email, fax, phone, face to face. Longer term case management (6 months)	Written (letter or fax)
Focus	Case management, on-the-ground support/capacity building, support drawing on nursing, allied health and medical expertise, advice tailored to the individual and their environment. Can do medication reviews through medical expertise (not face to face)		Case management, behavioural assessment, diagnostic clarity, treating co-morbidity. Person-centred clinical and behavioural management plans. Can do medication reviews through medical expertise (face to face)
Location	Community, RACF, transitional care	RACF only (commonwealth funded)	Community (Home, RACF, HDU), inpatient
Resource allocation	Local based consultant team with larger national team. Ability to respond to rural and remote F2F. Once qualified through triage process: DBMAS: 7 days until onsite SBRT: within 48 hours until onsite		Community services varied across WACHS and metro HSPs Specialist OAMH Inpatient services – Perth Metro

This document was developed and endorsed by representatives of Dementia Support Australia (DSA) and the Older Adult Mental Health Sub Network (OAMHSN) of the West Australian Mental Health Network (MHN) and is endorsed by the MHN Co-Leads as a MHN document.

No.	Date	Nature of change(s)
1	24/10/2018	Document endorsed by MHN Co-Leads Dr Helen McGowan and Mr Rod Astbury

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