

Older Persons Mental Health Community



Who does OPMHC service?

Eligibility Criteria

- (+65) with MH diagnosis or (55+) for Aboriginal or Torres strait islander clients.
- Co-morbid diagnoses/ complex mental health, secondary MH concerns related to the dementia processes
- Living in the Gold Coast catchment with stable accommodation
- Consenting to the referral, it's a voluntary service.

Who doesn't OPMHC Service?

Unsuitable Referrals

- Clients that have primary dementia diagnosis and behaviours directly related to a dementia process
- Acute mental health concerns that would be better fitted to the acute services, because of time frames and risk.
- Clients requiring therapy based interventions that may be better suited to private services, psychology, psychiatry and social groups.

General Statistics

Team size: 8 clinicians, 2 Psychiatrist

Service area: Kirra to Ormeau

Referrals from: Interstate, Inpatient MH units, GP, RACFs, NGO, Other QLD health services and ED

Currently: 175 clients currently open to this service

Approximately between 180-200 referrals for 2023

Points to note:

Waitlist for assessment range 2-4 weeks

Frequency of case management visits range 2-4 weekly

Medical reviews as indicated

Dementia Related Neuropsychiatric Concerns

Is covered by OPMHC services in most states.. Except QLD

Often there is confusion about what is Mental health and what is Dementia.

Some similar dementia related behaviours include:

Apathy and amotivation, agitation and confusion, decreased appetite, dysregulated sleep –

- if acute change in presentation, please consider screening for delirium
- GP involvement for assessment, screening, treatment optimisation

When does it need mental health input?:

If neuropsychiatric symptoms progress in severity e.g. significant neurovegetative disturbances, reversed sleep wake cycle, increased psychotic phenomena/paranoia and acting out on these delusions/hallucinations

- suitable for review by OPMHC in collaboration with GP +/- Geriatric services to co-manage symptoms of concerns

Example scenarios

Susan 65YO F:

Primary dementia in a dementia locked unit, medication noncompliance, agitated, crying, labile, confused – *Suited for Dementia Services*

Brian 75YO M:

Was coming out for meals, now not eating much, not socialising or going to happy hour, Appears low in mood- reports he “lost his spark”, seen crying –*GP review to determine if medication necessary – worth contacting the psychiatry GP line for recommendations*

Barry 67 YO M:

Longstanding Dx of paranoid Schizophrenia, now believes that food is poisoned and residents are going to kill him – infection screens come back clear, compliant with psychotropic medications – *suitable for referral to OPMHC however if becomes increasingly distressed (not eating, aggressive due to delusions)– for referral to ACT or ED presentation*

Lucy 80YO F:

Low mood, not eating, disrupted sleep routine, expressing helpless themes, refusing medications, expressing wish to die with plan, seen by kitchen staff to be hiding knives post meals – *referral to ACT or present to ED*

RISK

Suicide or Self Harm Risks:

- What has changed? New behaviours, refusal of medication, increased paranoia or agitation, hopeless/helpless themes
- What are the acute MH concerns? Increased delusions/ hallucinations – not redirectable/ increased suicidality – with plan & intent (intent is high chance of actioning) this) Impulsivity, previous self harm or suicide attempts
- Neurovegetative symptoms/changes? Sleep changes, changes to oral intake, Changes in energy/ motivation, low mood
- What has been tried? – Psychology, medication changes

Example questions to ask for suicide risk:

- Have you ever tried to end your life in the past?
- Have you been thinking of ending your life?
- What have you thought of doing to end your life?
- Do you have access to anything you would use to end your life?
- What are your protective factors (family/ religious)

Calling the ACT:

Situation: with resident – name, DOB, address

Background: Past MH history, current medication, current situation/changes (Neurovege symptoms) – timeframes

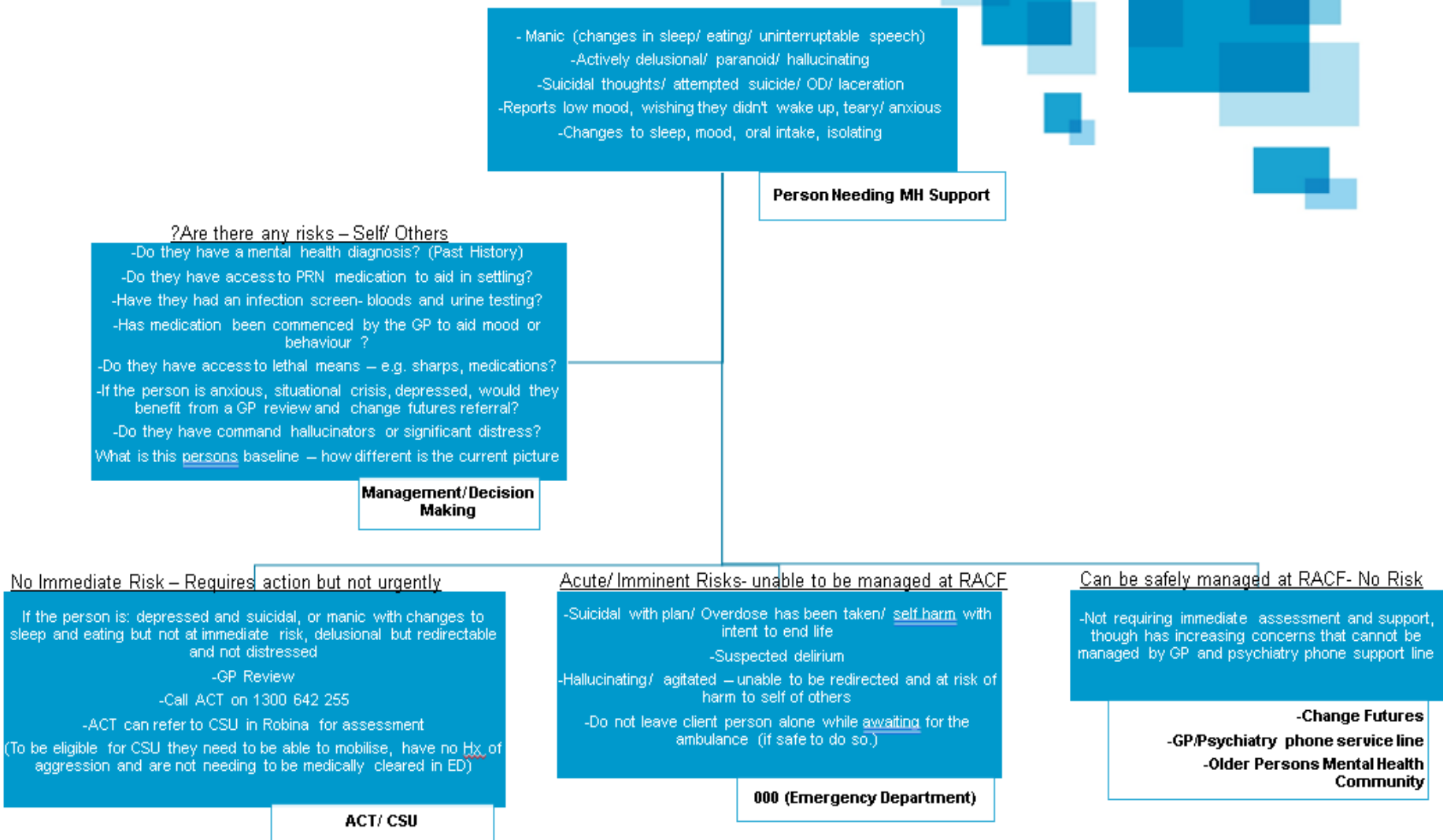
Assessment: What you have done – RV? Medication changes, reduced access to lethal means, increased staffing, can this continue? Has it helped?

Recommendation: medication review, assessment, admission for stabilisation


Safety:

- Reduce access to means: including sharp items, potential ligatures (e.g. cords, belts, shoelaces, ropes, bags) medication.
- Increase frequency of monitoring by staff and if waiting for an ambulance, try if feasible to stay with the person
- GP to consider PRN medication for agitation and acute phase of illness


RACF Mental Health Workflow



Referral Form

 Queensland Government Gold Coast Health OLDER PERSONS MENTAL HEALTH COMMUNITY REFERRAL	(Affix identification label here)
	URN: _____ Family name: _____ Given name(s): _____ Address: _____ Date of birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I
Facility: _____ This form is for use by non-mental health services, for example, GP and medical wards. For acute risk concerns please call the Acute Care Team on 1300 64 2255, if risk is imminent call 000. For primary dementia diagnostic screening please contact the Cognitive Disorders Clinic via GP smart referral. Alternatively for specialist dementia care please contact Dementia Outreach Service or Dementia Australia.	
Consumer details	
Phone: _____ Mobile: _____ Country of origin: _____ Language: _____ ATSI: _____	
Next of kin / Significant other details	
Name: _____ Address: _____ Phone: _____ Relationship to patient: _____ Substitute decision maker: <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, who is it, is this enacted? Include copy of EPOA or POA)	
GP referrer details	
Name: _____ Clinic name: _____ Address: _____ Phone: _____ Fax: _____	
Referral requirements (please attach any additional information that will be of assistance)	
Is patient aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient agree? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Risk factors / Alerts (allergies, vulnerability, falls, absconding from premises, violence, suicide, dangerous pets, access to weapons, lethal drugs, access to property etc.)	
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

OLDER PERSONS MENTAL HEALTH COMMUNITY REFERRAL

 Queensland Government Gold Coast Health OLDER PERSONS MENTAL HEALTH COMMUNITY REFERRAL	(Affix identification label here)
	URN: _____ Family name: _____ Given name(s): _____ Address: _____ Date of birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I
Facility: _____ Presenting problems (mental health concerns and case management needs? Mood, delusions, hallucinations)	
_____ _____ _____	
Past psychiatric history (previous diagnosis, mental health admissions, alcohol and other drugs Hx, past trialled psychotropics)	
_____ _____ _____	
Past medical history	
_____ _____ _____	
Relevant physical findings (including sight and hearing impairment)	
_____ _____ _____	
Current medications	
_____ _____ _____	
Relevant investigation results (including cognitive assessment, pathology, medical imaging, MSU)	
_____ _____ _____	
Current supports (ACAT completed? Private psychologist, private psychiatrist, last seen, other agencies involved?)	
_____ _____ _____	
Name (print): _____ Designation: _____ Signature: _____ Date: ____/____/____	
Older Persons Mental Health Community Telephone: 07 5635 7000 Fax: 07 5635 7099 Email: OPMHC@health.qld.gov.au	



Gold Coast Health
**OLDER PERSONS MENTAL
 HEALTH COMMUNITY REFERRAL**

Facility: _____

(Affix identification label here)

URN: _____
 Family name: _____
 Given name(s): _____
 Address: _____
 Date of birth: _____ Sex: M F I

Presenting problems *(mental health concerns and case management needs? Mood, delusions, hallucinations)*

Past psychiatric history *(previous diagnosis, mental health admissions, alcohol and other drugs Hx, past trialled psychotropics)*

Past medical history

Relevant physical findings *(including sight and hearing impairment)*

Current medications

Relevant investigation results *(including cognitive assessment, pathology, medical imaging, MSU)*

Current supports *(ACAT completed? Private psychologist, private psychiatrist, last seen, other agencies involved?)*

Name (print): _____ Designation: _____
 Signature: _____ Date: ____/____/____

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Current concerns and mood disturbances:
 e.g changes to sleep, oral intake, mood,
 stopping going to groups, medication non
 compliance, bizarre behaviours, how long
 has this been occurring, what has been
 tried to assist

Previous MH diagnosis, when
 was this diagnosis and by
 who?

Prior to referral: please ensure relevant
 screening has been completed.
 Specifically infection screening (bloods,
 urine) and cognitive.
 Send this information with the referral as
 required.
 Please include what has been trialled :
 e.g. medications, therapies, assessments

Other Services Available

Acute care team (ACT)

1300 642 255

For acute risk and immediate support 24/7

GP Psychiatry Support Line

1800 16 17 18

Free phone-in service exclusively for GPs, where you can talk directly with a qualified psychiatrist to help manage the mental health care of your patients.

You can call seeking information and advice about specific cases or just make some general enquiries. Advice includes, but is not limited to, diagnosis, medication, investigation, treatment pathways and safety planning. 7am until 7pm (AEST), Monday to Friday (not public holidays)

Change futures

Counselling and adjustment, therapy based with flexible service provisions
Referral can be completed online with minimal waitlists

Dementia Services Australia hotline

1800 100 500

For Immediate support 24/7

Older Persons Mental Health Community

Non-acute MH support that the person is consenting to
Mon- Fri (*not public holidays*) 8:30am - 5pm

PH: 5635 7000

Fax: 5635 7099

Questions:

