1. Purpose

This document provides a guideline for the aged persons mental health (APMH) Intensive Community Treatment (ICT) program. The ICT program offers an alternative to treatment in an APMH acute inpatient unit. This guideline is based on the previous Intensive Community Treatment program statement (October 2008), a recent evaluation of the ICT program and advice from existing ICT services, General Practice Victoria, consumers and carers.

This guideline replaces the previous Intensive Community Treatment program statement.

2. Background information

2.1 Legislative and policy context

The policy framework for APMH services in Victoria shapes the way services are delivered. It places an emphasis on community treatment, collocation and operational integration with aged care services while maintaining a specialist mental health emphasis.

The Mental Health Act 1986 (Vic) provides that people who are mentally ill should receive the best possible treatment and care in the least restrictive environment consistent with the effective giving of that treatment and care.

The Charter of Human Rights and Responsibilities Act 2006 (Vic) protects the rights of all Victorians and guides the development and interpretation of policy and legislation and the development and provision of services by public authorities. It requires all public authorities and their employees to act in accordance with the rights protected in the Charter.

Mental health services reform in Victoria aims to support people with a mental illness to access high-quality, timely care and to live successfully in the community. Improving mental health care for older people includes:

- increasing the capacity of the aged persons mental health system to provide effective care
- expanding services that provide treatment in the home to avoid unnecessary inpatient admissions and to provide a step-down function from inpatient care
- promoting consumer and carer participation in treatment and planning
- promoting the social inclusion of people with a mental illness, for example, by enabling them to remain connected with or increase engagement with their communities
- promoting early intervention in the course of an illness and in an episode of illness.

2.2 Need for service

In the context of an ageing population, demand for mental health treatment for older people will continue to grow. While prevalence studies vary considerably in their estimates, there is evidence of a strong association between comorbid physical illness, functional disability and depression in older age. An estimated 10 per cent of people with dementia experience severe to extreme behavioural and psychological symptoms associated with their illness that require intervention from mental health services (Brodarty et al. 2003).
Older people’s access to services to treat mental disorders can be limited. Draper et al.’s (2001) analysis of Medicare data indicated older people have less access to private psychiatry and are therefore more likely than younger people to access the public mental health system to meet their mental health treatment needs. Additionally, Australian Institute of Health and Welfare figures demonstrate that general practitioner (GP) home visits to the 75-plus population are declining.

In 2010–11 there were 215 acute inpatient APMH beds in Victoria. The distribution of acute inpatient beds is not spread evenly across the state, with some APMH services having less access to beds than others. The Dandenong APMH community team has provided an acute bed substitution program as the equivalent of five beds for some time. In 2003–04 two areas established ICT services as a substitute for 10 APMH acute beds through a pilot program. A third site commenced in 2004–05, a fourth in 2005–06, and two further services in 2010–11 following the positive evaluation of the program.

2.3 Evaluation

The ICT program was evaluated in 2009 by Health Outcomes International. The evaluation found that the ICT program:

- was aligned with current policy directions and settings
- was being targeted appropriately at consumers to whom this level of care can be delivered safely
- has had a positive impact on reducing the average length of stay and occupancy of inpatient units by enhancing capacity for early discharge and hospital avoidance
- was generally supported by carers, consumers and GPs who have experienced the program.

(Department of Human Services 2009b)

2.3.1 Personal and carer preference

The evaluation showed that both older people and their carers expressed a high degree of satisfaction with the ICT program. All carers who responded to a survey felt that referrals to ICT were appropriate. Of these, over 96 per cent had positive feedback and 75 per cent felt that intensive treatment in the home was preferable to an admission to an acute inpatient unit. The evaluation also found that very few older people refused the program when it was offered, indicating strong support for the program.

2.3.2 Model of care

While all ICT teams have access to allied health workers, the evaluation found that different services work from different models of care. The evaluation found that a biopsychosocial model of care, which emphasises the psychosocial aspects of recovery, has multiple benefits. These benefits include improved quality of life, strong uptake in social activities, improved diagnoses, and provision of additional services such as family therapy where needed.

2.4 Intensive community treatment and the broader service system

ICT sits within the continuum of care of the broader mental health service system. The ICT teams are embedded within the APMH community teams (within the aged persons assessment and treatment services or APATS) and have strong links with APMH inpatient units and residential care. ICT teams will often work closely with psychosocial support providers and residential support programs, including local councils and non-government providers, to provide holistic care to older people.

3. Program statement

3.1 Purpose

The purpose of the program is to provide ICT in area APMH services as an alternative to acute inpatient beds.
3.2 Aims

The aims of the program are to:

• provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness and to prevent hospitalisation where possible
• provide intensive treatment in the older person’s home during an acute phase of a mental illness, when this is the expressed wish of both the older person and their family or carer
• minimise the length of stay in an inpatient unit through providing ICT during an acute episode of illness.

3.3 Target group

The program’s target group includes:

• older people whose acute treatment for their mental illness can be delivered safely in their home as an alternative to being admitted to an APMH acute bed
• older people who have family or other carer supports available for the period of treatment
• older people whose length of stay in hospital can be minimised through intensive treatment at home.

3.4 Program principles

• ICT is provided during an acute episode of mental illness as a less restrictive alternative to hospitalisation.
• An acute episode of treatment can include pre- and post-hospitalisation ICT care in addition to a hospital stay.
• ICT is intended to prevent hospital admissions where possible, as well as enabling early discharge from a hospital admission.
• Where a person needs to be treated on an involuntary basis and it is possible to safely treat them at home, treatment must be provided under a community treatment order (CTO).
• At the time of initial assessment, the assessing team must expect ICT to achieve clinical outcomes comparable to that of an inpatient admission.
• It must be possible for intensive treatment in the home to be provided in a manner that assures the safety of the older person, family, carer and others.
• Both the older person and their family or carer must express a preference for treatment in the home as an alternative to hospitalisation.
• Carers or family who share a residence with the person receiving treatment will have the right to refuse ICT in their home even if the person expresses a preference for this type of treatment. This recognises that the support of the family or other carer is critical to the provision of effective ICT care.
• ‘Home’ is defined as the person’s usual home, which includes residential care and supported residential services (SRS), or the house of family or friends.
• There is a 24-hour, seven-day response to older people and families or carers on the program.
• People remain in the program for the period they require acute treatment or until it is determined that inpatient treatment is required in the circumstances. This is determined on the basis of clinical need by the consultant psychiatrist, in collaboration with the person receiving treatment, carers, GP and in consultation with the APMH community case manager.
• Ideally the person’s GP will agree to and participate in treatment. ICT teams will seek and support continued collaboration with the GP throughout the course of treatment.

3.5 Program description

Program funding is provided for ICT of older people with a mental illness. It is provided at a level to enable a discrete clinical sub-team to focus on acute treatment within an APMH community team. It is recognised that some services, particularly rural services, may align this function within the APMH community team. However,
the APATS and ICT functions and target groups are different, and this must be reflected in the profile and acuity of older people who receive treatment from the respective programs.

The ICT team functions on an outreach basis, delivering acute care to the person in their home. The ICT team must be multidisciplinary or have ready access to allied health professionals. Each person receiving treatment will be allocated a community treatment clinician during the acute course of treatment to act as a primary contact for the person, family or other carer and GP. The primary contact may be an ICT clinician or the person’s APMH community case manager. ICT engages family, carers and significant others in the older person’s life as partners in care.

ICT is an acute treatment service in the home, not a crisis assessment service. Responsibility for a crisis response for older people with a suspected mental illness remains with the APMH community team during office hours and the crisis assessment and treatment (CAT) service function after hours.

The funding for ICT is provided as an alternative to recurrent funding of APMH beds in a catchment area.

The following diagram summarises the progressions and decision points in the ICT program.

Figure 1: Progress through and decision points in the ICT program
3.5.1 Recovery-oriented practice
The concept of recovery was developed by consumers in the 1970s and 80s and has been defined as ‘a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness’ (Anthony 1993). Literature about recovery and older people suggests that, for older people, recovery-oriented practice is about supporting people to do valued activities, to preserve a sense of personhood and to celebrate life achievements (Boardman et al. 2010). ICT clinicians and GPs should be encouraged to keep recovery principles in mind when working with older people. Services may also support recovery by facilitating access to psychosocial support available in other parts of the service system. For more information see the Framework for recovery-oriented practice at <http://docs.health.vic.gov.au/docs/doc/Framework-for-Recovery-oriented-Practice>.

3.5.2 Referral
Most mental health referrals come through triage at the relevant mental health service. Triage services refer people to the most appropriate service to meet the person's needs. For older people, triage services may decide to refer a person to the APMH community team, who will then see the person and complete a biopsychosocial assessment. Where a person has been assessed as being in need of acute treatment for their mental illness, the APMH community case manager may refer to the ICT program. This referral process will include discussion with the team’s consultant psychiatrist about a provisional diagnosis and treatment plan, with a goal of an admission to acute care. Each ICT service is expected to work with the APMH community team to outline clear referral criteria to support consistent decision making.

Referral can also come from the APMH acute inpatient unit via the community case manager for the purpose of early discharge from the inpatient unit to continue the course of acute treatment at home.

3.5.3 Assessment for ICT
The APMH community team’s assessment of suitability for acute treatment at home will consider:

- personal factors – psychiatric treatment needs, medical comorbidities, functional dependency, capacity to cooperate with treatment, capacity to express a preference for treatment setting
- family or carer factors – family or carer availability to provide support, capacity to cooperate with a treatment plan, family or carer wishes (particularly when they share the same residence with the client)
- environmental factors – suitability of the home environment in relation to likely treatment plan requirements such as safety, hygiene and geographic location
- GP involvement – willingness of the GP to agree to and be involved in intensive home treatment
- risk assessment – level and seriousness of medical comorbidities, level of functional dependency, history of self-harm or harm to others, presence of suicidal ideation
- ICT team capacity – number and acuity of people currently on the program.

If the above factors indicate that home treatment is a possible safe option, this is to be discussed with the person and carer. A detailed discussion about what home treatment will involve must occur. Information about rights and obligations of the person and their family or carer must be given.

Exclusion criteria are:

- refusal by the older person or their carer
- high-risk psychiatric factors where a risk assessment precludes admission due to safety concerns
- medical comorbidities that may place the person at high risk of harm
- physical disabilities that may place the person at high risk of harm.

In some circumstances it may be possible to consider ICT as an option for a person living alone. Lack of an on-site carer should not be an absolute exclusion criterion, but the risks involved need to be carefully considered. An assessment should occur to assess living skills if the team is considering providing ICT to an older person living alone.
An unsuitable environment for treatment should not be an absolute exclusion criterion. Where it is unsafe to treat a person in their home, the APMH community team should consider using flexible funding to access alternative accommodation so the person can be safely treated in a home-like environment rather than requiring an inpatient admission.

Ideally the person’s GP will collaborate with the ICT team in providing intensive home treatment. However, while agreement and active involvement of a GP is highly desirable it should not be considered mandatory. If a GP is unavailable to work with the ICT team for the period of ICT, or if a person does not have a regular GP, a person may still be included in the program. In this instance the health service would need to provide the pathology, imaging and pharmaceutical services required.

Every person being treated involuntarily under the Mental Health Act (including people on CTOs) must have a treatment plan prepared in accordance with s. 19A of the Act. The authorised psychiatrist is responsible for preparing, reviewing (on a regular basis) and revising (as required) the treatment plan for each person receiving involuntary treatment.

### 3.5.4 Admission to ICT

The decision to admit the person to ICT or an acute inpatient unit will be made by the consultant psychiatrist and the ICT team manager, having regard to the assessment of suitability and team capacity to deliver effective treatment to the person, given their treatment plan requirements and the acuity of other people on the program at the time. Each ICT service is expected to have clear admission criteria to support consistent decision making.

The decision to admit to the ICT program will be communicated to the person, their family, carer and GP by the community case manager. The case manager will introduce the ICT member who will become the primary contact clinician.

A biopsychosocial assessment will be immediately undertaken and a care plan documented. The clinician will give the person and carer information, including a 24-hour contact number.

The registrar or consultant psychiatrist will be involved in the decision to admit the person to the ICT program. Comprehensive psychiatric and physical examinations and investigations must be commenced as soon as possible but within 24 hours of admission. Admission processes must comply with the Mental Health Act. Any person who is assessed as requiring involuntary treatment must be placed on a CTO.

After the mental state and physical examinations and consideration of relevant investigations the registrar or the ICT team will draw up and document the treatment plan in consultation with the person and their carer or family. Where very recent psychiatric and physical assessments are available these may be used. A treatment plan for a person being treated involuntarily should be authorised and signed by the authorised psychiatrist.

Psychology (including neuropsychology if required), social work and occupational therapy assessments will be undertaken where indicated and planned interventions to be provided during the course of the admission will be documented in the treatment plan.

### 3.5.5 General practitioner’s role

APMH services operate from a specialist consultation model, with the GP remaining the prescribing doctor. This model will be maintained in ICT wherever practical. The consultant psychiatrist retains overall responsibility for the person’s psychiatric treatment and makes recommendations to the GP for optimal medication management. Where involuntary treatment is provided, subject to a CTO, the person’s treatment plan will specify the psychiatrist as the monitoring psychiatrist and the GP will be specified as the supervising medical practitioner.

The GP is a key provider in ICT as the practitioner with the most comprehensive history of the person’s physical condition. GPs should be actively engaged in arrangements for sharing care wherever possible. Engagement and collaboration with GPs enhances continuity of care during and after the acute phase of illness, and after discharge from involvement with the APMH service. Working with the psychiatrist or registrar, the GP will provide referrals for diagnostic services. Community-based diagnostic services will be used where possible.
If a formal protocol for sharing care does not exist between the person’s GP and the APMH service, one needs to be implemented if the GP is willing to be actively involved in ICT. The policy document Sharing the care: General practitioners and public mental health services provides examples of such working arrangements between public mental health services and GPs and is available at <www.health.vic.gov.au/mentalhealth>.

3.5.6 Pathology
The registrar will request the GP to organise any necessary referral to the local domiciliary pathology service. If this is not practical the health service facilities will be used.

3.5.7 Imaging
The registrar will request the GP to refer to the local medical imaging service for relevant testing. If attendance is not practical the health service facilities will be used.

3.5.8 Medication
Any necessary prescription pharmaceuticals will be prescribed by the GP and obtained from the local pharmacy. If the person’s GP is not involved, the required prescriptions, as well as any pharmaceuticals requiring specialist prescription, will be obtained from the health service pharmacy.

Drugs storage must be compliant with the Drugs, Poisons and Controlled Substances Act 1981 (Vic). Administration of drugs by staff must comply with the Nurses Act 1993 (Vic).

3.5.9 Infection control
The health services infection control policy and procedures must be observed.

3.5.10 Therapies
The full range of therapies and interventions available to a person in the inpatient environment will be available to the person in their own home. This includes psychological, family, psycho-educational and occupational interventions, and therapies as outlined by the treatment plan.

3.5.11 Electroconvulsive therapy
Where ECT is prescribed as a treatment for a person on ICT the person may be treated as a day-patient where clinically appropriate. Due consideration must be given to clinical risk and the comfort of the person receiving ECT.

3.5.12 Review
Once in the program, the ICT clinician will review the person’s condition as often as required in accordance with clinical judgement. This will include examining existing and emerging risks and will generally occur daily (at a minimum) upon entry into the ICT program. Visits will decrease as the person improves and review may therefore become less frequent. Interviews will be conducted with the person and their family or carer to ascertain their perspectives on progress and their own feelings about the situation. Family and carer needs must be considered as part of the review. If the person's needs escalate and more clinician time than can be provided by the team is required, flexible funding may be used to pay for additional support to manage the person’s care. Admission to the inpatient unit may need to be considered.

A person’s progress will be reviewed weekly at a clinical team meeting. This should include input from the consultant or registrar and the community case manager. The GP should be encouraged to participate, if not in person, through telephone conferencing. The Enhanced Primary Care MBS item for case conferencing can be claimed by the GP for time involved. More information about GP case conferencing is available from Medicare at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-caseconf-factsheet.htm>.

As ICT provides an alternative to acute inpatient beds, the frequency and type of review by the registrar or consultant should reflect the practices of the acute inpatient unit. GPs should be encouraged to review the person’s physical state on request from the ICT team as required.
3.5.13 Safety

Frequent review of the person’s condition by the ICT clinician is necessary to identify any risks involved in continuing to deliver acute care at home. These risks may be to the person, family or carer.

A review that results in a decision to admit a person to the inpatient unit can be seen as a measure of service quality rather than an indicator of an episode of treatment with a less than optimal result.

3.5.14 Consumer, carer and family collaboration

Care at home must be based on close collaboration with the person receiving treatment and their family or other carer. The team must constantly assess and review the needs of both the person and their carer in relation to one another throughout the duration of treatment. At any time during admission to ICT the person and their family or carer can indicate they do not wish to continue with home treatment. It may be appropriate for ICT teams to consider accessing alternative accommodation for the person receiving treatment in order to continue acute treatment in an environment that is less restrictive than an inpatient unit. Where this is not possible, an admission to the inpatient unit will be arranged to continue with acute treatment.

Care at home relies very heavily on the participation of the person’s primary carer. The team should ensure that the primary carer is supported to continue to care for the person at home and should consider referring the carer to the Commonwealth Carer Respite Centre, the carer consultant or other carer-focused support services where appropriate. The Commonwealth Carer Respite Centre offers a range of services designed to support carers in their caring relationship. Carer consultants are employed in mental health services and provide or identify opportunities for peer support and psycho-education. More information is available at <www9.health.gov.au/ccsd> and <www.carersnetwork.org/cc.shtml>.

Older people will often have a broad network of people involved in their care, including partners, adult children, other family members or carers. For many people, and particularly for Aboriginal and Torres Strait Islander people and people from a culturally and linguistically diverse (CALD) background, family may include an extended family network. The team should be aware of family dynamics and their impact on the person receiving treatment, and refer family to support services where appropriate. For more information about working with carers and families, please see the Chief Psychiatrist’s guideline Working together with families and carers (2005) at <www.health.vic.gov.au/mentalhealth/cpg/families.pdf>.

3.5.15 Aboriginal and Torres Strait Islander people and people from a CALD background

There are longstanding disparities in the overall health and wellbeing of people from diverse cultural and linguistic backgrounds. It has been suggested that one contributor to these disparities is a lack of culturally responsive care (Department of Human Services 2009a). Culturally responsive care recognises the links between ethnicity, culture and language and aims to ensure that all people have their healthcare needs equally well met, for example, by ensuring access to accredited interpreters and culturally inclusive care. For more information please see the Department of Health’s Cultural responsiveness framework (2009) (accessible at <www.health.vic.gov.au/cald/cultural-responsiveness-framework>).

Government policy, legislation and the National standards for mental health services require area mental health services (AMHS) to ensure that people who speak limited or no English can access professional interpreting and translating services where significant decisions are concerned or when essential information is communicated. For more information see the program management circular Use of language services in area mental health services (October 2006, revised 2010) at <www.health.vic.gov.au/mentalhealth>.

3.5.16 Discharge

Discharge planning will commence pre-admission through formulating admission goals. The community case manager’s involvement in the weekly clinical review will ensure continuity in care planning for the post-acute phase. Each ICT service is expected to have clear discharge criteria to support consistent decision making.

The primary contact clinician will discuss all discharge plans with the person, their family or carer and their GP.
The consultant psychiatrist, together with the team, will determine when a person’s condition no longer requires acute care. The person will then be discharged for the planned follow-up by the community case manager and GP. The ICT team will provide a written discharge summary to the community case manager and GP.

3.5.17 Documentation and information sharing
All attending team members will record assessments, observations and interventions in the medical record.

If the person receiving treatment lives in a residential aged care facility or SRS, the residential service and the ICT team will need to clearly agree how medical records will be kept so the person’s care is not compromised. The GP working with the ICT team should receive a copy of the care plan and updates on care and services received by the person receiving treatment, with the person’s consent. Records include but are not limited to the person’s ICT assessments, treatment plan, review, medication administration and progress notes.

Information sharing should be guided by principles of collaboration, partnership, respect for the confidentiality of the person receiving treatment and good communication between the person, the ICT team, the GP and residential or other services. The consent of the older person to information sharing should be sought upon entry to ICT as well as at other key milestones. For more detailed guidance, please see the Chief Psychiatrist’s program management circular Confidentiality under the Mental Health Act 1986 accessible at <www.health.vic.gov.au/mentalhealth/pmc/confidentiality.pdf>.

There should be clear protocols in place to guide staff on how information about people receiving ICT will be exchanged and updated. Communication should be both verbal and written.

3.5.18 Rights
The Mental health statement of rights and responsibilities was adopted by Commonwealth and state health ministers in 1991 and outlines the rights and responsibilities of people, carers, advocates, service providers and the community. It is available at <www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-m-rights>.

Older people receiving ICT have the same rights as all other people receiving care through public mental health services. Rights are protected by the Mental Health Act and the Charter. People being treated involuntarily must be given a patient rights booklet and have the information clearly explained.

Issues that may particularly arise in the context of providing ICT to an older person for a mental illness include but are not limited to:

- capacity to consent to psychiatric treatment
- restraint
- need for a substitute decision-maker
- consent to medical treatment while on a CTO
- the need to transfer the person to hospital against their will
- duty of care – quality treatment and care commensurate with clinical need
- confidentiality – family or carer involvement and their need to access information as active participants in treatment planning, balanced with the person’s right to confidentiality
- complaints mechanisms.

ICT teams will need to have clear policies, procedures, protocols and information in place consistent with mental health services’ operational requirements, the Mental Health Act and the Charter to guide staff decision making when these issues arise.

3.6. Staffing
The team should be multidisciplinary and include a mix of nursing, occupational therapy, social work and psychology staff. If teams are unable to employ a mix of staff they must have ready access to allied health staff through other parts of their service. The team must include some consultant psychiatrist and registrar time. The
team leader should be a grade 4 clinical nurse specialist or allied health equivalent. The team profile should also include some administrative support.

The staffing profile should include additional clinician hours for periods of more intensive treatment as required. For further detail see section 3.10 ‘Funding’.

3.7 Hours of operation

The service will operate seven days a week from 8.30 am to 5 pm.

After-hours cover will be provided through the AMHS’s CAT function and the on-call arrangements of senior team staff. See section 3.9.1 regarding this service link.

3.8 Expected outcomes, key performance indicators and targets

3.8.1 Expected outcomes

The clinical outcomes for people receiving ICT will be equivalent to outcomes that could have been expected if the person had been admitted to an inpatient unit.

The patient, their family and carers should be equally or more satisfied with their treatment after an episode of ICT as they have been after an episode of inpatient-based care.

GPs’ expressed satisfaction with the care in the ICT program is equivalent to or exceeds expressed satisfaction by GPs relating to inpatient-based care.

The cost of care for people receiving ICT will be slightly less than or equivalent to inpatient-based care.

3.8.2 Key performance indicators

KPIs include:

- the number of people treated
- the number of people seen at least daily upon entry into ICT
- the acuity of people treated
- length of stay
- admission to an inpatient unit from ICT
- discharge from an inpatient unit to ICT
- readmissions to ICT
- adverse events.

3.8.3 Targets

Initially five people can receive treatment from the team at any one time. Over time the team may find it is able to treat up to seven people at once.

Direct contact visits of up to three times daily at admission and in the early phases of treatment, as indicated by clinical judgement, can be expected. Frequency of visits will gradually decrease as the person responds to treatment and the carer’s need for support is met. Treatment at any time during a course of ICT should be more intensive than what could be expected from the APMH community team.

3.8.4 Outcome measurement

At a minimum, services should administer HONOS 65+ on admission to and discharge from the ICT program.
3.9 Links with other services

3.9.1 Clinical mental health services

APMH community team

The ICT team will operate as a sub-unit within the APMH community team. Its focus is acute treatment in the community. Team members will not be expected to participate in the broader community team functions.

The wider team will continue to provide duty or triage, intake assessment and case management. All referrals to the ICT team will come through the APMH community team. Responsibility for crisis response remains with the broader team, as do linkages with other aged care services providers. ICT team resources will not be applied to these functions.

Some medical and allied health staff may work in the broader team and within the ICT team.

APMH acute beds

A close link between the ICT team and the inpatient unit will be needed to establish a system of management of people who are acutely unwell across the two settings. The team leader, the inpatient unit nurse unit manager, and the inpatient unit staff will need to work closely so the status information of all people receiving acute treatment is constantly updated, whether in the inpatient unit or at home. This will facilitate the flow of older people between the two settings as changing acuity requires.

Some medical and allied health staff may work on the inpatient unit and in the ICT team. Opportunities for rotation through the inpatient unit and the ICT team are to be encouraged.

Crisis assessment and treatment services or equivalent

Close working relationships between the ICT team and the AMHS’s CAT service (or equivalent) will be required for the success of after-hours arrangements. It is recognised that while all services provide an after-hours function not all services have a designated CAT team.

Services will negotiate an agreed protocol with their area’s CAT service (or equivalent). The crisis service operating in an APMH service area participating in the program receives additional resources to provide the necessary after-hours cover for the ICT team. The after-hours team will have access to advice from a roster of senior staff (team leader, registrar or consultant). Staff can be recalled as required by the after-hours team.

The ICT team and the CAT service or equivalent must collaborate closely to ensure that the needs of the person and their carer are met and any risks appropriately managed. The two teams must ensure that handovers contain all relevant information.

3.9.2 General practitioners

Much of the success of the program depends on GP engagement. In addition to close working relationships with individual GPs on a case-by-case basis as described in section 3.5.5, services need to ensure that Medicare Locals or the General Practice Network are informed of the service and fully understand the program. If formal protocols for sharing care do not yet exist between the relevant divisions services should work towards developing these as part of the program’s development.

3.9.3 Residential care facilities and supported residential services

The engagement of residential care facilities and SRS in the program is also important. If a person lives permanently or temporarily in a residential care facility or SRS the senior nurse or manager of the residential care facility or SRS must agree to the acute care being provided in the facility. The ICT clinician will be responsible for drawing up a care plan outlining the role of the treatment team and the plan will be co-signed by the residential care facility or SRS’s senior member of staff. Where a GP is working with the ICT team, the GP should input into this process. (Refer also to section 3.5.17 regarding the medical record.)
3.10 Funding

Funding is available as an alternative for five acute inpatient beds. Funding is inclusive of all salary costs, on costs and backfill. There should be some capacity in the budget to provide a pool of flexible funding to provide for additional clinicians, additional equipment, additional services, respite care and medication when required.

3.11 Reporting

Reporting will be through the Client Management Interface (CMI)/Operational Data Store (ODS) information system. Services need to set up a dedicated community subcentre with a linked program that includes the program code ‘Intensive Community Treatment’.

Participating consumers need to be in an open case and required subcentre episode.

This coding will enable data to be extracted for the period of time involved at the subcentre and the case contacts recorded as ‘Intensive Community Treatment’ program and funding source of ‘Aged Persons Mental Health Community Teams’. This will allow the length of time involved and the intensity of contacts made to be measured.

More specific instructions on how to set up the required subcentre and program will be available to the CMI coordinators.
References


Department of Human Services 2009a, Cultural responsiveness framework, State Government of Victoria, Melbourne.
