

Protocol between Victorian aged care assessment services (ACAS) and aged persons mental health (APMH)

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Introduction

Older people with mental illness often reside successfully in the community with assistance from families and general community services. These services include health services provided by general practitioners (GPs), community health centres, public and private hospitals, palliative care services; accommodation services including residential care services; and support services provided within the Home and Community Care Program (HACC) and other relevant programs currently in development.¹ The HACC program provides a range of basic support services within an older person's home to assist them with activities of daily living, optimise independence and assist them to stay living in the community. These include home care, nursing, personal care, home maintenance and meals services.

Both aged care assessment services (ACAS) and aged persons mental health (APMH) have similarities in their role in that they undertake assessment and facilitate access to services for older people. APMH and ACAS need to refer to each other and consult with each other on a regular basis. To ensure appropriate, responsive and timely service provision it is important that client-focused principles drive the relationship between ACAS and APMH to reduce duplication of assessment and to deploy respective expertise effectively.

Both ACAS and APMH have identified the need for a framework to guide the development of collaborative relationships between them.

This protocol is intended to scope those who are clients of either the APMH or ACAS systems or who are potentially eligible to be clients of these service systems and require access to an ACAS or APMH assessment.

The protocol is intended to support a good working relationship between ACAS and APMH. Considerable information about each service is included to promote an understanding of the role and target group of each service system.

The presence of a mental illness does not in itself necessitate a referral to a mental health service. Most people enter the APMH service system not because of a particular diagnosis but because the level of risk or behavioural disturbance cannot be managed safely by their GP or general aged care service providers. It should be noted that older people with quite challenging behaviour are accommodated in mainstream residential care facilities.

This protocol is not intended to resolve issues around people aged under 65 years with a psychiatric disability who require access to ACAS assessment or residential aged care facilities. A different mental health service system exists for people under 65 years of age. Further work needs to occur in developing a protocol between adult mental health services and ACAS.

Another protocol has been developed with disability services for assessing younger people with disabilities seeking accommodation in a residential aged care facility.² The protocol with disability services *does not* cover people with mental health issues.

¹ The Commonwealth is currently in negotiation with health services in Victoria with the view to funding the Dementia Behaviour Management Advisory Service.

² Department of Human Services 2005, *Disability Services: Aged care assessment services protocol – Younger people with a disability*

1. Purpose

The purpose of this protocol is to:

- provide a brief explanation of the objectives, roles, responsibilities, target groups and services provided by APMH and ACAS to improve understanding of respective program areas
- identify clear communication channels between APMH and the ACAS in order to streamline access to an assessment by either service
- outline the process for ACAS to follow when a referral to APMH is required
- outline the process for APMH to follow when a referral to ACAS is required
- outline the roles and responsibilities of APMH and ACAS in relation to an older person with mental illness who moves into a residential aged care facility.

1.1 Older people requiring ACAS assessment

The role of ACAS is to determine the overall care needs of frail older people to assist them to gain access to the most appropriate types of services. In doing this, ACASs comprehensively assess older people taking account of the restorative, physical, medical, psychological, cultural and social dimensions of their care needs.³

Residential care services, referred to as residential aged care facilities, provide accommodation and care for those whose care needs cannot be managed by the resources available in their home environment. Residential aged care services provide either:

- high-level care, sometimes referred to as nursing home care
- low-level care, sometimes referred to as hostel care.

ACAS provides assessment for eligibility for residential aged care services for both permanent care and respite care, Transition Care Program (TCP), Community Aged Care Packages (CACAP), Extended Aged Care Packages in the Home (EACH), or EACH Dementia. In keeping with ACAS's focus on comprehensive assessment, ACAS regularly refer clients to a wide range of health and community services. ACAS may also perform a consultative role with other service providers.

ACAS is funded on a 70-plus population-based funding model. The ACAS target group is interpreted on a day-to-day basis as frail older people but may include younger people who are displaying signs and symptoms of early onset of ageing.

1.2 Older people requiring APMH assessment

As previously stated, the presence of a mental illness does not in itself necessitate a referral to a mental health service. A more detailed overview of the APMH service system is contained in the document, *Victoria's mental health service: The framework for service delivery – aged persons services*.

APMH provides services to people who are 65 years or older; those who have, or appear to have, a severe mental illness; and/or whose behaviour cannot be managed in the community or by other aged care service providers in a less intrusive manner.

Challenging and difficult behaviour with persistent cognitive, emotional or behavioural disturbance is unmanageable when the safety and wellbeing of the person exhibiting the behaviour or others cannot be assured. Examples include:

- strong suicidal ideas or actual attempts
- violent or aggressive behaviour that is dangerous to others
- extensive and persistent rummaging or wandering that causes distress or danger to the wanderer or others

³ Department of Health and Ageing 2006, *Aged Care Assessment Program guidelines*, Australian Government p. 1

- other behaviours that make it difficult for the person to be cared for in an otherwise appropriate environment.

People aged under 65 years who exhibit symptoms associated with degenerative diseases such as dementia can be referred if behavioural disturbance is severe, as described above.⁴

1.3 Need for collaboration

In 1999–2000 the APMH service system embarked on a quality project to identify the indicators of a positive working relationship between APMH and ACAS.⁵ The indicators were identified as:

- service planning and development
 - planning for collaborative links between APMH and the aged care sector
 - joint participation in management and/or service planning and development activities
- service access
 - APMH target group identified and communicated
 - a timely, appropriate and consistent response to referrals from ACAS and other aged care providers
 - referral processes between ACAS and APMH that avoid duplication
 - APMH provides secondary consultation to ACAS and other aged care providers
 - APMH service quality is assessed
- case coordination and management
 - collaboration and shared processes for assessment and care planning where clients are known by both services
 - APMH monitor the quality of collaborative case coordination to improve service responsiveness
- education and training
 - APMH service includes ACAS in professional clinical education program within the auspice clinical program.

It is envisaged that local protocols will be developed to identify and guide local ACAS/APMH collaborative approaches. Of particular relevance to this protocol is:

- the collaborative practice of APMH services supporting clients when they are in transition to a residential aged care facility
- orientation of new staff to the other service, ACAS or APMH
- accepted modes of referral and response times
- communication of referral outcome to ACAS or APMH referrer
- each service familiarising themselves with the role and function of the other's assessment protocol
- identification of local conflict resolution procedures and complaints management
- development of strategies for informing ACAS if APMH no longer need to be involved with a relevant client such as a client who is waiting for a care package.

⁴ Department of Health and Community Services 1996, *Victoria's mental health service: The framework for service delivery – aged persons services*, Victorian Government. Available at <http://health.vic.gov.au/mentalhealth/frameworks/aged_persons_services.pdf>. Accessed 20 March 2008.

⁵ Lincoln Gerontology Centre 2000, *Evaluation of aged persons' mental health services' responsiveness to the needs of consumers of residential and community-based aged care*. Available at <<http://www.health.vic.gov.au/mentalhealth/archive/qis/res-aged.pdf>>. Accessed 20 March 2008

2. Background

2.1 ACAS

Structure and core responsibility

The Aged Care Assessment Program (ACAP) is a national program funded by the Commonwealth Department of Health and Ageing with funding contributions made by individual states and territories on a voluntary basis. There are 18 ACASs in Victoria, 15 of which are based in public health services or extended care centres, and three of which are based in community health services.

The ACAP operational guidelines set out the core requirements and responsibilities of ACAS.⁶

Objectives of service

The core objective of ACAS is to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs.

Selected ACAS team members are authorised as Commonwealth delegates under the Commonwealth *Aged Care Act 1997* to approve frail older people for entry to low- or high-level residential aged care, CACPs or flexible care (EACH/EACH Dementia packages or TCP). The decision to accept a person recommended for care by an ACAS rests with the provider of the Commonwealth-funded residential aged care facility, TCP, CACPs, EACH or EACH Dementia package.

ACAS do not case manage clients but in some circumstances undertake short-term care coordination. There are two different levels of care coordination that ACAS may provide:

- Level 1 care coordination is aimed at monitoring care plan implementation, and would typically be undertaken for clients who need help to access services. This may be because either the client or their carer would have difficulty in negotiating the service system without the help of the ACAS. Normally, level 1 care coordination would occur less than once a week.
- Level 2 care coordination is about helping clients who have complex needs or who are in an unstable or dangerous situation and require close monitoring or active assistance from an ACAS staff member. Level 2 care coordination would usually require some action from the ACAS staff member more than once a week.

Care coordination closure date is defined as the earliest of the following dates: when the assessment clinician and the client have agreed that no further ACAS involvement is required; when the coordination of the client's care needs have been taken on by a provider; when the coordination of the client's care is being managed competently by a carer; or when the client is referred for reassessment.⁷

2.2 Mental health service system

The specialist public mental health system consists of clinical services and psychiatric disability rehabilitation and support services (PDRSS). Clinical mental health services are managed by public hospitals and provide assessment, diagnosis, treatment and clinical case management to people with a serious mental illness. Psychiatric disability rehabilitation and support services are provided by non-government community organisations.

Specialist clinical mental health services in Victoria are provided on an area basis, and are often referred to as area mental health services (AMHS). They include adult mental health services, child and adolescent mental health services and aged persons mental health services.

⁶ Department of Health and Ageing 2006, *Aged Care Assessment Program guidelines*, Australian Government. Available at <<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acat-acapaag.htm>>.

⁷ Department of Health and Ageing 2006, *Aged Care Client Record User Guide*, Australian Government, Canberra

Each of these service categories provide inpatient psychiatric services, in addition to a range of residential and other community-based services.⁸

APMH provide services primarily to people aged 65 years and over. The client group includes:

- people who have had a mental illness for many years and who may now require ongoing support to treat their mental illness, psychological stress and/or significant changes in their social circumstances
- people who develop a mental illness later in life that cannot be managed by general health and aged care services
- people with severe psychiatric or behavioural difficulties associated with organic disorders such as dementia.

APMH service components⁹

Aged persons mental health teams

These services provide community-based assessment, treatment, rehabilitation and case management for older people. The service is delivered through multidisciplinary teams. They provide specialist expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions. The teams also provide education for consumers and carers as well as secondary consultation to other service providers.

Acute inpatient services

These services provide short-term inpatient management and treatment during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in the community. These services are located with other residential aged care facilities or general hospitals. In some rural services, aged acute inpatient beds are collocated with an adult inpatient unit.

APMH residential care

These services provide a range of specialist bed-based services to consumers who cannot be managed in mainstream residential aged care facilities due to their level of persistent cognitive, emotional or behavioural disturbance. APMH nursing homes and hostels specialise in caring for older people with a mental illness and provide longer term accommodation, ongoing assessment, treatment and rehabilitation. They are designed to have a familiar, homelike atmosphere, and residents are encouraged to participate in a range of quality-of-life activities.¹⁰

Service access

Access to APMH services is via the centralised psychiatric triage for each mental health service. The contact details for triage at each local health service are available at <<http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm>>.

^{8, 9} Department of Human Services. Available at <<http://www.health.vic.gov.au/mentalhealth/services/index.htm>>

¹⁰ Where possible clients will be discharged to a less restrictive environment such as a generic residential aged care facility; however, consumers may remain in these units as long as is warranted by their mental state. In some areas a small number of specialist mental health beds are located in mainstream facilities.

2.3 Legal framework

Mental Health Act

The *Mental Health Act 1986* (the MHA) requires that people with a mental disorder receive the best possible care and treatment in the least restrictive environment. A person who meets the criteria in section 8(1) of the MHA, including that the person has refused or is unable to consent to necessary treatment for their mental illness, can be placed on an involuntary treatment order (ITO) or a community treatment order (CTO). A person subject to an ITO or a CTO is an involuntary patient. Consent to psychiatric treatment for an involuntary patient is provided by the authorised psychiatrist. Involuntary treatment under the MHA does not mean that the person is not fit to make decisions with regard to other aspects of their life.

A person should only be placed in an APMH residential care facility on an ITO if there is no less restrictive way of effectively providing care and treatment to the person. An involuntary patient who can be effectively treated in the community or in a mainstream residential aged care facility can be placed on a CTO.

Aged Care Act

The ACAP is underpinned by the Aged Care Act (the Act) and associated Aged Care principles (the principles). The Act and the principles provide the legislative basis for ACATs to assess and approve people for subsidised care. They also outline the legislated requirements for matters such as the aged care planning process, approved service providers' responsibilities, subsidies and grants, types of services approved providers are to provide and administrative processes.

The Act and the principles provide the basis for the *ACAP assessment and approval guidelines – September 2006*, and the *Aged Care Assessment Program operational guidelines 2002* (the guidelines) which outline in more detail the processes to be followed. Guidelines also exist for each of the service programs and while these have been developed primarily for service providers they provide useful information to ACAT members regarding the types of services, eligibility criteria and other useful information.¹¹

Confidentiality

This protocol explains the respective roles and responsibilities of ACAS and APMH. In practice, a number of service providers may be involved in the assessment, referral, treatment and care of a person. This will necessarily involve sharing information about the person. Family members and carers may also have a role in this process.

Section 120A of the MHA is the principal law that regulates the disclosure of health information by public mental health services, both inpatient and community-based, the PDRSS sector and private psychiatric hospitals. The *Health Records Act 2001*¹² governs the use and disclosure of health information by ACAS. The Health Records Act and the Commonwealth *Privacy Act 1988*¹³ are the principal laws governing the disclosure of health information by private practitioners such as private psychiatrists and GPs.

Consent is usually the starting point when considering disclosure. This subject should be discussed with the person as soon as practicable in order to establish a clear basis for information sharing from the start. Most people will agree to the sharing of information with other treating clinicians or services or with family members or carers if time is taken to discuss the reasons and the benefits, although they may wish to place limits on the disclosure of some information, particularly sensitive information.

¹¹ Department of Health and Ageing 2007, *National introduction to Aged Care Assessment Program: Self directed learning package*: Generic section, Australian Government, Canberra

¹² Health Services Commissioner 2001 *Health Records Act*, Australian Government. Available at <<http://www.health.vic.gov.au/healthrecords/overview.htm>>

¹³ Australasian Legal Information Institute 1988 *Privacy Act*. Available at <<http://www.privacy.gov.au/act/privacyact/>>

The MHA and the Health Records Act prescribe a number of specific circumstances when information may be disclosed without a person's consent. For example, public mental health services may disclose information about a person to another service provider to enable the further treatment of the person, even in the absence of consent.

If a clinician decides to disclose information without consent, it would be good clinical practice to tell the person, unless this would pose a serious risk to the health, safety or welfare of an individual.

Charter of Human Rights

The Victorian *Charter of Human Rights and Responsibilities Act 2006*¹⁴ (the charter) seeks to promote and protect certain human rights. The charter requires public authorities, which include public mental health services and clinicians, to act compatibly with the rights that are protected by the charter and to give proper consideration to these rights when making decisions. The obligations on public authorities came into operation on 1 January 2008.

An example of how the charter will be relevant is the right to privacy. The charter requires that a person must not have their privacy unlawfully or arbitrarily interfered with. Under the charter, any decision to disclose information without consent must have a legal basis and should not be arbitrary. This will require an individual judgement, having regard to the relevant law, for example, section 120A of the MHA and the reasons for the disclosure. A decision to disclose information that has been made in this context and in good faith will be consistent with the charter.

Further information about the charter is available from the Victorian Equal Opportunity and Human Rights Commission website at <www.humanrightscommission.vic.gov.au>.

3. Referral

APMH and ACAS will refer to each other and consult with each other frequently. For good service provision and continuity of care the ACAS–APMH relationship must be based on client-focused principles.

ACAS are mandated to make referrals using the service coordination tool templates (SCTT). APMH are encouraged to also utilise these referral tools.¹⁵

Consistent with the principles of collaboration, a positive working relationship between ACAS and APMH would be demonstrated in the referral process by:

- a preliminary informal discussion prior to referral between services
- acknowledgement of the referral and communication of the outcome of the referral to ACAS or APMH referrer.

Some scenarios of cross-referral are described further in the framework for service delivery.¹⁶

A referral to assess testamentary capacity is usually not accepted by ACAS or APMH; however, testamentary capacity can be assessed if required for current clients of either service. Private specialists such as neuro-psychologists, neurologists, psychiatrists or geriatricians may also need to be approached when assessment of competency is required.

If the referral is not accepted then either service will engage in secondary consultation and/or suggestion of alternative services.

¹⁴ Department of Justice 2006, *Charter of Human Rights and Responsibilities Act 2006*. Available at: <www.justice.vic.gov.au/humanrights>

¹⁵ Further information on referral tools is available at <<http://www.health.vic.gov.au/pcps/coordination/sctt2006.htm>>

¹⁶ Department of Health and Ageing 1996, *The framework for service delivery aged persons services*, Victorian Government, Melbourne

3.1 Referral to ACAS

Eligibility for assessment by an ACAS is determined at the ACAS intake. This initial screening process is a demand management strategy designed to ensure that ACAS focus on their specialist roles and responsibilities within the aged care system and can make a timely response to individual need. A comprehensive ACAS assessment is carried out for every person whose referral is accepted.

ACAS intake operates five days a week during business hours.

With consent, ACAS gather relevant information in order to determine if an ACAS assessment is the most appropriate response to individual need. This process of initial information gathering and determination of the appropriateness of the referral is carried out routinely for all referrals to ACAS.

Priority categories

ACAS respond to referrals in a timely and efficient manner by allocating a priority category at the time of referral. Priority refers to the length of time within which the person needs contact of a clinical nature by the ACAS. This decision on priority of access is based on the urgency of the person's need as assessed by the ACAS at referral. These priorities are outlined below.

Priority 1 (within 48 hours): refers to a person who, based on information available at referral, requires an immediate response (response within 48 hours). An urgent assessment is required if the person's safety is at risk (such as high risk of falls or abuse) or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves or their carer is unavailable. This may be due to a crisis in the home involving either the person or the carer or a sudden change in the client's or carer's, medical, physical, cognitive or psychological status.

Priority 2 (between 3 and 14 days): should be used when information available at referral indicates that the person is not at immediate risk of harm. Referrals that indicate progressive deterioration in the person's physical, mental or functioning status or that the level of care currently available to the person does not meet their needs or is not sustainable in the long term should be allocated to this priority category.

Priority 3 (more than 14 days): refers to cases where the referral information indicates that the person has sufficient support available at present, but that they require an assessment in anticipation of their future care requirements. Examples include the carer planning a holiday that will result in the care recipient requiring substitute care and recognition that the person is having increased difficulty living independently and options for future care need to be discussed with the person and their carer or family.¹⁷

3.2 Referral to APMH

Access to APMH is via the centralised psychiatric triage for each mental health service. The contact details for triage at each local health service are available at <<http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm>>.

For referral to APMH the client must usually be aged 65 years or over, and appear to have a severe mental illness and/or behaviour that cannot be managed in a less intrusive manner by general aged care providers (see introduction).

Important information to be aware of

Not all older people with mental illness require assessment by APMH. Families, GPs and other psychosocial supports can, in many circumstances, support an appropriate management plan.

¹⁷ Australian Institute of Health and Welfare 2002, *Aged care assessment data dictionary*, Version 1 p. 95

APMH assess older people who appear to have a serious mental illness or who require specialist mental health assessment and/or management. Some issues to consider are:

- It is preferred that the client (or where the client is not capable, their representative/family) and their GP are made aware of and are accepting of the referral.
- It is highly recommended that the client is seen by their GP prior to or at the time of the referral for a baseline mental state examination and a thorough physical examination including investigations that may include bloods such as FBE, TFT, LFT, U&Es, blood sugars, serum blood levels and MSU. Further tests like ECG, chest X-ray and CT brain scan may be necessary for some patients to rule out an underlying physical cause for the client's change in behaviour.
- The GP is the key prescribing medical practitioner in the shared-care model used by APMH. If there is no GP already involved APMH will facilitate the involvement of a medical practitioner. APMH services work in a shared care model with GPs. APMH is a specialist service and will not take over care of patient from a GP, but work in collaboration with the GP in managing the mental health issues. Following assessment, GPs are informed of the findings and outcome. They are then given advice in managing their patients. APMH will not prescribe but advise about any medication to be prescribed and investigations to be done. It is ultimately the decision of the GP whether he/she accepts the advice. If case management is required for a patient, the GP is informed regularly of progress and developments.
- If the person is on a CTO the authorised psychiatrist will consent to the mental health treatment and prepare a treatment plan.
- Alternative treatment options may be available to clients with private health insurance or a DVA Gold Card. These alternative options could include access to private psychiatrists, private psychiatric hospitals and purchasing additional help.

Priority/urgency

Referrals are responded to according to the clinical assessment of risks as assessed by triage/intake.¹⁸

Access to APMH acute units and APMH residential care

- Access to the APMH service system is via the APMH triage/intake. APMH clinicians conduct the assessments and coordinate admissions. A key principle in treating clients is to do so in the least restrictive manner (see sections 1.2 and 2.2).
- Approval by ACAS is required for entry to APMH residential care facilities. Access to APMH residential care is at the discretion of the relevant APMH. ACAS may indicate that APMH residential care is appropriate but only after consultation with the relevant APMH team. ACAS clinicians should describe the behaviours on the Aged Care Client Record rather than include a recommendation to this specialist type of facility.
- ACAS assessment is not necessary for transfer out of APMH residential care into generic residential aged care unless the intention is to move to a higher level of care. ACAS may provide input and assistance even if further formal assessment is not required, as would be the case when the transfer is to the same level of care.

4. Assessment

APMH and ACAS have different but complementary roles; however, both services have a significant role in assessment and determining eligibility for services. APMH and ACAS should familiarise themselves with the role and approaches of the other service's local assessment protocols and practices.

Joint assessment should be undertaken where appropriate and this is consistent with the recommendations of the 1999–2000 quality project referred to in this document.¹⁹ Following

¹⁸ The department's Mental Health Branch is currently undertaking a project to assess triage processes with the view to promoting good practice and consistency in the categorisation of urgency and the response time of services across the mental health sector.

assessment, feedback will be provided to the referrer and relevant others, including the referring ACAS or APMH. Local protocols will determine what format this feedback will take.

4.1 ACAS assessment

ACAS assessment principles

- Comprehensive and holistic – A comprehensive assessment should include an evaluation of a person's restorative, physical, medical, psychological, cultural and social dimensions of care.
- Independent – The care needs and preferences of the person and carer are paramount in the ACAS assessment process. ACAS recommendations about care should not give inappropriate consideration to the interests of service providers or other organisations.
- Multidisciplinary and multidimensional – ACAS should comprise or have access to a range of disciplines, skills and expertise sufficient to make accurate and complete assessments of the person's needs.²⁰ Multidisciplinary assessment can be achieved through case conferencing, joint assessments, follow-up visits, cross referral, multidisciplinary or delegation processes. Case-conferencing is a vital component of comprehensive assessment, particularly for complex assessments.

Client focused – A focus on the person and outcomes is essential to the delivery of the ACAS. As part of the client focus, ACAS should promote the person's right to:

- privacy and confidentiality
- be informed
- involve a carer or other advocate
- complain
- appeal²¹
- complete acute treatment (for people with a mental illness, their condition should be stable prior to being assessed).²²

As part of the ACAS assessment of a client of the APMH service system, ACAS will identify and document the level of ongoing support committed by the APMH service system when considering the person's suitability for mainstream residential aged care, CACPs or an EACH/EACH Dementia package. ACAS may indicate that APMH residential care is appropriate, but only after consultation with the relevant APMH team (see section 3.2 *Access to APMH acute units and APMH residential care*).

4.2 APMH assessment

The document *Victoria's mental health service – The framework for service delivery aged persons services* provides a detailed overview of assessment in APMH. Some extracts are provided below.

APMH services conduct a comprehensive assessment of elderly people who have or are thought to have a mental illness in order to determine:

- their mental state and requirements for psychiatric treatment
- the level of support available
- additional supports to maintain the client in the community
- the level of risk of harm to self/others and management strategies.

¹⁹ Lincoln Gerontology Centre 2000, *Evaluation of aged persons mental health services' responsiveness to the needs of residential and community-based aged care services reference*. Available at <<http://www.health.vic.gov.au/mentalhealth/archive/qis/res-aged.pdf>>. Accessed 9 February 2006

²⁰ Department of Health and Ageing 2002, *Aged Care Assessment Program operational guidelines*, Australian Government, Canberra, Section 3 p. 10

²¹ Department of Health and Ageing 2002, *Aged Care Assessment Program operational guidelines*, Australian Government, Canberra, Section 3 p. 11

Joint assessments should be conducted where appropriate and duplication of assessment should be avoided.²³

APMH assessment process

The allocated case manager will make contact with the client to arrange a time and date for the initial interview and, where necessary, with:

1. the referrer and/or family
2. other agencies, for example, interpreters
3. the client's GP (the client's GP remains the primary medical provider and will always be informed of a referral involving one of their patients; although APMH services provide consultation to GPs, prescribing medication remains the GP's role).

The model of assessment is bio-psycho-social, which incorporates mental state examination, the requirements for psychiatric treatment, the level of support available and required, and the level of risk of harm to self/others and how risk will be managed.

Following the initial interview the case manager will consult with their multidisciplinary team, which may occur in one or more of the following ways:

1. informal discussion with peers
2. consultation with the consultant psychiatrist
3. formal presentation of the assessment to the multidisciplinary team
4. review of the case at supervision.

The outcomes of the assessment including the initial goals and interim plan are documented and forwarded to the client's GP. The referring agency will also receive the outcomes of the assessment including the initial goals and interim plan. Clients are referred to APMH for specialist assessment and opinion and this may result in just one assessment and report or transfer into the APMH case management phase.

4.3 Transition from APMH residential care to mainstream care

ACAS assessment is not essential for transfer between aged persons mental health residential care and mainstream care at the same level of care (low or high care). However, APMH services that are facilitating transition of a client between specialist services and mainstream residential services are encouraged to consult with ACAS to enable access to the most appropriate care and setting. In principle, the APMH service system will continue to support the APMH client in mainstream residential aged care, or while waiting for mainstream residential aged care, or an EACH/EACH Dementia or CACPs package, for as long as required.

5. Grievance procedures

Establishing a positive collaborative working relationship between ACAS and APMH should support a common view of client needs. If ACAS or APMH have the view that the outcome of a referral is unsatisfactory, attempts should be made to resolve the issue at a local level. Local protocols should outline agreed ways of proceeding.

5.1 ACAS complaints

Individuals, their carers or advocates, have the right to complain and to have their complaints dealt with promptly and impartially.

Complaints relating to the conduct or operation of individual ACAS or an ACAS member should be directed to the ACAS manager initially. If the complaint cannot be resolved at this level, it

²³ Department of Health and Community Services 1996, *Victoria's mental health service: The framework for service delivery – Aged persons services*, Victorian Government. Available at <http://www.health.vic.gov.au/mentalhealth/publications/downloads/aged_persons_services.pdf>. Accessed 9 February 2006

should be directed to the Victorian Department of Human Services in its capacity as the day-to-day program managers of the ACAS program.

Appeal process

People who are not satisfied with an assessment outcome, with respect to residential aged care, community care or flexible care, have the right to appeal to the Secretary of the Commonwealth Department of Health and Ageing for a review of that decision.²⁴ Any person whose interests are affected by a reviewable decision can make a request in writing to the Secretary of the Department of Health and Ageing for a reconsideration of the reviewable decision. This could include aged care service providers as well as potential and current care recipients and their immediate families, carers or legal guardians. This request for a review/appeal should be made within 28 days of the date on which the person received written notice of the decision, and within any extended period approved by the Secretary.

Clients are to be advised of their appeal rights in relation to residential aged care and community care. If the person being assessed has dementia or is otherwise mentally confused, a carer or advocate should be advised of the outcome and the person's rights.²⁵

5.2 APMH complaints

All APMH will have an established mechanism to deal with complaints at a local level. This procedure should be followed where issues are unresolved or where the complaint relates to breaches of client care standards. Local protocols should identify local conflict resolution procedures and complaints management.

Some issues can be reported to the Office of the Chief Psychiatrist. The Chief Psychiatrist has responsibility under the Mental Health Act for the medical care and welfare of persons receiving treatment or care for a mental illness. The Chief Psychiatrist's responsibilities include monitoring the clinical standards of psychiatric practice and treatment provided by public mental health services and responding to complaints from consumers, carers and others. More information and the contact details of the Chief Psychiatrist are available at <www.health.vic.gov.au/mentalhealth>.

^{24,25} Department of Health and Ageing 2002, *Aged Care Assessment Program operational guidelines*, Australian Government, Canberra, Section 6 p. 33