

DEPARTMENT OF HUMAN SERVICES

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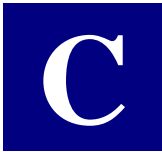
**BED SUBSTITUTION IN ACUTE PSYCHIATRIC
TREATMENT FOR OLDER PEOPLE – AN
EVALUATION OF THE INTENSIVE COMMUNITY
TREATMENT PROGRAM**

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FINAL REPORT

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CONTENTS

- EXECUTIVE SUMMARY 1**
- E.1 Program Aims and Description..... 1
- E.2 Objectives of Evaluation 1
- E.3 Evaluation Methodology..... 2
- E.4 The ICT Model 2
- E.5 Appropriateness of the Program..... 3
- E.6 Effectiveness of the Program..... 3
- E.7 Service Outcomes 4
- E.8 Efficiency of the Program..... 5
- E.9 Conclusion and Future Directions 7

- INTRODUCTION 10**
- 1.1 Background Information 10
- 1.2 Aims and Principles of the ICT Program 12
- 1.3 Program Description 13
- 1.4 Purpose and Objective of Evaluation 13
- 1.5 Pilot Sites..... 14
- 1.6 Evaluation Methodology..... 14
- 1.7 Ethics Approval..... 15
- 1.8 Structure of this Report..... 15

- THE ICT MODEL 17**
- 2.1 Service Model Comparisons..... 17
- 2.2 Service Activity..... 23
- 2.3 Staffing 25
- 2.4 Funding and Expenditure 26
- 2.5 Service Catchment and Admission Rates 28
- 2.6 ECT..... 29

- APPROPRIATENESS OF THE ICT PROGRAM 30**
- 3.1 Policy Context..... 30
- 3.2 Surveys Undertaken..... 32

- 3.3 Target Group..... 35
- 3.4 Mix of Services..... 39

- EFFECTIVENESS OF THE ICT PROGRAM 41**
- 4.1 Accessibility 41
- 4.2 Response Times..... 42
- 4.3 Awareness of the Service..... 44
- 4.4 Communication 45
- 4.5 Impact on Inpatient Units..... 46
- 4.6 Service Outcomes..... 50

- EFFICIENCY OF ICT PROGRAM 59**
- 5.1 Funding and Cost..... 59
- 5.2 Staffing 60
- 5.3 Comparison to Inpatient Funding..... 61

- CONCLUSION AND FUTURE DIRECTIONS..... 65**
- 6.1 Conclusion..... 65
- 6.2 Key Elements of ICT Program Model and Service Improvement Opportunities..... 66
- 6.3 Future Direction..... 67

- Appendices
- APPENDIX A - PROGRAM STATEMENT I
- APPENDIX B -STAFF SURVEY..... XII
- APPENDIX C: GENERAL PRACTITIONER SURVEY..... XVII
- APPENDIX D: CARER AND PROFESSIONAL CARER SURVEY XX



TABLES

Table 1.1: Service Commencement	11
Table 1.2: Summary of Methodology	14
Table 2.1: Service Model Comparisons.....	18
Table 2.2: Admissions to ICT Program.....	23
Table 2.3: Daily Average Clients on ICT Program.....	24
Table 2.4: Average Length of Stay on ICT Program.....	24
Table 2.5: Occupancy Rate	24
Table 2.6: Staffing Summary	25
Table 2.7: Staffing Details ^{1,2}	26
Table 2.8: Estimate of Funding Provided 2003/04 to 2008/09 ^{1,2,3}	27
Table 2.9: Expenditure 2007/08 and 2006/07 ³	27
Table 2.10: Estimated Resident Population 65+ (2007).....	28
Table 2.11: Estimated Resident Population 65+ 2007 and 2001	29
Table 2.12: Clients on ECT 2006/07 and 2007/08.....	29
Table 3.1: Staff Survey Response Rates.....	33
Table 3.2: Where Respondents Worked.....	33
Table 3.3: Professional Category of Respondents.....	33
Table 3.4: Number of Respondents Who Have Referred to the ICT	34
Table 3.5: Policy Alignment with Other Services.....	34
Table 3.6: Referral Source	35
Table 3.7: Survey Response Rates.....	36
Table 3.8: Admission to an Acute Unit More Appropriate	36
Table 3.9: Survey Response Rates.....	37
Table 3.10: Discharge Location	38
Table 3.11 : Principal Diagnosis of ICT Clients ¹	38
Table 3.12: Comparison of Principal Diagnosis ICT/ Inpatient ^{1,2}	39
Table 3.13: Number of GPs who consider Level and Mix of Service was Appropriate	40
Table 4.1: Accessibility Rating - Referring Staff ¹	41
Table 4.2: Accessibility Rating - ICT Staff.....	42
Table 4.3: Accessibility Rating – GPs.....	42
Table 4.4: Response Time Rating - Referring Staff	43

Table 4.5: Response Time Rating - ICT Staff.....	43
Table 4.6: Response Time Rating – GPs.....	43
Table 4.7: After Hours Support – GPs Rating.....	44
Table 4.8: How GPs Became Aware of the Service.....	44
Table 4.9: Level of Communication with ICT Psychiatrists.....	45
Table 4.10: Level of Communication with other ICT clinicians.....	46
Table 4.11: Changes in HoNOS65+ Score while on Program.....	51
Table 4.12: Beneficial Aspects of the Service	52
Table 4.13: Overall Service Rating.....	53
Table 4.14: Service Preference	53
Table 4.15: Inpatient Unit Service Rating	54
Table 4.16: Service Rating Comparison.....	54
Table 4.17: Number of Carers who believe Service has resulted in fewer Admissions/Decreased Length of Stay	54
Table 4.18: Beneficial Aspects of the Service	55
Table 4.19: Beneficial Nature of Service Rating – GPs.....	56
Table 4.20: Number of GPs who consider Service should be continued	56
Table 4.21: Beneficial Nature of Service Rating – Referring Staff.....	57
Table 4.22: Beneficial Nature of Service Rating - ICT Staff.....	57
Table 4.23: Beneficial Aspects of the Service	57
Table 5.1: Funding Per Admission 2007/08.....	59
Table 5.2: Cost per Admission ³	59
Table 5.3: Cost per ICT day ³	60
Table 5.4: Admissions per FTE.....	61
Table 5.5: Clients Per FTE Per Day	61
Table 5.6: Comparison of Funding Per Inpatient Admissions to Funding Per ICT Admission (2007/08) ¹	62
Table 5.7: Comparison of Funding Per Inpatient OBD to Funding Per ICT OBD (2007/08) ¹	63
Table 5.8: Comparison of Total Costs to DHS (2007/08)	63



FIGURES

Figure 1.1: Conceptual Overview of Evaluation	13
Figure 4.1: Number of Inpatient Admissions by Year	47
Figure 4.2: Inpatient Unit Average Length of Stay	48
Figure 4.3: Total Occupied Days by Year	48
Figure 4.4: Inpatient Unit % Occupancy by Year	49



ABBREVIATIONS

Terms, abbreviations and acronyms	Meaning
ABS	Australian Bureau of Statistics
ALOS	Average length of stay
APMH	Aged Persons Mental Health
APAT	Aged Persons Assessment team
BASIS 32	Behaviour and Symptom Identification Scale
BPSD	Behavioural and psychological symptoms of dementia
CALD	Culturally and linguistically diverse
CAIR	Community Aged Intensive Recovery
DHS	Department of Human Services
ECT	Electroconvulsive therapy
FTE	Full Time Equivalent
GP	General Practitioner
HREC	Human Research Ethics Committee
HOI	Health Outcomes International
HoNOS	Health of the Nation Outcome Scales
HoSS	Hospital Substitution Service
HoST	Hospital Substitution Team
ICT	Intensive Community Treatment
LGA	Local Government Area
MH&DD	DHS Mental Health and Drugs Division
NOCC	National Outcomes and Casemix Collection
OBDs	Occupied Bed Days
PAG	Project Advisory Group
PGAT	Psychogeriatric Assessment and Treatment Team
RACF	Residential Aged Care Facility
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
RUG ADL	Resource Utilisation Groups – Activities of Daily Living



EXECUTIVE SUMMARY

Health Outcomes International (HOI) was engaged by the then Department of Human Services (the Department) in April 2008 to undertake an evaluation of the Intensive Community Treatment (ICT) Program – a bed substitution program for the acute psychiatric treatment of older people.

E.1 PROGRAM AIMS AND DESCRIPTION

The ICT Program aims to:

- Provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness;
- Provide intensive treatment in the older person's home during an acute phase of mental illness; and
- Minimise the length of stay in an inpatient unit through the provision of intensive community treatment during an acute episode of illness.

The funding for intensive community treatment is provided as a substitute for recurrent funding of five acute aged in-patient beds in a catchment area.

The intensive community treatment (ICT) team is multidisciplinary and functions on an outreach basis, delivering acute care to the client in their home, be that a private home or a residential setting. The ICT Program includes a 24 hour response capacity. Each client was to be allocated a community treatment nurse who will be the primary contact for the client, family, other carer, General Practitioner and APMH community case manager during the acute course of treatment.

Intensive community treatment 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 Service function after hours.

The four pilot ICT Programs covered by this evaluation were part of Barwon Health (located in Geelong), Eastern Health (located in Forest Hill), Gippsland Health (located in Wonthaggi) and Southern Health (located Dandenong).

E.2 OBJECTIVES OF EVALUATION

The key objectives for this evaluation were to:

- Determine whether the ICT is a feasible substitute for acute inpatient psychiatric treatment for older people;
- Provide the data and information to enable the Mental Health and Drugs Division (MH&DD) to model the demand for inpatient beds and establish appropriate numbers of substitution places to facilitate access to acute psychiatric treatment for older people into the future; and
- Make recommendations regarding future development, improvements and implementation of the bed substitution model.

Subsequent to project commencement it was determined that due to a lack of availability of consistent data the second objective was not required to be reported on as part of this

evaluation.

The evaluation of the ICT pilots aimed to inform the MH&DD as to whether the bed substitution model is an appropriate, effective and efficient treatment and support option.

E.3 EVALUATION METHODOLOGY

The evaluation comprised four stages namely:

- Stage one: project planning culminating in an approved project plan;
- Stage two: incorporating the preparation of an Evaluation Framework and an Environmental Analysis paper, both of which were considered by the Project Advisory Committee which was established for the evaluation;
- Stage three: data collection and analysis which resulted in the collection, analysis and presentation of data to the Project Advisory Committee for discussion and deliberation (this included conducting staff, carer and general practitioner surveys for each service; and
- Stage four: the Final Report.

E.4 THE ICT MODEL

E.4.1 SERVICE MODEL COMPARISONS

A comparison of key elements of the service model for each service found that:

- The regional ICT Services (Barwon and Gippsland) have seamless teams which are fully integrated with the APMHS Community Team. The metropolitan ICT Services (Eastern and Southern) have discrete ICT teams although the triage and ICT teams at Eastern have recently been merged;
- All services have access to and close working relationships with consultant psychiatrists and registrars, and aim to make the best use of their limited available time. With the exception of Gippsland, psychiatric input is as required and not provided on a structured sessional basis;
- Discharge from the ICT Program is appropriately based on clinical judgement. Whilst it is difficult to be specific, Gippsland will generally discharge a patient when they need to be seen less than three (3) times per week whereas Southern and Eastern will discharge when a patient needs to be seen less than once per week;
- GPs are generally not involved a decision to admit to the ICT Program and have varying degrees of involvement when their patient is on the Program;
- The Southern Health ICT Program does not have access to flexible funding which can be used for additional nursing, equipment and respite care; and
- All ICT Programs have access to allied health workers although there would appear to be different emphases on the psycho-social aspects of the service provision.

E.4.2 SERVICE ACTIVITY

An analysis of service activity revealed that:

- Barwon and Eastern have the highest number of admissions to the ICT Program and daily average client numbers;
- With the exception of Eastern no ICT service has averaged more than the expected number of clients on the Program at any one time (five to seven). This is because:
 - Activity is reduced on weekends due to only one staff being rostered;
 - The Southern service is capped at five places;

- o Gippsland sees less clients due to the large geographical area serviced and the distances required to be travelled.
- There is a general consistency across services with the length of time that clients are on the Program ranging from 18.9 to 26 days for 2007/08.

E.4.3 SERVICE CATCHMENT AND ADMISSION RATES

There are significant differences in the size of the populations being serviced by the ICT pilots.

Eastern is servicing the largest population. Eastern and Southern have the lowest admission rates per thousand population (1.2 and 1.3 admissions per '000 population respectively) compared to Barwon (2.0 admissions per '000 population) and Gippsland (4.1 admissions per '000 population). Southern is likely to be low due to the fact that its activity is capped at a maximum of five clients at any one time and it has a relatively small number of admissions. Eastern is likely to be low as activity is ultimately limited by the number of staff and the population is large.

E.5 APPROPRIATENESS OF THE PROGRAM

The evaluation has concluded that the ICT Program was an appropriate response to an identified need. The evaluation found that:

- The implementation of ICT Program pilots were supported by an evidence base;
- The ICT Program pilot was supported by appropriate policy settings;
- The ICT Program is aligned with current policy directions.

The evidence suggested the Program would have at least as much focus on prevention of hospital admissions as on early discharge and this has proved to be the case.

The evaluation also concluded that the ICT Program is being targeted appropriately at clients where care can be delivered safely and where there is appropriate support.

Most clients are being discharged back into the community. It was noted that Gippsland ICT manages a significantly higher number of clients with behavioural and psychological symptoms of dementia (BPSD) as there is no behavioural support team in that region.

Generally the combination of services (i.e. nursing, allied health and medical) provided is appropriate and culturally and linguistically diverse (CALD) clients were adequately serviced.

E.6 EFFECTIVENESS OF THE PROGRAM

The evaluation concluded that the ICT Program was operating effectively.

In particular the evaluation found that:

- The accessibility of the Program is generally good or excellent from the perspective of staff;
- GPs considered accessibility was adequate or completely met their need;
- GPs considered that response times and after hours support were satisfactory;
- The overwhelming majority of referring staff considered response times as excellent (60.7%) or good (33.9%), a combined total of 94.6%;
- Communication between GPs and ICT clinicians is adequate; and
- Communication with carers was good or excellent.

E.6.1 IMPACT ON INPATIENT UNITS

ICT Program Managers reported that there were many factors influencing inpatient admissions that cannot be directly linked to whether the AMHS has an ICT Program (e.g. specific patient factors including higher levels of complexity and risk profile of clients, increasing ageing populations and associated referral rates).

However available data indicates that at Eastern the introduction of the ICT Program has had a very positive impact on the inpatient unit with ALOS, OBDs and occupancy rates all decreasing significantly. This has been achieved in the context of rising admissions and large aged population increases in the catchment. The ICT Program has allowed clients to be discharged from the inpatient unit earlier than would otherwise have been the case.

At Barwon, which currently only has four designated aged psychiatric in-patient beds, the ICT Program has allowed inpatient admissions, occupied bed days and ALOS to be contained thus helping the region maintain a low level of acute beds for this patient population group in the context of an increasing aged population.

At Gippsland the ICT Program has contributed to a significant decline in ALOS achieved by allowing earlier discharge from the inpatient unit. It has also assisted in containing the number of admissions in the context of an increasing aged population and higher referral rates.

Overall inpatient admissions are increasing in the context of large aged population increases. However the evidence suggests that the ICT Program, while not being able to reverse this trend, has contained the increase in the number of admissions. The ICT Program has had a very positive impact on reducing ALOS and occupancy of inpatient units.

E.7 SERVICE OUTCOMES

The evaluation considered service outcomes from the perspective of staff, carers and general practitioners.

E.7.1 CLINICAL OUTCOMES

The Project Advisory Group identified HoNOS65+ as being a measure for determining client acuity and data availability given the routine collection of HoNOS65+ in clinical services. However, given that the ICT was not anticipated to ensure a reduced level of acuity and its focus was on a treatment and support approach to reduce the level of disruption to the client and to build capacity, it is considered that perhaps the HoNOS65+ is not the best indicator.

While the available HoNOS65+ data is not statistically valid and there were significant issues identified with its reliability, comparability, and widely varying scores on admission and discharge to/from the ICT Program between services, encouragingly the percentage reduction in HoNOS65+ scores while on the Program was very consistent ranging from 23.3% at Southern to 27.8% at Eastern.

E.7.2 CARERS EXPERIENCE

Carers shared their experience of the ICT Program through a survey and there was overwhelming support for the ICT Program. The evidence showed that:

- Frequency of visits from staff, communication and clients being able to stay at home were the three most commonly identified benefits to carers;
- Carers rated the information and explanations that were provided about the ICT Program and the extent to which they were included in the decision to transfer the person they care for to the Program very highly;
- All carers (100%) who responded to the survey considered that the person they cared for was appropriate for treatment on the ICT Program;
- The overwhelming majority of carers who responded to the survey rated the ICT Program as excellent (69.2%) or good (26.9%), a combined total of 96.1%;
- 75.8% of survey respondents preferred the ICT Program in comparison to the acute unit;
- Carers rated their satisfaction with the ICT Program above respective inpatient units. Combined ratings for ICT Program for good and excellent were 94.8% compared to 80% for inpatient units; and

- The majority of carers who responded (82.1%) considered that the service had resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit.

In addition ICT managers reported that stakeholder support for the ICT Program is very positive. They advised very few or no patients refuse the service when it is offered to them.

E.7.3 GENERAL PRACTITIONERS EXPERIENCE

General Practitioners shared their experience of the ICT Program through a survey. The evidence showed that:

- GPs support the continuation of the ICT Program. 74% of respondents were clear that the service should continue;
- The most frequently rated major benefit was clients being able to stay at home followed by preventing hospital admissions; and
- 61.1% of respondents indicated that the beneficial nature of intervention was adequate or completely met their needs. There was a high level of "don't knows" (27.8%) in relation to this question.

E.7.4 STAFF EXPERIENCE

Community team, ICT and selected staff from inpatient units shared their experience of the ICT Program through a survey and there was overwhelming support for the ICT Program. The evidence showed that:

- The majority of staff who stated that they had referred to the ICT Program rated the benefit of the intervention as excellent (68.8%) or good (22.9%), a combined total of 91.7%. This was very similar for staff who worked in the ICT Program; and
- The two most common cited benefits were the client being able to stay at home and the frequency of visits by staff.

Staff respondents also identified other substantial carer and client benefits including:

- Client being able to stay at home or be discharged earlier, thus avoiding or reducing the risks and disruption associated with a hospital admission (e.g. disorientation, confusion, falls and medication events);
- Allows for increased monitoring and more intensive support including an improved risk management capability and facilitating a prevention of severe relapses;
- More input and communication with carers and a reduction in carer stress;
- Psycho-social aspects of recovery can be dealt with as staff see the family frequently and assist with issues as they unfold;
- Helping the client and family map their way through support services; and
- In the case of Gippsland if the ICT clients can remain in the local general hospital, they stay close to and involve their family and maintain the GP in care of patient, providing a better environment and reducing stigma.

E.8 EFFICIENCY OF THE PROGRAM

The evidence indicates that the key driver of being cost efficient (as measured by either ICT cost per admission, ICT cost per client day or funding per actual admission) is whether the ICT team has a sufficient number of admissions.

The evaluation concluded that the ICT Program was in the case of metropolitan and regional teams a very efficient method of service delivery. The ICT model for the rural service piloted was not as cost efficient.

However in the rural setting the higher cost of an ICT admission is at least partially offset by improved efficiencies of the community team as health professionals can undertake both ICT visits and community team visits when travelling to a particular location. In addition there are economic and other benefits to the client and their carers identified in this Report including clients not having to travel to a remote location for treatment and reduced falls arising from admission to hospital.

E.8.1 FUNDING AND COSTS

The MH&DD allocated ICT funds to Barwon, Eastern and Gippsland to establish a new ICT program. As Southern had piloted the original model, the funds to deliver the ICT program are currently part of their global aged person's community mental health budget.

The financial analysis that could be undertaken was limited by a number of factors. The actual expenditure figures are not available for Gippsland and estimates were provided by the other ICT Program services.

The level of reported expenditure at Eastern and Barwon was similar. Southern expenditure was less than half of the other services in 2007/08. This difference is attributed to Southern employing about half the number of staff, not having access to flexible funding and not charging overheads to the ICT Program.

There is a wide discrepancy in funding per actual admission across the sites. Gippsland receives 170% more funds per actual admission than Eastern. This is attributed primarily to a lower level of activity at Gippsland.

The cost per admission and cost per client day are greater for Barwon than for Southern or Eastern. Gippsland has the highest level of funding per actual admission which is attributed primarily to a lower level of activity at Gippsland as a result of the large geographical area being serviced.

It is not possible to determine whether there is any difference in cost effectiveness between an ICT team operating as a discrete team (as is the case with Eastern and Southern) as opposed to an integrated team. The financial figures are not reliable enough and the number of pilot sites not large enough to be conclusive in this regard.

E.8.2 STAFFING

Information on staffing numbers was indicative only and any interpretation should be treated with caution. Analysis showed that:

- Staffing does not appear to be at the initially approved staffing level;
- Gippsland maintains less than half (40% to 45%) of the client load per FTE compared to Eastern and Southern respectively and this is attributed to the increased travel time required due to a large geographical area being serviced. Barwon also maintains a lower case load than Eastern and Southern;
- Eastern has the highest number of admissions per FTE. Gippsland is significantly lower (approximately half of Eastern); and
- The discreet ICT teams at Eastern and Southern have a significantly higher number of admissions per FTE and clients per day than the integrated teams of Barwon and Gippsland. HOI consider that the primary driver for this is overall level of demand and not the internal structure of the team.

E.8.3 COMPARISON TO INPATIENT FUNDING

Treatment on the ICT Program is more cost effective to DHS when compared to acute inpatient admissions. The ICT model for the rural team is not as cost effective when compared to inpatient activity on a unit costs basis however as identified previously there are other significant benefits that help to offset this.

E.9 CONCLUSION AND FUTURE DIRECTIONS

E.9.1 CONCLUSION

The ICT Program is appropriate, effective and in the case of metropolitan and regional teams an efficient method of service delivery.

The evaluation has demonstrated that:

- The ICT Program is aligned with current policy directions and settings;
- The ICT Program is being targeted appropriately at clients where care can be delivered safely and where there is appropriate support;
- Generally the combination of services (nursing, allied health and medical) is appropriate;
- The accessibility of the Program is generally good or excellent;
- Response times and after hours support are satisfactory or excellent;
- Communication between carers and Program staff is generally good or excellent;
- Where GPs are involved communication with Program staff is satisfactory;
- Carers considered that the person they cared for was appropriate for treatment on the ICT Program;
- The overwhelming majority of carers rated the ICT Program as excellent or good;
- 75% of survey respondents preferred the ICT Program in comparison to the acute unit;
- Carers rated their satisfaction with the ICT Program above respective inpatient units; and
- GPs support the continuation of the ICT Program.

It was also noted that the ICT Program is being utilised as a hospital admission prevention program more than as an early discharge program. It is not considered to be a direct substitute for acute inpatient beds. Stakeholders considered and HOI (through the evidence presented in this evaluation) concurs, that the ICT Program greatly enhances the capacity for early discharge and hospital avoidance and has considerable benefits for clients and carers.

The ICT Program has helped to contain the increase in the number of inpatient admissions in the context of large aged population increases. The ICT Program has had a very positive impact on reducing ALOS and occupancy of inpatient units helping them to cope with increasing admissions with out increasing bed numbers.

Substantial benefits to carers and clients were indentified including:

- Client being able to stay at home or be discharged earlier, thus avoiding or reducing the risks and disruption associated with a hospital admission (e.g. disorientation, confusion, falls and medication events);
- Allowing for increased monitoring and more intensive support including an improved risk management capability and facilitating a prevention of severe relapses;
- More input and communication with carers and a reduction in carer stress;
- Psycho social aspects of recovery can be dealt with as staff see the family frequently and assist with issues as they unfold;
- Helping the patient and family map their way through support services; and
- In the case of Gippsland If the patient can remain in the local general hospital (Gippsland), they stay close to and involve their family and maintain the GP in care of patient, providing a better environment and reducing stigma.

In conclusion the evaluation has demonstrated that the ICT Program is an integral part of the continuum of APMH services, with substantial support and significant client benefit but it does not, nor will it, replace the need for inpatient beds.

E.9.2 KEY ELEMENTS OF ICT PROGRAM MODEL AND SERVICE IMPROVEMENT OPPORTUNITIES

One of the key evaluation objectives was to make recommendations regarding future development, improvements and implementation of the bed substitution model.

OPERATIONAL ELEMENTS

The evaluation has identified that there are a number of key operational elements required as part of the ICT Program service delivery framework which may need to be strengthened (at least in some services) to ensure Program efficiency and effectiveness. These are:

- Implementation of clear referral, admission and discharge criteria. The criteria for each process should clearly specify the input required by the consultant psychiatrist;
- Having a capacity to maintain the client case load over the weekend i.e. adequate staffing over seven days, within existing resources;
- Identifying a separate budget for flexible (brokerage) funding;
- Ensuring at least some consultant psychiatrist time is provided on a 'planned or structured' sessional basis (as occurs at Gippsland);
- Placing sufficient emphasis on the psycho-social aspects of recovery; and
- Engaging the GP community actively in shared care arrangements as per the Program Statement.

PROGRAM MANAGEMENT ELEMENTS

As a result of the findings HOI recommends that MH&DD consider the following

- MH&DD may need to review the data definitions in the CMI related to the ICT program to improve capacity to capture information. This would enable DHS to track key ICT indicators i.e. number of clients admitted, the average length of stay, the average number of clients on the Program per day, the number of staff, the funding provided per actual admission, the number of patients discharged from the inpatient unit to the ICT Program, the number of clients discharged from the ICT Program to a mental health inpatient unit and carer and client satisfaction.
- Reinforce the need for AMHS to record client information including HONOS scores in CMI;
- Negotiating with Southern Health to redistribute the same level of funds (equivalent of 5 aged acute beds) so that their ICT Program can operate at the same level of capacity (employ staff numbers equivalent to other services) as the other ICT services, including access to flexible funding;
- Redraft the ICT Program Statement to emphasise the focus on the prevention of hospital admissions as well as early hospital discharge and the other suggested program improvement opportunities identified above.

E.9.3 FUTURE DIRECTIONS

Based on the evaluation findings HOI consider that the ICT Program should be rolled out to other regions. The Department will need to determine the basis for any roll out taking into account a number of factors including the:

- Aged population greater than 65 years;
- Existing number of acute beds;
- Occupancy of those acute beds;
- The number of acute beds compared to notional required beds based on any formula to be developed by the Department and
- Population density.

Based on the experience of the ICT Program pilot, in metropolitan or major regional centres funding for the equivalent of five inpatient beds is suitable where catchment populations are at least in excess of approximately 40,000- 50,000 aged persons 65+ and access to acute beds is very tight. This level of funding also allows a team to be viable in both size and capability. HOI consider there is a case for APMH services servicing very large catchment populations which also have a limited number of acute beds to receive additional resources.

The basis for roll out to rural areas requires further consideration by the Department.

Prior to any service roll out the Department should:

- Update the ICT Program Statement;
- Develop a basis for the ICT Program roll out;
- Update the basis for the budget; and
- When funding new services within the context of global resource allocations, DHS should ensure the number of positions to be appointed is agreed and agreed service outputs and outcomes tracked for at least the first three years.



INTRODUCTION

This chapter sets out a brief description of the Intensive Community Treatment (ICT) Program, the purpose and objectives of this Evaluation, the pilot sites involved in the evaluation, an overview of the evaluation methodology, and an outline of the structure of this Report.

1.1 BACKGROUND INFORMATION

1.1.1 POLICY CONTEXT

The policy governing the configuration and strategies for aged persons mental health services (APMHS) in Victoria is articulated in the document *Victoria's Mental Health Services: The Framework for Service Delivery: Aged Persons Service*. This document, which was published in 1996, is still the major framework under which APMHS are delivered today. The primary thrust of the Framework was to develop or strengthen specialist public mental health services for aged persons with "severe and/or complex mental disorders whose needs exceed the clinical or practical capacities of other practitioners and agencies".

The Framework provides for area based, comprehensive mental health services for the population 65 years and over. There are seventeen APMHS established across the state. Each APMHS is expected to have three components:

- **Community teams** – providing assessment, treatment and support to people in their own homes, including in generic aged residential care.
- **Acute inpatient services** – providing acute treatment for short periods of time for people who are unable to be cared for in the home environment.
- **Extended care services** – residential programs for people requiring a higher level of care than can be provided in the community but not needing acute treatment.

A key issue facing the Mental Health and Drugs Division (MH&DD) is how to ensure that there is sufficient access to acute psychiatric treatment for older people as the proportion and number of older people increase.

The Aged Persons Mental Health Services Framework provided a planning guideline, which indicates that to maintain current Aged Persons Mental Health acute inpatient beds to population ratio, Victoria will require additional beds.

The distribution of acute inpatient beds is not evenly spread across the state with some area APMHS having less access to beds than other areas. A gradual expansion of acute bed capacity in line with population numbers raises issues of infrastructure and viability. Cost efficiency is usually only reached if five beds are opened at once and there are few facilities which have physical space for five new beds. While the building of new hospitals will address the need for new beds in some areas, it will not be able to cater for the need across Victoria or necessarily be the most appropriate treatment and support option.

While acute psychiatric treatment has traditionally been provided in a hospital bed there is increasing evidence that it may be possible to provide such treatment in non-hospital environments. MH&DD in consultation with the sector developed the ICT pilot to provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness. The ICT pilot was informed by similar initiatives developed and implemented by Southern Health in 1998 and Barwon Health in 2000 (both funded by DHS).

1.1.2 SERVICE HISTORY

An ICT Program Statement was developed in 2003 after extensive consultation (Appendix A). The two APHMS initially chosen to pilot the program were Barwon Health and Eastern Health (Peter James) with both areas identified as having an under supply of acute inpatient beds for their catchment.

The pilots were funded as substitute for five acute beds in each Area.¹

Following consultation and receipt of a funding proposal, DHS funding was approved in late 2003 early 2004 with funding backdated to November 2003 to allow for establishment costs. It was expected that the services would become operational by March 2004.²

A third pilot was approved at Latrobe Regional Hospital in January 2005 following receipt of a submission. Funding was back dated to 1 December 2004 to allow for establishment costs, with services to commence by May 2005. It was noted that this timing may be difficult given past recruitment difficulties. It was also noted that the focus would be in South West Gippsland chosen on the basis of accessibility, demand, workforce and available support.³ An additional amount of funding was provided for a Crisis Assessment and Treatment Service position which was to support the after-hours arrangements for the ICT Program.

Southern Health commenced a bed substitution service in 1998. A need was recognised for five additional beds. This service has been included in this evaluation.

Barwon Health and Southern Health operated a similar service to the ICT program prior to the formal establishment of the pilots. This means the impact of the ICT on acute inpatient units will be limited as the impact from these earlier initiatives will have flowed through the system.

Barwon Health operated three beds prior to the pilot with main differences being an increase in the size of the program and the fact that there was a staff on call roster established as part of the pilot.

The Gippsland Psychogeriatric Assessment Team (PGAT) team was providing a very limited bed substitution service but it was a real struggle to keep people in community due to a lack of resources.

1.1.3 SERVICE COMMENCEMENT

Table 1.1 presents the dates the services were due to commence and the date they actually commenced.

Table 1.1: Service Commencement

	Due to Commence	Commenced	Months delay
Barwon	Mar-04	Jul-04	5
Eastern	Mar-04	Aug-04	6
Gippsland	May-05	Sep-05	4
Southern	Commenced in 1998.		

Table 1.1 shows that the services were established later than originally planned. This was due the time taken to establish procedures and recruit appropriately skilled staff combined with the fact that proposed commencement dates were likely to have been too ambitious.

¹ DHS Memorandum to Director Mental Health from Manager Service Planning and Development 16 September 2003.

² DHS Letter to Barwon Health and Eastern Health undated.

³ DHS Memorandum from Manager Service Partnerships, Planning and Implementation to Director Mental Health. 12 January 2005

1.2 AIMS AND PRINCIPLES OF THE ICT PROGRAM

ICT Program Statement issued by the Department of Human Services (refer Appendix A for complete Program Statement) provides overarching aims, principles and eligibility criteria allows for pilot sites to develop local variations in service delivery as part of the implementation.

1.2.1 AIMS OF THE ICT PROGRAM

The ICT Program aims to:

- Provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness;
- Provide intensive treatment in the older person's home during an acute phase of mental illness; and
- Minimise the length of stay in an inpatient unit through the provision of intensive community treatment during an acute episode of illness.

1.2.2 PRINCIPLES OF THE ICT PROGRAM

The ICT is based on a set of principles, including:

- Intensive community treatment is provided during an acute episode of mental illness as an alternative to hospitalisation, as a less restrictive option;
- An acute episode of treatment can include a pre and post hospitalisation course of intensive community treatment in addition to a hospital stay;
- Where a patient 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;
- The expectation of intensive community treatment achieving clinical outcomes comparable to that of an inpatient admission must exist at the time of initial assessment;
- It must be possible for intensive treatment in the home to be provided in a manner that assures the patient's, family's, carer's and others' safety;
- Both the patient and their family or carer must express a preference for treatment in the home as an alternative to hospitalisation;
- The family or other carer, who shares a residence with the patient, will have the right to say no even if the patient expresses a preference for treatment in their home;
- 'Home' is defined as the patient's usual home, the house of other family or friends or residential care;
- There will be a 24 hour response to patients and families or carers on the program;
- Patients remain in the program for the period they require acute treatment. This will be determined on the basis of clinical need by the consultant psychiatrist, in collaboration with patient, carers, General Practitioner and in consultation with the APMH community case manager; and
- The cooperation of the patient's General Practitioner is required for intensive community treatment to be offered.

1.2.3 TARGET GROUP

The target group for ICT is defined as 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;

- Who have family or other carer supports available for the period of treatment; and
- Whose length of stay in hospital can be minimised through intensive treatment at home.⁴

1.3 PROGRAM DESCRIPTION

Program funding is provided for intensive community treatment (ICT) of older people with a mental illness. It is provided at a level to enable the establishment of a discrete clinical sub team, to focus on acute treatment, within the structure of an Aged Persons Mental Health (APMH) community team.

The intensive community treatment team is multidisciplinary and functions on an outreach basis, delivering acute care to the patient in their home context, be that a private home or a residential setting. The ICT Program includes a 24 hour response capacity. Each client maybe allocated a community treatment nurse who will be the primary contact for the patient, family, other carer, General Practitioner and APMH community case manager during the acute course of treatment.

Intensive community treatment 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 Service function after hours.

The funding for intensive community treatment is provided as a substitute for recurrent funding of five APMH beds in respective catchment areas.

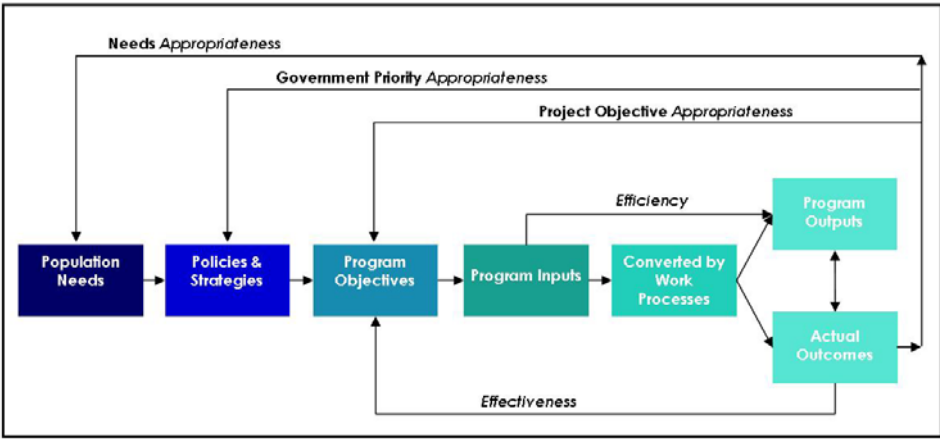
1.4 PURPOSE AND OBJECTIVE OF EVALUATION

1.4.1 PURPOSE OF EVALUATION

The evaluation of the ICT pilots will inform the Mental Health and Drugs Division (MH&DD) as to whether the bed substitution model is an appropriate, effective and efficient treatment and support option.

The conceptual framework for appropriateness, effectiveness and efficiency is presented in Figure 1.1.

Figure 1.1: Conceptual Overview of Evaluation



1.4.2 OBJECTIVES OF EVALUATION

The key objectives for this evaluation as specified in the Tender Brief are to:

⁴ Aged Persons Mental Health Intensive Community Treatment Program Statement.

- Determine whether the ICT is a feasible substitute for acute inpatient psychiatric treatment for older people;
- Provide the data and information to enable the Mental Health and Drugs Division to model the demand for inpatient beds and establish appropriate numbers of substitution places to facilitate access to acute psychiatric treatment for older people into the future; and
- Make recommendations regarding future development, improvements and implementation of the bed substitution model.

Subsequent to project commencement it was determined that due to a lack of availability of consistent data the second objective was not required to be reported on as part of this evaluation.

The primary evaluation questions identified in the Evaluation Framework were as follows:

- Whether home based services are appropriate for the target group (appropriateness);
- Whether ICT is feasible as an option to maintain and possibly expand (appropriateness/effectiveness);
- What if any are impacts on associated acute inpatient units (appropriateness/effectiveness/efficiency);
- Identify the different models of care and the critical success factors for the implementation of ICT and how can any further the development of ICT be improved (effectiveness/efficiency); and
- What impact will the model have on future bed numbers (appropriateness/effectiveness)?

1.5 PILOT SITES

The four pilot ICT Programs (which have been operating under different names) covered by this evaluation and the respective health services are listed below:

- Barwon Health (located in Geelong) – Intensive Community Treatment Program;
- Eastern Health (located in Forest Hill) – formerly Hospital Substitution Team (HoST);
- Gippsland Health (located in Wonthaggi) - Community Aged Intensive Recovery (CAIR) Program; and
- Southern Health (located Dandenong) – Hospital Substitution service (HoSS).

1.6 EVALUATION METHODOLOGY

The methodology for this project comprised four stages as set out in Table 1.2 below.

Table 1.2: Summary of Methodology

STAGE	TASKS UNDERTAKEN
1. PROJECT PLANNING	<ul style="list-style-type: none"> • Initial project meeting with the Department (DHS) • Confirm key stakeholders to be consulted • Identify and collect documentation • Final project plan submitted to DHS
2. ENVIRONMENTAL ANALYSIS	<ul style="list-style-type: none"> • Review of documentation provided during project planning • Develop draft Evaluation Framework • Present and discuss Evaluation Framework with the Project Advisory group(PAG) • Submit Final Evaluation Framework

STAGE	TASKS UNDERTAKEN
	<ul style="list-style-type: none"> • Consultations (face to face) with pilot sites • Review of documentation and literature provided by DHS and pilot sites. • Obtain ethics approval • Preparation of Environmental Analysis Paper • Present Environmental Analysis Paper to the DHS and the PAG
3. DATA COLLECTION AND ANALYSIS	<ul style="list-style-type: none"> • Develop a data collection template for each service based on the data required as per the Evaluation Framework and what data is available, taking account of what had been provided during the site visits • Develop survey forms and corresponding letters • Data collection and compilation • Services administered surveys with the survey forms returned to HOI for compilation and analysis • Follow up with services as appropriate • Preparation of Progress Report • Present Progress Report to the DHS and the PAG
4. PREPARE FINAL REPORT	<ul style="list-style-type: none"> • Prepare draft final report • Present draft report to the DHS and PAG • Submit final report

1.7 ETHICS APPROVAL

Initially an ethics application was prepared for the DHS Human Research Ethics Committee ((HREC). The DHS HREC then advised that an application would need to be submitted to the HREC at each Health Service. Following deliberation at health service level only Barwon required a formal submission and ethics approval was subsequently obtained from the Barwon HREC. The schedule governing the conduct of the evaluation had to be extended to cover for this additional phase.

1.8 STRUCTURE OF THIS REPORT

This document presents the findings from the evaluation of the ICT Bed Substitution Program. Accordingly, the structure of the remainder of the report is:

Chapter 2 - The ICT Model: Provides an overview of the various ICT Models of Care employed across the four regions. The service history, service activity, staffing, funding and expenditure levels are presented together with service catchment information.

Chapters 3 - Appropriateness: Address the question of whether the ICT Program is an appropriate response to an identified need.

Chapter 4 - Effectiveness: address the question of whether the ICT Program is operating effectively. In particular this chapter seeks to address the following: Accessibility of the Program; Program response times; awareness of the Program; the adequacy of communication with key stakeholders; the impact on inpatient units; and service outcomes from the perspective of staff carers and GPs.

Chapter 5 - Efficiency: This chapter address the question of whether the ICT Program is operating efficiently. In particular the chapter analyses funding, cost and staffing per unit of activity. It contrasts financial performance of the ICT Program to inpatient units and identifies opportunities to improve the operation of the ICT Program.

Chapter 6 - Conclusion and Future Directions: This chapter sets out the main conclusions of the evaluation, identifies the key elements required for successful implementation of the ICT Program and associated opportunities for improvement and proposes future directions for the ICT Program.



THE ICT MODEL

This Chapter presents a comparison of key elements of the ICT service model for each service, service activity, staffing, funding and expenditure levels are presented together with service catchment information.

2.1 SERVICE MODEL COMPARISONS

This section provides a comparison of key elements of the service model for each service and these are presented in tabular format in Table 2.1. The key findings to be drawn from the table are then presented.

Table 2.1: Service Model Comparisons

Parameter	Program Statement	Gippsland	Southern	Barwon	Eastern
General philosophy	The full range of therapies and interventions available to a patient in the inpatient environment will be available to the patient in their own home. This will include psychological, family, psycho educational and occupational interventions and therapies as outlined by the treatment plan.	Biological psychosocial model	Primarily biological. Do address psycho social aspects – low threshold to get allied health worker involved.	Holistic model, which provides person and carer centred services from a multidisciplinary team including occupational therapy, social workers, and neuro psychologist in addition to medical and nursing services.	Biological psychosocial model. Interventions are different. Have medical input. Manage acute issues–then start psychosocial services.
Structure	Discrete clinical sub team. Each patient will be allocated a community treatment nurse who will be the primary contact for the patient, family, other carer, General Practitioner and APMH community case manager during the acute course of treatment.	Seamless clinical team. Staff work in both community teams and ICT (assists with reducing travel time). Main contact person remains the same through whole continuum – other staff members can & do step in when required.	Discrete sub team. Clients already have a case manager. Clients are not allocated a specific ICT clinician due to the nature of the roster system/staffing profile; more complex treatment-related queries are directed to the Team Leader, and the client's APMHS Case Manager is involved in the client's longer-term care planning before, during, and after the ICT admission.	Seamless clinical team. Staff work in both community team and ICT team. Community case manager remains the primary contact point whilst client is in ICT. Psychosocial interventions also supported by case manager support workers [psychiatric state enrolled nurses).	Discrete clinical sub team (triage & ICT sub teams amalgamated recently). APAT case managers are attached to clients. ICT don't appoint an individual ICT staff member to a client when in ICT as have shared case load.
Hours of Operation	The service will operate 7 days a week, 8.30 – 5pm. After hours cover will be provided through the Crisis Assessment and Treatment Service (CATS) function of the Area Mental Health Service and on call arrangements of senior team staff	8:30- 5:00 pm seven days per week. After hours response coordinated by Mental Health 24 hour Triage Service	8:30 – 5:00 pm seven days per week. After hours psychiatric triage service (for all ages). HoSS alert triage if there is likely to be a call about a client – this is a very rare occurrence..	8:30 - 5:00 pm seven days per week. On call ICT service to support triage service after hours. Information provided daily to triage about current clients and issues.	8.30 – 5:00 pm seven days per week . After hours support provided by Crisis Assessment and Treatment Service

Parameter	Program Statement	Gippsland	Southern	Barwon	Eastern
Weekend staffing	24 Hour response	1 staff member on duty. No formal on call arrangement unless Div 2 Nurse then Div 1 on call.	Div 2 nurse on duty with senior nurse and consultant on call.	One clinician on duty. On call support provided by both the on call staff member and triage after hours. This is supported by the data system where crisis plans, care plans are updated and assessable to on call and triage staff.	One staff member rostered on the weekend. Manager and consultant psychiatrist on call for telephone support. Trialling two staff on weekend from mid October 2009. Approximately two referrals per month are declined due to the lack of weekend staff.
Eligibility Criteria for admission (also indicate whether informal or formal)	<p>The decision to admit the patient to intensive community treatment or the acute inpatient unit will be made by the consultant psychiatrist and intensive community team manager, having regard to the assessment of suitability and team capacity to deliver effective treatment to the patient, given the patient's treatment plan requirements and the acuity of other patients on the program at the time.</p> <p>Specific criteria in 3.5.2 of Program Statement</p>	<ul style="list-style-type: none"> • Early discharge from acute in-patient unit – informal or CTO • Acuity level necessitating more than 2 visits per week • In-patient admission alternative 	<p>Criteria yet to be formalised. Generally consistent with "ICT Program Statement" (3.5.2).</p> <p>GP availability to be involved in intensive home treatment considered less crucial, as psychiatric prescriptions provided by HoSS, as well as relevant pathology/radiology request slips (regular verbal or written communication with GP).</p> <p>Consultant involvement in decision to admit to ICT has not been considered mandatory to date. Notwithstanding this, consultant involvement generally does occur with HoSS referrals.</p>	Per 3.5.2 of Program Statement	<p>The decision to admit the patient to ICT is made by the consultant psychiatrist and the ICT team leader. Factors influencing this decision will include; the assessment of suitability and team capacity to deliver effective treatment to the patient, given the patient's treatment plan requirements and the acuity of other patients on the program at the time.</p> <p>Per 3.5.2 of Program Statement</p>

Parameter	Program Statement	Gippsland	Southern	Barwon	Eastern
Treatment	<p>A nursing assessment will be immediately undertaken on admission and a patient care plan documented.</p> <p>The registrar or consultant will see the patient as soon as possible, but within 24 hours, to admit the patient to the program, and will conduct comprehensive psychiatric and physical examinations and investigations. Psychology, including neuropsychology if required, social work and occupational therapy assessments will be undertaken and planned interventions to be provided during the course of the admission documented in the treatment plan.</p>	<p>Mgt plan including risk assessment at admission updated at weekly review when psychiatrist present. (one day per week) . Management Plan document sent to GP and/or carers on admission with updates to follow weekly. No registrar. Morning review of all patients without psychiatrist.</p>	<p>Initial formal care plan by the senior nurse who performs the initial HoSS assessment, including a formal "Risk Assessment Screening Tool". Formal care plan is updated on an "as needed" basis, at least fortnightly. A less formal plan is incorporated into the documentation done for each home visit to reflect the plan for the more short-term day-to-day issues and address identified risk issues. An informal brief risk assessment is documented each visit. Further "Risk Assessment Screening Tool" form completed on "as needed" basis.</p> <p>Weekly team multidisciplinary clinical review meeting with doctor. Patients are usually seen by a registrar or consultant weekly, particularly early in the admission. All admissions have at least one consultant psychiatrist review. Psychiatric medical staff will touch base with team leader once a day (or every other day) & provide advice if required.</p> <p>HoSS clients identified as requiring allied health input as part of their admission may be referred to the relevant APMHS area to work collaboratively .</p> <p>Case Manager will attend weekly Clinical Review meeting & see patient around every two weeks. They are included in key stakeholder meetings, and are considered responsible for managing client's more long-term non-treatment related goals</p>	<p>Suicide risk assessment completed at the start & end of ICTP period, Action plan completed and crisis management plans and care plans updated. Completed documentation is available on the data system. On call ICT Program list updated. Client is monitored daily. Aim for medical officer to see patient at least weekly. The consultant psychiatrist will review the client when indicated and is available for consultation. They also supervise the medical officer. Results from the daily meeting will indicate the need for family meetings and carer supports, together with allied health interventions and psychosocial activity. This may include neuro psychologist referral, or other counselling services.</p>	<p>Assessment mostly already done by APAT. Risk assessment done weekly. Psychiatric assessment complete. Treatment plan completed and updated after every contact via the progress notes. Every morning team meeting go through all clients (have to know all clients). Constantly communicate with carers/GP. A medical officer sees client as needed but at a minimum once every 10 working days.</p>

Parameter	Program Statement	Gippsland	Southern	Barwon	Eastern
Pattern of visits	Direct contact visits of up to three times daily at admission and in early phases of treatment can be expected. Frequency of visits will gradually decrease as patient shows response to treatment and the carer's need for support is met. Pilot teams can expect to deliver approximately 3000 - 4000 direct contact visits over the course of a year.	Varies from daily (visits more often if in vicinity i.e. local area or in local hospital) to 3 per week as needed Minimum 3 times a week after which discharge.	Initially daily visits (or twice a day if required). If assessed condition has improved/stabilised and risk assessment deems it appropriate, frequency of visits then reduced to alternate days (after ~ 2 weeks). Minimum three times/week.	Daily visits and / or contacts from the nominated case manager and/ or case manager support staff, Medical officer up to twice a week. Consultant psychiatrist review at the start of the admission and as indicated in consultation with the medical officer and / or case manager.	Start intensively then taper off. Very few clients get seen three times a day. Bi polar may get 4 times day. Early discharge clients don't get seen every day – sometimes every third day. Others get seen daily for the first week then reduce. Funded for three per day if required.
Discharge	The consultant psychiatrist will determine when a patient's condition no longer requires acute care and the patient will be discharged for the planned follow up by the community case manager and General Practitioner. The intensive community treatment team will provide a written discharge summary to the community case manager and General Practitioner.	Once a client needs to be seen less than three times per week.	When acuity and required input reduced (generally, if client doesn't need more than one visit per week) Discharge plan discussed at weekly Clinical Review meeting.	When no longer need intensive follow up. Discharge after medication regime settled and other support services in place . Decision to discharge from acute unit lies with Medical Director. Discharge criteria is loose.	Clinical review determines when client ready for discharge. Generally if don't need to see a client more than once a week then ready for discharge.
GP Involvement	GP remains the prescribing doctor wherever practical. The consultant psychiatrist retains overall responsibility for the patient's psychiatric treatment but makes recommendations to the General Practitioner for optimal psychiatric management. The General Practitioner is a key provider in any intensive community treatment as the doctor with the most comprehensive history of the patient's physical condition.	GPs integrally involved - manage medical care. Formally advise GP when their patient comes onto the program.	Manage medical care. Letter & brochure sent to GPs when client comes onto the program & discharge summary sent on discharge.	Unlikely GPs will know the client is specifically on the ICT program. GP looks after physical well being . If change drugs or move the patient i.e. from home to SRS will tell GP . GPs don't need to agree for a client to be placed on the ICT.	Shared care. Advise GP when first see client. Advise GP of changes to medication who then prescribes. GPs do injections. Look after physical well being. Not practical for them to attend case meetings. GPs don't really understand the difference between APAT & ICT. GPs don't need to agree for a client to be placed on the ICT.

Parameter	Program Statement	Gippsland	Southern	Barwon	Eastern
Drugs & other diagnostics	<p>Drugs Any necessary prescription pharmaceuticals will be prescribed by the General Practitioner and obtained from the local pharmacy. If the patient's General Practitioner is not involved the required prescriptions as well as any pharmaceuticals requiring specialist prescription will be obtained from the Health Service Pharmacy.</p> <p>Pathology & Imaging The registrar will request the GP to organise any necessary referrals to local services. If this is not practical the services at the Health Service will be used.</p>	Prescribe psychotropic drugs. Refer for other diagnostics.	When on HoSS the service prescribes, funds & dispenses psychotropic drugs. Service also provides imaging and pathology.	Use community scrips and services.	GPs prescribe and refers to private services.
Flexible Funding	A pool of flexible funding to provide for additional nursing, additional equipment, respite care and medication when required.	Available. Where required pay RACF staff to do specials with their own staff (as no agency staff in region).	Not available.	Available. \$62k in 2007/08 and \$55k in 2006/07.	Yes Budget approx \$40k. Have not used all funds.
BPSD		BPSD in scope	In frequent BPSD	See BPSD	No BPSD & don't see clients in RACF as have Behavioural Support Team. Will see those in low level care if its a functional illness (no dementia clients)

Key Findings

- The regional ICT Services (Barwon and Gippsland) have seamless teams which are fully integrated with the APMHS Community Team. The metropolitan ICT Services (Eastern and Southern) have discrete ICT teams although the triage and ICT teams at Eastern have recently been merged.
- All ICT services have access to and close working relationships with consultant psychiatrists and registrars and aim to make the best use of their available time. With the exception of Gippsland, psychiatric input is as required and not provided on a structured sessional basis.
- Discharge from the ICT Program is appropriately based on clinical judgement. Whilst it is difficult to be specific, Gippsland will generally discharge a patient when they need to be seen less than three (3) times per week whereas Southern and Eastern will discharge when a patient needs to be seen less than once per week.
- GPs are generally not involved a decision to admit the ICT Program and have varying degrees of involvement when their patient is on the Program.
- The Southern Health ICT Program does not have access to flexible funding which can be used for additional nursing, equipment and respite care.
- All ICT Programs have access to allied health workers although there would appear to be different emphases on the psycho social aspects of the service provision.

Service Improvement Opportunities

- To develop clear referral, admission and discharge criteria at all services. The criteria for each process should clearly specify the input required by the consultant psychiatrist.
- To develop a capacity to maintain the client case load over the weekend i.e. adequate staffing over 7 days, within existing resources
- To ensure there is at least some psychiatrists' time provided on a structured sessional basis.

2.2 SERVICE ACTIVITY

This section presents activity statistics for the ICT Program.

Table 2.2 presents the admissions to the Program by year since 2004/05

Table 2.2: Admissions to ICT Program

Site	2004/05	2005/06	2006/07	2007/08	Total
Barwon ³	108	116	72	87	383
Eastern ¹	58	96	122	49 ¹	325
Gippsland (Sept- August) ³	NA	36	46	46	128
Southern ³	51	45	48	55	199
Total	217	289	288	188	1035

Note (1): Data for Eastern in 2007/08 is incomplete as for some months or part months clients were not recorded on the Client Management Interface (CMI) as being in the ICT Program. Months for which no data was provided were September/October 2007 and March 2008. Months for which limited data appears to have been recorded were August 2007 and January, February, April, May 2008.

Note (2): Given the delay in receiving data from Eastern they were able to provide data for the seven month to January 2009. Based on that data it is estimated that they will treat 126 clients in 2008/09. This has been used as the proxy figure for 2007/08 in the financial and staffing analysis presented elsewhere in this report

Note(3): For other health services data is sourced from manual records maintained by the health services.

Table 2.2 above shows that Barwon and Eastern have the greatest number of admissions. Gippsland has the smallest number of admissions. At Eastern Health there has been a significant increase in admissions to the Program since its commencement. This is because in the early days of the Program community staff were sceptical about the ICT and this impacted on the number of community team referrals. At Barwon the number of admissions per annum has varied significantly and there is no apparent for this variation.

Table 2.3 presents the daily average clients on the ICT Program.

Table 2.3: Daily Average Clients on ICT Program

Daily Average Clients	2004/05	2005/06	2006/07	2007/08	Overall Average
Barwon	6.3	6.9	5.3	6	6.1
Eastern	4.6	7.4	7.2	5.1 ¹	6.4
Gippsland (Sept- August)	NA	3.1	3.0	2.5	2.9
Southern	4.2	3.3	3.7	3.9	3.8
Total	15.1	20.7	19.2	17.5	19.1

Note (1): Eastern: This figure is not accurate as it is unclear for which dates there was no data being entered into the CMI. Refer to note (1) in table 2.2. In 2008/09 daily average was 7.4.

Table 2.3 shows that Barwon and Eastern have the highest number of daily average clients.

The Southern service is capped at five places. In addition to the ICT service provided 7-days a week, Southern ICT carries a small cohort of clients whom they case manage on an ongoing basis (usually around five clients). Targeted clients typically suffer a chronic functional mental illness, and have frequent relapses that had previously required either recurrent inpatient or ICT admissions. The clients are seen Monday-Friday due to weekend staffing restrictions, with the aim of preventing re-admissions via intensive monitoring and support.

The Program Statement states that over time, the ICT program may be able to deliver services to seven clients at one time. Only Eastern and to a lesser extent Barwon are close to achieving this level of activity at peak periods.

Table 2.4 presents the average length of stay of clients on the ICT Program.

Table 2.4: Average Length of Stay on ICT Program

Mean length of stay	2004/05	2005/06	2006/07	2007/08	Overall Average
Barwon	21.6	21.2	25.1	25.4	23.0
Eastern	29.1	28.0	21.4	18.9	23.9
Gippsland (Sept- August)	NA	31.0	24.0	20.0	25.0
Southern	30.0	26.0	28.0	26.0	28.0

Table 2.4 shows that there is a general consistency across services with the length of time that clients are on the Program. In 2007/08, it ranged from 18.9 to 26 days.

Table 2.5 presents the "occupancy" rate for the Program based on the initial target per the ICT Program Statement of five places. The occupancy rate for Barwon is based on eight places (being the three places in existence prior to the ICT Program plus the five additional places).

Table 2.5: Occupancy Rate

Occupancy rate	2004/05	2005/06	2006/07	2007/08	Overall Average
Barwon	78.8%	86.3%	66.3%	75.0%	76.6%
Eastern	92.3%	147.1%	143.3%	102.2%	127.4%
Gippsland (Sept- August)	NA	62.0%	60.0%	50.0%	57.3%
Southern	84.0%	66.0%	74.0%	78.0%	75.5%
Overall	84.0%	89.8%	83.3%	76.1%	83.2%

Table 2.5 shows that Eastern is operating in excess of its five funded places and that Gippsland has the lowest occupancy rate (57% since Program inception).

Key Findings
<ul style="list-style-type: none"> Activity information has been sourced mainly from manual records which are not maintained consistently between health services. Eastern has relied on the Client Management (CMI) and there were significant gaps in that data in 2007/08. Overall for the purposes of the evaluation activity data is sufficiently reliable. Barwon and Eastern have the highest number of admissions to the ICT Program. Gippsland has lowest number of admissions. Barwon and Eastern also have the highest number of daily average clients and Gippsland has the lowest. With the exception of Eastern no ICT service has averaged more than the expected number of clients on the Program at any one time (five to seven). This is because: <ul style="list-style-type: none"> Activity is reduced on weekends due to only one staff being rostered The Southern service is capped at five places Gippsland sees less clients due to the large geographical area serviced and the distances required to be travelled. There is a general consistency across services with the length of time that clients are on the Program. It ranged from 18.9 to 26 days for 2007/08. <p><u>Service Improvement Opportunity</u></p> <ul style="list-style-type: none"> There is a need to ensure client information including HONOS is collected in CMI.

2.3 STAFFING

This section presents staffing information on staffing levels. The information must be considered indicative only as staffing estimates have been provided for the integrated teams (Barwon and Gippsland).

Table 2.6 presents a summary of the staffing proposed in the originally approved budget submissions, the current allocated FTE as per health services for the 2008/09 year and the associated current full year costs (including on costs).

Table 2.6: Staffing Summary

Sites	Initial Budget Submission	Allocated FTE 2008/09	Full Year Cost of Allocated FTE (\$)
Barwon ¹	7.2	7.2	555,514
Eastern	6.5	6	565,951
Gippsland ²	6.56	5	NA
Southern	NA	3.5	239,234

Note (1): Barwon: Staff are integrated into the APMHS community team and data is indicative only.

Note (2) Gippsland: The approved FTE allocation is five. As staff are part time and integrated into the APMHS community team it is difficult to work out fractions involved in the ICT. The figure should be considered indicative only.

Table 2.6 shows that staffing numbers as presented, do not appear to be at the initially submitted staffing level for Gippsland and Eastern.

Table 2.7 compares the detailed current approved staffing level (per the health service) to the indicative staff profile per the ICT Program Statement.

Table 2.7: Staffing Details ^{1,2}

Staff Details	Indicative Profile	Allocation FTE 2008/09		
		Barwon	Eastern	Southern
Team leader (Clinical Nurse Specialist Grade 4 or equivalent)	1	0.5	1	1
Consultant psychiatrist	0.2	0.2		0.05 ³
Registrar	0.3	0.3	0.5	0.1
Nursing Grade 3	4	2.5		0.5- 0.55
RPN-4			2	
RN Div 2		2.0	1	1.8
Occupational Therapy	0.3	0.5		
Social Worker	0.3	0.7	0.5	
Psychology	0.3			
Administrative worker	0.5	0.5	1	
Total	6.9	7.2	6	3.5

Note (1): No data provided by Gippsland.

Note (2): Additional staff resources are provided to the ICT teams by respective Health Services but are not necessarily included in these figures. Examples include admin support, management, allied health and psychiatrist time.

Note (3): At Southern estimate only, as medical staff FTE not specific to ICT and employed as 0.05, however will increase hours to cover for annual leave as required. Southern do provide allied health services. Unable to estimate FTE.

Staffing at Southern is about half that of Eastern which is consistent with the lower level of salary expenditure and activity.

Key Findings

- Information on staffing numbers is indicative only and any interpretation should be treated with caution.
- Staffing does not appear to be at the initially approved staffing level.
- The staffing profile of services includes a range of nursing medical and allied health staff with the majority of staff being nurses (as outlined in the Program Statement).

2.4 FUNDING AND EXPENDITURE

This section presents financial information. The information must be considered indicative as no service maintains a separate cost centre for the ICT Program.

The MH&DD allocated ICT funds to Barwon, Eastern and Gippsland to establish a new ICT Program. As Southern had piloted the original model, the funds to deliver the ICT Program are currently part of their global aged person's mental health budget and no separate funding line has been established.

Estimated funding provided by DHS for the ICT Program since the inception of the pilot is set out in table 2.8. Pilots were funded as a substitute for recurrent funding of five acute inpatient beds in a catchment area.

Table 2.8: Estimate of Funding Provided 2003/04 to 2008/09 ^{1,2,3}

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total
Barwon	520,000	691,232	721,548	764,538	794,613	841,355	4,333,286
Eastern	520,000	691,232	721,548	764,538	794,613	841,355	4,333,286
Gippsland	-	520,000	721,548	764,538	794,613	841,355	3,642,054
Southern ⁴	NA	NA	NA	NA	NA	NA	

Note (1): Source: DHS.

Note (2): 2003/04 to 2005/06 amounts are estimates only and based on funding letters and budget applications at that time.

Note (3): Increases over period relate to indexation which is linked to CPI and specific health services industrial agreements.

Note (4): Southern funds were allocated as part of the PGAT global budget at the time that project commenced (in 1998) based on the equivalent of five beds. The amount is not currently identifiable as a separate budget line item and thus has been presented as not available for the purposes of this Report.

Table 2.9 presents the estimated expenditure figures for the years ended 30 June 2008 and 30 June 2007 where data was provided.

Table 2.9: Expenditure 2007/08 and 2006/07 ³

Comparison	Barwon ²	Eastern	Southern	Eastern	Southern
	2007/08			2006/07	
Salaries and wages	435,786	414,000	202,056	491,000	187,377
Salary related on costs	87,157	107,000	74,724	163,000	52,000
Direct operating costs	45,668	74,000	10,000	77,000	8,000
Flexible funding – e.g. brokerage	71,204	0	0	0	0
Corporate & admin overhead charges	65,368	84,000	0	100,000	0
Equipment/set up costs/minor works	18,183	22,000	25,808	13,000	25,600
Total Expenditure	723,366	701,000	312,588	844,000	272,977
Revenue	794,614	795,000	NA ¹	764,000	NA
Surplus/(deficit)	71,248	94,000	NA ¹	(80,000)	NA

Note (1): Funding allocated for Southern is not available as it is incorporated into APMHS funding lines. The surplus/deficit is not available.

Note (2): Barwon figures based on notional allocation of 7.2 staff.

Note (3): No data for Gippsland.

Table 2.9 shows that the level of reported expenditure at Eastern and Barwon was similar. Southern expenditure is less than half of the other services in 2007/08. This is as a result of them employing about half the number of staff, they do not utilise flexible funding and they have not charged overheads. Eastern operated a surplus in 2007/08 of \$94,000 and a deficit in 2006/07 of \$80,000. This change was largely as a result of reduced expenditure on salaries and related on-costs (a reduction of \$133,000). Barwon also operated a surplus in 2007/08 of \$71,248.

Key Findings

- Financial data is indicative only.
 - There is no flexible (brokerage) funding available at Southern. Eastern shows zero expenditure although the manager has reported that some funds are available, but quantum unclear.
- Service Improvement Opportunities
- ICT services to have a separate budget for flexible (brokerage) funding.
 - To consider negotiating with Southern Health to redistribute the same level of funds (equivalent of 5 aged acute beds) so that their ICT Program can operate at the same level of capacity (employ staff numbers equivalent to other services) as the other ICT services.
 - When funding new services within the context of global resource allocations, DHS should ensure the number of positions to be appointed is agreed and agreed service outputs and outcomes tracked for at least the first three years.

2.5 SERVICE CATCHMENT AND ADMISSION RATES

Table 2.10 presents the estimated APMH catchment population and population being serviced by each ICT service based on ABS data and the admission rate per thousand aged population serviced.

Table 2.10: Estimated Resident Population 65+ (2007)

Sites	Catchment ¹	Population Serviced ¹	Admissions per 1000 population Serviced
Barwon	42,584	42,584 ²	2.0
Eastern	119,266	103,860 ³	1.2
Gippsland	42,590	11,170 ⁴	4.1
Southern	42,200	42,200 ⁵	1.3

Note (1): Based on 2007 ABS data.

Note (2): Barwon incorporates LGAs of Colac Otway, Golden Plains, Greater Geelong, and Surf Coast.

Note (3): Eastern incorporates LGAs of Knox, Manningham, Maroondah, Monash and Whitehorse.

Note (4): Gippsland incorporates LGAs of Bass Coast and South Gippsland.

Note (5): Southern incorporates LGS of Cardinia, Casey and Greater Dandenong.

Table 2.10 shows that Eastern and Gippsland ICT teams are not servicing all of their catchment population. Eastern is not servicing Yarra Ranges and Gippsland is only servicing South West Gippsland and excludes Baw Baw.

Eastern is servicing the largest population. Eastern and Southern have the lowest admission rate per thousand population (1.2 and 1.3 respectively). Southern is likely to be low due to the fact that its activity is capped at a maximum of five and it has a lower level of staffing. Eastern is likely to be low as activity is limited by the number of staff employed and the population is large.

Table 2.11 presents the growth in the catchment since 2001. There has been significant growth in all catchments.

Table 2.11: Estimated Resident Population 65+ 2007 and 2001

Site	Catchment 2001 ¹	Catchment 2007 ¹	% Increase
Barwon	33,716	42,584	26.3
Eastern ¹	89,411	119,266	33.4
Gippsland ²	33,819	42,590	25.9
Southern	31,322	42,200	34.7
Total	188,268	246,640	31.0

Note (1): Based on ABS data

Key Findings

- There are significant differences in the size of the populations being serviced by the ICT pilots.
- Eastern is servicing the largest population. Eastern and Southern have the lowest admission rates per thousand population (1.2 and 1.3 admissions per '000 population respectively) compared to Barwon (2.0 admissions per '000 population) and Gippsland (4.1 admissions per '000 population). Southern is likely to be low due to the fact that its activity is capped at a maximum of five clients at any one time and it has a relatively small number of admissions. Eastern is likely to be low as activity is ultimately limited by the number of staff and the population is large.

2.6 ECT

The first course of treatment for electro convulsive therapy (ECT) is usually administered to the client as a registered inpatient except at Barwon where due to the limited number of inpatient beds, clients are admitted to the ICT Program. Follow-up ECT is usually provided as an outpatient and is not a driver for being admitted to the ICT Program. Table 2.12 presents the number of clients on ECT for 2007 and 2008 and this confirms that Barwon has the highest rate of clients on ECT.

Table 2.12: Clients on ECT 2006/07 and 2007/08

Site	Number of Clients	Percentage of Clients
Barwon	25	15.7%
Eastern	Not available	NA
Gippsland	8	8.7%
Southern	3	2.9%

Key Finding

- ECT is not a driver for being admitted to the ICT Program.

APPROPRIATENESS OF THE ICT PROGRAM

This chapter addresses the question of whether the ICT Program is an appropriate response to an identified need. In particular this chapter seeks to address the following:

- How well does the implementation of the ICT align with the current policy directions of associated services?
- Have appropriate clients been targeted by the ICT service providers?
- Have the targeted consumers received an appropriate mix (i.e. the combination of nursing, allied health and medical services) and level of service and support?

Support for the Program among key stakeholders is analysed in chapter four.

3.1 POLICY CONTEXT

This section addresses the questions of how well the implementation of the ICT aligns with the current policy directions of associated services.

3.1.1 EVIDENCE BASE

O'Connor in his unpublished funding application⁵ states that:

"In adult psychiatry, crisis intervention teams have reduced admissions, costs and stigma, though early claims were possibly over-stated⁶. In a meta-analysis of five randomised controlled trials of intensive community treatment of younger people, most of whom were acutely psychotic, crisis team clients showed greater improvement than those admitted to hospital on some (but not all) psychopathology scales and family burden was reduced⁷. Nearly half those allocated to home-based care needed admission to hospital *at some point*, showing that even intensive community treatment is not feasible, safe and appropriate in every instance. It is possible to *reduce* admissions, though, without jeopardising the safety and wellbeing of clients and families. There is widespread agreement however that, when given the choice, most clients and families prefer home-based treatments⁸.

With respect to aged psychiatry, no similar studies have been conducted, despite the current shift in practice in the United Kingdom from inpatient admission units to "hospitals in the home."

"Nothing is known of the efficacy of aged psychiatry intensive community treatment teams. It cannot be assumed that aged care programs will work as well as those for younger adults. Older clients are more likely to be cognitively impaired, have multiple medical co-morbidities, greater functional incapacity and take larger numbers of medical and psychiatric medications that increase the risk of falls and other mishaps⁹. Very old depressed men are at greater than average risk of suicide and many of those with chronic psychoses have limited family supports. Residents of

⁵ O'Connor, Prof D. Unpublished funding application to Department of Human Services.

⁶ Hoult J. Community care of the acutely mentally ill. *British Journal of Psychiatry* 1986, 149, 137-144

⁷ Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews* 2002, CD001087.

⁸ Joy CB. Op cit.

⁹ O'Connor DW, Brodaty H, Chiu E, Ames D. Psychiatry of old age. In, *Foundations of Clinical Psychiatry* (eds Bloch S, Singh BS), 3rd ed. Melbourne, Melbourne University Press, 2007

aged care facilities may test the capacity of staff to cope by virtue of their dementia, psychosis or affective disorder. Specialist, intensive mental health programs for older people therefore warrant independent scrutiny. "

Callaly et al ¹⁰undertook a study of the intensive home based treatment program (IHBP) and its impact on admissions in an aged care setting at Barwon Health. The study aimed to test the intervention hypothesis that admissions and length of stay would reduce while having a comparable clinical outcome. Clinical outcomes were compared using the Brief Psychiatric Rating Scale (BPRS) and the Montgomery Asberg Depression Rating Scale (MADRS).

In their study patients were typically selected for inpatient admission if they presented with risks associated with severe psychosis or suicide, unclear diagnosis, comorbid medical problems or carer inability to cope. Patients selected for the IHBP were more likely to have issues regarding treatment compliance, inadequate social supports, carer breakdown or chronic psychiatric illness. There was however substantial overlap between the clinical characteristics of the two groups.

They reported that inpatients showed significantly greater clinical improvement than patients on the IHBP (on the BPRS the mean difference was 7.65 for the IHBP and 17.5 for the inpatient group and on the MADRS the mean difference was 7.4 for the IHBP group and 19 for the inpatient group) and that perhaps this occurred because more severely ill people were selected for inpatient treatment). Patients on both programs nevertheless showed significant clinical improvement. They noted that when there are higher scores on symptom rating scales there is much more room to move and one could expect a greater symptom reduction in more acutely ill patients.

The authors concluded that this study suggested that the IHBP overall did not decrease number of admissions or length of stay. They considered that this may have been a result of other structural changes in the system. They noted that overall admissions to the ward increased in parallel with the IHBP treatment rate and they suggested that a general increase in service activity may be a factor.

With regard to diagnoses they concluded that the IHBP has been particularly useful in treating older people with depression and anxiety outside of the hospital setting. While 5% of all case managed patients and 7% of those on the IHBP had ECT, 20% of inpatients had ECT which is what was expected as these are the most severely ill group.

The IHBP was originally intended as an alternative to inpatient care. However, it has become evident over time that is also used to prevent deterioration in people who may require inpatient care in the future. The extra level of care provided by the IHBP provides both an alternative to hospitalisation, as well as having an early intervention function.

3.1.2 POLICY CONTEXT

New Directions for Victoria's Mental Health Services: The Next Five Years was published by DHS in 2002 and was the strategy document in place when the ICT Program pilots were funded. This document identified the need to further strengthen APMH service system to meet growing demand. Priorities in *New Directions* included:

- Further development of APMH community teams, to support mainstream aged community and residential services caring for older people with a mental illness;
- Strengthening links between aged acute inpatient services and APMH and other residential services;
- Improving consumer pathways from acute to APMH and other residential care services including the development of transitional 'step-down' services;
- Expanding psychosocial activity programs targeted at older people as part of the delivery of psychiatric disability support services; and

¹⁰ Callaly, P. Kris,J. Suters,J. Moon,K. Dunn,P. Henry,M. Callaly, T. Berk,M. A study an intensive home based treatment program and its impact on admissions in an aged care setting. *South African Psychiatry review* 2004; 7:21-24.

- The need to involve aged mental health specialists as required in interdisciplinary teams and care planning for older clients of Health Services is noted in the *Improving Care for Older People* strategy.

Since the publication of *New Directions* additional funds have been invested in community teams, additional acute and residential beds have been opened and new service models piloted. This evaluation relates to the Intensive Community Treatment (ICT) pilot.

While acute psychiatric treatment has traditionally been provided in a hospital bed there is increasing evidence that it may be possible to provide such treatment in non-hospital environments. The then Mental Health Branch (MHB) in consultation with the sector developed the ICT pilot to provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness¹¹.

DHS has recently published its new strategy for mental health "Because mental health matters, Victorian Mental Health Reform Strategy 2009-2019". In that strategy Reform Area 4: Specialist Care - Meeting the needs of adults and older people with moderate to severe mental health problems, and Goal 4.1: Building a more responsive system of specialist mental health care geared to early intervention, relapse prevention and recovery, are directly relevant to the ICT Program.

The strategy notes that Aged Persons Mental Health Services and mainstream health and aged care services are expected to experience increased and sustained demand driven by the ageing population, the increased prevalence of depression and anxiety and organic conditions such as dementia and the unknown impact of increased usage of alcohol and drug usage on an ageing population.

In order to meet current and future service demand, consideration will be given to progressively expanding the core capacity of the public aged persons mental health service system. Such a strategy would also provide this service sector with the capacity needed to intervene earlier and more intensely in the illness pathway and during an illness episode. In line with this, consideration will be given to expanding sub-acute treatment options for older people with a severe mental illness, including services that provide intensive treatment in the home. This will avert the need for an inpatient admission in some instances and provide a 'step-down' function for older people leaving acute inpatient care.¹²

3.2 SURVEYS UNDERTAKEN

This section provides details of the surveys undertaken as part of this evaluation.

3.2.1 STAFF SURVEY

The purpose of the staff survey (Appendix B) was to inform the evaluation from the perspective of staff who work within the ICT Program and staff who refer to it (i.e. relevant staff from community teams and psychiatric inpatient units).

WHO RESPONDED TO THE SURVEY

Table 3.1 presents the number of survey responses and the response rates.

¹¹ ICT Evaluation Request for Tender . 19 December 2007

¹² Because mental health matters, Victorian Mental Reform Strategy 2009-2019. Page 97. Mental Health and Drugs Division, Department of Human Services, February 2009

Table 3.1: Staff Survey Response Rates

Site	Number of Responses	% of All Responses	Total Sent	% Response Rate
Barwon	10	15.2%	10	100.0%
Eastern	30 ¹	45.5%	45	66.7%
Gippsland	7	10.6%	10	70.0%
Southern	19	28.8%	25	76.0%
Overall	66	100.0%	90	73.3%

Note (1): At Eastern one (1) survey response was received from eight clinicians. This has been counted as eight (8) responses.

Table 3.1 shows that 66 responses were received with a very good response rate of 73%. The majority of respondents were from Eastern (45%) and Southern (29%).

Table 3.2 presents where the survey respondents worked. As expected, the majority of respondents were from Community Teams (53%), but there was good coverage across all services.

Table 3.2: Where Respondents Worked

Site	Inpatient Unit	Community Team	ICT	Other	No response	Total
Barwon	1	8	1	0	0	10
Eastern	7	15	7	0	1	30
Gippsland	0	0	6	1	0	7
Southern	4	12	3	0	0	19
Total	12	35	17	1	1	66
% of Total	18.2%	53.0%	25.8%	1.5%	1.5%	100.0%

Table 3.3 presents the professional category of survey respondents.

Table 3.3: Professional Category of Respondents

Site	Consultant	Registrar	Nursing	Allied Health	Other	Total
Barwon	0	0	7	3	0	10
Eastern	3	3	14 ¹	10	0	30
Gippsland	0	0	5	2	0	7
Southern	0	0	14	4	1	19
Total	3	3	40	19	1	66
% of Total	4.5%	4.5%	60.6%	28.8%	1.5%	100.0%

Note (1): It has been assumed that eight clinicians responding on the one survey form from Eastern are nurses. This may not be correct.

Table 3.3 shows that as expected the majority of respondents were nurses (61%). There were only six respondents (9%) who were medical officers (consultants/registrar) and they were all located at Eastern. Information was obtained from consultant medical officers during site visit consultations at Southern, Barwon and Gippsland. When combined with the survey HOI consider that medical officer input to evaluation was satisfactory.

Table 3.4 presents the number of respondents that had referred to the ICT. The table shows that 85% of respondents had referred to the ICT Program (92% if no responses are excluded).

Table 3.4: Number of Respondents Who Have Referred to the ICT

Site	Yes	No	No Response	Total Responses
Barwon	10	0	0	10
Eastern	26	1	3	30
Gippsland	7	0	0	7
Southern	13	4	2	19
Total	56	5	5	66
% of Total	84.6%	7.7%	7.7%	100.0%

It should be noted that the analysis in subsequent chapters excludes those respondents who left the answer blank.

Comment
<ul style="list-style-type: none"> • There was a satisfactory survey response rate across all locations with good coverage of relevant programs and professional staff categories. • The staff survey provides a sound evidence base for the purposes of the evaluation.

3.2.2 STAFF PERSPECTIVE

Table 3.5 presents the combined responses from all staff to the question “Does the service align with current policy directions of associated services”?

Table 3.5: Policy Alignment with Other Services

Site	Yes	No	Don't Know	Total
Barwon	15	0	0	15
Eastern	23	0	14	37
Gippsland	10	2	2	14
Southern	8	0	8	16
Total	56	2	24	82
Percent	68.3%	2.4%	29.3%	100.0%

Note (1): Some staff answered the question twice

Table 3.5 shows that the majority of respondents considered that the ICT Program did align with other policy directions of associated services (68%). Twenty nine percent of staff did not know which is considered to be because some front line staff are not aware of the policy issues impacting on aged persons mental health services. Their focus is on clinical treatment.

Key Findings

Findings

- The implementation of ICT Program pilots were supported by the evidence base.
- The ICT Program pilot was supported by appropriate policy settings.
- Evidence suggests the Program would have at least as much focus on prevention of hospital admissions as on early discharge.
- The ICT Program is aligned with current policy directions.

3.3 TARGET GROUP

This section addresses the question of whether appropriate clients have been targeted by the ICT service providers.

The target group for ICT is defined as 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;
- Who have family or other carer supports available for the period of treatment; and
- Whose length of stay in hospital can be minimised through intensive treatment at home

3.3.1 REFERRAL SOURCE

Table 3.6 presents the referral source of clients to the Program.

Table 3.6: Referral Source

Site	Inpatient Unit	Community
Barwon	20%	80%
Eastern	50%	50%
Gippsland (Sept- August)	34%	66%
Southern	17%	83%

Table 3.6 shows that Eastern Health has the highest level of inpatient unit referrals (50%). Southern has the lowest level of inpatient referrals (17%). At Eastern Health in the early days of the Program community staff were sceptical about the ICT and this impacted on community team referrals.

Community referrals are almost entirely from the community teams with clients and their circumstances being well known to the case manager.

Each service has a referral and admission process involving the referring service and what they judge to be an appropriate level of clinical input. An assessment is usually done prior to a decision to admit the client. In some services consultant input is not always specifically sought prior to admission although there is ongoing informal communication with consultants as required (refer to table 2.1 for more details).

GENERAL PRACTITIONER SURVEY

The purpose of the GP survey (example at Appendix C) was to inform the evaluation from the perspective of GPs who have had clients admitted to the ICT Program.

Who Responded to the Survey

Table 3.5 presents the number of surveys sent out and the response rates.

Table 3.7: Survey Response Rates

	Number of Responses	% of Total	Surveys sent out	Response rate
Barwon	16	43.2%	45	36%
Eastern	7	18.9%	60	12%
Gippsland	2	5.4%	33	6%
Southern	12	32.4%	35	34%
Overall	37	100.0%	173	21%

Table 3.7 shows that 37 responses were received (response rate 21%). Thirty four percent of the respondents were from Southern and 36% from Barwon. The overall response rate was relatively low as anticipated.

The majority of GPs who responded (83%) had less than five (5) patients in the ICT Program. One respondent from Southern had had greater than 10 patients and two GPs had had between 5 and 10 patients (one from Southern and one from Barwon).

It should be noted that the analysis in subsequent chapters excludes those respondents who left the answer blank.

Comment

- The survey response rate was low which makes it difficult to draw definite conclusions. However very useful information on the perspective of GPs was obtained.

Through the conduct of this survey GPs were asked if they felt that admission to an acute unit would have been more appropriate for any of their clients and the results are presented in Table 3.8.

Table 3.8: Admission to an Acute Unit More Appropriate

	Yes	No	Don't know	Total
Barwon	0	0	0	0
Eastern	3	0	2	5
Gippsland	0	1	0	1
Southern	1	8	2	11
Overall	4	9	4	17
Percentage	23.5%	52.9%	23.5%	100.0%

Table 3.8 shows that nine (9) or 53% of the respondents considered that admission to an acute was not more appropriate. Four respondents or 28.5% thought admission to acute would have been more appropriate.

In a 2007 GP survey conducted by Gippsland 79% (11) of GPs considered that that the ICT was more appropriate for their clients than the acute inpatient unit.

Feedback from clinicians obtained during site visits was that appropriate clients were being targeted.

CARER SURVEY

The purpose of the carer and professional carer survey was to inform the evaluation from the perspective of carers. Examples of the surveys are at Appendix D.

Who Responded to the Survey

Table 3.9 presents the number of survey responses and the response rates.

Table 3.9: Survey Response Rates

	Number of Responses	% of Total	Total Sent	Response Rate
Barwon - carers	18	46.2%	26	69.2%
Barwon - professional carers ¹	5	12.8%	5	100.0%
Eastern - carer	6	15.4%	35	17.1%
Gippsland - carer	5	12.8%	20	25.0%
Gippsland - professional carer	0	0.0%	7	0.0%
Southern - carer	5	12.8%	16	31.3%
Total	39	100.0%	109	35.8%

Note (1): At Barwon one (1) survey response was received from one supported residential service representing multiple carers. This has been counted as one (1) response.

Table 3.9 shows that 39 responses were received (response rate 36%). The majority of respondents were from Barwon (59%). Responses from the other services were evenly distributed.

It should be noted that the analysis in subsequent chapters excludes those respondents who left an answer blank.

Comment

- The survey response rate was satisfactory taking account of the group being surveyed and consistency of response to provide an adequate evidence base for the purposes of the evaluation.

All carers (100%) responding to the survey considered that the person they cared for was an appropriate candidate for treatment on the ICT Program.

Except for Eastern CMI data we were not able to obtain specific details of numbers CALD clients. However information obtained during site visits suggested that CALD clients were accessing and utilising the services and that the services were suited to this client group with appropriate interpreter support as per the delivery of other APMHS.

3.3.2 DISCHARGE LOCATION

An indicator of whether appropriate clients have been targeted is whether the majority of clients targeted were able to be treated and then discharged to a community setting.

When interpreting the results it should be noted that the Program Statement states that "a review that results in a decision to admit a patient to the ward can be seen as a measure of service quality rather than an indicator of an episode of treatment with a less than optimal result".

Table 3.10 presents the percentage of clients on the ICT Program discharged to acute mental health inpatient units and community settings.

Table 3.10: Discharge Location

	% Discharge to Acute Inpatient MH Unit	% Discharge to a Community Setting
Barwon	11%	89%
Eastern	7%	93%
Gippsland	21%	79%
Southern	20%	80%

Table 3.10 shows that number of discharges to an acute mental health unit is relatively low. The majority of all discharges are to community settings.

3.3.3 DIAGNOSIS OF ICT CLIENTS

Table 3.11 presents the percentage of clients by diagnosis for the ICT Program by service.

Table 3.11 : Principal Diagnosis of ICT Clients ¹

Principal Diagnoses	Barwon ²	Eastern	Gippsland	Southern
Schizophrenia, schizotypal & delusional disorders	16%	20.0%	14.1%	22.7%
Mood (affective disorders)	62%	58.8%	48.4%	56.5%
Organic	6%	3.3%	32.8%	14.3%
Neurotic stress related & somatoform disorders	0%	4.0%	1.6%	5.2%
Disorders of Adult personality	0%	0.3%	0.0%	0.0%
Disorders due to psycho active substance abuse	0%	1.3%	0.0%	0.0%
Other or not recorded	15%	12.5%	3.1%	1.3%
Total	100%	100%	100%	100%

Note (1): Data was presented in different formats by each service. We have aimed to present the data consistently based on ICD10AM classifications. Data was not provided at client level and has not been validated. The data should be considered as indicative only.

Note (2): Barwon data is for 2007/08. Data for other services is since inception of the ICT where data was available

Table 3.12 shows general consistency of diagnosis between services except that Gippsland had a high level of organic diagnosis which relate to clients with behavioural and psychological symptoms of dementia (BPSD). The reason for the high level of these type referrals is the absence of a separate behavioural support team. These clients are supported by the Behavioural Support Teams in the other Health Services.

Whilst the number of Gippsland clients with BPSD is reducing they have advised that there is the need for ongoing education to acute health, facility staff and GPs in relation to the management of this group of clients.

One would anticipate the principal diagnosis profile of patients treated on the ICT Program would be similar to that of inpatient units. Table 3.12 presents a comparison of the diagnosis between the inpatient units and the ICT Program for the health services where data was provided.

Table 3.12: Comparison of Principal Diagnosis ICT/ Inpatient ^{1,2}

Principal Diagnoses	Barwon		Eastern	
	ICT	Inpatient	ICT	Inpatient
Schizophrenia, schizotypal & delusional disorders	16%	23.1%	20.0%	12.9%
Mood (affective disorders)	62%	49.5%	58.8%	48.5%
Organic	6%	14.3%	3.3%	31.3%
Neurotic stress related & somatoform disorders	0%	13.2%	4.0%	2.1%
Disorders of Adult personality	0%	0.0%	0.3%	0.2%
Disorders due to psycho active substance abuse	0%	0.0%	1.3%	1.2%
Other or not recorded	15%	0.0%	12.5%	3.7%
<i>Total</i>	<i>100%</i>	<i>100.0%</i>	<i>100.0%</i>	<i>100.0%</i>

Note (1): Inpatient unit data not validated and relates to period 2006/07 – 2007/08 where data available. As provided by health service. ICT data since inception where available.

Note (2): Data should be considered indicative only.

Table 3.12 data shows that the number of inpatient admissions for BPSD significantly exceeds those for the ICT Program which is expected as the ICT program for those services does not target BPSD clients (as there are other service options). With this exception the profile is similar except at Barwon there are no ICT Program clients with neurotic stress related & somatoform disorders.

Key Findings

- The ICT Program is being utilised to prevent hospital admissions more than an as an early discharge program which is not fully reflected in the Program Statement.
- The ICT Program is being targeted appropriately at clients where care can be delivered safely and where there is appropriate support.
- Most clients are being discharged back into the community.
- Gippsland ICT manages a significant higher number of clients with BPSD as there is no behavioural support team in that region.

Service Improvement Opportunity

- To ensure the ICT Program Statement emphasises the focus on the prevention of hospital admissions avoidance as well as early hospital discharge

3.4 MIX OF SERVICES

This section addresses whether the mix of services is appropriate (i.e. the combination of nursing, allied health and medical services).

Table 3.13 presents whether GPs thought that the level and mix of service was generally appropriate.

Table 3.13: Number of GPs who consider Level and Mix of Service was Appropriate

	Yes	No	Don't know	Total
Barwon	0	0	0	0
Eastern	1	1	3	5
Gippsland	1	0	0	1
Southern	8	1	2	11
Overall	10	2	5	17
Percentage	58.8%	11.8%	29.4%	100.0%

Table 3.13 shows that 10 respondents (58.8%) indicated that the level and mix of service was generally appropriate. A high proportion of respondents did not know (29.4%).

As indicated in section 2.3 all services have access to allied health workers although there would appear to be different emphasis on the psycho social aspects of the service provision. Some services operate more from a medical model perspective.

Eastern operates from a biological psycho social model and there service places a particular emphasis on psycho social recovery. They reported significant benefits from this approach including:

- Allowing for additional services such as family therapy to be matched to need;
- A strong uptake by clients in social activities;
- Quality of life improvement;
- Improving client diagnoses. For example some people with depression/anxiety have been found to have personality disorders;
- Identifying a need for behaviour management plans in some cases which can then be used a teaching tool for staff or carers who have to comply with the plan.

Services indicated that there was a need to ensure adequate psychiatrist's time was available. While all services reported close cooperation with psychiatrists and working arrangement that suited the current medical staffing levels, there was a need to ensure to that adequate psychiatrist time was available on an ongoing basis with some of that time on a "planned or structured basis (i.e. a session) as is the case with Gippsland

Key Findings

- Generally the combination of nursing, allied health and medical services is appropriate.
- CALD clients are adequately serviced.

Service Improvement Opportunities

- There is a need for ICT teams to ensure at least some psychiatrists' time is provided on a 'structured or planned' sessional basis to support the Program
- There is a need for all teams to place sufficient emphasis on the psycho social aspects of recovery.

Strong support for the Program was expressed from all stakeholder groups which is discussed further in Chapter 4.

EFFECTIVENESS OF THE ICT PROGRAM

This chapter address the question of whether the ICT Program is operating effectively. In particular this chapter seeks to address the following:

- Accessibility of the Program;
- Program response times;
- Awareness of the Program;
- The adequacy of communication with key stakeholders;
- The impact on inpatient units; and
- Service outcomes from the perspective of staff, carers and GPs.

4.1 ACCESSIBILITY

To be effective the service needs to be accessible to health professionals who refer to the Program (principally community case managers, triage teams and acute inpatient units). This section addresses whether the Program is accessible.

Table 4.1 presents how staff who refer to the service rated the accessibility of the ICT Program. It shows that the overwhelming majority of staff rated accessibility as excellent (64.8%) or good (13%), a combined total of 77.8%.

Table 4.1: Accessibility Rating - Referring Staff ¹

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total Responses
Barwon	0	0	0	0	10	0	10
Eastern	0	8	2	3	13	0	26
Gippsland	0	0	0	1	6	0	7
Southern	0	0	2	3	8	0	13
Total	0	8	4	7	37	0	56
Percentage	0.0%	14.3%	7.1%	12.5%	66.1%	0.0%	100.0%

Note (1): Ten staff did not respond to this question.

Table 4.1 shows that the overwhelming majority of staff rated accessibility as excellent (64.8%) or good (13%), a combined total of 77.8%.

Ten staff at Eastern rated accessibility as average or unsatisfactory because:

- There was no access for clients in Yarra Ranges (refer 2.7);
- Referrals could only be taken Mon- Thurs and consultant review was required. They did note that once a referral was received by the ICT Team, response times were good;

- There were certain criteria for acceptance and the service was not very responsive to patient needs at all times. (note: this could be seen as positive in that the Program has criteria which it is using to determine suitability of the client)
- There was no vacancy available when the referrer required.

Table 4.2 presents how ICT staff rated the accessibility of the ICT Program. All ICT staff rated accessibility favourably with over 70% rating it as excellent (70%) and just under 30% rating access as good.

Table 4.2: Accessibility Rating - ICT Staff

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total
Barwon	0	0	0	0	9	0	9
Eastern	0	0	0	6	5	0	11
Gippsland	0	0	0	2	5	0	7
Southern	0	0	0	1	4	0	5
Total	0	0	0	9	23	0	32
Percentage	0.0%	0.0%	0.0%	28.1%	71.9%	0.0%	100.0%

Table 4.3 presents how GPs rated the accessibility of the ICT Program.

Table 4.3: Accessibility Rating – GPs

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	0	0	1	1
Eastern	5	0		1	0	0	6
Gippsland	0	0	0	0	1	0	1
Southern	4	0	0	0	4	2	10
Overall	9	0	0	1	5	3	18
Percentage	50.0%	0.0%	0.0%	5.6%	27.8%	16.7%	100.0%

Table 4.3 shows that eight (8) respondents (88.9% of those who were able to give an opinion) indicated that the accessibility of the service was adequate or completely meet their need. Half the GPs were not able to rate accessibility.

Overall, GPs considered accessibility was adequate or completely met their need.

Key Findings

- The accessibility of the Program is generally good or excellent from the perspective of staff.
- GPs considered accessibility was adequate or completely met their need.

4.2 RESPONSE TIMES

To be effective the service will need to be able to respond to a need identified by health professionals. This section examines response times of the ICT Program.

Table 4.4 presents how staff who refer to the service rated the response times of the ICT Program. The overwhelming majority of staff who responded rated response times as excellent (60.7%) or good (33.9%), a combined total of 94.6%.

Table 4.4: Response Time Rating - Referring Staff

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total Responses
Barwon	0	0	0	0	10	0	10
Eastern	0	0	2	11	13	0	26
Gippsland	0	0	0	3	4	0	7
Southern	0	0	0	5	7	1	13
Total	0	0	2	19	34	1	56
Percentage	0.0%	0.0%	3.6%	33.9%	60.7%	1.8%	100.0%

Similarly as presented in table 4.5 the overwhelming majority of ICT staff who responded rated response times as excellent (75%) or good (21.9%), a combined total of 96.9%.

Table 4.5: Response Time Rating - ICT Staff

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total
Barwon	0	0	0	0	9	0	9
Eastern	0	0	0	1	9	1	11
Gippsland	0	0	0	3	4	0	7
Southern	0	0	0	3	2	0	5
Total	0	0	0	7	24	1	32
Percentage	0.0%	0%	0.0%	21.9%	75.0%	3.1%	100.0%

Table 4.6 presents how GPs rated response times of the ICT Program.

Table 4.6: Response Time Rating – GPs

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	0	0	1	1
Eastern	4	0	0	2	0	0	6
Gippsland	0	0	0	0	1	0	1
Southern	4	0	0	0	3	3	10
Overall	8	0	0	2	4	4	18
Percentage	44.4%	0.0%	0.0%	11.1%	22.2%	22.2%	100.0%

Table 4.6 shows eight (8) respondents (44.4%) indicated that response times were adequate or completely meet their need. Half the GPs were not able to rate response times. Of those who were able to answer the question 80% indicated that response times were adequate or completely meet their need

Table 4.7 presents how GPs rated the level of afterhours support.

Table 4.7: After Hours Support – GPs Rating

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	1	0	0	1
Eastern	6	0	0	0	0	0	6
Gippsland	0	0	0	0	1	0	1
Southern	4	0	0	1	3	2	10
Overall	10	0	0	2	4	2	18
Percentage	55.6%	0.0%	0.0%	11.1%	22.2%	11.1%	100.0%

Table 4.7 shows six (6) respondents (28.5%) indicated that after hours support was adequate or completely meet their needs however there was a large number of GPs who were not able to rate after hours support. Of those who were able to rate after hours support 75% considered the after hours support was adequate or completely meet their needs.

Key Findings

- GPs considered that response times and after hours support were satisfactory
- The overwhelming majority of referring staff considered response times as excellent (60.7%) or good (33.9%), a combined total of 94.6%.

4.3 AWARENESS OF THE SERVICE

This section examines the level awareness of the ICT Program.

For the service to be effective there needs to be an awareness of the service so that all potential clients are considered for the program and in the case of GPs that they are involved to the level they require, in the medical treatment of the patient as stated in the Program Statement. The General Practitioner is a key provider in any intensive community treatment as the doctor with the most comprehensive history of the patient's physical condition).

There is high level awareness of the ICT Program by staff as the service is integral part of the service continuum that is available for clients.

Table 4.8 presents how GPs responded to the question "How did you become aware of the service?".

Table 4.8: How GPs Became Aware of the Service

Site	Through Division	Word of mouth	From the Health Service	Patient	Don't know	Total
Barwon	0	0	1	0	0	1
Eastern	0	0	1	1	1	3
Gippsland	0	1	0	0	0	1
Southern	0	0	5	1	0	6
Total	0	1	7	2	1	11
Percentage	0.0%	9.1%	63.6%	18.2%	9.1%	100%

Table 4.8 shows that 63.6% of GPs became aware the ICT program through the health service. 18.2 % of GPs became aware of the Program from the patient and 9.1% through word of mouth. This is likely to reflect that GPs are not necessarily specifically aware of the service unless they have had a patient on the Program.

In South Gippsland and Barwon the survey asked the question “Are you aware of the service?” In Gippsland of the two responses received one was not aware of the service and that GP thought the service would have been of use to his patients. At Barwon fifteen of the sixteen respondents were not aware of the service. This result was not surprising as Barwon has not actively engaged GPs as part of its Program.

ICT Program management have indicated that they do not “market” the ICT Program to GPs. Rather potential clients will be referred to triage services who then ensure client needs are considered in line with various program criteria.

Key Finding	
<u>Service Improvement Opportunity</u>	
<ul style="list-style-type: none"> Barwon should engage its GP community more actively in the Program in line with the Program Statement. 	

4.4 COMMUNICATION

This section assesses the level of communication between key stakeholders which is an indicator of the effectiveness of the Program.

4.4.1 GENERAL PRACTITIONER PERSPECTIVE

Tables 4.9 and 4.10 presents how GPs rated the level of communication with psychiatrists and other ICT clinicians respectively.

Table 4.9: Level of Communication with ICT Psychiatrists

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	0	0	1	1
Eastern	3	0	0	1	2	0	6
Gippsland	0	0	0	0	1	0	1
Southern	1	1	0	1	4	3	10
Overall	4	1	0	2	7	4	18
Percentage	22.2%	5.6%	0.0%	11.1%	38.9%	22.2%	100.0%

Table 4.9 shows that 11 respondents (61.1%) indicated that communication with psychiatrists was adequate or completely met their need. There is a high level of “don't know” responses (22.2%).

Table 4.10: Level of Communication with other ICT clinicians

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	0	0	1	1
Eastern	4	0	0	1	1	0	6
Gippsland	0	0	0	0	1	0	1
Southern	2	1	0	1	5	1	10
Overall	6	1	0	2	7	2	18
Percentage	33.3%	5.6%	0.0%	11.1%	38.9%	11.1%	100.0%

Table 4.10 shows that nine (9) respondents (50.0%) indicated that communication with other ICT clinicians was adequate or completely met their need.

4.4.2 CARERS

Carers were asked to rate the information and explanations that were provided about the ICT Program and the extent to which they were included in the decision to transfer the person they care for to the Program. The overwhelming majority of carers who responded rated the service as excellent (69.2%) or good (26.9%), a combined total of 96.1%.

Key Findings

- Communication between GPs and ICT clinicians is adequate.
- Communication with carers is good or excellent.

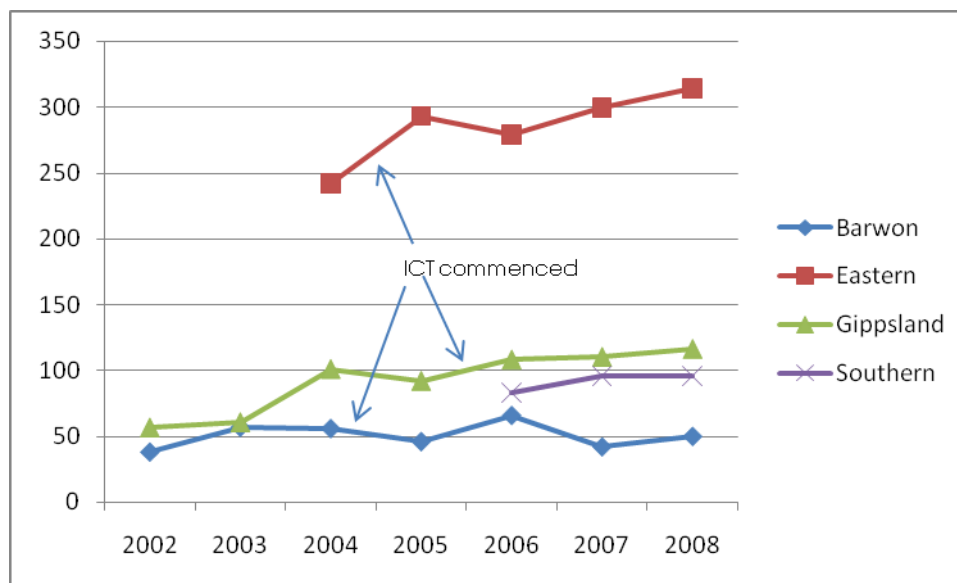
4.5 IMPACT ON INPATIENT UNITS

This section analyses the impact of the ICT Program on key inpatient unit activity indicators for each health service. Key activity data indicators have been provided by health services and they have not been validated at record level.

4.5.1 INPATIENT ADMISSIONS

Figure 4.1 presents the number of inpatient admissions by unit by financial year for each health service.

Figure 4.1: Number of Inpatient Admissions by Year



Note(1): As noted in the Environmental Analysis Paper it is not possible to examine the impact of the ICT Program at Southern Health. Their ICT service has operated for approximately 10 years and the acute unit that the ICT program referred to and received admissions from, has changed (i.e. the last three years has been Amaroo ward, the two years prior to that was Pine Lodge a private clinic and prior to that an adult unit).

Figure 4.1 shows that:

- Inpatient admissions continued to increase following the introduction of the ICT Program in all Health Services except Barwon; and
- At Barwon there was small decline in admissions in the first year (56 admissions in 2004 compared to 46 admissions in 2005), an increase in 2006 and a subsequent reduction in 2007. 2008 Barwon admissions remained below 2004 levels.

The continued increase in admissions needs to be seen in the context of significant catchment population increases (section 2.7) which health services have advised has resulted in an increase referral rates. It is likely that admissions would have increased significantly beyond those experienced, without the advent of ICT Program.

In a quality improvement study at Barwon they examined 51 patients who were admitted direct to the acute unit (to determine if they could have been admitted to ICT). It was concluded that all admissions were justified.

4.5.2 INPATIENT AVERAGE LENGTH OF STAY

Figure 4.2 presents the average length of stay (ALOS) for each inpatient unit by financial year.

Figure 4.2: Inpatient Unit Average Length of Stay

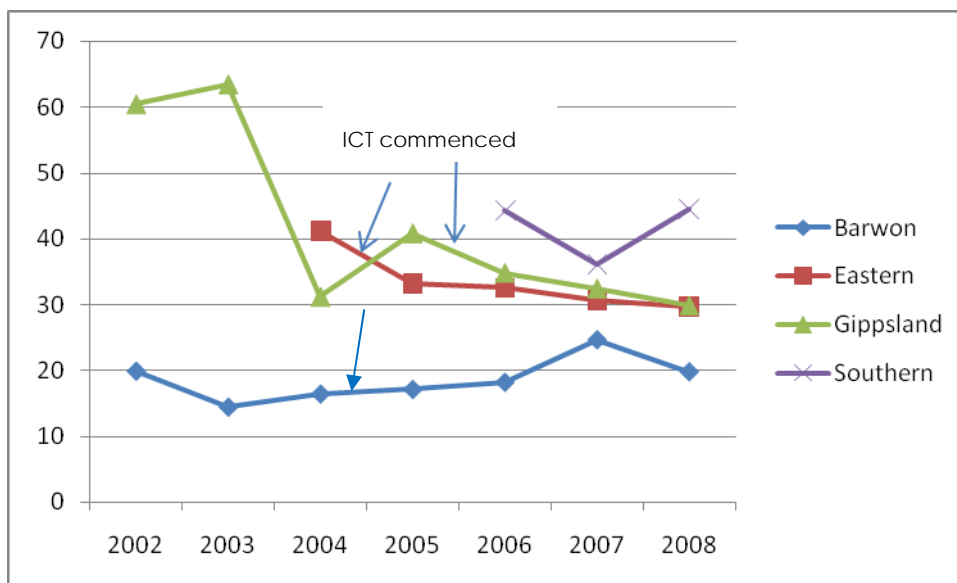


Figure 4.2 shows that at:

- Barwon the ALOS has increased gradually since the introduction of the ICT;
- Eastern the ALOS decreased significantly in 2005 (41 days in 2004 compared to 33 days in 2005) with further small reductions since then; and
- Gippsland the ALOS decreased significantly in 2005 (41 days in 2005 compared to 35 days in 2006) with further small reductions since then.

4.5.3 INPATIENT OCCUPIED BED DAYS

Figure 4.3 presents the occupied bed days (OBDs) by unit by financial year for each health service.

Figure 4.3: Total Occupied Days by Year

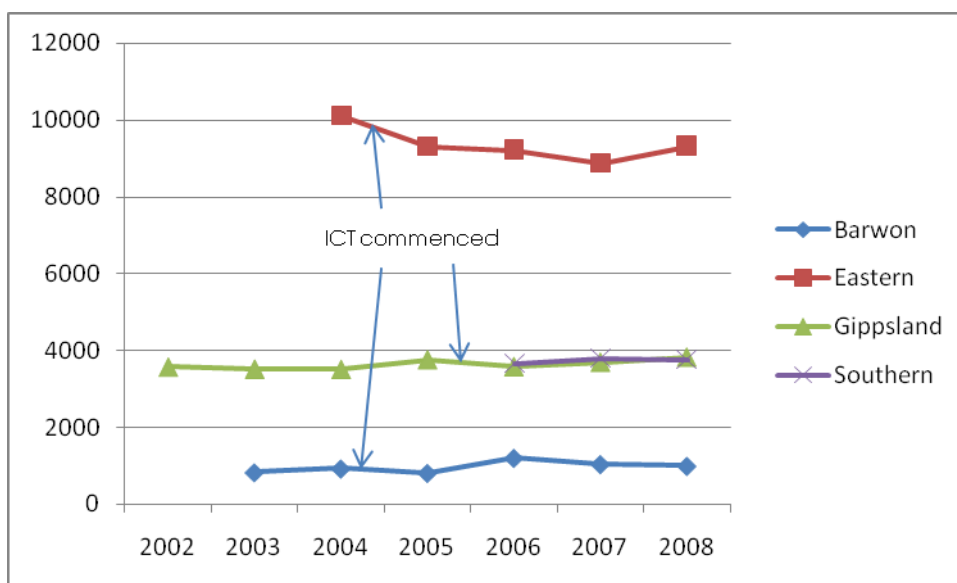


Figure 4.3 shows that at:

- Eastern there has been decline in OBDs since the introduction of the ICT; and
- Barwon, Gippsland and Southern OBDs have remained relatively steady.

Figure 4.4 presents the occupancy rate (%) by unit by financial year for each health service.

Figure 4.4: Inpatient Unit % Occupancy by Year

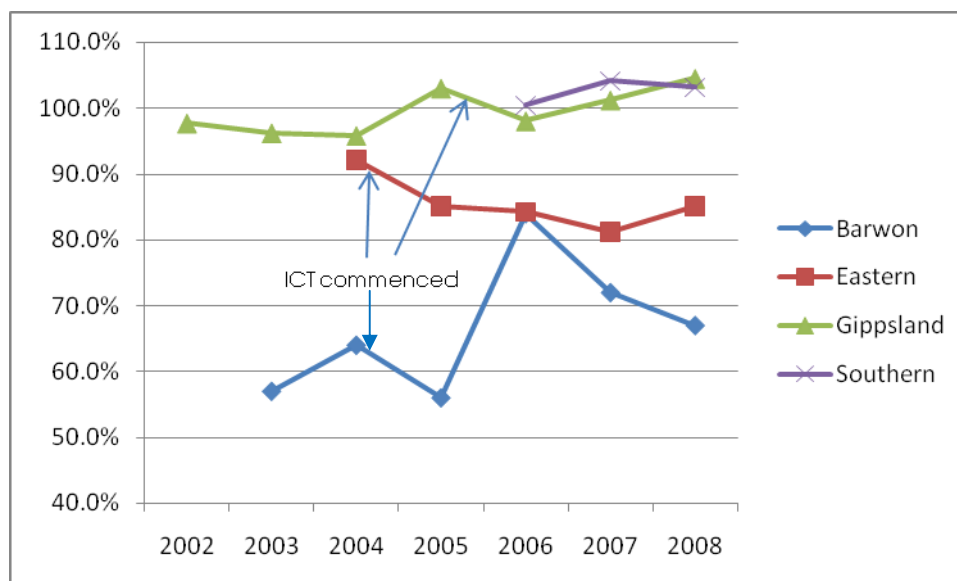


Figure 4.4 shows that at:

- Barwon occupancy rates declined in 2005 after the introduction of the ICT, then increased sharply in 2006 with subsequent significant declines from the 2006 level. These changes were driven primarily by the movement in admissions;
- Eastern occupancy has declined significantly driven by a reduction in OBDs at least partly as a result of the introduction of the ICT Program; and
- Gippsland occupancy rates declined after the introduction of the ICT and then increased steadily.

These changes in occupancy need to be viewed in context of increased pressure on inpatient units as a result of significant population increases (section 2.7 and reported increases in referral rates).

In a study undertaken by Eastern (not able to be verified by the evaluators but supported by the thrust of the data presented above) inpatient unit bed availability improved from 11% prior to ICT to 15% from July 04 to December 2005 and 24% from January 2006 to April 2007.

Overall health services reported that there are very few (if any) out of area referrals with minimal impact on the above analysis.

4.5.4 KEY FINDINGS

Key Findings

- ICT Program managers reported that there are many factors influencing key inpatient indicators that cannot be directly linked to whether the AMHS has an ICT Program (e.g. specific patient factors, the higher level of complexity and risk profile of clients that appear to be presenting, increasing ageing populations and associated referral rates).
- However available data indicates that at Eastern the introduction of the ICT Program has had a very positive impact on the inpatient unit with ALOS, OBDs and occupancy rates all decreasing significantly. This has been achieved in the context of rising admissions and large aged population increases in the catchment. The ICT Program has allowed clients to be discharged from the inpatient unit earlier than would otherwise have been the case.
- At Barwon, which currently only has four designated aged psychiatric inpatient beds, the ICT Program has allowed inpatient admissions, occupied bed days and ALOS to be contained thus helping the region maintain a low level of acute beds for this patient population group in the context of an increasing aged population.

Key Findings

- At Gippsland the ICT Program has contributed to a significant decline in ALOS achieved by allowing earlier discharge from the inpatient unit. It has also assisted in containing the number of admissions in the context of an increasing aged population and higher referral rates.
- Overall inpatient admissions are increasing in the context of large aged population increases. However the evidence suggests that the ICT Program while not being able to reverse this trend it has contained the increase in the number of admissions. The ICT Program has had a very positive impact on reducing ALOS and occupancy of inpatient units.

4.6 SERVICE OUTCOMES

The expected outcomes as per the Program Statement are:

- The clinical outcomes for patients receiving intensive community treatment will be equivalent to outcomes that could have been expected if the patient had been admitted to the inpatient unit;
- Ratings of patient and family or other carer's expressed experience of an episode of intensive community treatment is equivalent to or exceeds the ratings of expressed experience by patient and family or other carer after an episode of inpatient based care;
- General Practitioners expressed satisfaction with their patients' care in the intensive community treatment program is equivalent to or exceeds expressed satisfaction by General Practitioners whose patients experience an episode of inpatient based care.

This section examines each of these areas in turn. The section also presents the perspective of ICT staff and staff who refer to the Program.

4.6.1 CLINICAL OUTCOMES

The PAG identified HoNOS65+ as being a measure for determining client acuity and data availability given the routine collection of HoNOS65+ in clinical services. However, given that the ICT is not anticipated to ensure a reduced level of acuity and its focus is on a treatment and support approach to reduce the level of disruption to the client and to build capacity, it is considered that perhaps the HoNOS65+ is not the best indicator.

Despite the introduction of the HoNOS65+ as part of the National Outcomes and Casemix Collection (NOCC) in 2004 there are a number of issues requiring consideration:

- No single outcome measure was considered appropriate for introduction to routine Australian mental health services. Therefore a suite of measures for aged persons mental health programs include the HoNOS65+, the Life Skills Profile-16 (an abbreviated version designed to assess abilities' with respect to basic life skills over the preceding three months), Focus of Care and activities of daily living (RUG-ADL) and the consumer rated Behaviour and Symptom Identification Scale (BASIS-32);
- Training is required in rating the HoNOS family of measures, though the frequency and quality of the training varies considerably across teams, services and jurisdictions;
- Collection is mandated according to a collection protocol, though the compliance with this varies considerably across teams, services and jurisdictions and in most services has not reached the nationally mandated 85%;
- Ratings are to be entered into the CMI though there have been issues with this process:
 - It is possible that there are still clinicians and services completing and filing the hard copy HoNOS65+ but not entering onto the CMI;
 - Historically there was flexibility in the data system that would enable the wrong HoNOS measure to be used (for example, the HoNOS for an APMH client)

- o Many clinicians were not able to access individual client outcome measure reports which reduced their clinical application and resulted in clinicians seeing the activity as bureaucratic data collection;
- o Significant enhancements were only made to the CMI in September 2008 to facilitate NOCC protocol collection, including the introduction of a task list and reporting capability;
- o Barwon collection is done in their local tool and this does not have the task function which is in CMI. Their data is collected against the client and not against the clients pathway so this at time differs from the NOCC protocol and requires the data collected to be mapped back to the concept of NOCC episodes. The old CMI issue of wrong measures collected remains an issue with Barwon's collection.

Table 4.11 presents the average admission and discharge HoNOS65+ score for clients where there was a score recorded for both admission and discharge and where there was data available. The change is then calculated as a crude measure of change between admission and discharge without the use of statistical modelling or consideration of the change score frameworks being developed and debated nationally.

When interpreting the results it should be noted that:

- The data sources varied considerably and included hard copy validation, extraction from CMI and self-reports;
- The eligibility criteria for the Program will easily be reflected in the HoNOS65+ ratings:
 - o that the client is agreeable and suitable to remain in the community, that there are not significant issues with behaviour (overactivity, aggressive, disruptive or agitated, uncooperative or resistive) – rated in item 1;
 - o two services do not take clients with organic/cognitive issues – rated in item 4;
 - o all services require that the client have family support, and secure accommodation – rated in items 9 and 11 respectively.
- Discharge from ICT may in fact be to an inpatient unit and therefore the discharge score could be higher;
- A measure is not considered valid where there are two or more ratings of 9; therefore it is possible that the number of clients on admission and the number of measures are in fact different and same again on discharge;
- It is not uncommon for a community clinician to rate higher than an inpatient clinician and may be the result of:
 - o community clinicians may know the client better and therefore they may elicit more information on which to rate;
 - o while inter-reliability is reasonable 0.7-0.8 this is only if the clinician rates a client based on all information and according to the glossary – that is not rating this client compared to the 'unwellness' of clients typically seen in that setting or the same client compared to how 'unwell' they have been on a previous admission/intake

Table 4.11: Changes in HoNOS65+ Score while on Program

Sites	Number of Records	Admission HoNOS65+	Discharge HoNOS65+	% Reduction
Barwon ¹	40	12.35	9.0	27.1%
Eastern ²	74	11.3	8.1	27.8%
Gippsland ³	Refer note ³			
Southern ⁴	32	15.94	12.22	23.3%

- Note (1): Barwon: Based on data from medical record extracted by HOI. List of 92 randomly selected episodes were provided to Barwon commencing from July 2006. Forty of those episodes had an entry and exit score recorded.
- Note (2): Eastern: Based on episodes from 9 August 2004 to 30 Jan 2009 as extracted from CMI.
- Note (3): Gippsland: Based on average total scores as provided HoNOS score on admission was 20.33 and on discharge was 15, an overall reduction of 26.2%. It is not clear how many records were involved and the data was not validated.
- Note (4): Southern Obtained from manual data base and covers period January to August 2008. Older data was available i.e. prior to 2002 but this was not used due to its age

Table 4.11 shows that while there was widely varying scores on admission and discharge to/from the ICT Program between services, the percentage reduction in HoNOS65+ scores while on the Program was very consistent ranging from 23.3% at Southern to 27.8% at Eastern.

The national data confirms that there is generally a reduction or change in scores from admission/intake to discharge, however the extent of the change between the treatment modalities – standard community care, inpatient and ICT – have not been detailed here. That is while there is a percentage reduction; this is likely that there is a similar percentage reduction for those treated in other settings such as the inpatient unit. This crude method of measuring change does not take into account any thresholds of significance. National work has highlighted that a lot of change figures fall into a median change rate i.e. no real change and that changes at 4-7 are better indicators of significant improvement or deterioration.

Heath Services stated that their inpatient acute units generally reported larger reductions (data not validated).

However this in itself does not reflect a failing of the ICT. There are a range of issues detailed above that need consideration when interpreting the results. Other more important factors to consider are whether the Program was less disruptive, the experience better and that there was a greater capacity in engaging with treatment.

Key Findings
<ul style="list-style-type: none"> • While there is potential value in utilising the HoNOS65+ in the evaluation of the ICT Program, there are a range of issues detailed above that need careful consideration when interpreting the ratings. • Encouragingly while there was widely varying scores on admission and discharge to/from the ICT Program between services, the percentage reduction in HoNOS65+ scores while on the Program was very consistent ranging from 23.3% at Southern to 27.8% at Eastern.

4.6.2 CARERS EXPERIENCE

SERVICE QUALITY

Aspects of the service that carers consider have been the most beneficial are presented in Table 4.12. The table presents the total number of respondents who rated that particular aspect of the service as beneficial and the associated percentage.

Table 4.12: Beneficial Aspects of the Service

Beneficial Aspects	Total Responses	Percentage of Respondents
Client being able to stay home	20	42.6%
Frequency of visits from staff	30	63.8%
Respite	12	25.5%
Referrals to other services	8	17.0%
Communication	18	38.3%
Other	3	6.4%

Table 4.12 shows that frequency of visits from staff, communication and clients being able to stay at home were seen as being the three most commonly identified benefits to carers.

Table 4.13 presents how carers rated the ICT Program. The overwhelming majority of carers who responded rated the ICT Program as excellent (69.2%) or good (25.6%), a combined total of 94.8%.

Table 4.13: Overall Service Rating

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total
Barwon	0	0	0	6	17	0	23
Eastern	0	0	1	2	3	0	6
Gippsland	0	0	1	1	3	0	5
Southern	0	0	0	1	4	0	5
Total	0	0	2	10	27	0	39
Percentage	0.0%	0.0%	5.1%	25.6%	69.2%	0.0%	100.0%

As reported previously, all carers (100%) considered that the person they cared for was appropriate for treatment on the ICT Program.

ICT managers reported that stakeholder support for the ICT Program is very positive. They reported very few or no patients refuse the service when it is offered to them.

A summary of the results of relevant surveys conducted by Eastern Health surveys are presented below (note no source data sighted by evaluators);

- **Consumer survey results:** 94% reported the service had been of benefit. 53% rated the service as excellent, 35% good and 12% average.
- **Carer survey:** 50% rated service as excellent and 50% as good.

COMPARISON TO ACUTE UNIT

Carers were requested where they could to compare their experience of an acute unit and the ICT Program and indicate which service they would prefer the person they care for to be treated in and why. The results are presented in table 4.14.

Table 4.14: Service Preference

Site	ICT	Inpatient	Don't Know	Total
Barwon	16	2	2	20
Eastern	1	3	1	5
Gippsland	5	0	0	5
Southern	3	0	0	3
Total	25	5	3	33
% of Total	75.8%	15.2%	9.1%	100.0%

Table 4.14 shows that 75.8% of carers preferred the ICT Program.

Understandably a number of carers indicated that it was difficult to make a comparison as the circumstances associated with each episode of care was unique and it was recognised that alternatives needed to be available.

Three respondents at Eastern preferred the inpatient unit with only one providing commentary. That person indicated that they preferred the inpatient unit while the client was extremely neurotic/psychotic but once that was over the ICT was "fine and very satisfactory".

Carers were also asked to provide an overall rating for the inpatient service if they had had relevant experience and the results are presented in Table 4.15.

Table 4.15: Inpatient Unit Service Rating

	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total
Barwon	0	0	3	3	14	0	20
Eastern	0	0	1	1	0	1	3
Gippsland	0	0	1	2	1	0	4
Southern	0	0	0	1	2	0	3
Total	0	0	5	7	17	1	30
Percentage	0.0%	0.0%	16.7%	23.3%	56.7%	3.3%	100.0%

Table 4.16 compares the aggregated service ratings for the ICT Program and the inpatient unit.

Table 4.16: Service Rating Comparison

Service Rating	Acute	ICT
Poor	0.0%	0.0%
Unsatisfactory	0.0%	0.0%
Average	16.7%	5.1%
Good	23.3%	25.6%
Excellent	56.7%	69.2%
Don't know	3.3%	0.0%
Total	100.0%	100.0%

Table 4.16 shows that carers rated the ICT Program above inpatient units. Combined ratings for ICT good and excellent were 94.8% compared to 80% for the inpatient unit. Care should be taken in interpreting these figures given the small numbers involved.

Table 4.17 presents the number of carers who believe the ICT Program has resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit. Table 4.17 shows the majority of carers (82.1%) consider that the service had resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit.

Table 4.17: Number of Carers who believe Service has resulted in fewer Admissions/Decreased Length of Stay

Site	Yes	No	Don't Know	Total
Barwon	19	1	3	23
Eastern	4	1	1	6
Gippsland	5	0	0	5
Southern	4	0	1	5
Total	32	2	5	39
% of Total	82.1%	5.1%	12.8%	100.0%

Key Findings

- Frequency of visits from staff, communication and clients being able to stay at home were the three most commonly identified benefits to carers.
- Carers rated the information and explanations that were provided about the ICT Program and the extent to which they were included in the decision to transfer the person they care for to the Program very highly.
- All carers (100%) who responded to the survey considered that the person they cared for was appropriate for treatment on the ICT Program.
- The overwhelming majority of carers who responded to the survey rated the ICT Program as excellent (69.2%) or good (26.9%), a combined total of 96.1%.
- 75.8% of survey respondents preferred the ICT Program in comparison to the acute unit.
- Carers rated their satisfaction with the ICT Program above respective inpatient units. Combined ratings for ICT Program for good and excellent were 94.8% compared to 80% for inpatient units.
- The majority of carers who responded (82.1%) consider that the service had resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit.
- In addition ICT managers reported that stakeholder support for the ICT Program is very positive. They advised very few or no patients refuse the service when it is offered to them.

4.6.3 GENERAL PRACTITIONERS EXPERIENCE

SERVICE QUALITY

Aspects of the service that GPs consider have been the most beneficial are presented in Table 4.18. The data presents the percentage of respondents who rated that particular aspect of the service as beneficial).

Table 4.18: Beneficial Aspects of the Service

Site	Allow earlier discharge from hospital	Prevent hospital admission	Respite care	Clients being able to stay at home	Other
Barwon	0%	0%	0%	0%	0%
Eastern	25%	50%	0%	100%	0%
Gippsland	0%	100%	0%	100%	0%
Southern	50%	70%	0%	80%	10%
Overall	40%	67%	0%	87%	7%

Table 4.18 shows that the most frequently rated major benefit from the GP’s perspective was to do with the clients capacity to stay at home followed by prevention of hospital admissions. One respondent indicated that another major benefit of the service was the ability to get a second opinion regarding management. No respondents felt that respite care was a major benefit of the service.

Table 4.19 presents how GPs responded to the question “How beneficial was the intervention?”.

Table 4.19: Beneficial Nature of Service Rating – GPs

Site	Don't know	Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Total
Barwon	0	0	0	0	0	1	1
Eastern	3	0	1	1	1	0	6
Gippsland	0	0	0	0	1	0	1
Southern	2	0	0	0	6	2	10
Overall	5	0	1	1	8	3	18
Percentage	27.8%	0.0%	5.6%	5.6%	44.4%	16.7%	100.0%

Table 4.19 shows that 61.1% of respondents indicated that the beneficial nature of intervention was adequate or completely met their needs. One GP from Eastern indicated that the benefit to the patient was inadequate, commenting that one patient had bounced back to hospital several times. There was a high level of “don't knows” (27.8%).

In Gippsland 16 GPs responded to a survey conducted in 2007. In that survey 44% (7) were completely satisfied with the care provided to the patient by the program, 50% (8) said it was adequate, and 6%(1) said it was inadequate.

Table 4.20 presents how many GPs thought the service should be continued. Fourteen GPs (74%) were clear that the service should continue. Only one GP though the service should not continue.

Table 4.20: Number of GPs who consider Service should be continued

Site	Yes	No	Don't know	Total
Barwon	1	0	0	1
Eastern	3	1	2	6
Gippsland	1	0	0	1
Southern	9	0	2	11
Overall	14	1	4	19
%	73.6%	5.3%	21.1%	100%

Key Findings

- GPs support the continuation of the ICT Program. 74% of respondents were clear that the service should continue.
- The most frequently rated major benefit was clients being able to stay at home followed by preventing hospital admissions.
- 61.1% of respondents indicated that the beneficial nature of intervention was adequate or completely met their needs. There was a high level of “don't knows” (27.8%)

4.6.4 STAFF EXPERIENCE

Table 4.21 presents how staff who refer to the service responded to the question “how beneficial was the intervention?” The overwhelming majority of staff who responded rated the benefit of the intervention as excellent (68.8%) or good (22.9%), a combined total of 91.7%.

Table 4.21: Beneficial Nature of Service Rating – Referring Staff

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total Responses
Barwon	0	0	0	1	9	0	10
Eastern	0	0	1	3	12	2	18
Gippsland	0	0	0	4	3	0	7
Southern	0	0	0	3	9	1	13
Total	0	0	1	11	33	3	48

Table 4.22 presents how staff who work in the service responded to the question “how beneficial was the intervention”. The overwhelming majority of ICT staff who responded rated the beneficial nature of the intervention as excellent (68.8%) or good (25.0%), a combined total of 93.8%. This was very similar to referring staff.

Table 4.22: Beneficial Nature of Service Rating - ICT Staff

Site	Poor	Unsatisfactory	Average	Good	Excellent	Don't know	Total
Barwon	0	0	0	0	9	0	9
Eastern	0	0	1	3	6	1	11
Gippsland	0	0	0	4	3	0	7
Southern	0	0	0	1	4	0	5
Total	0	0	1	8	22	1	32
Percentage	0.0%	0.0%	3.1%	25.0%	68.8%	3.1%	100.0%

Aspects of the service that both staff who refer to and work in the service consider has been the most beneficial or had the greatest impact are presented in table 4.23. The table presents the percentage of responses who rated that particular aspect of the service as beneficial.

Table 4.23: Beneficial Aspects of the Service

Beneficial Aspects of the Service	Percentage of Responses - Referring Staff	Percentage of Responses - ICT Staff
Client being able to stay home	98.4%	96.3%
Frequency of visits from staff	83.6%	96.3%
Respite	37.7%	40.7%
Referrals to other services	27.9%	44.4%
Communication	49.2%	40.7%
Other	32.8%	18.5%

Table 4.23 shows that the two most common cited benefits were the client being able to stay at home and the frequency of visits by staff.

While there are some differences of emphasis between what referring staff and ICT staff rate as beneficial, they are not considered to be of any significance to the evaluation i.e. ICT staff place a greater emphasis on referrals to other services (44.4%) compared to 28.8% for referring staff.

Staff respondents also identified other substantial carer and client benefits including:

- Allows early discharge from acute unit;
- Prevents admission on occasions;

- Less restrictive environment for clients;
- The risks associated with admitting aged psychiatric patients i.e. disorientation, confusion, falls and medication events, are avoided;
- Increased monitoring and more intensive support;
- In the case of Gippsland if the ICT clients can remain in the local general hospital, they stay close to and involve their family and maintain the GP in care of patient, providing a better environment and reducing stigma;
- Increased risk management capacity;
- Able to apply injections to non compliant clients;
- Intensive assessment capacity;
- Increased support to carers and a reduction in carer stress;
- Improved support and education for carer staff in RACF and carers;
- More input and communication with carers;
- Psycho social education on a 1:1 basis with families. Psycho social aspects can be dealt with as staff see the family frequently and can deal with issues as they unfold;
- Helping the patient and family map their way through support services;
- A seven (7) day a week input allows a better overall picture of clients presentation;
- Relieves pressure on case manager when client needs become more frequent or unpredictable in times of acute mental illness;
- Improved response times;
- Nurtures independence;
- Prevention of severe relapse due to intensive support;
- The strengthening of relationships between GP's, allied health staff, acute local hospital staff and community services; and
- Eliminated out of area referrals.

All services indicated that the Program was an essential part of their service offering.

Key Findings

- The overwhelming majority staff who stated that they had referred to the ICT Program rated the benefit of the intervention as excellent (68.8%) or good (22.9%), a combined total of 91.7%. This was very similar for staff who worked in the ICT Program.
- The two most common cited benefits were the client being able to stay at home and the frequency of visits by staff.
- There is a long list of other perceived benefits from the service.

EFFICIENCY OF ICT PROGRAM

This chapter address the question of whether the ICT Program is operating efficiently. In particular, the chapter analyses funding, cost and staffing per unit of activity. It compares the funding cost to DHS of treatment on the ICT Program compared to an inpatient unit.

5.1 FUNDING AND COST

This section compares unit funding and costs for each service.

Table 5.1 presents the funding per admission based on 2007/08 data.

Table 5.1: Funding Per Admission 2007/08

Sites	Funding \$	Admissions	Funding per Admission \$
Barwon	794,613	87	9,133
Eastern	794,613	126 ¹	6,306
Gippsland (Sept- August)	794,613	46	17,274
Southern	NA ²	55	

Note (1): Based on estimate of Eastern admissions for 2007/08.

Note (2): Southern funds were allocated as part of the PGAT global budget at the time that project commenced (in 1998) based on the equivalent of five beds. The amount is not currently identifiable as a separate budget line item and thus has been presented as not available for the purposes of the analysis in this section.

Table 5.1 shows there is a wide discrepancy in funding per actual admission. Gippsland received 170% more funds per admission than Eastern. This is attributed primarily to a lower level of activity at Gippsland due the geographical dispersion of clients and associated travel time.

Table 5.2 presents the cost per admission after including an overhead estimate for Southern to ensure the figures are more comparable.

Table 5.2: Cost per Admission ³

Sites	2007	2008	2008 % Variation Over Eastern
Barwon	NA	8,315	49%
Eastern	6,918	5,563 ¹	
Southern ²	6,365	6,369	14%

Note (1): Eastern based on estimate of admissions for 2007/08

Note (2): Southern figures include an estimated overhead of 12% of costs (\$37,511) based on the average overhead for the other services.

Note (3): No figures available for Gippsland.

Table 5.2 shows that Eastern has the lowest cost per admission of \$5,563 with Southern and Barwon having a higher cost by 15% and 49% respectively.

Table 5.3 presents the cost per ICT day for Barwon, Eastern and Southern after including an overhead estimate for Southern to ensure the figures are more comparable.

Table 5.3: Cost per ICT day ³

Site	2007	2008	% Variation Over Eastern 2008
Barwon	NA	330	27%
Eastern	323	260 ¹	
Southern ²	226	246	-5%

Note (1): Eastern based on estimate of activity for 2007/08.

Note (2): Southern figures include an estimated overhead of 12% of costs (\$37,511) based on the average overhead for the other services.

Note (3): No figures for Gippsland.

Table 5.3 shows that cost per ICT day for Southern are slightly less than for Eastern (5% in 2008). The difference would be even greater if the days the Southern ICT team looks after the additional special cohort of five chronic clients were counted (refer section 2.3).

The key driver of cost effectiveness is the number of admissions. Those services with a lower level of activity are not as cost effective as those with a higher level of activity.

Key Findings

- The financial analysis that could be undertaken was limited by a number of factors. The actual expenditure figures are not available for Gippsland and estimates were provided for other ICT Program services.
- There is a wide discrepancy in funding per actual admission. Gippsland receives 170% more funds per admission than Eastern. This is attributed primarily to a lower level of activity at Gippsland as a result of the large geographical area being serviced.
- The level of reported expenditure at Eastern and Barwon was similar. Southern expenditure was less than half of the other services in 2007/08. This is as a result of Southern employing about half the number of staff, not utilising flexible funding and not charging overheads.
- The cost per admission and cost per client day are significantly greater for Barwon than for Southern or Eastern. Gippsland has the highest level of funding per actual admission which is attributed primarily to a lower level of activity at Gippsland as a result of the large geographical area being serviced.
- The key driver of cost effectiveness is the number of admissions. Those services with a lower level of activity are not as cost effective as those with a higher level of activity.
- It is not possible to determine whether there is any difference in cost effectiveness between an ICT team operating as a discrete team (as is the case with Eastern and Southern) as opposed to an integrated team. The financial figures are not reliable enough and the number of pilot sites not large enough to be conclusive in this regard. In Gippsland the higher cost of that integrated ICT team is likely to be at least partially offset by improved efficiencies of the community team as health professionals can undertake both ICT visits and community team visits when travelling to a particular location.

5.2 STAFFING

This section analyses staffing levels for each health service.

Table 5.4 presents the number of admissions per approved FTE by Health Service. Eastern has the highest number of admissions per FTE. Gippsland is significantly lower (approximately half of Eastern) and this is attributed to a reduced case load due to the increased travel time required as a result of the large geographical area being serviced.

Table 5.4: Admissions per FTE

Sites	Approved FTE	2007/08 Admissions	Admissions Per FTE
Barwon	7.2	87	12.1
Eastern ¹	6	126 ¹	21.0
Gippsland (Sept- August)	5	46	9.2
Southern	3.5	55	15.7

Note (1): Eastern: For purposes of this analysis we have used the estimated 2007/08 admissions

Table 5.5 presents the number of clients per FTE per day.

Table 5.5: Clients Per FTE Per Day

Sites	Approved FTE	2007/08 Daily Average	Clients Per FTE per Day
Barwon	NA	6	0.8
Eastern	6	7.4 ¹	1.2
Gippsland (Sept- August)	5	2.5	0.5
Southern	3.5	3.9	1.1

Note (1): Eastern: For purposes of this analysis we have used the 2008/09 daily average.

Table 5.4 shows that Gippsland maintains less than half (40% to 45%) of the client load per FTE compared to Eastern and Southern respectively and this is attributed to the increased travel time required due to a large geographical area being serviced. Barwon also maintains a lower case load than Eastern and Southern. It should be noted that in the case of Barwon and Gippsland workers are not “less busy” as they will also have a community caseload.

This section shows that the discreet ICT teams at Eastern and Southern have a higher number of admissions per FTE and clients per day than the integrated teams of Barwon and Gippsland. HOI consider that the primary driver for this is overall level of demand and not the internal structure of the team.

Key Findings

- Information on staffing numbers is indicative only.
- Gippsland maintains less than half (40% to 45%) of the client load per FTE compared to Eastern and Southern respectively and this is attributed to the increased travel time required due to a large geographical area being serviced. Barwon also maintains a lower case load than Eastern and Southern.
- Eastern has the highest number of admissions per FTE. Gippsland is significantly lower (approximately half of Eastern).
- The discreet ICT teams at Eastern and Southern have a significantly higher number of admissions per FTE and clients per day than the integrated teams of Barwon and Gippsland. HOI consider that the primary driver for this is overall level of demand and not the internal structure of the team.

5.3 COMPARISON TO INPATIENT FUNDING

This section compares the DHS funding per ICT admission and ICT OBD to DHS funding for aged psychiatric acute inpatients.

The analysis is done on this basis as this is the cost to DHS. Actual cost data was not available for inpatient units nor all ICT units. The analysis assumes that patient characteristics are similar which may not be the case.

It is important to note that this is not a full economic analysis. In addition to costs there are other significant benefits identified from participating in the ICT Program which are likely to have an economic benefit when compared to inpatient treatment including: containing the increase in inpatient admissions; reducing ALOS and occupancy for inpatient units (section 4.5); reducing the pressure for capital funding for more inpatient beds; reducing the risks to patients e.g. falls and adverse medication events; implementing effective psycho-social interventions in the context of the clients home environment (section 4.6.4).

In 2007/08 inpatient units were funded at \$451 per available day (\$454 for rural units). ICT Units are funded to the equivalent of five inpatient beds with the Program Statement stating that “over time, the ICT Program may be able to deliver services to seven patients at one time”.

Table 5.6 presents the funding per actual inpatient admission to the funding per actual ICT admission. The table also includes costs per ICT admission for further comparative purposes.

Table 5.6: Comparison of Funding Per Inpatient Admissions to Funding Per ICT Admission (2007/08) ¹

Sites	Funding per Inpatient Admission ² \$	Funding Per ICT Admission \$	Cost Per ICT Admission \$	% Difference Funding Per ICT Admission to funding Per Inpatient Admission %
Barwon	13,075	9,133	8,315 ³	(30.2)
Eastern	15,771	6,306	5,563	(60.0)
Gippsland	14,321	17,274	NA	20.6
Southern	17,147	NA	6,369 ⁵	(62.9) ⁵

Note (1) Figures should be considered indicative.

Note (2): Funding per inpatient admission is estimated based on available beds days and actual bed days as provided by health services. The figure is calculated by taking the available funding (i.e. available bed days multiplied by the unit price) divided by the number of actual admissions.

Note (3): Barwon costs per admission are based on estimates and they may be unreliable

Note (5): Percentage uses cost per ICT admission as a proxy for funding data.

Table 5.6 shows that for Eastern and Barwon the funding per ICT admission is significantly less than for inpatient admissions (60% and 30.2% respectively). For Southern, using cost per ICT admission as a proxy for funding data, ICT funding per admission is also significantly lower than funding per inpatient admission (63%).

For Gippsland funding per ICT admission is greater than inpatient funding per admission.

Table 5.7 presents the funding per actual inpatient occupied bed day (OBD) to the funding per actual ICT client day. The table also includes costs per ICT OBD for further comparative purposes.

Table 5.7: Comparison of Funding Per Inpatient OBD to Funding Per ICT OBD (2007/08) ¹

Sites	Funding per Inpatient OBD ² \$	Funding Per ICT OBD ICT \$	Cost per ICT Day \$	% Difference Funding ICT OBD to Inpatient OBD %
Barwon	660	363	330 ³	(45.1)
Eastern	531	294	260	(44.5)
Gippsland	434	871	NA	100.6
Southern	437	NA	246	(43.7)

Note (1) Figures should be considered indicative.

Note (2): Funding per inpatient OBD is estimated based on available beds days and actual bed days as provided by health services. The figure is calculated by taking the available funding (i.e. available bed days multiplied by the unit price) divided by the number of actual OBDs.

Note (3): Barwon costs per OBD are based on crude estimates and they may be unreliable.

Table 5.7 shows that for Eastern and Barwon the funding per ICT OBD is significantly less than for inpatient OBDs (44.5% and 45.1% respectively). For Southern, using cost per ICT OBD as a proxy for funding data, ICT funding per OBD is also significantly lower than funding per inpatient OBD (44%).

Gippsland funding per ICT OBD is greater than inpatient funding per OBD by 100%.

Barwon, Eastern and Southern see more clients per FTE (refer to section 5.2) than Gippsland and therefore are more productive (as measured by throughput). They have significantly lower funded costs per OBD than their respective inpatient units (around half).

Gippsland has a higher funded cost per unit of activity than its inpatient unit due to its lower activity per FTE, which in turn is at least partially related to increased travel time as a result of the geographical dispersion of the catchment. Offsetting this is that their integrated ICT team structure improves efficiencies of the community team as health professionals can undertake both ICT visits and community team visits when travelling to a particular location.

Looking at the numbers another way, Table 5.8 models the cost to DHS for admissions to the ICT Program compared to what would have occurred if they had been admitted to the inpatient unit assuming the patients stayed the same average length of time as other inpatients (which may not be the case).

Table 5.8: Comparison of Total Costs to DHS (2007/08)

Site	Admissions	Total Cost to DHS for Admissions to ICT \$	Total Cost to DHS if Admitted to Inpatient Unit \$	Difference \$	Percentage Variation %
Barwon	87	794,613	1,137,542	342,929	30%
Eastern	126	794,613	1,987,100	1,192,487	60%
Gippsland	46	794,613	658,746	(135,867)	(21)%
Southern	55	350,295 ¹	943,106	592,812	63%
Total	314	3,170,070	4,726,496	1,556,426	42%

Note (1): Southern figures for ICT based on Southern ICT expenditure.

Table 5.8 shows that overall treatment on the ICT Program is cost effective when compared to acute admissions (an overall saving of 42%).

Based on the analysis in this section it is clear that treatment on the ICT Program is cost effective when compared to treatment in an acute inpatient unit for metropolitan and regional services. No direct conclusion can be drawn in relation to cost effectiveness of rural units based on a

sample of one pilot site. However the economic and other benefits are considerable as the client and their family do not have travel to a remote location for treatment assuming there was a bed available, and staff can undertake both community team and ICT service consultations when visiting a particular location.

Key Findings

- The ICT service model for metropolitan and regional teams is cost effective when compared to inpatient units.
- The ICT model for the rural team is not as cost effective when compared to inpatient activity on a unit costs basis. However there are other substantial economic and other benefits to the client and their carers identified in this Report including clients not having to travel to a remote location for treatment.
- In the rural setting the higher cost of an integrated ICT team per admission may be offset by improved efficiencies of the community team as health professionals can undertake both ICT visits and community team visits when travelling to a particular location.
- The evidence indicates that the key driver of being cost efficient (as measured by either ICT cost per admission, ICT cost per client day or funding per admission) is whether the ICT team has a sufficient number of admissions.



CONCLUSION AND FUTURE DIRECTIONS

This chapter sets out the main conclusions of the evaluation, identifies the key elements for the successful operation of the ICT Program and associated opportunities for improvement and proposes future directions for the ICT Program.

6.1 CONCLUSION

The ICT Program is appropriate, effective and in the case of metropolitan and regional teams an efficient method of service delivery.

The evaluation has demonstrated that:

- The ICT Program is aligned with current policy directions and settings;
- The ICT Program is being targeted appropriately at clients where care can be delivered safely and where there is appropriate support;
- Generally the combination of services (nursing, allied health and medical) is appropriate;
- The accessibility of the Program is generally good or excellent;
- Response times and after hours support are satisfactory or excellent;
- Communication between carers and Program staff is generally good or excellent;
- Where GPs are involved communication with Program staff is satisfactory;
- Carers considered that the person they cared for was appropriate for treatment on the ICT Program;
- The overwhelming majority of carers rated the ICT Program as excellent or good;
- 75% of survey respondents preferred the ICT Program in comparison to the acute unit; and
- Carers rated their satisfaction with the ICT Program above respective inpatient units. GPs support the continuation of the ICT Program.

It was also noted that the ICT Program is being utilised as a hospital admission prevention program more than as an early discharge program. It is not considered to be a direct substitute for acute inpatient beds. Stakeholders considered and HOI (through the evidence presented in this evaluation) concurs, that the ICT Program greatly enhances the capacity for early discharge and hospital avoidance and has considerable benefits for clients and carers.

The ICT Program has helped to contain the increase in the number of inpatient admissions in the context of large aged population increases. The ICT Program has had a very positive impact on reducing ALOS and occupancy of inpatient units helping them to cope with increasing admissions with out increasing bed numbers.

Substantial benefits to carers and clients were identified including:

- Client being able to stay at home or be discharged earlier, thus avoiding or reducing the risks and disruption associated with a hospital admission (e.g. disorientation, confusion, falls and medication events);

- Allows for increased monitoring and more intensive support including an improved risk management capability and facilitating a prevention of severe relapses;
- More input and communication with carers and a reduction in carer stress;
- Psycho social aspects of recovery can be dealt with as staff see the family frequently and assist with issues as they unfold;
- Helping the patient and family map their way through support services; and
- In the case of Gippsland If the patient can remain in the local general hospital (Gippsland), they stay close to and involve their family and maintain the GP in care of patient, providing a better environment and reducing stigma.

In conclusion the evaluation has demonstrated that the ICT Program is an integral part of the continuum of APMH services, with substantial support and significant client benefit but it does not, nor will it, replace the need for inpatient beds.

6.2 KEY ELEMENTS OF ICT PROGRAM MODEL AND SERVICE IMPROVEMENT OPPORTUNITIES

One of the key evaluation objectives was to make recommendations regarding future development, improvements and implementation of the bed substitution model.

OPERATIONAL ELEMENTS

The evaluation has identified that there are a number of key operational elements required as part of the ICT Program service delivery framework which may need to be strengthened to ensure Program efficiency and effectiveness. These are:

- Implementation of clear referral, admission and discharge criteria. The criteria for each step should clearly specify the input required by the consultant psychiatrist;
- Having a capacity to maintain the client case load over the weekend i.e. adequate staffing over seven days, with existing resources;
- Identifying a separate budget for flexible (brokerage) funding;
- Ensuring at least some consultant psychiatrist time is provided on a 'planned or structured' sessional basis (as occurs at Gippsland);
- Placing sufficient emphasis on the psycho-social aspects of recovery; and
- Engaging the GP community actively in shared care arrangements as per the Program Statement.

Other key operational elements required that have been successfully implemented by all services include:

- Clear and appropriate risk assessment and risk management protocols;
- Good communication and collaboration with the carers and clients;
- Clear, timely and relevant documented care plans and treatment documentation;
- Frequency of visits and services tailored to client need;
- Effective response times;
- Good communication with other relevant services and service providers;
- Flexibility of service arrangements as appropriate to local requirements e.g. either discrete or integrated teams; and
- Adequate transport availability to ICT staff to deliver the home based program.

PROGRAM MANAGEMENT ELEMENTS

As a result of the findings HOI recommends that MH&DD consider the following:

- MH&DD may need to review the data definitions in the CMI related to the ICT program to improve capacity to capture information This would enable DHS to track key ICT indicators i.e. number of clients admitted, the average length of stay, the average number of clients on the Program per day, the number of staff, the funding provided per actual admission, the number of patients discharged from the inpatient unit to the ICT Program, the number of clients discharged from the ICT Program to a mental health inpatient unit and carer and client satisfaction.
- Reinforce the need for AMHS to record client information including HONOS scores in CMI ;
- Negotiating with Southern Health to redistribute the same level of funds (equivalent of 5 aged acute beds) so that their ICT Program can operate at the same level of capacity (employ staff numbers equivalent to other services) as the other ICT services, including access to flexible funding;
- Redraft the ICT Program Statement to emphasise the focus on the prevention of hospital admissions as well as early hospital discharge and the other suggested program improvement opportunities identified above.

6.3 FUTURE DIRECTION

Based on the evaluation findings HOI consider that the ICT Program should be rolled out to other regions. The Department will need to determine the basis for roll out taking into account a number of factors including the:

- Aged population greater than 65 years;
- Existing number of acute beds;
- Occupancy of those acute beds;
- The number of acute beds compared to notional required beds based on any formula to be developed by the Department (currently 4 beds per 10,000 population 65 years+; and
- Population density.

Based on the experience of the ICT Program pilot, in metropolitan or major regional centres, funding for the equivalent of five inpatient beds is suitable where catchment populations are at least in excess of approximately 40,000- 50,000 aged persons 65+. This level of funding also allows a team to be viable in both size and capability. HOI consider there is a case for APMH services servicing very large catchment populations which also have a limited number of acute beds to receive additional support.

The basis for roll out to rural areas requires further consideration by the Department

Prior to any service roll out the Department should:

- Update the ICT Program Statement;
- Develop a basis for the ICT Program roll out;
- Update the basis for the budget;
- When funding new services within the context of global resource allocations, DHS should ensure the number of positions to be appointed is agreed and agreed service outputs and outcomes tracked for at least the first three years.



APPENDIX A - PROGRAM STATEMENT

1. PURPOSE

The purpose of this document is to provide a program statement for the Aged Persons Mental Health Intensive Community Treatment Program. This program will provide an alternative to acute treatment in an Aged Persons Mental Health acute inpatient unit and will substitute for acute beds in an area Aged Persons Mental Health Service. The development of this program statement has been based on the experience of both the Frankston and Dandenong (Osborne 2000). Aged Persons Mental Health Services in conducting acute treatment in the patient's home.

2. BACKGROUND INFORMATION

2.1 LEGISLATIVE AND POLICY CONTEXT

The Mental Health Act provides that persons who are mentally ill should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.

The policy framework for Aged Persons Mental Health Services in Victoria, that shapes the way services are delivered, places an emphasis on community treatment and collocation and operational integration with aged care services, whilst maintaining a specialist mental health emphasis.

In September 2002 the Government announced its policy 'New Directions for Victoria's Mental Health Services'. A key direction 'Expanding Service Capacity' indicates additional services for older people will be established to meet the needs of a growing aged population. 'New Directions' also provides for the possibility of 'Creating New Service Options'.

2.2 NEED FOR SERVICE

Demand for mental health treatment for older people will continue to grow in the context of a growing aged population. While prevalence studies vary enormously in their estimates of particular conditions amongst older populations it is accepted that there is a strong association between co morbid physical illness, functional disability and depression in older age. It has been estimated that 10% of people with dementia experience severe to extreme behavioural and psychological symptoms associated with dementia requiring intervention from mental health services (Brodarty et al 2003).

Older people's access to services to treat mental disorders can be limited. Draper's et al (2001) analysis of Medicare data indicated older people have less access to private psychiatry and are therefore more likely to have to rely on the public mental health system to meet their mental health treatment needs, compared to younger people. At the same time Australian Institute of Health and Welfare figures demonstrate General Practitioner home visits to the 75 plus population were declining.

In 2004-2005 there were 213 acute APMH beds in Victoria to meet the needs for inpatient mental health care of the older population. The distribution of acute inpatient beds is not evenly spread across the state with some area APMHS with less access to beds than other area APMHS. In addition equivalent of 5 beds have been provided as an acute bed substitution program by Dandenong APMH community team for sometime. In 2003-2004 two areas commenced providing intensive community treatment services under a pilot program, as a substitute for 10 APMH acute beds. A third site commenced in 2004-2005.

2.3 CONSUMER PREFERENCE

Both Frankston and Dandenong Aged Persons Mental Health Services have had experience in providing acute treatment in the community as a substitute for inpatient based acute care. Both services recorded high degrees of patient and carer satisfaction.

3. PROGRAM STATEMENT

3.1 PURPOSE

To provide an intensive community treatment program in area Aged Persons Mental Health Services, as a substitute for acute beds.

3.2 AIMS

- To provide older people with an alternative treatment setting to hospitalisation during an acute phase of their mental illness.
- To 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 patient and family or other carer.
- To minimise the length of stay in an inpatient unit through the provision of intensive community treatment during an acute episode of illness.

3.3 TARGET GROUP

- 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

- Intensive community treatment is provided during an acute episode of mental illness as an alternative to hospitalisation, as a less restrictive option.
- An acute episode of treatment can include a pre and post hospitalisation course of intensive community treatment in addition to a hospital stay.
- Where a patient 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.
- The expectation of intensive community treatment achieving clinical outcomes comparable to that of an inpatient admission must exist at the time of initial assessment.
- It must be possible for intensive treatment in the home to be provided in a manner that assures the patient's, family's, carer's and others' safety.
- Both the patient and their family or carer must express a preference for treatment in the home as an alternative to hospitalisation.
- The family or other carer, who shares a residence with the patient, will have the right to say no even if the patient expresses a preference for treatment in their home.
- 'Home' is defined as the patient's usual home, the house of other family or friends or residential care.
- There will be a 24 hour response to patients and families or carers on the program.
- Patients remain in the program for the period they require acute treatment. This will be determined on the basis of clinical need by the consultant psychiatrist, in collaboration

- with patient, carers, General Practitioner and in consultation with the APMH community case manager.
- The cooperation of the patient's General Practitioner is required for intensive community treatment to be offered.

3.5 PROGRAM DESCRIPTION.

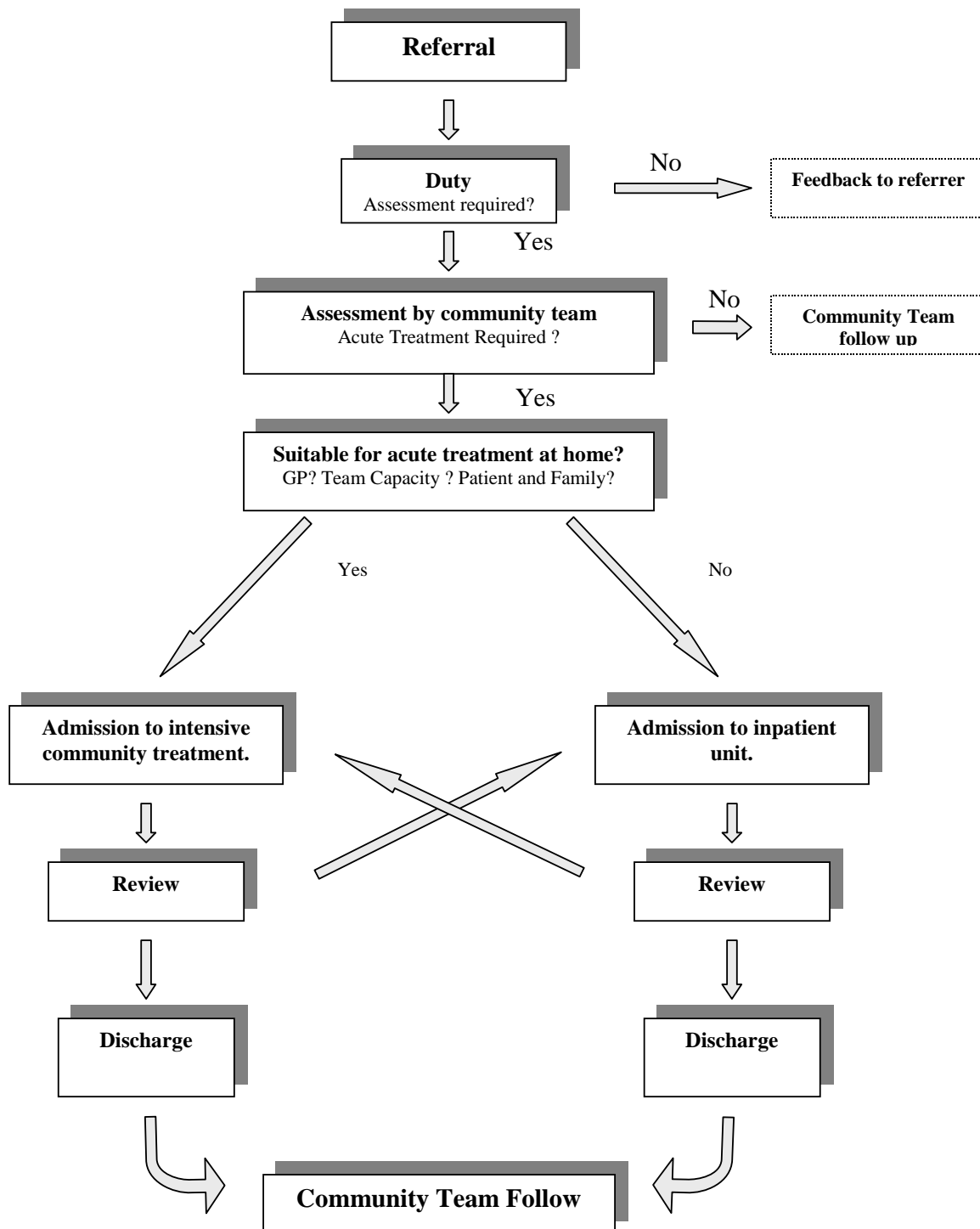
Program funding is provided for intensive community treatment of older people with a mental illness. It is provided at a level to enable the establishment of a discrete clinical sub team, to focus on acute treatment, within the structure of an Aged Persons Mental Health community team.

The intensive community treatment team will be multidisciplinary and function on an outreach basis, delivering acute care to the patient in their home context, be that a private home or a residential setting. The program includes a 24 hour response capacity. Each patient will be allocated a community treatment nurse who will be the primary contact for the patient, family, other carer, General Practitioner and APMH community case manager during the acute course of treatment.

Intensive community treatment 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 Service function after hours.

The funding for intensive community treatment is provided as a substitute for recurrent funding of APMH beds in a catchment area.

The following diagram summarises the patient flow and decision points in the intensive community treatment program.



3.5.1 REFERRAL

Referrals will come from the APMH community case manager. The patient will have already been referred to and seen by the APMH community team. The team will have completed a biopsychosocial assessment. The patient will have been assessed as in need of acute treatment for their mental illness. This process will have included discussion with the team's consultant psychiatrist regarding formulation, provisional diagnosis and treatment plan and goals of an admission to acute care.

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

3.5.2 ASSESSMENT FOR INTENSIVE COMMUNITY TREATMENT

The APMH community team's assessment of suitability for acute treatment at home will have considered:

Patient factors – psychiatric treatment needs, medical co morbidities, 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 where they share the same residence with the client.

Environmental Factors – suitability of the home environment in relation to likely treatment plan requirements – eg safety, hygiene, geographic location

General Practitioner involvement – general practitioner willingness to agree and availability to be involved in intensive home treatment.

Risk Assessment – level and seriousness of medical co morbidities, level of functional dependency, history of self harm or harm to others, presence of suicidal ideation.

Intensive Community Treatment Team Capacity – number and acuity of current patients on the program.

If patient, family or carer and environmental factors, General Practitioner agreement, level of risk and team capacity indicate that home treatment is a possible safe option this is to be discussed with the patient and carer. A detailed discussion about what home treatment will involve must occur. Information about patient and family or carer rights and obligations are to be given.

EXCLUSION CRITERIA

- Patient or carer refusal
- High risk psychiatric factors
- High risk medical co morbidities
- High risk physical disabilities
- Unsuitable environment
- General Practitioner disagreement

In some circumstances it may be possible to consider intensive community treatment as an option for a patient living alone. Lack of an on site carer should not be an absolute exclusion criteria, but the risks involved need to be carefully considered.

While active involvement of a GP is highly desirable it should not be considered mandatory. If a GP is unavailable to enter a shared care arrangement for the period of intensive community treatment, but is agreeable to intensive community treatment being delivered, a patient can be included. In this instance the Health Service would need to provide the pathology, imaging and pharmaceutical services required.

Every involuntary patient under the *Mental Health Act 1986* (including people on community treatment orders) must have a treatment plan prepared in accordance with section 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 patient.

3.5.3 ADMISSION TO INTENSIVE COMMUNITY TREATMENT

The decision to admit the patient to intensive community treatment or the acute inpatient unit will be made by the consultant psychiatrist and intensive community team manager, having regard to the assessment of suitability and team capacity to deliver effective treatment to the patient, given the patient's treatment plan requirements and the acuity of other patients on the program at the time.

The decision to admit to the intensive community treatment program will be communicated to the patient, family or carer and General Practitioner by the community case manager. The case manager will introduce the intensive community team member who will become the intensive community treatment team's primary contact nurse.

A nursing assessment will be immediately undertaken and a patient care plan documented. The nurse will give the patient and carer information including a 24 hour telephone contact number.

The registrar or consultant will see the patient as soon as possible, but within 24 hours, to admit the patient to the program, and will conduct comprehensive psychiatric and physical examinations and investigations. Admission processes must comply with the Mental Health Act. Any patient who requires treatment as an involuntary patient must be placed on a Community Treatment Order.

After the mental state and physical examinations and consideration of relevant investigations the registrar will draw up and document the treatment plan. A treatment plan for an involuntary patient should be authorised and signed by the authorised psychiatrist.

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

3.5.4 GENERAL PRACTITIONER'S ROLE

APMHS operate from a specialist consultation model, with the General Practitioner remaining the prescribing doctor. This model will be maintained in intensive community treatment wherever practical. The consultant psychiatrist retains overall responsibility for the patient's psychiatric treatment but makes recommendations to the General Practitioner for optimal psychiatric management. Where involuntary treatment is provided, subject to a CTO, the patient's treatment plan will specify the psychiatrist as the monitoring psychiatrist and the General Practitioner will be specified as the supervising medical practitioner.

The General Practitioner is a key provider in any intensive community treatment as the doctor with the most comprehensive history of the patient's physical condition. Engagement of the General Practitioner enhances continuity of care during and after the acute phase of illness and after discharge from involvement with the APMHS.

If a formal shared care protocol does not exist between the patient's General Practitioner and the APMHS one needs to be implemented if the General Practitioner is willing to be actively involved in intensive community treatment. 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 General Practitioners and is available at www.health.vic.gov.au/mentalhealth.

3.5.5 PATHOLOGY

The registrar will request the GP to organise any necessary referral to the local domiciliary pathology service. If this is not practical the services at the Health Service will be used.

3.5.6 IMAGING

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

3.5.7 MEDICATION

Any necessary prescription pharmaceuticals will be prescribed by the General Practitioner and obtained from the local pharmacy. If the patient's General Practitioner is not involved the

required prescriptions as well as any pharmaceuticals requiring specialist prescription will be obtained from the Health Service Pharmacy.

Drugs storage will be compliant with the Drugs and Poisons Act. Administration of drugs by staff must comply with the Nurses Act.

3.5.8 INFECTION CONTROL

The Health Services infection control policy and procedures will be observed.

3.5.9 THERAPIES

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

3.5.10 ECT

Where ECT is required by a patient on intensive community treatment the patient may be treated on a day patient basis where clinically appropriate and due consideration is given to clinical risk and patient comfort.

3.5.11 REVIEW

The patient's condition, including existing and newly emerging risks will be reviewed, as often as required, but at a minimum daily by the intensive community treatment nurse. Interviews will be conducted with the patient and the 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. When escalating patient needs require more nursing time than can be provided by the team, flexible funding can be used to pay for additional nursing required to manage the patient's care. Admission to the ward may need to be considered.

The registrar will review the patient at a minimum twice a week and more frequently as needed. The consultant will review the patient once a week at a minimum and more frequently if needed. General Practitioners should be encouraged to review the patient's physical state on request from the intensive community treatment team as required.

Patients' progress will be reviewed weekly, at a clinical meeting by the team. The community case manager will attend. Where possible the General Practitioner 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 General Practitioner for time involved.

3.5.12 SAFETY

Daily review, or more frequently as indicated, of the patient's condition by nursing staff with regard to the risks involved to the patient, family or carer and the staff of continuing to deliver acute care at home is necessary.

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

3.5.13 CONSUMER & CARER COLLABORATION

Care at home must be based on close collaboration with the patient and family or other carer. The team needs to be constantly assessing and reviewing both patient and carer needs in relation to one another throughout the duration of treatment. At all times in the period of admission to intensive community treatment the patient and family or carer can indicate they do not wish to continue with home treatment. An admission to the inpatient unit will be arranged to continue with acute treatment.

3.5.14 DISCHARGE

Discharge planning will have commenced pre admission in the formulation of the goals of the admission. The community case manager's involvement in the weekly clinical review of the patient will ensure continuity in care planning for the post acute phase.

The primary contact nurse will discuss all discharge plans with the patient and family or carer.

The consultant psychiatrist will determine when a patient's condition no longer requires acute care and the patient will be discharged for the planned follow up by the community case manager and General Practitioner. The intensive community treatment team will provide a written discharge summary to the community case manager and General Practitioner.

3.5.15 DOCUMENTATION

All team members and General Practitioner attending will record assessments, observations and interventions in the medical record.

Where the patient lives in a residential aged care facility, services will need to be clear about how medical records will be kept and come to an agreement with the residential facility about this so the patient's care is not compromised. For example the patient's intensive community treatment assessments, treatment plan, nursing care plan, reviews, medication administration and progress notes should be recorded in the patient's residential facility file and medication chart. The service may wish to also maintain a duplicate intensive community treatment medical record.

3.5.17 RIGHTS

Patients receiving intensive community treatment have the same rights as all other patients and clients receiving care through public mental health services. Patient rights are protected by the Mental Health Act. Involuntary patients must be given a patient's rights booklet and the information explained.

- Issues that may particularly arise in the context of providing intensive community treatment to an older person for a mental illness include but are not limited to:
- Capacity to consent to psychiatric treatment
- Restraint, locked door
- Need for substitute decision maker
- Consent to medical treatment while on a CTO
- Need to transfer patient to hospital against their will
- Quality treatment and care commensurate with clinical need – Duty of Care
- Patient Confidentiality - Family or Carer involvement and their need to know as active participants in the treatment plan.
- Complaints mechanisms

Intensive community treatment teams will need to have clear policies, procedures protocols and information in place consistent with other components of the mental health service and the Mental Health Act to guide staff decision-making when these issues arise.

3.6 STAFFING

The team will be multidisciplinary. A suggested profile includes:

Team leader / Clinical Nurse Specialist Grade 4 -	1
Consultant psychiatrist	0.2
Registrar	0.3
Nursing Grade 3	4
Occupational Therapy	0.3
Social Worker	0.3
Psychology	0.3
Administrative worker	0.5

Plus the provision of additional nursing 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 7 days a week, 8.30 – 5pm.

After hours cover will be provided through the Crisis Assessment and Treatment Service (CATS) function of the Area Mental Health Service and on call arrangements of senior team staff. See section 3.9.1 regarding this service link.

3.8 EXPECTED OUTCOMES / KEY PERFORMANCE INDICATORS / TARGETS

3.8.1 EXPECTED OUTCOMES

- The clinical outcomes for patients receiving intensive community treatment will be equivalent to outcomes that could have been expected if the patient had been admitted to the inpatient unit.
- Ratings of patient and family or other carer's expressed experience of an episode of intensive community treatment is equivalent to or exceeds the ratings of expressed experience by patient and family or other carer after an episode of inpatient based care.
- General Practitioners expressed satisfaction with their patients' care in the intensive community treatment program is equivalent to or exceeds expressed satisfaction by General Practitioners whose patients experience an episode of inpatient based care.
- The cost of care for patients receiving intensive community treatment will be slightly less than or equivalent to inpatient based care.

3.8.2 KEY PERFORMANCE INDICATORS

- Number of patients treated
- Length of stay
- Admissions to inpatient from intensive community treatment
- Discharge from inpatient to intensive community treatment
- Readmissions to intensive community treatment
- Adverse events

3.8.3 TARGETS

Initially five patients can receive treatment from the team at any one time. Over time the team may find it is able to treat up to 7 patients at any one time.

Direct contact visits of up to three times daily at admission and in early phases of treatment can be expected. Frequency of visits will gradually decrease as patient shows response to treatment and the carer's need for support is met. Pilot teams can expect to deliver approximately 3000 - 4000 direct contact visits over the course of a year.

3.9 LINKS WITH OTHER SERVICES

3.9.1 CLINICAL MENTAL HEALTH SERVICES

APMH community team

The intensive community treatment 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 intensive community treatment team will come from the APMH community team. Responsibility for crisis response remains with the broader team as do linkages with other aged care services providers. Intensive community treatment team resources will not be applied to these functions.

Some medical and allied health staff may work in the broader team and within the intensive community treatment team.

APMH acute beds

A close link between the intensive community treatment team and the inpatient unit will be needed to establish a system of management of acute patients across the two settings. The team leader, the ward Nurse Unit Manager and medical staff will need to work closely together so all have constantly up dated information of the status of all acute patients, whether in the ward or at home. This will facilitate acute patient flow between the two settings as changing acuity of patients requires.

Some medical and allied health may work on the inpatient unit and in the community intensive treatment team. Opportunities for nurse rotation through the inpatient unit and the intensive community treatment team are to be encouraged.

Crisis Assessment and Treatment Services (CATS)

Close working relationships between the intensive community treatment team and the CATS function of the Area Mental Health Service will be required for the success of after hours arrangements.

Services will negotiate an agreed protocol with their area's CATS function. CATS operating in APMHS areas participating in the program receive additional resources to provide the necessary after hours cover for the intensive community treatment team. CATS will have access to after hours advice from a roster of senior intensive community treatment staff (team leader, registrar, consultant). Staff can be recalled as required by the CATS.

There will be a verbal and written handover at the beginning of the day and at the end of the day between the two teams.

3.9.2 GENERAL PRACTITIONERS

The success of the program will depend very much on General Practitioner engagement. In addition to close working relationships with individual General Practitioners on a case by case basis as described in section 3.5.4, services need to ensure Divisions of General Practice are informed of the service and fully understand the program. If formal Shared Care protocols do not exist between the relevant Divisions services should work towards developing these as part of the program's development.

3.9.3 RESIDENTIAL CARE

Residential care's engagement in the program is also important. If a patient lives permanently or on a temporary basis in a residential facility the senior nurse or manager must agree to the acute care being provided in the facility. The intensive community team nurse 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 facility's senior member of staff.

(Refer also to section 3.5.16 regarding the medical record.)

3.10 FUNDING

Funding is available as a substitute for 5 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 nursing, additional equipment, respite care and medication when required.

3.11 REPORTING

Reporting will be through RAPID. Reporting will be via the CMI (Client Management Interface).

Services need to set up -

Dedicated Community Subcentre with a

Linked Program which 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 measurement of the length of time involved and the intensity of contacts made.

More specific instructions on how to set up the required subcentre and program will be available to the CMI coordinators. Contact Phil Barelli at the Mental Health Branch on 9616 8799 for advice.

3.12 EVALUATION

Evaluation activities of the program will be undertaken. The aim will be to examine the effectiveness of community treatment for an older person during the acute phase of a mental illness in terms of clinical outcomes, consumer and carer experience, General Practitioner satisfaction and cost effectiveness in comparison to in-patient based acute care.

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APPENDIX B -STAFF SURVEY

ICT STAFF SURVEY

The Department of Human Services has commissioned Health Outcomes International, as independent consultants, to conduct the evaluation of the Intensive Community Treatment Program. As part of the evaluation, Health Outcomes International in conjunction with the local Intensive Community Treatment Program is conducting a survey of staff who work in the service and staff who have (or could have) referred to the service.

You are invited to participate in the Evaluation of the Intensive Community Treatment Program. Your views and perspectives on the service are important and will contribute to the improvement of mental health service provision in Victoria.

The evaluation project aims to inform the Health Service and the Department of Human Services whether the bed substitution model is an appropriate, effective and efficient treatment and support option for people with a mental illness.

Whilst completing the survey is voluntary you are encouraged to participate. By completing the survey you are telling us that you:

- Consent to take part in the evaluation project;
- Consent to the use of the information you provide. **Note that your information will be combined with others completing the survey and will in no way be identifiable to you.**

Should you have any queries please contact XX in the first instance

STAFF SURVEY

We would like to learn about your experience as a staff member who has referred to or worked in the ICT Program.

1. Where do you work?

Psychiatric inpatient unit Community team ICT unit

Other (specify)

2. Which staff category do you belong to?

Medical consultant Nursing Psychologist Allied Health

Medical Registrar Manager Other (specify)

The next set of questions relates to staff who refer (or can refer) to the ICT Program.

3. Have you referred clients to the ICT program?

Yes No

If not why not:

If you answered yes to the previous question

4. The following table provides asks you to the rate the ICT service. Please circle the relevant response that best represents your point of view about. You are able to circle "Don't know" if you are unsure.

		Poor	Unsatisfactory	Average	Good	Excellent	Don't know
A.	The accessibility of service was...	1	2	3	4	5	0
B.	The response times were...	1	2	3	4	5	0
C.	How beneficial was the intervention?	1	2	3	4	5	0

If any answer is Average, Unsatisfactory or Poor please explain.

5. Would you refer other clients to the ICT program?

Yes No

If not why not:

6. What aspects of the service have been most beneficial or had the greatest impact to the client. (Please circle, more than one if necessary)

Client being able to stay home frequency of visits from staff Respite
Referrals to other services Communication Other (specify)

7. What has been the impact if the ICT Program on your Unit?

8. Did the intervention in the ICT have any unanticipated positive and negative outcomes for your client?

Yes No Don't know

If yes please explain

9. How do you think this service could be improved?

10. Does the service align with current policy directions of associated services?

Yes No Don't know

If no please explain

If you currently work in the ICT Program or you have worked previously in the ICT Program please answer the following questions from that perspective. If you have not worked in that service you should stop here

11. The following table provides asks you the rate the ICT service. Please circle the relevant response that best represents your point of view about. You are able to circle "Don't know" if you are unsure.

		Poor	Unsatisfactory	Average	Good	Excellent	Don't know
1.	The accessibility of service is...	1	2	3	4	5	0
	The response times are...	1	2	3	4	5	0
	How beneficial was the intervention?	1	2	3	4	5	0

If any answer is Average, Unsatisfactory or Poor please explain.

12. What aspects of the service have been most beneficial or had the greatest impact to the client. (Please circle, more than one if necessary)

- Client being able to stay home frequency of visits from staff Respite
 Referrals to other services Communication Other (specify)

13. What has been the impact on other referring services?

14. Did the intervention in the ICT have any unanticipated positive and negative outcomes?

Yes No Don't know

If yes please explain

15. How do you think this service could be improved?

16. Does the service align with current policy directions of associated services?

Yes No Don't know

If no please explain

Name and contact details (phone/email) **(optional)** _____

If we want to contact you for clarification.



APPENDIX C: GENERAL PRACTITIONER SURVEY

This appendix presents an example of the GP survey. A covering letter was attached to the survey explaining its purpose.

CONTACT DETAILS (OPTIONAL)

Name	
Contact Details	

SURVEY

Q1: Approximately how many of your patients have been in the HoSS service in the last three years?

- Less than 5
- Between 5 and 10
- Greater than 10

Q2: How did you become aware of the service?

- Through Division Word of mouth
- From the Health Service Other (specify)

Q3: The following table asks you to rate the HoSS service. Please circle the relevant response that best represents your point of view. You are able to circle "Don't know" if you are unsure.

		Totally inadequate	Inadequate	Neither adequate nor inadequate	Adequate	Completely met needs	Don't know
A.	The accessibility of service was...	1	2	3	4	5	0
B.	The response times were...	1	2	3	4	5	0
C.	The level of after hours support was...	1	2	3	4	5	0
D.	For my patient the benefit of the intervention was...	1	2	3	4	5	0
E.	The level of communication with the ICT psychiatrist was...	1	2	3	4	5	0
F.	The level of communication with other ICT clinicians was...	1	2	3	4	5	0

If any answer is totally inadequate or inadequate please explain. Provide other comment as required.

Q5: Do you feel that admission to an acute unit would have been more appropriate for any of your patients?

Yes No Don't know

If yes please comment:

Q6 Was the level and mix of service provided generally appropriate? If no please explain?

Yes No Don't know

If no please explain?

Q7: What do you see as being the major benefits from the service (tick more than one box if required?)

Allow earlier discharge from hospital

Prevent hospital admission

Respite care

Clients being able to stay at home

Other (please specify)

If other please specify

Q8: Are there any aspects of this service that could be improved?

Yes No Don't know

If yes, please comment.

Q9: Do you think this service should be continued?

Yes No Don't know

If no please comment.



APPENDIX D: CARER AND PROFESSIONAL CARER SURVEY

This appendix presents an example of the carer and professional carer survey. A covering letter was attached to the survey explaining its purpose and carers were individually contacted to explain the purpose of the survey

CARER SURVEY

Thank you for agreeing to participate in this survey.

1. Approximately when did the person you care for receive treatment on the ICT Program and for how long?

Date (month/year): _____ Length of time: _____

The next set of questions relate to the ICT Program

2. Who was the key health professional that discussed with you the transfer to the ICT Program?

Acute inpatient ward clinician ICT program clinician Community
Team clinician GP Don't know

3. Overall how would you rate the information and explanations that were provided to you about the ICT program and the extent to which you were included in the decision to transfer the person you care for to the program.

Excellent Good Average Unsatisfactory
Poor

If unsatisfactory or poor please explain.

4. In your view was the person you care for someone who was appropriate for the ICT program?

Yes No Don't know

If no please explain.

5. Please tell us what aspects of the service has been beneficial to you. (Please circle, more than one if necessary)

Client being able to stay home Frequency of visits from staff

Respite Referrals to other services Communication

Other (specify) _____

6. Overall how would you rate the service received?

Excellent Good Average Unsatisfactory

Poor

If unsatisfactory or poor please explain

7. In your opinion has the availability of this service resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit than otherwise would have been the case.

Yes No Don't know

8. How do you think this service could be improved?

The next set of questions relate to a previous (the most recent) acute psychiatric inpatient experience that has been had by the person you are a carer for (if applicable).

9. Approximately when was the admission to the inpatient unit?

Month _____ Year _____

10. Overall how would you rate the service received?

Excellent Good Average Unsatisfactory
Poor Don't know

If unsatisfactory or poor please explain

11. When comparing the two types of services which one would you prefer the person you care for to be treated in and why?

ICT Inpatient Don't know

Name and contact details (optional) _____

If we want to contact you for clarification.

Thank you for taking the time to complete this survey

PROFESSIONAL CARER SURVEY

Thank you for agreeing to participate in this survey.

1. Approximately when did that person receive treatment on the ICT Program and for how long?

Date (month/year): _____

Length of time: _____

The next set of questions relate to the ICT Program

2. In your view was the person you care for someone who was appropriate for the ICT program?

Yes No Don't know

3. Please tell us what aspect of the service you believe has been beneficial to the person you care for. (Please mark than one box if necessary)

Client being able to stay home Frequency of visits from staff

Respite Referrals to other services Communication

Other (specify) _____

4. Overall how would you rate the service received?

Excellent Good Average Unsatisfactory

Poor

If average, unsatisfactory or poor please explain

5. In your opinion has the availability of this service resulted in fewer admissions to an acute psychiatric facility or a reduced length of stay in such a unit than otherwise would have been the case.

Yes No Don't know

6. How do you think this service could be improved?

The next set of questions relate to a previous (the most recent) acute psychiatric inpatient experience that has been had by the person you are a carer for (if applicable).

7. Approximately when was the admission to the inpatient unit?

Month _____ Year _____

8. Overall how would you rate the service received?

Excellent Good Average Unsatisfactory
Poor Don't know

If unsatisfactory or poor please explain

9. When comparing the two types of services which one would you prefer the person you care for to be treated in and why?

ICT Inpatient Don't know

Name and contact details (optional) _____

If we want to contact you for clarification.

Thank you for taking the time to complete this survey