Aged persons mental health intensive community treatment

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 (APMH) acute inpatient unit and will substitute for acute beds in an APMH 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 patients' homes.

2. Background information

2.1 Legislative and policy context

The *Mental Health Act 1986* provides that people who are mentally ill should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be provided effectively.

The policy framework for APMH 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, while maintaining a specialist mental health emphasis.

In September 2002 the Victorian 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 among older populations it is accepted that there is a strong association between comorbid physical illness, functional disability and depression in older age. It has been estimated that 10 per cent 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 et al's (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 with younger people. At the same time Australian Institute of Health and Welfare figures demonstrate general practitioner (GP) home visits to the 75-plus population were declining.

State Government Victoria

In 2004–05 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 APMH services with less access to beds than others. In addition, the equivalent of five beds have been provided as an acute bed substitution program by Dandenong APMH community team for some time. In 2003–04 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 2004–05.

2.3 Consumer preference

Both Frankston and Dandenong APMH 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 APMH 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 providing 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 (CTO).
- 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 the patient, carers, GP and in consultation with the APMH community case manager.
- The cooperation of the patient's GP 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 a discrete clinical sub team to be established to focus on acute treatment within the structure of an APMH community team.

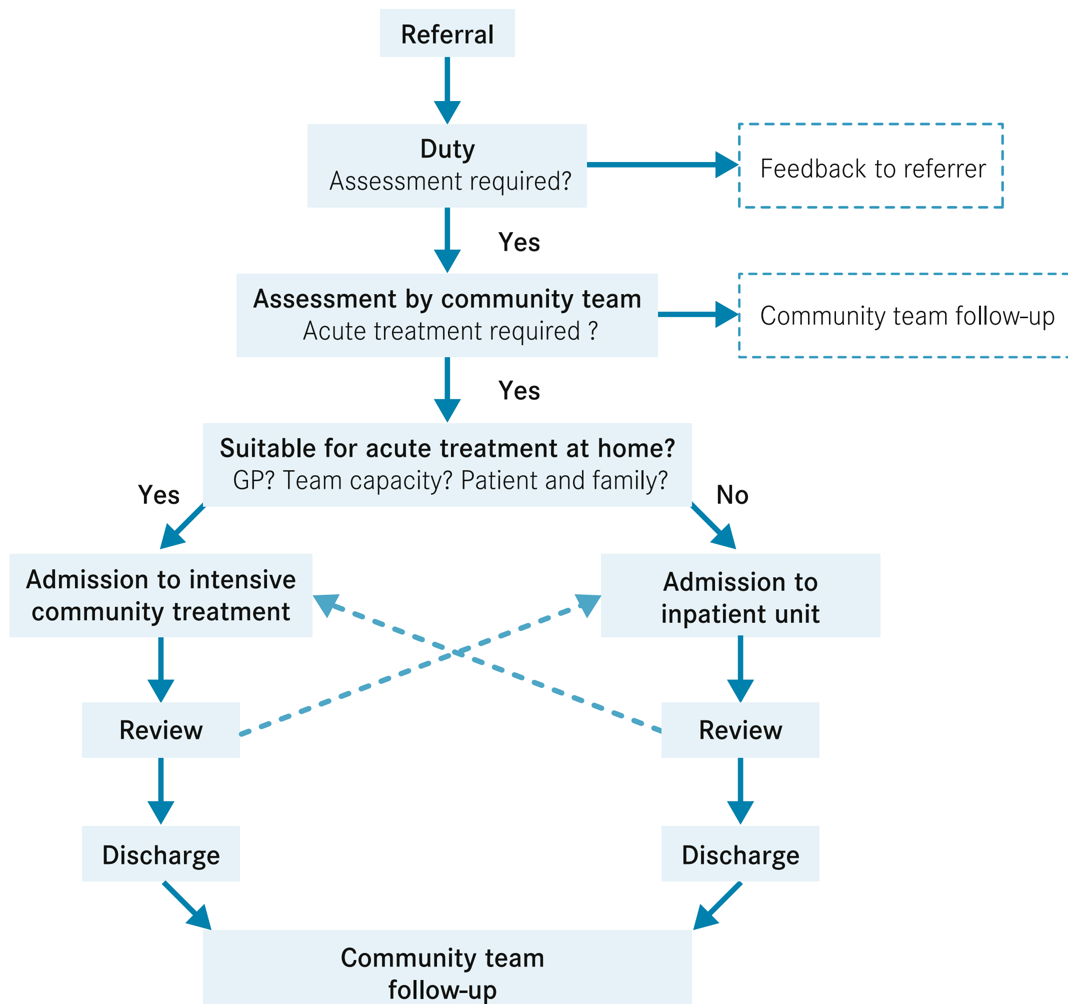
The intensive community treatment team will be multidisciplinary and function on an outreach basis, delivering acute care to the patient in their home context, be that a private home or a residential setting. The program includes a 24-hour response capacity. Each patient will be allocated a community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

Patient flow and decision points



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

If patient, family or carer and environmental factors, GP 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 comorbidities
- High-risk physical disabilities
- Unsuitable environment
- GP 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 (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 GP 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 CTO.

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

APMH services operate from a specialist consultation model, with the GP 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 GP 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 GP will be specified as the supervising medical practitioner.

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

If a formal shared care protocol does not exist between the patient's GP and the APMH service one needs to be implemented if the GP 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 GPs 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 the GP to refer to the local medical imaging service for relevant testing. If attendance is not practical the health service facilities will be used.

3.5.7 Medication

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

Drugs storage 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 Electroconvulsive therapy (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. GPs should be encouraged to review the patient's physical state on request from the intensive community treatment team as required.

A patient's progress will be reviewed weekly at a clinical team meeting. The community case manager will attend. Where possible the GP should be encouraged to participate, if not in person, through telephone conferencing. The Enhanced Primary Care MBS item for case conferencing can be claimed by the GP for time involved.

3.5.12 Safety

Daily review (or more frequently as indicated) of the patient's condition by nursing staff is necessary to identify any risks involved in continuing to deliver acute care at home. These risks may be to the patient, family or carer.

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 and 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 through formulating admission goals. 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 GP. The intensive community treatment team will provide a written discharge summary to the community case manager and GP.

3.5.15 Documentation

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

If 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 also wish to maintain a duplicate intensive community treatment medical record.

3.5.16 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 a substitute decision maker
- consent to medical treatment while on a CTO
- need to transfer the 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

This should also include providing 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 seven days a week from 8.30 to 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 and 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 carers' 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.
- GPs expressed satisfaction with their patients' care in the intensive community treatment program is equivalent to or exceeds expressed satisfaction by GPs 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. The overtime team may find it is able to treat up to seven patients at any one time.

Direct contact visits of up to three times daily at admission and in the early phases of treatment can be expected. Frequency of visits will gradually decrease as the patient responds 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 updated 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

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 APMH service 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 GP engagement. In addition to close working relationships with individual GPs 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 temporarily 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 five acute inpatient beds. Funding is inclusive of all salary costs, on costs and backfill. There should be some capacity in the budget to provide a pool of flexible funding to provide for additional 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 a dedicated community subcentre with a linked program that includes the program code 'Intensive Community Treatment'.

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

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

More specific instructions on how to set up the required subcentre and program will be available to the CMI coordinators. 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, GP satisfaction and cost effectiveness in comparison to inpatient-based acute care.

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