

The Intensive



**Community Treatment
Team**

Northland Mental Health Services

Statement:

The Northland Intensive Community Treatment Team was established to provide assertive, intensive and ongoing clinical support to clients who require these services to live with their whanau and, in their communities.

Target Population

- People with poorly treated major mental disorders, often treatment resistant.
A diagnosis of Schizophrenia.
Recurrent or prolonged hospitalization events.
Often co-existing substance abuse.
Often housing instability.
Issues of risk.
History of criminal justice involvement.
- Evaluation of research undertaken has proven that an Intensive Community team is effective at reducing the number and duration of hospitalizations, improving quality of life and housing stability.
- There is variable evidence in relation to the impact on arrests and substance abuse. It is not indicated for all mental health clients, as it is not a cost effective option for people who do not meet the criteria.

The Intensive Community Team:

- The ICT Team consists of a Psychiatrist, 3 Registered Nurses and 5 Community Support Workers . The Psychiatrist provides clinical care for ALL ICT clients.
- Who will working in pairs organise their skill range via a daily client review to deliver care and programs to meet the client need thus enhancing their ability to live meaningful lives in the community.
- The ICT service provision will be over daylight hours seven days per week with support extending for the early evening as required.
- An evening medication run is arranged to support clients in compliance with medication regimes and maintaining their wellness at home.
- A further ICT Service was introduced in 2007 in the Mid and Far North areas of 4 Registered Nurses and 3 Community Support workers. Increased the client numbers to 96. This is a five day a week service with other support provided by the normal community team.

Criteria for Entry:

Reside within the Northland Health Board boundaries and be aged between 18 to 65 years.

Have an established Axis 1 diagnosis or;

Have a severe Axis 2 diagnosis with ongoing disability.

Be at risk to themselves or others (identified in a Risk Plan).

Be a high user of other services ie. Respite, multiple IPU admissions, is a high user of CMHN time.

Have treatment compliance issues.

May have received treatment in a Correction Facility and returning to the community.

Referral Source:

ICT referrals can be made from CMH Services

Regional Forensic Services.

Justice Liaison Services of the Northern Correctional Facility Ngawha.



Operating Procedures

The Referral Process for the CMMH Service:

To enable the ICT Team to assess referrals appropriately;

- All referrals shall be in writing to the ICT Team Psychiatrist.
- Included in the referral will be the following supporting information
 - Current community risk assessment
 - Current community management plan
 - Current community coordinated care plan
 - Current medication treatment
 - A copy of the letter to the client.

To enable the ICT Team to organise a response and prioritise referrals;

- The Treatment Files will be requested from the CMMH Service.
- The Referrals will be considered at the ICT weekly Referral Meeting.
- Within 7 days of the ICT Referral Meeting The Protocol will be,
- Notification of receipt of the referral will be sent either declining the referral with reasons or, organizing an assessment time with the CMMH Service and the client at the CMMH.
- Two members of the ICT Team will attend the initial assessment meeting.
- Within a week and after the ICT Team Referral Meeting a further assessment will occur preferably at the client's residence with the family.
- After this meeting official notification in writing will be given of acceptance of the client on to the ICT Team caseload.

- It is envisaged that the assessment process will be over a two meeting process and may take 5 weeks.

The Referral Process from the Northern Region Correction Service

The Justice Dept. has established a Regional Correctional Facility at Ngawha, which will house known and new clients whilst they are under the Criminal Justice Act. Follow up protocol are;

- A written referral will be made to The ICT Team a minimum of 6 weeks prior to release.
- Justice Dept. information included should be
 - Discharge Address and contact numbers
 - Next of Kin or Significant Others.
 - Sentence Conditions of Release.
 - Probation Service Contact
 - Forensic History
- Treatment information should include
 - Current risk assessment
 - Current management plan
 - Current medication treatment
 - Past Psychiatric history and treatment

The ICT Team will be the point of access to Mental Health Services and will Triage the client to the appropriate service in the area. Written notification will complete the process.

Crisis Team Liaison Protocol

This is an after hours procedure

- A client alert profile will be given to the Crisis Team for any emergency response after hours including a Risk Assessment and Current Plan.
- The Crisis Team will notify ICT of any ICT client contact.
- ICT will notify the Crisis Team of the client caseload. ICT will provide any DAO or emergency service during normal working hours.

Inpatient Unit Protocol

The Inpatient Unit is situated on Ward 6 and Ward 7 on the Whangarei Hospital site. Clients are admitted with severe Mental Health issues. These services will be used for short stay periods to monitor new medication regimes and address psychosis management needs.

Upon admission of an ICT Team client:

- Clinical responsibility will remain with the ICT Team.
- Admissions will occur by liaison with IPU Staff.
- The ICT Team will have daily contact with The IPU.
- Daily management will be the responsibility of the IPU Staff.
- Care Planning / Leave / Respite / Discharge will be the responsibility of the ICT Team.
- ICT Psychiatrist will provide cover for ICT clients in The Unit

The following documentation will be provided by the ICT Team:

- Completed Admission Forms
- Completed Initial Assessments
- Completed Risk Assessment
- Care Protocol Plan
- Medication Chart
- Physical Status Assessment by Inpatient Unit Doctor.

The ICT Team will organize transport to The Unit during working hours.

Respite Service Protocol

A list of Respite Providers will be established. When Respite Care is required:

- The ICT Team Clinician will organise the documentation
- The Respite Provider is contacted seeking access
- When respite is available transport client to Respite Care
- Will notify the Crisis Team of respite use.

The following documentation will be provided:

- Signed Respite Care Request Form
- Care Plan
- Risk Assessment
- Medication Chart and Medication
- Critical contacts

The ICT Team will maintain daily contact until Respite is completed.

Outcome Data

- Whangarei ICT data only
- Matched each client with themselves
- Looked at the two years prior to entry into ICT
- Compared with two years after entry into ICT

Client Base from January 2006

- 37 clients who had been in ICT two years or more
- Another 14 clients with 12 month data

2 year matched outcomes, Whangarei ICT (n=37)

	2-1 year prior to ICT	1-0 years prior to ICT	First year in ICT	Second year in ICT
Inpatient bed days	2248	3566	1036	524
Average bed days	61	96	28	14
Statistical significance				

2 year matched outcomes, Whangarei ICT (n=37)

	2-1 year prior to ICT	1-0 years prior to ICT	1-0 years prior to ICT	Second year in ICT
Inpatient admissions	38	66	66	17
Average admissions	1.0	1.8	1.8	0.5
Statistical significance				

2 year matched outcomes, Whangarei ICT (n=37)

	2-1 year prior to ICT	1-0 years prior to ICT	First year in ICT	Second year in ICT
Inpatient bed days Minus 3 Elias House clients	1830	3102	809	524
Admissions Minus 3 Elias House Clients	35	57	25	12
Statistical sig.				

12 month matched outcomes, Whangarei ICT (n=14)

	2-1 year prior to ICT	1-0 years prior to ICT	First year in ICT	Second year in ICT
Inpatient bed days	568	1750	627	325
Admissions	12	21	23	12
Statistical significance				



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