Policy Directive

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Discharge Planning for Adult Mental Health Inpatient Services

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Summary The Discharge Planning for Adult Mental Health Inpatient Services presents a structured and standardised process for ensuring safe and successful transition of people with a mental illness from time of admission to hospital to post-discharge. It supports consumer safety, reduced adverse events and aims for improved consumer, family and carer outcomes. It recognises that mental illness may impair many aspects of a consumer's life, often for extended periods of time. Effective discharge planning recognises the importance of engaging other agencies, service providers, carers and the consumer.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Community Health Centres, Public Hospitals

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This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

Discharge Planning Policy:

Adult Mental Health Inpatient Services

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- Mental Health and Drug and Alcohol Office Discharge Planning Steering Committee

- Mental Health Senior Officers Group including the:
  – Department of Community Services
  – Department of Education & Training
  – Department of Corrective Services
  – Department of Ageing Disability & Homecare
  – Department of Housing
  – New South Wales Police

- Consumer and Family / Carer Groups

- Relevant Non Government Organisations

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Glossary

Term	Definition
Discharge Care Coordinator	Nominated clinician responsible for ensuring access to and coordination of the range of services necessary to meet the identified needs of a consumer with a within and outside the hospital. Professionals responsible for the care management of consumers are interchangeably called case managers, case coordinators and sometimes caseworkers.
Care Plan (CP)	A component of the MH-OAT Mental Health Clinical Modules. All consumers must have an individual Care Plan (CP). This module is used to document the individual consumer's identified needs along with their strengths. Interventions are developed collaboratively and goals identified to meet the consumer's needs. The Care Plan (CP) also identifies the person who is responsible to assist in this process. Care planning should be commenced shortly after assessment and admission.
Discharge Care Plan	A comprehensive plan for the ongoing care and needs of a consumer after their discharge from hospital. The discharge plan is seen as part of a continuum of care and may include a number of different care providers. The development of the plan includes the consumer and their family or primary carer throughout the process and involves multidisciplinary health teams, the consumer's general practitioner (GP), community mental health, relevant government agencies and community service providers. The completed plan should be provided to the consumer and family, and relevant community agencies (with the consumer's consent). The plan must be placed in the consumer's medical record.
Discharge Planning	The various activities that need to be put in place before the consumer is discharged. Discharge planning occurs in collaboration with the consumer, the family/primary carer and other stakeholders to ensure effective transition between inpatient settings and from inpatient services to the community and reduce the risk of relapse.
Discharge Summary (D1)	A component of the MH-OAT Mental Health Clinical Modules which is to be completed on or before the day of discharge. The tool records key information necessary for effective communication between inpatient and community services. It summarises assessment and the consumer's response to interventions, including progress in achieving the goals set out in the Discharge Plan for the purpose of informing the clinicians who will take the person's care over in the community. A copy of the current Care Plan (CP) should be attached whenever possible. Copies of the D1 must be available to key services such as the Community Mental Health team and the consumer's GP. In inpatient services, the module is to be completed and signed by the medical officer.
Mental Health-Outcome and Assessment Tools (MH-OAT)	The standardised MH-OAT clinical modules have been developed to support comprehensive clinical assessments and accurate documentation for all mental health consumers of NSW Area Mental Health Services. The standardised clinical modules provide for the documentation of clinical practice at different points in the cycle of care (assessment, care planning, review and discharge), along with standardised measures of outcomes and case complexity. *Note MH-OAT clinical modules are undergoing modification and titles of the current MH-OAT clinical modules may change. Clinicians need to ensure that they are using the most up to date modules.*

Primary Carer	The NSW Mental Health Act 2007 defines the 'primary carer' of a person (the 'patient') as a) The guardian of the patient, or b) The parent of a patient who is a child, or c) If the patient is over the age of 14 years and is not a person under guardianship, the person nominated as the primary carer, or d) The spouse of the patient, if the relationship is close and continuing, or e) Any person who is primarily responsible for providing support or care to the patient (other than on a substantially commercial basis, or f) A close friend or relative of the patient. For the purposes of the Act, a person must nominate a person to be the primary carer in writing.

Executive Summary

Effective discharge planning is essential to the safe and successful transition of mental health consumers from hospital to the community. For mental health inpatient services, discharge planning is part of the continuum of care that starts with the person's admission to hospital.

By linking inpatient units with primary health care providers, carers, and community services, effective discharge planning performs a key function of all successful mental health services in maintaining continuity of care.

It has major benefits for consumers and their carers. It also assists busy mental health professionals to provide safe and effective care in a quality mental health system.

Strategic Aim

This Policy sets the direction for successful statewide mental health services discharge planning. Implementation supports each consumer's safe and successful transition from inpatient environments into the community. It maps a *structured discharge planning process* that will:

- ✓ Improve consumer, family and carer and community safety;
- ✓ Improve communication between all stakeholders;
- ✓ Improve continuity of care for consumers; and
- ✓ Facilitate better access to community mental health care, primary health care and community support services.

Discharge Planning Principles

- Admission and discharge are part of a continuum;
- Consumers, family/primary carer are partners in care;
- Discharge criteria is based on comprehensive assessment of the consumer's medical and psycho/social needs;
- Effective discharge practice incorporates monitoring and evaluation components;
- Clear and timely communication between the consumer, primary carer and all clinicians and other health professionals is essential;
- A comprehensive discharge care plan should be developed before discharge;
- Provision of consumer and primary carer information and education is essential prior to discharge;
- Standardised and monitored discharge processes support continuous system-wide improvement.

Essential steps for effective discharge practice

1. Identify a key clinician/care coordinator responsible for ensuring each step of the discharge process is completed;

2. Estimate the date of discharge, the consumer's likely needs, and any risks at that time;
3. Develop a discharge care plan with the consumer, primary carer, external clinicians and support agencies;
4. Conduct regular reviews and keep all participants informed of progress;
5. Document follow-up and support arrangements in the MH-OAT D1 Discharge Summary and in the consumer's written information, the 'discharge care plan';
6. Monitor and evaluate the discharge process: formal discharge and post-discharge follow-up.

Critical success factors

The following factors are fundamental to successful discharge planning:

- Engage key staff, consumers, primary carers, clinicians and support agencies in discharge planning;
- Involve the multidisciplinary mental health team to develop and implement discharge planning;
- Ensure consistent senior level and stakeholder support throughout discharge process;
- Ensure timelines are met and each step is implemented; and
- Identify and maintain focus on key performance indicators.

Local Implementation

All Area Health Services must develop and implement **Local Protocols** that follows this Policy Directive's principles and practices that address:

- Governance Mechanisms;
- Collaboration Mechanisms for frontline managers and senior clinicians;
- Discharge Process Map;
- Roles and Responsibilities of relevant personnel;
- Risk Identification and Management (identify points at which the Local Protocol could fail and remedial response);
- Performance Management (refer Key Performance Indicators, section 4.2);
- Staff Education and Training; and
- Referral Networks Map (community health care providers, other government departments and NGOs contacts).

Monitoring and evaluation are key components of responsive, effective discharge processes. The discharge planning process and its outcome for consumers should be routinely monitored and periodically evaluated in conjunction with other continuous improvement mechanisms addressing the delivery of mental health services.

1. Introduction

1.1 What is Discharge Planning?

Discharge planning is a structured and standardised process for ensuring the safe and successful transition of people with a mental illness between inpatient settings and from hospital to the community. It is part of the continuum of care that commences at the time of admission.

Mental illness can impair many aspects of a consumer's life, often for extended periods of time. Many consumers may have physical, intellectual and/or drug and alcohol co-morbidities requiring assertive follow-up. It is imperative that the wellbeing and safety of children in the consumer's care are reviewed prior to discharge, and factors impacting on that care, including changes in accommodation or level of support, and the effect of medications on cognitive functions are addressed. Successful discharge from adult mental health inpatient units, and discharges for adult mental health consumers from hospital generally, is critical because it minimises the risk of adverse events.

This policy details a *structured discharge planning process* to minimise those risks through systematically addressing each consumer's:

- Physical and mental health needs; and
- Psychosocial needs including accommodation, income assistance, food, care of dependent children, parenting needs, education, employment, family and social connectedness.

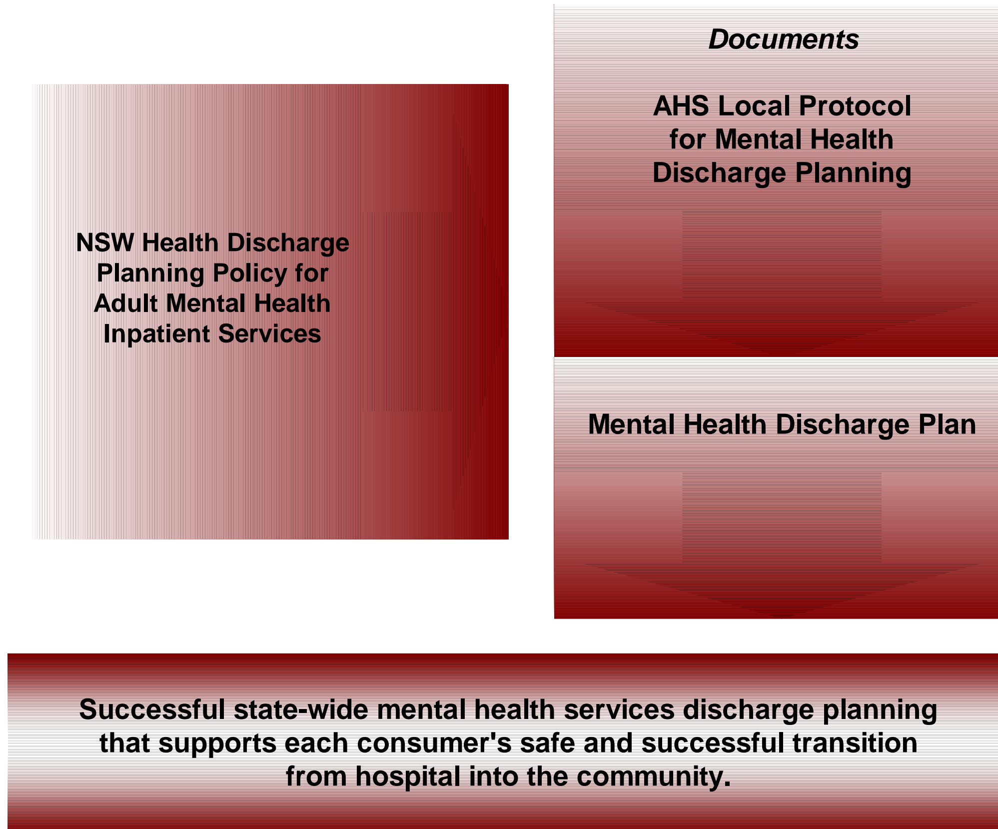
Effective discharge planning can only be delivered by mental health services that are responsive to consumer needs and inter-linked with other agencies, service providers, carers, and the consumer. Successful discharge planning requires inpatient units, community services, General Practitioners (GPs), families and/or the primary carer, and non-government organisations (NGOs) to work together. From the outset, an effective discharge is planned by *and* with the consumer's participation.

1.2 Strategic Aim

This Policy sets the direction for successful statewide mental health services discharge planning. Implementation supports each consumer's safe and successful transition from inpatient environments into the community. It maps a *structured discharge planning process* that will:

a) Improve consumer, family and carer and community safety;
b) Improve communication between all stakeholders;
c) Improve continuity of care for consumers; and
d) Facilitate better access to community mental health care, primary health care - GPs and other community support care services.

The policy sets the direction for developing, implementing and performance managing the discharge planning process as illustrated below:



2. Background

2.1 Context

For many consumers, the period after leaving a mental health inpatient unit is a particularly vulnerable time. In response, a number of policies have been developed to promote safe transition from hospital to the community. Key aspects of the following documents have informed the development of this Discharge Planning Policy:

- 1998: NSW Health released the *Policy guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospital facilities (PD2005_121).* The policy guidelines identified the importance of clear and consistent discharge planning to ensure safe transition between the hospital and community environments.

- 2004: NSW Health released the *Framework for Suicide Risk Assessment and Management for NSW Health staff* to support the 1998 policy and provide comprehensive guidelines for staff working in health staff or other healthcare settings.

- 2005: NSW Mental Health Sentinel Events Review Committee released its first report, *Tracking Tragedy: A systemic look at suicides and homicides amongst mental health inpatients.*

- 2006: Release of *A New Direction for NSW: The State Plan,* which provides a framework of priorities for the NSW Government over the coming 10 years.

- 2006: Release of *NSW: A New Direction for Mental Health*, outlining reforms to health services to balance hospital focussed care with community care and to build stronger links between the public, private and community services, between hospitals and GPs and between State and Federal Governments.

- 2007: The NSW Health Minister released *A New Direction for NSW: The State Health Plan*, which introduced strategies and targets to be achieved in the area of health in NSW over the next five to ten years.

- 2007: Mental Health Act 2007: An significant feature of the Act is that it recognises the important role family and friends can play in supporting a person in the community, with specific provisions requiring notification of primary carers of key events. The Act also requires that the mental health facility to takes all reasonably practicable steps to ensure there is consultation in discharge planning with primary carers and any agencies involved in providing services to the person, their primary carer or any dependent children or other dependants of the person.

This Policy also accords with the outcomes of the NSW Government's Response to the Legislative Council's Select Committee Inquiry into Mental Health Services in NSW. Additionally, it addresses recommendations arising from Coronial findings regarding the discharge of consumers from adult mental health inpatient services.

2.2 Rationale

Currently, discharge practices and protocols vary considerably across NSW mental health services. This is evidenced by background reports and reviews, as well as anecdotes from health care professionals, consumers, family and/or carers, and the general community. While there is evidence of areas of good practice, gaps remain in the discharge planning process and practice.

Examples include:

- Little or no communication and/or involvement by the mental health services with the consumer's family and/or carer;
- Little or no involvement by the consumer in decisions about their care;
- Minimal education or advice for the consumer prior to their discharge;
- Absent or inadequate follow-up and support from mental health services;
- Poor or in-consistent co-ordination with community mental health services;
- Limited monitoring and/or active intervention/treatment for the consumer in the immediate post discharge period;
- Inadequate links with GPs, care professionals, non-government organisations (NGOs), and other community support services;
- Planning for the transition between hospital and community care is often inefficient, delaying discharge from inpatient units.

3. Discharge Planning

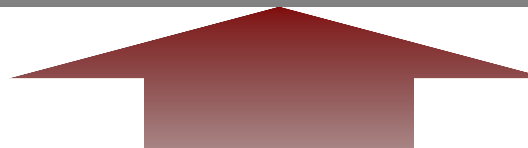
This Policy Directive standardises the development, implementation and review of the discharge planning process. This process correlates with the consumer journey, from admission to re-integration in the community. The framework for discharge planning is illustrated below:

Discharge Planning Principles

- **Admission and discharge are part of a continuum.**
- **Consumers, family/carers are partners in care.**
- **Discharge criteria are based on comprehensive assessment of the consumer's medical and psycho/social needs.**
- **Effective discharge practice incorporates monitoring and evaluation components.**
- **Clear and timely communication between the patient, carers and all clinicians and other health professionals is essential.**
- **A comprehensive discharge care plan should be developed before discharge.**
- **Consumer and carer information and education should be provided prior to discharge.**
- **Discharge processes should be formalised and monitored for continuous improvement.**

Steps

1. **Identify a key clinician/care coordinator responsible for ensuring each step of the discharge process is completed.**
2. **Estimate the date of discharge, the consumer's likely needs, and any risks at that time.**
3. **Develop a discharge care plan with the consumer, carer, external clinicians and support agencies**
4. **Conduct regular reviews and keep all participants informed of progress.**
5. **Follow-up and support arrangements must be documented in the MH-OAT D1 Discharge Summary and in the consumer's written information, the 'discharge care plan'.**
6. **Monitor and evaluate the discharge process: formal discharge and post-discharge follow-up.**



Success Factors

- **Engage key staff, consumers, carers, clinicians and support agencies in discharge planning.**
- **Involve the multidisciplinary mental health team to develop and implement discharge planning.**
- **Ensure consistent senior level and stakeholder support throughout discharge process.**
- **Ensure timelines are met and each step is implemented.**
- **Identify and maintain focus on key performance indicators.**

3.1 Disclosure of information

Provision of information to other relevant health service providers is a necessary and appropriate part of managing the ongoing care of the consumer in the community. A provider will only be relevant if they are going to have a direct and ongoing involvement in care. Consumers should be advised of who information will be provided to, and the reasons why. If they have concerns about release of information, this should be discussed with them and their primary carer, and attempts made to resolve their concerns in the context of the need to ensure the best possible ongoing care and the obligations under the Mental Health Act.

3.2 Discharge Process

The Process Summary is further elaborated in the following table. It is important that the documentation in a consumer's medical record reflects this process:

No.	Process
1.	Nominate the consumer's Discharge Planning Coordinator early in the admission to guide the process.
2.	Involve the consumer and their family and/or primary carer in discharge planning. Contact the consumer's family and/or primary carer to keep them informed of the expected discharge dates and times (where appropriate).
3.	Involve the relevant health or community support providers (for example community care coordinator or case manager, local mental health service, psychologist or private psychiatrist, Housing & Accommodation Support Initiative (HASI) provider). Note section 6 *Discharge Planning for Specific Population Groups* identifies factors to consider when planning for discharge.
4.	Conduct regular multidisciplinary reviews of the consumer and document in their clinical notes.
5.	Develop the discharge care plan, in line with the MH-OAT Care Plan (CP) detailing: a) Medical and community support follow-up arrangements; b) Emergency contact numbers; c) Consumer management plan (including coping strategies); d) Key referral services and programs (eg HASI); and e) Contingency and Relapse Response plans.
6.	Conduct a Mental State Assessment immediately prior to discharge including risk of harm to self and others, and reassess discharge decision at that time.

7.	Identify risks of harm to self and others (including dependent children) and develop a response, in accordance with *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities PD2005_121*, and the *Framework for Suicide Risk Assessment & Management for NSW Health Staff.* See section 5 for more details.
8.	Ensure the consumer completes the MH-OAT consumer-rated measures (SR1 and SR2 modules) unless contraindicated (refer to *Your Guide to MH-OAT* – Section 2 The standard MH-OAT data collection protocols).
9.	Check medication supply and prescriptions are provided to the consumer in accordance with the MH-OAT D1 Discharge Summary. A copy of the MH-OAT D1 Discharge Summary and Discharge Definitions are at Appendices 2 & 3.
10.	Identify and contact the relevant Community Mental Health Team, GPs and referral services and programs (where appropriate) to continue treatment and provide assertive follow up.
11.	On discharge, book an appointment for follow-up with a relevant health provider. Ensure that the timeframe for the follow-up appointment complies with the level of suicide risk determined. Establish steps to be taken by the GP or other health provider if the consumer misses the appointment.
12.	Take into account legal order status such as Community Treatment Order (CTO), Protected Estate[1], or Guardianship (including length and expiry dates). If a view is formed that a consumer with a Protected Estate order no longer requires management of their affairs, the Office of the Protective commission should, with the consent of the consumer, be advised.
13.	Provide a copy of the discharge care plan to the consumer and, with the consumer's consent, their families and/or primary carer (including children where relevant) as appropriate.
14.	On discharge, complete the MH-OAT D1 Discharge Summary. Where relevant, other members of the treating team should also provide written summaries. Inform the consumer about this step and obtain consent. The D1 Discharge Summary must include information relevant to the general practitioner such as advice about any recent changes to management and medication requirements, the level of risk of self-harm where appropriate, and the contact details for the mental health professional responsible for the coordination of the person's care.
15.	Fax a copy of the D1 Discharge Summary to the Community Mental Health team and nominated GP within seven days. A copy of the MH-OAT Care Plan (CP), or the consumer's discharge plan (with the consumer's consent) should be attached to the MH-OAT D1 Discharge Summary wherever possible.

[1] In the case of a consumer whose financial affairs are controlled under the Protected Estates Act the Office of the Protective Commissioner is informed in accordance with Clause 8 of the *Protected Estates Regulation 2003.*

16.	Ensure a copy of the MH-OAT D1 Discharge Summary, and a copy of the MH-OAT Care Plan (CP)/consumer's discharge plan is placed on the medical record.
17.	Be timely; whenever possible, discharge the consumer into the care of family and/or primary carer at a time when support services are most likely to be available. In cases where discharge is sooner than anticipated, involve the acute community mental health team where appropriate. Note: if a voluntary consumer seeks discharge out of business hours or against medical advice, inpatient clinicians must follow the self-discharge procedure detailed at section 6.13.

Document	Purpose	Audience
MH-OAT Care Plan (CP) and/or Discharge plan	Identifies and documents care and discharge planning requirements	• Inpatient treatment team • Consumer (copy on discharge) • Nominated Primary Carer (with consumer's consent) • Community Mental Health team • GP and other relevant mental health professionals (with consumer's consent) • Medical Record
MH-OAT D1 Discharge Summary	Provides written summary of care, clinicians involved, psychiatric diagnosis, medication and follow-up appointment details, legal status and risk alerts	• Community Mental Health Team • GP/Private Psychiatrist • Medical Record

4. Implementation

Implementation of this Policy Directive comprises the following:

- **Governance**: Development and implementation of Area Health Service ***Local Protocols for Adult Mental Health Discharge Planning for Inpatient Settings*** and ongoing performance management is the responsibility of Area Chief Executives, through their Area Director of Mental Health. Clinical and executive collaboration and input into the Local Protocols and performance management is critical for success.

- **Implementation**: ***Local Protocols*** support standardised development, implementation and review of discharge planning from the time of admission to inpatient services in accordance with this Policy Directive.

  All Area Health Services must develop and implement ***Local Protocols for Adult Mental Health Discharge Planning for Inpatient Settings*** that

take into account their operating environment and the needs and capacity of local communities. The operating environment includes the varying structural arrangements in inpatient facilities in metropolitan, regional and rural areas.

Each **Local Protocol** needs to take account this Policy Directive's principles and practices and document:

- Governance Mechanisms;
- Collaboration Mechanisms for frontline managers and senior clinicians;
- Discharge Process Map;
- Roles and Responsibilities of relevant personnel;
- Risk Identification and Management (identify points at which the Local Protocol could fail and remedial response);
- Performance Management (refer Key Performance Indicators, section 4.2);
- Staff Education and Training; and
- Referral Networks Map (community health care providers, other government departments and NGOs contacts).

Local Protocols must also consider discharge requirements from Psychiatric Emergency Care Centres (PECC). Protocols must also be in place for people whose mental health assessment in an Emergency Department determines that a hospital admission is not required at the time, but who may continue to present some risk of harm to self or others. Note that the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* includes guidelines for Emergency Departments, which outline assessment and safe management principles.

Area Mental Health Services should consider developing/amending local Memoranda of Understandings (MOUs) or operational guidelines with government agencies, to enhance communication, engagement and effective discharge practices.

- **Performance Management:** Process and outcome Key Performance Indicators for each AHS are essential.

4.1 Policy Directives Relevant to Discharge Planning

Implementation also needs to accord with the following Department of Health policy directives:

Policy	Implication
a) Discharge Planning: Responsive Standards (PD2007_092)	A responsive and standardised approach to discharge planning for the health system, from pre-admission to post-discharge.
b) Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour (PD2005_121)	Policy directive for all NSW health staff and staff in private hospital facilities
c) Framework for Suicide Risk Assessment and Management for NSW Health Staff	Comprehensive guidelines for assessing and effectively managing suicide risk for staff working in six health settings including Mental Health Inpatient Units, Emergency Departments and General Hospital Wards
d) Child Protection Roles and Responsibilities – Interagency (PD2006_104)	Outlines NSW Health's roles and responsibilities in relation to the health, safety and wellbeing of children and young people and provides practical information to assist workers to identify and respond to children and young people at risk of harm.
e) NSW Children and Young Persons (Care and Protection) Act 1998	NSW Health workers are mandatory reporters of risk of harm to children and young people under this Act. All health workers who come into contact with children and young people who have experienced abuse and/or neglect, or who are at risk, must make a report to the DoCS Helpline (on 13 36 27).
f) Protecting Children and Young People – Department of Community Services Risk of Harm Report Form (PD2006_109)	Provides the standard fax reporting form for reporting children and young people at risk of harm to the Department of Community Services (DoCS) Helpline. The Form is used for documenting a telephone or a fax report. It is to be placed on the client's file.
g) Child Protection Issues for Mental Health Services - Risk of Harm Assessment Checklist (PD2006_003)	Assists mental health clinicians assessing pregnant women and carers of children (parents and others) to recognise and respond appropriately to specific risk factors associated with symptoms of mental illness.
h) Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services (2nd Edition) (GL2005_049)	Provides guidance for referral to, and communication with, sexual assault services where this is identified in the discharge planning process.
i) Standard Procedures for working with Health Care Interpreters (PD2006_053)	Provides guidance for health care workers on using interpreters.

4.2 Key Performance Indicators

Performance measurement is critical to successful implementation. Key Performance Indicators (KPIs) are tabulated below for the purposes of monitoring, evaluation and review. Significantly the KPIs should also motivate staff and result in continuous improvement of discharge planning processes.

Implementation	Key Performance Indicator (KPIs)
Policy Implementation Process	Area Mental Health Services must develop a Local Protocol for adult mental health inpatient discharge practice which will include the following components documented, implemented and updated as required: a) Governance Mechanisms; b) Accountability Mechanisms for frontline managers and senior clinicians; c) Discharge Process Map; d) Roles and Responsibilities of relevant personnel clearly articulated; e) Performance Management / data collection; f) Staff Education and Training; and g) Referral Networks Map and MOU's /operational guidelines with local government agencies in place.
Monitoring Discharge Planning Process	Mandatory statewide KPIs are: a) Readmission rates within 28 days; b) Rate of community contact within seven days of discharge of acute mental health inpatient unit. Other KPIs which may be monitored locally include: c) % of consumers with estimated dates of discharge written in the medical record; d) Variance between the estimated and actual date of discharge; e) No. of MH-OAT D1 Discharge Summaries completed and forwarded to follow up service provider within seven days; f) % of consumers discharged from hospital with a written discharge care plan; and g) Length of stay greater than 35 days and the reasons for the extended length of stay.

5. Consumers at Risk of Harm to Self or Others

5.1 Self Harm

Consumers reassessed at risk of suicide require close monitoring and support. The first 28 days following discharge is a period of increased risk. Discharge planning must take this into account and ensure continuity of care.

Prior to approved leave and inpatient discharge, the suicide risk status of a person must be reassessed **to determine whether leave/discharge can be approved at this time**.

Consumers due to be discharged from a mental health inpatient unit of hospital should, wherever possible, be allocated to a community mental health key worker (eg care coordinator, acute care service, emergency service team) prior to discharge. A discharge plan must be documented for consumers at risk of suicide. It must include the rationale for discharge. The discharge care plan must be filed in the medical record.

Persons presenting to the Emergency Department who have been assessed as being at some level of risk of harm to self, but not in need of a hospital admission at the time, must have a formal suicide risk assessment and management plan in place.

The table below correlates assessed risk with response guidelines as set out in the Framework for Suicide risk Assessment and Management for NSW Health Staff:

5.2 Suicide Risk Rating & Response

Risk Rating	Response Guidelines	Comment
High Risk	Consumers assessed to be at ongoing high risk* of suicide when discharged must have a **follow up appointment** with the relevant health provider (for example, mental health extended hours team, care co-ordinator, general practitioner, private psychiatrist) within **24 hours** of discharge. *eg where there is a diagnosis of personality disorder.	The rationale and reasons for the decision to discharge the consumer into community, and the management plan supporting the decision, must all be clearly documented. Contingency planning for urgent and rapid re-assessment are to be in place.
Medium Risk	Consumers assessed to be at medium risk of suicide when discharged must have a **follow up appointment** with the relevant health provider (for example, mental health extended hours team, care co-ordinator, general practitioner, private psychiatrist) within **one week** of discharge.	Contingency planning for urgent and rapid re-assessment is to be in place.

Low Risk	Consumers assessed to be at low risk of suicide when discharged must have a **follow up appointment** with the relevant health provider within **one week** of discharge from an inpatient unit and access to appropriate health service if required prior to the appointment.	Contingency planning is to be in place.

The Discharge Care Coordinator responsible for discharge planning should also:

a) Refer to NSW Health's *Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities PD2005_121*.
b) Complete and send a *Notification to NSW Police Force and Firearms Registry Form* (refer copy at Appendix 7), if the consumer has been assessed as being at risk and is known to have access to a firearm.
c) Ensure the relevant health provider (care co-ordinator, local mental health service, general practitioner, psychologist or private psychiatrist) receives a verbal report at discharge. A discharge summary (at least as an interim summary report) should be sent to all relevant health providers on the day of discharge. The MH-OAT D1 module may be used for this purpose. The management plan documenting interventions and contingency plans should clearly articulate roles, responsibilities and timeframes for the period between assessments. The consumer should be informed and consent to this process. Written advice including the full discharge care plan should follow within seven days.
d) Provide the consumer and, with their consent, a family member, primary carer or friend, a copy of discharge care plan with information including referrals for community services. This includes a 24-hour telephone contact number for emergency help and support services.

*The following principles and actions apply to the discharge planning process for all consumers **at risk of self-harm**:*

a) Assertive follow up should occur at home where possible, with re-assessment of risk factors within one week of discharge;
b) Ensure ongoing review of the consumer, and where appropriate, include their family and/or primary carer;
c) Identify and manage safety risks;
e) Ensure the consumer and their family/primary carer have immediate access to acute services if the risk of suicide escalates with 24-hour telephone contact numbers for emergency help and support services;
d) Treat any underlying conditions including any drug and alcohol issues;
e) Identify and manage precipitants or other factors predisposing the person to relapse, or related risk factors;
f) Agree on explicit strategies to prevent relapse;

g) Where the consumer is the primary carer of a child and there is concern about the child's safety or wellbeing, notification must be made to the Department of Community Services (DoCS) Hotline;
h) Encourage the consumer to have regular and/or specialist reviews by a psychiatrist;
i) Encourage the consumer to see their General Practitioner; and
j) Ensure accommodation, income maintenance, food, employment and social skills development needs are addressed.

5.3 Harm to Others

Discharge planning must include an assessment of the risk posed by the consumer to the health and welfare of others, including any risk to children who are in contact with the consumer. Prior to discharge, a formal assessment of risk of harm to others must be conducted. Indicators of risk include threatening statements and/or a history of violence against others. This risk and a response must be documented in the discharge care plan and relevant MH-OAT modules. Where the risk is valid, staff should notify the local Police on the basis that they have reasonable grounds to believe there is a serious and imminent threat to a member of the public. If the consumer is at risk and is known to have access to a firearm, staff are required to complete a *Notification to NSW Police Force and Firearms Registry Form* (refer to copy at Appendix 7).

6. Discharge Planning for Specific Population Groups

This section details factors that need to be taken into account when discharge planning for the specific population groups:

- Family and/or Carers (including the nominated primary carer);
- Consumers who are Carers of Infants, Children or Adolescents;
- Young People;
- Pregnant Consumers;
- Consumers on Community Treatment Orders;
- Consumers with Accommodation needs;
- People from Culturally and Linguistically Diverse (CALD) backgrounds;
- Aboriginal and Torres Strait Islander People;
- Consumers with Intellectual Disabilities;
- Consumers under a criminal charge, warrant or Court Order;
- Clients of the Department of Corrective Services;
- Access to Firearms;
- Voluntary and Involuntary patients; and
- Patients who have Absconded.

6.1 Family and/or Primary Carer

A key principle of discharge planning is that the consumer, the family and/or carers, should be involved in the discharge planning process, where

appropriate, and, where possible, establish family and/or carer(s) support. Mental health staff, in particular the person's Discharge Care Coordinator, needs to inform family and/or primary carer of their roles, equipping them with practical strategies, knowledge and skills.

Family and/or primary carer involvement in discharge planning should be a priority, enabling their direct input into planning for the short and long term. Where required, use interpreters to explain the discharge process and plan to families and/or primary carer. Age appropriate information should be provided for children and young people who are in the care of, or have contact with, a consumer with mental illness

The information in the table below sets the standard for how to include family and/or primary carer in discharge planning:

Title	Comment
Discharge Planning Process	a) Involve the consumer and the family and/or primary carer in each step of the discharge planning process. b) Regularly contact families/ primary carer to keep them informed of the expected discharge dates and times. c) At discharge, provide a copy of the MH-OAT Care Plan or other written plan covering discharge details and ongoing care arrangements for family and/or primary carer and other stakeholders (with the consumer's consent).
Contingency & Relapse Response Planning	a) A documented Contingency & Relapse Response Plan is part of the written discharge information. Contingency planning allows the clinician, the consumer and their family/primary carer to anticipate likely escalations of risk such as family relationship problems, increased symptoms and how to overcome any initial difficulty in accessing the acute care service. It sets out indicators for risk and strategies for relapse prevention. The plan should include: – How to identify early indicators of relapse (e.g. withdrawal, rumination, poor appetite, poor sleep patterns, irrational thoughts, hallucinations, re-emergence of suicidal or self-harm ideation or behaviour; or other warning signs for the individual; – Previous effective strengths and strategies; – Who the consumer is more responsive to (support persons); – How to contact support persons; – How to contact support agencies; – Who to contact in an emergency; – How to contact emergency services; and – What to do to ensure any children's wellbeing and safety. b) Involve the consumer and the family and/or primary carer in contingency and relapse response planning. c) Where appropriate, the consumer's children should be asked about their experiences and given age appropriate information and emergency contact numbers.

6.2 Consumers caring for Infants, Children or Adolescents

Comprehensive assessment at admission must identify and document (in MH-OAT Form A1) any children in the consumer's care and the actions planned to ensure the children's safety and wellbeing.

The MH-OAT Care Plan (CP) should document staff observations of risk factors that may impact on the consumer's capability to care for their children. These could include changes in accommodation or level of support, and the impact of medications on cognitive functions. The NSW Health Policy, *Child Protection Issues for Mental Health Services - Risk of Harm Assessment Checklist PD2006_003* advises mental health clinicians on how to assess pregnant women and carers of children (parents and others) and recognising and responding appropriately to specific risk factors associated with symptoms of mental illness. All of this information should be reviewed prior to discharge and documented in the medical record.

If other services or agencies have or need to be involved, this should occur prior to discharge and be included in follow-up arrangements noted in the discharge care plan. It should be noted that:

a) If the consumer is the principal carer of an infant or a toddler, regular liaison with the child and family team, with the approval of the consumer, is strongly indicated; and
b) When there are concerns about a child's safety, a report of risk of harm must be completed (as required under section 23 of the *Children and Young Persons (Care and Protection) Act 1998)*. If concerns are still present at discharge, further communication and collaboration with DoCS must take place.

6.3 Care of Young People

If a young person under 16 years of age is an inpatient of an adult mental health unit, it is good practice to discuss the care and discharge planning with the local Child and Adolescent Mental Health team. It is also mandatory to involve the young person's parents or guardians in discharge planning process. In circumstances where the consumer is a young person for whom the Minister or Director-General of Community Services has parental or care responsibility, a Department of Community Services caseworker should participate in the discharge planning process.

6.4 Pregnant Consumers

Discharge planning for consumers who are pregnant needs to take into account the following:

- Ensure the consumer is connected with antenatal services and to assist with booking if required;

- Due to the high risk of relapse, liaise with appropriate maternity services (perinatal psychiatrist/perinatal mental health coordinator) with the consumer's consent;
- Early childhood nurses can provide, or facilitate access to, psychosocial support, guidance and monitoring of the infant's progress; and
- If there are concerns about the safety of the child after birth, consideration may need to be given to making a prenatal risk of harm report to the Department of Community Services Helpline (13 36 27).

It is recommended the person's Discharge Planning Coordinator refers to the NSW Health policy, Child Protection Issues for Mental Health Services - Risk of Harm Assessment Checklist PD2006_003. The policy advises mental health clinicians on how to assess pregnant women and carers of children (parents and others) and to recognise and respond to specific risk factors associated with symptoms of mental illness.

6.5 Consumers on Community Treatment Orders

A Community Treatment Order (CTO) is an order made under the Mental Health Act 2007 by the Mental Health Review Tribunal or a magistrate. It sets out the terms under which a person must accept medication, therapy, rehabilitation or other services for a period of up to twelve months. The consumer must know of his/her right to have the CTO reviewed.

The following factors indicate appropriate circumstances under which an application for a CTO may be submitted or re-submitted prior to expiry:

a) Severity of the acute episode and associated recovery and adjustment issues;
b) Specific rehabilitation needs requiring community care coordination and support;
c) Past history of poor treatment response or co-morbidity;
d) Treatment avoidance necessitating a CTO; and
e) Ongoing significant risk of harm to self or others.

A CTO can be a component of discharge planning. It is implemented by the health care agency that has developed an appropriate treatment plan.[2] The treatment plan sets out details of the treatment that will be provided to the consumer. A Care Coordinator from a community mental health team must be allocated to the consumer. This should occur early in the admission and the clinician should commence working with the person prior to discharge

6.6 Consumers with Accommodation Needs

Discharge planning should include an assessment of the consumer's accommodation needs. The following factors can assist in assessing that need:

[2] Centre for Mental Health, *Mental Health Act Guide Book* (*Amended May 2003)*

a) Substance misuse;
b) Antisocial behaviour;
c) Family dispute or relationship breakdown;
d) Lack of coping/practical skills;
e) Learning disabilities;
f) Need for supported/supervised accommodation (e.g. hostel, HASI);
g) Inability to remain at home due to frailty and/or poor mobility;
h) History of sleeping rough;
i) History of repeat usage of mental health services;
j) Lack of a permanent residence;
k) Lack of family or community support whilst in hospital; and
l) Where there is a possibility of domestic violence, safe accommodation arrangements must be put in place.

There are a number of services that can assist with accommodation and where appropriate, be considered as part of the discharge planning process.

- *Department of Housing Homelessness Risk Assessment Tool:* This tool can be used to determine if the consumer should be referred to the Department of Housing. Referral to the Department of Housing should be completed prior to discharge. A copy of this tool is at Appendix 6.

- *Supported Accommodation Assistance Program (SAAP):* A joint Commonwealth and State support program for people who are homeless or at risk of homelessness. SAAP aims to resolve crises; re-establish family links where appropriate; and re-establish the capacity of clients to live independently. It is administered through the NSW Department of Community Services and covers women's refuges, youth and adult crisis accommodation services.

- *Housing and Accommodation Support Initiative (HASI):* This program provides housing that is linked to clinical and psychosocial rehabilitation services for people with a range of levels of psychiatric disability. HASI is designed to assist consumers requiring accommodation support to foster community participation, maintain successful tenancies, improve quality of life and, most importantly, to assist in their recovery from mental illness. Referral to HASI services may be considered as part of a person's discharge planning.

6.7 Consumers from Culturally and Linguistically Diverse Backgrounds

Discharge planning for consumers from Culturally and Linguistically Diverse Backgrounds (CALD) requires a culturally sensitive approach. Health professionals should be aware of their own values and beliefs. It is recommended that, when working cross-culturally, staff approach CALD consumers with sensitivity and respect for the social context of the consumer's problems. It is important to understand the personal meaning of the illness for the consumer, their family and their community. The process should take into account the following factors:

a) Lack of proficiency in English;
b) Impeded access to health services due to language difficulties and cultural expectations;
c) Lack of awareness of available community services;
d) Stressors experienced during the process of adapting to mainstream Australian culture.

CALD consumers and their families should have access to interpreter services to facilitate the discharge process where appropriate. Consent is essential. Three-way telephones or conference phones should be available for use with telephone interpreters. Health staff should refer to *Interpreters: Standard Procedures for working with Health Care Interpreters PD2006_053* for guidance on use of interpreters.

Where complex or unknown cultural dynamics are involved, cultural advice should be sought from the NSW Transcultural Mental Health Centre (refer Appendix 8: Useful Contacts/Websites).

6.8 Aboriginal and Torres Strait Islander People

The specific historical, cultural, spiritual and social factors of Aboriginal and Torres Strait Islander people must be taken into consideration in discharge planning. Many Aboriginal people's contact with government services may have been negative which can cause suspicion and mistrust. This may be acutely important for Aboriginal people with mental health problems and disorders.

Discharge planning needs to reflect the key principles for working with Aboriginal communities, including:

a) Services working in partnership;
b) Holistic approach to mental health;
c) Flexibility;
d) Accessibility of services;
e) Ability to follow people across areas;
f) Respect and sensitivity for indigenous people;
g) Involvement of family and others in care;
h) Treating an individual as part of a family and the community;
i) Provision of education and training; and
j) Illness prevention.

Health staff should liaise with specialist Aboriginal health representatives in their area (e.g. Aboriginal Mental Health Workers or Aboriginal Medical Services) to ensure that discharge planning is commenced early and is consistent with the needs of the local Aboriginal community.

The process should also:

a) Provide the consumer and family with relevant 24-hour contact numbers for assistance;
b) Identify community liaison contact(s) who can engage additional support for the consumer such as extended family, elders and community members;
c) Ensure actions are taken to resolve precipitating events and other life stressors;
d) Refer the consumer to Aboriginal health or medical services whenever possible;
e) Establish contact between consumer and Case Worker prior to discharge;
f) Obtain funds, where available, to assist with transport and accommodation of family at the time of discharge;
g) Negotiate contingency plans with the consumer and their family;
h) Empower the family with basic management strategies to monitor behaviour; and
i) Ensure, where possible, that the family is present at time of discharge to accompany the consumer home.

Another significant factor is risk of suicide. When discharging Aboriginal people who are at long-term risk of suicide, the clinician needs to take into account the consumer's:

a) Current mental state and wellbeing; and
b) Nature and impact of their home/community environment.

The consumer may be at a significantly increased level of risk on return to a troubled home or community environment. For consumers who have been hospitalised for lengthy periods, the impact of their return to the community, and their ability to cope, needs to be assessed sensitively and risks identified and addressed. It is also important to note that many Aboriginal people feel distinctly uncomfortable in hospital environments and that statements of intent regarding suicide may be retracted in order to leave an inpatient unit.

6.9 Consumers with Intellectual Disabilities

In addition to the standard procedures outlined in this Policy Directive, the NSW Department of Ageing, Disability and Home Care (DADHC) has provided the following information to assist in planning for discharge of consumers with intellectual disabilities:

Prior to discharge:

a) Notify the consumer's guardian prior to discharge or transfer;

b) Consumers with a dual diagnosis of intellectual disability and mental illness are likely to require additional support from a range of services including mental health. DADHC is responsible for the assessment of intellectual disability, whether a new assessment or a reassessment (refer Appendix 8: Useful Websites/Contacts);

c) Include the key worker from accommodation services, disability service and/or the person's guardian or advocate in the discharge planning process;

d) Community-based services, including disability services, may require information and guidance from mental health staff;

e) Discharge planning (including contingency and relapse response planning) needs to consider the particular needs of a consumer with intellectual disabilities, particularly in circumstances requiring readmission;

f) Relapse prevention needs to differentiate between behaviours related to the intellectual disability and re-emergence of mental health symptoms;

g) There may be a need for joint assessment and case management and continuing inter-agency education about mental health and intellectual disability.[3]

6.10 Consumers under a criminal charge, warrant or Court Order

Under the Mental Health Emergency Response 2007 - Memorandum of Understanding between NSW Health, the Ambulance Service of NSW and the NSW Police Force, mental health staff should notify police of the discharge of a consumer who:

a) Has committed a crime; or
b) Has pending criminal charge(s) / warrant(s); or
c) Is subject to a Court Order [for example an S33 of the Mental Health (Criminal Procedure) Act 1990]; or
d) Is subject to a Forensic Order.

6.11 Clients of the Department of Corrective Services

If the consumer is a client of the Department of Corrective Services (DCS), include the DCS case manager or Probation and Parole Officer in the discharge planning process, subject to the consumer's consent.

6.12 Consumers with access to Firearms

If it is known that the consumer has access to fire arms, the discharging clinician is required to complete Firearms Notification form and submit to the NSW Police Firearms Registry prior to discharge (refer Appendix 7: Notification to NSW Police & Firearms Registry).

[3] Chan J, Hudson C, Vulic C. (2004) Services for adults with intellectual disability and mental Illness: Are we getting it right? Australian e-Journal for the Advancement of Mental Health (AeJAMH), Vol. 3, Issue 1.

6.13 Voluntary patients

Voluntary patients (as defined under the Mental Health Act 2007) must be discharged at their own request at any time. They cannot be prevented from leaving hospital unless reclassified under the Act as involuntary. The discharge must be documented in the medical record noting the reasons for discharge and whether it is against medical advice. The following factors may also apply:

a) If the voluntary patient is assessed by mental health staff to be at risk of harm to self or others, there is a responsibility to ensure that a medical officer assesses the person promptly.
b) If a consumer less that 18 years of age is admitted to a hospital as a voluntary patient, the medical superintendent must, as soon as practicable after admission, do all such things as are reasonably practicable to notify their parent or primary carer or guardian of the admission.

There may be times when a voluntary consumer seeks discharge out of business hours or against medical advice. There are also occasions where a voluntary consumer refuses to accept ambulatory or community follow-up for mental health treatment, or community agencies, for example supported accommodation.

In such situations, inpatient clinicians must consider whether the safety and wellbeing of the consumer or others requires further action. The clinician responsible must:

a) Ascertain why the consumer wishes to leave prior to formal discharge;
b) Request that the consumer discusses reasons, and follow up management with the medical officer;
c) Inform relevant senior nursing and medical staff to ensure that a comprehensive assessment is conducted as soon as possible;
d) Where there is a concern for the consumer if discharged, a change of legal status from voluntary to involuntary may be required. After assessing the person, the medical officer can decide such a change is necessary in accordance with the Mental Health Act 2007. The consumer must be informed of the change in legal status. The involuntary detention provisions of the Act must be followed and the person must be presented to a magistrate unless discharged;
e) Take into consideration the safety, welfare and wellbeing of children for whom the consumer has responsibility or contact. In some circumstances, the clinician may decide to make a Risk of Harm report to Department of Community Services (DoCS) Helpline. If a previous report has been made, and there is ongoing concern about risk to children, the clinician should again contact the DoCS Helpline to ensure that DoCS staff are aware of current circumstances;
f) Make reasonable attempts to provide assertive follow up of the consumer at home by the local acute community team within 24 hours of the self-discharge;
g) All action taken by staff must be documented in the medical record and the MH-OAT D1 Discharge Summary; and

h) An assessment should be made of the consumer's access to firearms.

6.14 Involuntary Patients under the Mental Health Act 2007

The discharge process for involuntary patients should take into account the following options:

Discharge	Comment
a) Discharge by Psychiatrist	Patients must be discharged from involuntary treatment when they no longer meet the criteria of mentally disordered or mentally ill under the Mental Health Act 2007. An involuntary patient may also be discharged by a Registrar, in consultation with a psychiatrist, under delegation from the Medical Superintendent.
b) Discharge by Superintendent	Under the Mental Health Act 2007, the Superintendent may discharge an involuntary patient following an appeal.
c) Conditional Discharge	Under the Mental Health Act 2007, consumers may be placed on a Community Treatment Order (CTO). Only a clinician who has met the consumer should write a treatment plan for a CTO. The consumer requires a full explanation of the CTO.
d) Judicial Discharge	Under the Mental Health Act 2007, a consumer may be discharged by a magistrate or following an appeal heard by the Mental Health Review Tribunal.
e) Mentally Disordered Consumers	The discharge of a person meeting the criteria of 'mental disordered' under the Under the Mental Health Act 2007 must comply with section 31. The Act also requires a daily re-assessment of any consumers detained as 'mentally disordered'.
f) Persons Under Guardianship	For the discharge or transfer of a person under the Disability Services Act 1993 and the Guardianship Act 1987 notice must be given in advance to the person's guardian.
g) Persons Under Bonds or Probation Orders	Notice of discharge must be given to the person's probation officer or parole officer.
h) Forensic Consumers	The Mental Health Review Tribunal reviews persons classified as forensic patients within the meaning of the Mental Health (Criminal Procedure) Act 1990. The Tribunal is required to make a recommendation to the Minister for Health as to the person's detention, care, treatment or release. A forensic consumer cannot be discharged from the hospital without a formal order or approval made in accordance with the relevant forensic provisions.

6.15 Leave from an Inpatient Unit prior to Discharge

As part of the discharge planning process to assist the consumer's reconnection to the community, some consumers are granted day leave, overnight leave and weekend leave. This process is sometimes called trial leave, and is important for consumers who have had lengthy periods of hospitalisation.

Other examples of day leave include consumers attending significant family events, or having to attend appointments that cannot be rescheduled (eg specialist medical appointment booked well ahead). Local protocols must be in place setting out the specific criteria and purpose for granting leave to inpatients from hospital.

General principles of good clinical practice for the management of temporary leave include:

a) Where appropriate, involvement of the acute community care team to ensure after hours and flexible assertive community support and prompt intervention in crisis situations;
b) Comprehensive recording in the consumer's notes of the short leave plan including all information relating to the leave;
c) Details of the level of support available to the consumer by family/friend;
d) Communication processes negotiated with the client, the community team and a family member or friend who has accepted responsibility for the care of the person whilst on leave; and
e) Clear contract with the consumer indicating expected time of return and process of notification if return is delayed.

Special attention must be given to granting leave to involuntary patients who should be escorted by a staff member (or a family member/carer if appropriate). Arrangements and responsibilities of leave are to be explained to the patient and family/carers including information and instruction regarding risks and responsibilities of escorted leave and the circumstances and contact details of the unit should the staff of the mental health unit need to be contacted. Leave arrangements are to be documented in the patient's medical record.

6.16 Handover Process at time of Return

It is important for health staff in the inpatient unit to be aware of any significant events that the person experienced during the leave that may have had an impact on the person's current mental state or on other matters affecting discharge planning.

If the community mental health staff has been involved with providing care to the consumer, a report should be provided as soon as possible to the treating clinician or documented in the medical record on the in-patient unit, outlining assessment and key interventions undertaken.

Local Protocols must outline actions to be taken by health staff when any consumer does not return from leave as agreed upon, and the circumstances when Police should be notified.

6.17 Involuntary Patient Absent Without Leave (Absconding)

Absconding from a mental health facility is an indicator of high suicide risk in some people. All reasonable attempts must be made to locate a person who has absconded.

NSW Health's Policy Directive Patients Absconding From a Psychiatric Hospital PD2005_002 outlines principles for dealing with the management of consumers who abscond from an inpatient unit. That Policy Directive should be read in conjunction with these explanatory notes.

The management of people who abscond from an inpatient unit includes:

a) Immediate notification of relevant senior medical and nursing personnel;
b) Notification to the person's relatives or significant others and/or the primary carer. Relatives or other relevant people should be asked if they are aware of favoured places the person might visit;
c) Notify relevant community mental health team requesting they assist in the search by visiting the person's home if appropriate;
d) Notify police by the relevant senior clinician on duty. The Absconded Patient Form is to be filled out and sent to Police (refer Appendix 5);
e) Careful consideration needs to be given as to whether the risks warrant notification of third parties if there is concern for their safety; and
f) Consideration of the need to make a report to the DoCS Helpline where there is the possibility of the person being in contact with children, and the risk which may arise from any such contact.

On return of an absconding patient to the Inpatient Unit, the following should occur:

a) Police, the community team and relatives must be informed. Police must be formally advised in writing;
b) The person should be interviewed to ascertain any factors that contributed to his or her absconding to assist with continued in-patient management;
c) A comprehensive assessment including re-assessment of observation/ supervision category should take place;
d) If the consumer is strongly opposed to continued hospitalisation and is assessed as having low risk of harm to themselves or others, alternative community treatment should be explored (including assertive 'hospital in the home' community care that may be negotiated with the consumer and their support network). In these circumstances a comprehensive early discharge process as outlined earlier for vulnerable consumers must be undertaken.

If the person cannot be located, the treating team may choose to:

a) Make a missing person's notification to police; or
b) Discharge the consumer and close the consumer's file as an 'active' consumer of the mental health service. However it is important that a

contingency care plan be included in the clinical notes to guide the clinical intervention should the person represent to the service.

Relevant documentation for the reporting of the incident must be completed in accordance with the *NSW Health Incident Management Policy PD2007_061*.

Appendices

Appendix 1: Checklist for Discharge Care Plan

The information to be addressed and documented in a discharge care plan for the Consumer includes:

Consumer information

- ☐ Full name & current address
- ☐ Admission date
- ☐ Discharge date

Inpatient Mental Health Service contact details

Name/address & contact details:

- ☐ Discharge care coordinator
- ☐ Treating Psychiatrist/Registrar

Medications

- ☐ List medications provided to consumer

Clinicians providing ongoing care

Name, address & contact details:

- ☐ General Practitioner
- ☐ Community Mental Health Service Clinician

Follow up appointments

- ☐ Provider/s details, date/s, time/s location/s of next community contact (eg GP, psychiatrist, ambulatory clinic, other)

Access to urgent mental health support

- ☐ After hours emergency contact number and other relevant information

Support needs for family and/or primary carer

Refer section on *Discharge Planning: Family and/or Primary Carer Support* (Section 6.1).

- ☐ List of information resources provided to the consumer and their family and/or carers at discharge
- ☐ Documented Contingency & Relapse Response Plans
- ☐ Details on how the consumer can re-enter the previous level of care. (Include information on how to call the mental health service or hospital 24 hours)

Other agencies/government services involved

- ☐ List of agencies, how to contact, and planned follow up arrangements

Appendix 2: MH-OAT D1 Discharge Summary Form

PLEASE PRINT CLEARLY PH 606

NSW HEALTH Working as a Team

AHS:
FACILITY:
SERVICE UNIT:

SURNAME_____________________ MRN __________
GIVEN NAME _____________ DOB_________ SEX ___
ADDRESS ______________________________________
____________________ WARD/SERVICE UNIT _______

Admission date: ____/____/____ **Discharge date:** ____/____/____

Preferred language: ________________

Interpreter:
❑ Not needed ❑ Needed ❑ Requested ❑ Booked ❑ Used ❑ Refused Refused by whom___________
(Interpreter to countersign if possible) Telephone interpreter service number: 131450

Reason for referral: Include referred by whom.

Summary of care: Include medical, nursing, psychology, occupational therapy, social work interventions and outcomes.

Have standard outcome measures been collected? ❑ Yes ❑ No

Legal status on discharge: Include CTO, CCO, Protected Estates Act, Guardianship, bail etc.

ALERTS

CURRENT RISK
- ❑ SUICIDE- History
- ❑ SELF HARM
- ❑ HARM TO OTHERS
- ❑ DV / ELDER ABUSE
- ❑ SUBSTANCE USE
- ❑ ABSCONDING/ WANDERING
- ❑ FIRE RISK
- ❑ FALLS RISK
- ❑ DRUG REACTION / MEDICAL/ALLERGY
- ❑ ACCOMMODATION
- ❑ CHILD PROTECTION
- ❑ DOMESTIC SAFETY ISSUES

VULNERABILITY
- ❑ SEXUAL ABUSE
- ❑ PHYSICAL ABUSE
- ❑ EXPLOITATION
- ❑ REPUTATION

STAFF ALERTS
- ❑ ANIMALS ON PREMISES
- ❑ POOR LIGHTING
- ❑ LOCATION ISSUES
- ❑ UNWANTED VISIT
- ❑ WEAPONS
- ❑ OTHER: ___________

Accommodation on discharge:
❑ House / Flat ❑ Hostel ❑ Residential Care ❑ Crisis accommodation
❑ Nursing home ❑ Unknown

Address:

Ph:

Staff Name: Signature: Designation: Date:

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BINDING MARGIN DO NOT WRITE

MENTAL HEALTH D1 – DISCHARGE SUMMARY ADULT

Name: DOB: MRN:

Significant cultural issues:

Clinicians responsible for care: Include contact details.

1. **Case Coordinator** ____
2. **Registrar** ____
3. **GP** ____
4. **Consultant / Other** ____

Psychiatric diagnosis:
The diagnosis that was the Focus of Care for this episode.
1. ____
2. ____
Previous or long term diagnosis
1. ____
2. ____

Physical findings: Include medical diagnosis and allergies.

Medication / dosage	Prescriber	PHARMACY STAMP HERE Inpatient use only

Days supply given: ____ **days** **Webster pack required?** ❑ **Yes** ❑ **No**
Depot next due: ___/___/____ **To be given by:** ____
Last injection site: ____

Recommended care plan: Include actions and persons responsible for follow up, consider needs / support of children / siblings and others.

Follow up appointments:
With: ____ Location: ____ Time: ____ Date: ____
With: ____ Location: ____ Time: ____ Date: ____

Consumer support:
❑ Family ❑ Spouse / Partner ❑ Friend/s ❑ Self ❑ Other ____
Details: ____

PLEASE ENSURE THAT THE CONSUMER AND THEIR CARERS / SIGNIFICANT OTHERS HAVE BEEN INFORMED OF THEIR RIGHTS AND RESPONSIBILITIES. AN INFORMATION PACK SHOULD BE MADE AVAILABLE TO ALL PARTIES INVOLVED IN THE ONGOING CARE AND SUPPORT OF AN INDIVIDUAL.
I understand my rights and responsibilities and/or have received an information pack.
Consumer signature: ____ Carer Signature: ____

Is there a current care plan attached to this summary? ❑ **Yes** ❑ **No**
Copies to:
1. ____ 2. ____
3. ____ 4. ____

Staff Name: Signature: Designation: Date:

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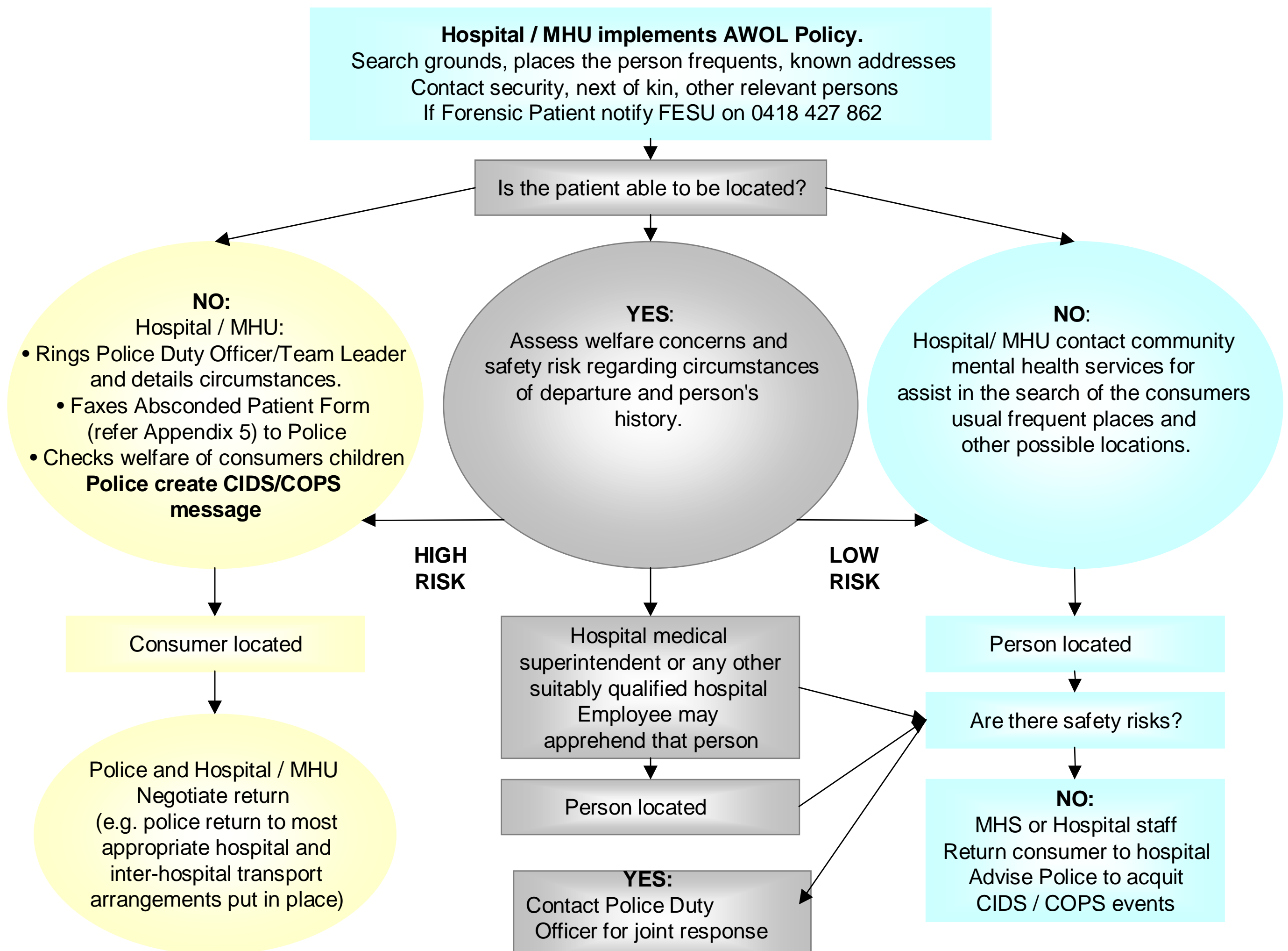
BINDING MARGIN DO NOT WRITE

Appendix 3 MH-OAT Definitions of Discharge

Term	Definition
(31) Discharge: No further treatment by a mental health service arranged.	This category refers to occasions where a person is discharged from a *mental health service setting* without referral for further treatment in a *mental health service setting*. Included under this category are instances where a person is referred to a private medical practitioner, or is simply discharged to their usual residence or own accommodation.
(32) Discharge: Transferred for more intensive care to a different mental health service setting or hospital, with communication of referral information.	This category principally refers to planned transfers from ambulatory or community– residential mental health care to in-consumer psychiatric care. It also includes transfers from general acute psychiatric in-consumer units to specialised high–acuity in-consumer facilities.
(33) Discharge: Transferred for less intensive care to another mental health service setting or Hospital, with communication of referral information.	This category principally refers to planned transfers from in-consumer psychiatric care into Ambulatory or Community–residential mental health care. It also includes transfers from specialised high acuity in-consumer facilities to general acute psychiatric in-consumer units.
(36) Discharge: Lost to care (including AWOL and discharged at own risk).	In in-consumer psychiatric care and community-residential mental health care settings this category refers to the case where a consumer has left care against advice, has been discharged at their own risk, or has otherwise been 'lost to care'.

Appendix 4: Procedure if a Patient Absconds

Staff procedures for Involuntary and Forensic Patients under the Mental Health Act 2007 are detailed below:



Appendix 5: Absconded Patient Report to Police

Health Facility*:* ____*(name of hospital/unit)*

Patient Particulars: Voluntary / Involuntary (circle whichever applicable) **NB: Attach copy of order if Involuntary**

Surname: ______________________________ Other Names**:** _________________________ ___ Sex: __

DOB: ______________ Admission Date**:** _______________ Photo Available: Y /N MRN: ___________

Residential Address**:** ____

Patient Description: *(Please circle)* Height_______________(cm) Weight__________________(kg)

Build:	Medium	Muscular	Obese	Solid	Thin	
Hair:	Black	Blonde	Brown	Coloured	Fair	Grey
	White	Red/Ginger	Light Brown	Multi	Bald	Shaved
Eyes:	Black	Blue	Blue/Grey	Brown	Green	
	Green/Hazel	Grey	Hazel	Other_______________________		
Complexion:	Acne/Spotted	Black	Dark Brown	Fair	Freckled	
	Medium	Olive	Ruddy	Sallow	Tanned	
Cultural Background:	Aboriginal	Black/African	Asian	Indian/Pakistani	White/European	
	Mediterranean/Middle Eastern		South American		Pacific Islander	
Distinguishing Features:	Scars	Tattoos	Disability			
	Other details:____					

Next of Kin contact details: Informed: Yes / No By Who (name):______________________________

Name: ____ Relationship___________________________________

Address: ____ Phone No: __________________________________

Are there children involved and who may be at risk? Is reporting to DoCS indicated ?

Absconding Information: Date:______________ Time: _____________ Ward: ______________

Reasons for concern (eg. Medical Conditions): ____

Risk Level (high, moderate, low): ____________ Possible Destination: _____________________________

Mental State: _________________________ Warnings (eg. Violent/Suicidal): __________________________

Full description of clothing when last seen: ____

____

Circumstances of disappearance:

Hospital Information: Reporting Person's Name: ___________________________ DOB: ________

Designation: __________________________ Phone No: _____________________ Date: ______________

Action taken by ward to locate patient ____

____

____

Absconded Persons Doctor: ______________________________________ Phone No: _________________

Mental Health Director / Designate notified: Yes / No Time_________________ Date: _______________

Signature: Search Conducted: Yes / No

Fax form to: (1) Local Police Station for report to be made, and (2) to Missing Persons Unit on 02 9689 7881 for analysis

(Note: form continued over)

Appendix 5 (cont):Notification of location or return to Hospital

Patient's Name: ______________________________ **D.O.B** __________

Health Facility ____

(For Hospital Use Only)

Police Notification: Station reported to: __________________ Event No: __________

Police Officers Name: __________________ Rank: __________________

Form Faxed: Yes / No Date: ______________ Time: ______________

(For Hospital and Mental Health Service Use Only)

Outcomes: Person Sighted: Yes / No Located: Yes / No Deceased: Yes / No

Circumstances of Location/Sighting: ____

____

____

Police notified of patients return: Yes / No Officers name: ____________________

Date: __________ Time: ____________ Rank: ____________________

Relatives notified of patients return: Yes / No Relatives name: __________________

Date: ___________ Time: ___________

Admissions Office notified: Yes / No Date: ____________ Time: ______________

Absconded Person's Doctor notified: Yes / No Date: ____________ Time: ___________

Reporting person's name: ________________ Signature: ____________ Date: / /

(For Police Use Only)

Outcomes: Person Sighted: Yes / No Located: Yes / No Deceased: Yes / No

Circumstances of Location/Sighting: ____

Advise Police immediately if absconded patient returns to hospital or is located elsewhere

Appendix 6: Identification/Referral of Consumers with High Risk of Homelessness

(To be undertaken once stabilised after admission and before discharge)

TRIGGER FACTOR

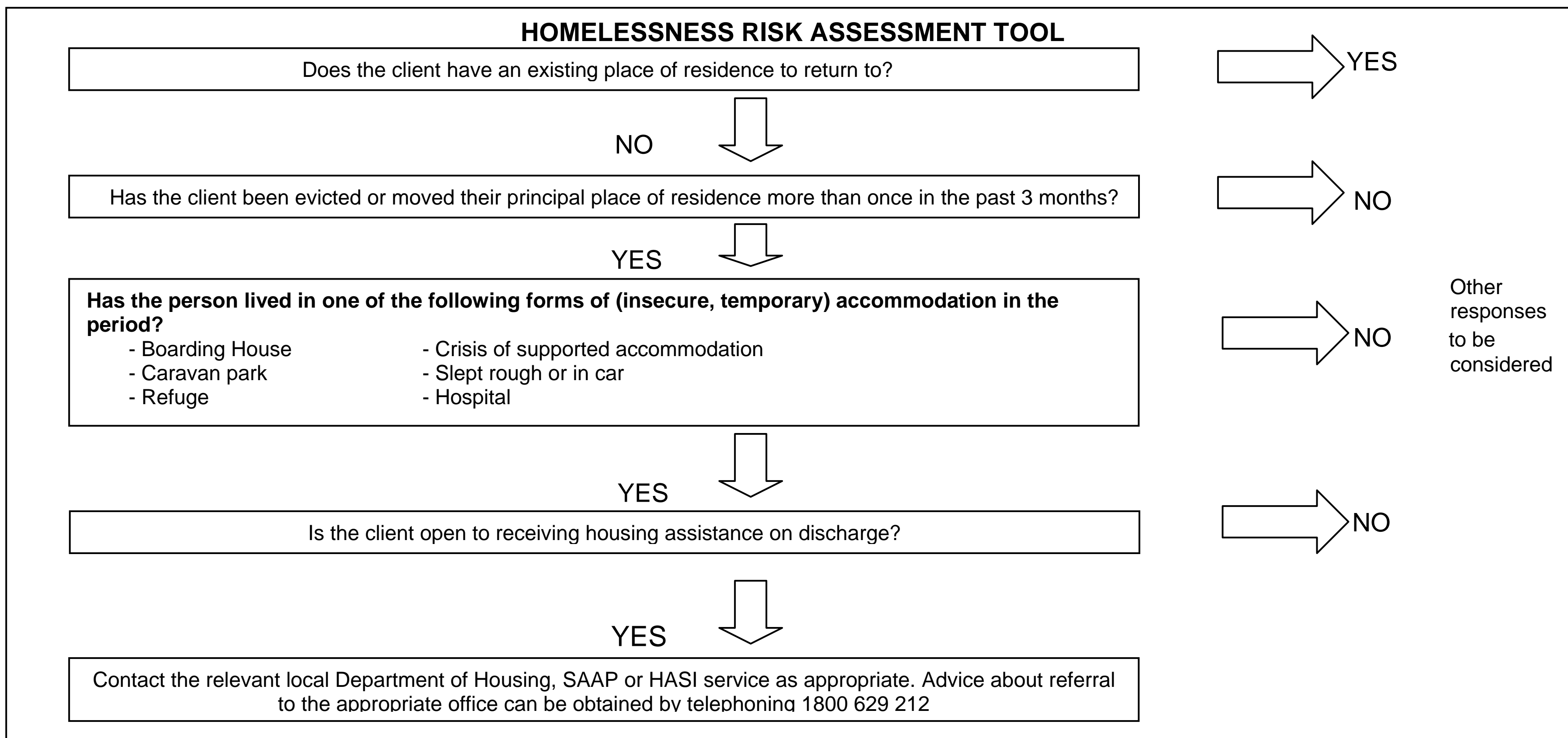
- Leaving hospital following an episode of mental ill health

WELFARE NEED

- Substance misuse
- Antisocial behaviour
- Family dispute or relationship breakdown
- Lack of coping or practical skills
- Learning disabilities
- History of sleeping rough

PROTECTIVE FACTORS

- Strong networks of family and friends
- Employed in training or education
- Co-operating with or actively seeking assistance
- Statutory or voluntary help



Appendix 7: Notification to NSW Police & Firearms Registry

NOTIFICATION TO NSW POLICE AND THE FIREARMS REGISTRY PURSUANT TO SECTION 79 OF THE FIREARMS ACT 1996

s79 of the Firearms Act 1996 provides for the notification to the NSW Police Commissioner by certain health professionals if they are of the opinion that a person to whom they have been providing professional services may pose a threat to their own or public safety if in possession of a firearm. In this instance, health professional means a Medical Practitioner, Registered/Enrolled Nurse, Registered Psychologist, Counsellor or Social Worker.

A particular circumstance involves high risk mental health patients known to have access to firearms. The Director-General, NSW Health, has written to Area Health Services to ask that in these cases health practitioners advise police as soon as practicable before the patient is discharged.

s79 protects the clinician from criminal or civil action in respect of breaching privacy. Nonetheless clinicians should inform patients that if the clinician becomes aware the patient has access to a firearm the police may be informed.

Process for notifying NSW Police of risk concerns:

1. **Ring Local Area Command Duty Officer to discuss the matter.**
2. **Fax this completed form to Local Area Command Duty Officer.**
3. **Fax this completed form to NSW Firearms Registry: 02 6670 8550**
   Attention: Manager Review and Assessment NSW Firearms Registry.

Patient's Family Name:	Given Name(s):	Date of Birth:
Residential Address		Telephone
Where is the patient currently located **(eg inpatient, emergency department, residential)?**		
If an inpatient address to which the patient will be discharged?	Anticipated date and time of discharge? ***(to ensure safety issues can be addressed at least 6hrs notice must be provided to police)*** Date: / / Time: __________	
Description of circumstances which lead you to believe that the person may pose a threat if in possession of a firearm *(include: relevant conversation, circumstances, observations, firearm type, effect of medical condition or treatment/medication on person's capacity etc. Use over page if more space is needed)*		
Does the person have access to their own firearm? Yes: ☐ No: ☐ Not known: ☐		
Does the person have access to other firearms? (eg spouse, other relatives, friends, neighbour) Yes ☐ No ☐ Unknown ☐ Name of person and location of firearm:		
Details of person submitting this report: Medical Practitioner ☐ Registered/Enrolled Nurse ☐ Registered Psychologist ☐ Counsellor ☐ Social Worker ☐ Contact Telephone: ______________________ Ext: ______________ Mobile: __________________ ContactAddress:____ Name: ______________________________Signature: _________________________Date:_________		

Note: Further details may be required by police to support legal process or legal action needed to protect persons.
The Information contained herein is confidential and any action by a practitioner does not give rise to any criminal or civil action of remedy (or breach privacy laws). If you have any enquiries, contact the NSW Firearms Register, Manager Review and Assessment on 1300 362 562, or the Duty Officer at your nearest Local Area Command.

Appendix 8: Useful Contacts / Websites

Organisation	Website	Contact	Comment
ARAFMI	http://www.arafmi.asn.au	1800 811 747 - Rural Freecall	ARAFMI NSW (Inc) provides support and advocacy for families and friends with mental illness or disorder.
BeyondBlue	http://www.beyondblue.org.au	1300 224 636 - Info Line	*Beyondblue* is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia.
COPMI	http://www.copmi.net.au	(08) 8132 0786 - Secretary	Children of Parents with Mental Illness (COPMI) resource centre is a national initiative of the Australian Infant,Child, Adolescent and Family Mental Health Association.
Department of Community Services Helpline	http://www.community.nsw.gov.au	132 111 - DoCS Helpline	The NSW Department of Community Services (DoCS) is the leading NSW Government agency responsible for community services
GROW	http://www.grow.net.au		GROW is a community of persons working towards mental health through mutual help and a 12 step program of recovery. Small groups of people who have experienced depression, anxiety or other mental or emotional distress, come together on a weekly basis to help each other deal with the challenges of life.
Mental Health Association of NSW	http://www.mentalhealth.asn.au	1300 794 991 – Freecall info@mentalhealth.asn.au	The Mental Health Association of NSW Inc is a non-government organisation and registered charity funded by Northern Sydney Area Health. Members are people who are interested in mental health issues.
NSW Health	http://www.health.nsw.gov.au	(02) 9391 9000 - Telephone	NSW Health is responsible for ensuring that the people of NSW are provided with the best possible health care.
ORYGEN	http://www.orygen.org.au		ORYGEN is an organisation made up of a specialist youth mental health service, a research centre and a range of education, training, advocacy and health promotion activities. The overall goal of ORYGEN is to integrate knowledge gained from clinical practice and research activities to implement, and advocate for, high quality mental health services for young people.
Transcultural Mental Health Centre		02 9840 3800 1800 648 911	The Transcultural Mental Health Centre offers information and resources for people of non-English speaking backgrounds suffering or caring for someone with a mental illness.
SANE Australia	http://www.sane.org	1800 18 7263 – Telephone	SANE Australia is a national charity working for a better life for people affected by mental illness – through campaigning, education and research.
Department of Ageing, Disability & Home Care (DADHC)	http://www.dadhc.nsw.gov.au	(02) 8270 2000	DADHC is the leading NSW Government Agency in NSW for services to older people, people with a disability and their carers.