NSW Government Response to Tracking Tragedy 2004

2nd Report of the NSW Mental Health Sentinel Events Review Committee

NSW Department of Health

This report can be downloaded from the NSW Health website
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December 2005

INTRODUCTION

The objectives of the NSW Mental Health Sentinel Events Review Committee, which reports directly to the Minister for Health, are to independently review the circumstances of suicide deaths and homicides involving patients of mental health services, to identify systemic problems, and to advise on opportunities for improving the safety of both patients of mental health services and the wider community.

The second report of the Committee, *Tracking Tragedy 2004 - A systemic look at homicide by mental health patients and suicide death of patients recently discharged from mental health inpatient units* (Tracking Tragedy 2), was released in March 2005. The NSW Government values the important work of the Committee and NSW Health welcomes the opportunity to respond to the Committee's findings.

In its second report the Committee makes 24 recommendations traversing a wide range of matters that affect service delivery to people with mental illnesses recently discharged from inpatient services who are at risk of suicide or who, in very rare cases, may be at risk of committing homicide. In making its recommendations, the Committee has focussed appropriately on the assessment and management of risk of violence among mental health patients.

The NSW Government's response to the report which follows will contribute significantly to improving the care and safety of patients of mental health services and the community in NSW. All the Committee's recommendations are supported and either are being or will shortly be implemented.

In a range of cases the Committee has recommended the development and setting of practice standards for patient and community safety of mental health services. Developing and promulgating minimum standards for follow up will be the responsibility of the new Clinical Safety and Standards Steering Group will be established and auspiced by, and report through, the Mental Health Program Council. The Steering Group will bring together leading mental health clinicians from across NSW to review existing protocols and policy guidelines and develop statewide clinical standards based on experience and the practical realities of conditions on the ground. Clinicians, patients and carers will be widely consulted on new draft standards before their promulgation as NSW Health policy. Specifically the Clinical Safety and Standards Steering Group will review the protocols, policies and guidelines for recommendations 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20, and advise the Centre for Mental Health on appropriate clinical standards to address requirements. To ensure consistency and efficiency across initiatives within NSW Health, mechanisms are being established for the Clinical Safety and Standards Steering Group to report to the Mental Health Priority Taskforce.

One of the key common themes in the Committee's recommendations is the need for improvements in documentation and communication among mental

health care providers, particularly in relation to discharge planning from an inpatient setting.

Assertive follow up is crucial to the successful journey from inpatient to community mental health services. NSW Health has identified the first month, and in particular the first week, after discharge as the critical period for following up people recovering from episodes of severe mental illness. One of the first tasks of the Steering Group will be to examine safest practices in this important area and make appropriate recommendations for practice standards.

While much remains to be done, it is important to note the Committee's observation that the common perception that any suicide death or homicide by a person in contact with public mental health services represents a failure of that service is not always so. Indeed, as the Committee notes, NSW mental health services in general do a very effective job of managing people with severe mental illnesses.

As the report notes, while the risk of suicide is greatest in the period shortly after discharge from inpatient facilities, suicide deaths by patients of mental health services are still quite uncommon at 13 per 1,000 separations within 30 days of discharge. Homicide deaths by patients of mental health services, at an average of only seven per year, are extremely rare.

Suicide and homicide deaths are also not readily predictable. Assessing people who are at risk of suicide is inherently complex wherever they come into contact with the health system. Prediction is complicated by the risk factors present in those people discharged who subsequently commit suicide also being present in the great majority of people discharged who do not.

NSW Health has nevertheless in 2005 taken a number of steps to improve mental health services in NSW. These have been guided by the recommendations made by the Committee and in the earlier report of the Legislative Council's Select Committee Inquiry into Mental Health Services.

Structural initiatives

NSW Health is particularly committed to having in place the best systems and processes to prevent where possible suicide and homicide deaths in NSW. The Centre for Mental Health, within the Department of Health and the NSW Coroner meet regularly and both are represented on the Mental Health Sentinel Events Review Committee.

The Health Department has also revised and updated its Incident Management Policy covering Reportable Incidents and the Root Cause Analysis system. These changes will assist Area Health Services to respond effectively to systemic issues identified in suspected suicides and homicides and will provide a better basis for routine reporting, analysis and management of mental health sentinel events.

New key mental health policy documents

NSW Health has developed the *Framework for Suicide Risk Assessment and Management for NSW Health Staff,* which was released in November 2004. The Framework document outlines key strategies for NSW Health staff working with people who are at risk of self-harm or at risk of harming others.

The Framework is being supported by a statewide training program in all health settings, addresses recommendations of the committee concerning:

- Standardised risk management systems, including triage and admission;
- Identifying, managing and documenting levels of risk;
- Guidelines for suicide risk assessment and management for staff working in six health settings, including Emergency Departments, mental health inpatient and community mental health services; and
- Working with and better engaging families and carers of people with mental illness.

NSW Health has also developed draft *Discharge and Follow-up Protocols for NSW Mental Health Inpatient Service* to accompany the Framework in guiding improvements in mental health service delivery in Area Health Services. This document sets out protocols to be implemented in key treatment settings throughout all Area Health Services.

Suicide prevention remains the responsibility of the entire community. Suicide prevention and homicide prevention will continue to be high priorities of the NSW Government. To that end, these initiatives build on a range of policy strategies that have been in place for some years in NSW Health, including the whole-of-government approach to suicide prevention released in 1999, *We Can All Make a Difference: NSW Suicide Prevention Strategy*.

Representatives of government and non-government agencies involved in suicide prevention recognised the need for a high level group to lead suicide prevention initiatives. To that end the NSW Suicide Prevention Working Group has been established, with representation from Government, non-government organisations and the community, to support and advise on ongoing suicide prevention policy direction in NSW.

NSW Health acknowledges that these policies in themselves are not enough. Their implementation is the key. Successful implementation of mental health policy in NSW requires close collaboration with key stakeholders – in particular mental health clinicians, patients and carers.

The responses set out below to the 24 recommendations of the Tracking Tragedy 2004 report reflect the directions and goals of NSW Health to continue improving mental health services for all people of NSW.

John Hatzistergos
Minister for Health

RESPONSE TO RECOMMENDATIONS

REPORTING AND REVIEW SYSTEMS

Recommendation 1

NSW Health examine the effectiveness of current reporting and review processes for suspected suicide deaths of patients of Alcohol and Drug Services.

(*Implementation timeframe 6 months)*

NSW Health supports this recommendation and the proposed timeframe. In line with current NSW Health policy, all Drug and Alcohol Services are required to complete a Reportable Incident Brief (RIB) as for the death of known drug and alcohol patients, including suspected suicide deaths. RIBs are completed as part of the Incident Information Management System (IIMS) according to the appropriate Severity Assessment Code (SAC) rating. These reports are then forwarded to NSW Health for appropriate action.

NSW Health will conduct an extensive investigation over the next 6 months to measure compliance with this policy within Drug and Alcohol Services. Any gaps in compliance will be identified and documented, and appropriate measures will be put in place to address any shortcomings in the reporting and review processes.

Recommendation 2

NSW Health develop and trial a standardised terms of reference and documentation format for the external review of a homicide by a patient of a mental health service.

(*Implementation timeframe 12 months*)

NSW Health supports this recommendation and will implement it within the timeframe proposed. Under the revised legislation, effective from 1 August 2005, a Root Cause Analysis (RCA) investigation will be mandatory for SAC 1 incidents and this will include cases involving a homicide by a mental health patient.

The Sentinel Events Review Committee has developed draft terms of reference and a documentation format for review of homicides as proposed in this recommendation. The template and guidelines under development within NSW Health's Patient Safety and Clinical Quality Program for use across the State for RCA completion, effective from 1 August 2005 have been based on this documentation format.

Recommendation 3

NSW Health work with the NSW Coroner to develop systems for communication between the Coroner and local mental health services to ensure that services receive prompt and comprehensive notification of suspected suicides deaths.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation in principle, subject to consultation with the NSW Coroner.

NSW Health is working in close collaboration with the NSW Coroner. The implementation of this recommendation will involve a change to current Coroner's Office procedures and may entail consideration of amendments to existing legislative requirements.

NSW Health recognises that this measure will support the implementation of a statewide system to detect suspected suicide deaths of patients of mental health services in a timely and accurate manner. When in place, such a system will enhance opportunities to provide postvention support for bereaved families, carers and friends. It will also assist Area Mental Health Services to better identify and manage a clustering of suicides in a local area in a more timely manner. A further advantage is that timely advice of suspected suicide deaths in the community would allow more immediate review of systems and the development of improvements to the delivery of patient care in the community.

The suggested timeframe for implementation is feasible, but cannot be guaranteed as the procedural and legal changes required by the Coroner may extend beyond 12 months.

Recommendation 4

NSW Health ensure the development of

- a unique identifier, and
- electronic record systems

to ensure the constant availability and prompt transfer of relevant clinical information between services and between service providers.

(*Implementation timeframe 24 months)*

NSW Health supports this recommendation and development of both a Unique Patient Identifier and the Electronic Health Record is underway.

The Centre for Mental Health considers the development of the Unique Patient Identifier as a priority for mental health patients.

Unique identifiers allowing access to past mental health treatment history of a patient will be available at Area Health Service level in October 2005 and is expected at State level by December 2005. The currency of this information will initially depend on supply of data from Area Health Services.

The data will be used by clinicians to view patient treatment history. Timeliness and coverage will depend on data supply from Area Health Services and computer and web access availability to clinicians.

NSW Health's development and implementation of the Electronic Health Record (EHR) is a complex and ongoing project across the entire Health System. It is not possible to develop the EHR for patients of Mental Health Services alone. When in place, the EHR will supply real-time electronic clinical and historic data to support patient care. The Centre for Mental Health will ensure that mental health patients are included at every stage of the project to ensure the EHR is available to improve communication and safety for mental health patients from the outset of its implementation, when this occurs.

Recommendation 5

NSW Health evaluate the effectiveness of the current system of reporting and review of suspected suicide deaths. This evaluation should consider whether RCA methodology facilitates meaningful involvement of local clinicians, and consider additional methods for such involvement if necessary.

(*Implementation timeframe 24 months)*

NSW Health supports this recommendation and it will be implemented within the suggested timeframe. The Root Cause Analysis (RCA) process has been in place since 2003 and has recently been reviewed.

NSW Health's Quality Branch and the Centre for Mental Health conducted an analysis of the RCA system by examining all reported suicides, including those rated SAC 1, those referred for RCA and the outcome of RCAs completed within the specified six week timeframe. Feedback has been provided to Area Health Services and to the Area Directors of Mental Health.

The effectiveness of the relevant components of the *Patient Safety and Clinical Quality Program* is being externally evaluated and the Sentinel Events Review Committee's recommendation concerning the involvement of local clinicians is to be included in the evaluation. Depending on the findings of that evaluation, consideration may be given to establishing additional methods for meaningfully involving local clinicians.

The current system of reporting and reviewing suspected suicide deaths is addressed through the Patient Safety and Clinical Quality Program which is designed to provide a comprehensive system-wide response to improving clinical care while providing a particular focus on the patient journey through health system redesign.

Key components of the Program are:

- Systematic management of incidents and risks
- Policy setting and standards development
- Establishment of the Clinical Excellence Commission to replace and build on the foundation work carried out by the Institute for Clinical Excellence
- A Quality Assessment Program for all public health organisations
- Clinical Governance Units in each Area Health Service
- A new Incident Information Management System (IIMS).

Reporting of suspected suicide deaths is conducted through the IIMS. When the incident is rated 1 on the Severity Assessment Code (SAC) a mandatory Root Cause Analysis (RCA) is conducted.

CHILDREN, FAMILIES AND CARERS

Recommendation 6

NSW Health commence immediately the development of a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder, for implementation within 24 months.

(Implementation timeframe 6 months)

This recommendation is supported and is in the process of implementation.

There are a number of initiatives underway that address this recommendation. These include:

1. *Integrated Perinatal and Infant Care Clinical Pathways and Guidelines* has been developed by the Centre for Mental Health in the context of the NSW *Families First* whole-of-government initiative to provide clinicians with a good practice model of care for working with mentally ill parents of young children. The document includes a focus on child protection issues and mental health clinicians' clinical competencies in assessing parenting capacity.

2. A comprehensive mental health training strategy to support the implementation of *Integrated Perinatal and Infant Care Clinical Pathways and Guidelines* and the *Crossing Bridges Downunder* program, aimed at the needs of children (up to young adulthood) of parents with a mental illness.

3. NSW Health working collaboratively with the Department of Community Services (DoCS) to review the reporting process identified in the Child Protection Legislation (including pre-natal reporting). This includes a service agreement that provides guidelines for NSW Health and DoCS workers to enhance responsiveness and active partnership in the notification of children at risk.

4. An evaluation of the Mental Health Outcomes and Assessment Tools (MH-OAT) modules is commencing in 2005. Relevant to this Recommendation the evaluation will review the systematic identification of all children in the care of mentally ill parents/carers, including comprehensive management plans for child protection issues, a child protection risk assessment guide and improved documentation.

5. The Centre for Mental Health is developing the *NSW Strategic Framework: Children of Parents with a Mental Illness (COPMI)* in line with the *National Principles and Actions for Services and People Working with Children of Parents with a Mental Illness* (2004), a *National Mental Health Plan Priority* theme.

   The purpose of the strategic framework is to increase the resilience of children of parents with a mental illness, to enhance the children's safety and to reduce the level of physical and emotional risks throughout developmental stages.

The initiatives described above will be considered by the Centre for Mental Health, through reference to the Clinical Safety and Standards Steering Group. This will ensure that the requirement of the recommendation for clear clinical guidelines for the management of risk to this group of children is met.

Recommendation 7

NSW Health implement and audit minimum standards for the involvement and documentation of the involvement of families and carers in mental health care during:

- assessment;
- discharge planning from acute mental health inpatient units;
- ongoing community care; and
- contingency planning and response to escalating concerns or to changing clinical situations.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation and has taken a number of steps towards its implementation.

The current review of the Mental Health Act (the Act) is focusing on an enhanced role for families and carers in the treatment of people with mental illness, while respecting the rights of patients. Concerns regarding privacy have impeded appropriate information sharing with families and carers. The proposed revisions to the Act would allow clinicians to share information with families on a clearly articulated legal basis.

To support the development of family oriented mental health services the Centre for Mental Health has provided funding to South East/Illawarra Area Health Service to expand the *Working With Families (WWF) Program*, statewide. The program has a dual focus on:

- improving individual clinician practice in regard to family involvement in the assessment and care of their relative; and
- achieving systemic change to enable clinicians to work in a family focussed way, be responsive to the unique needs of families and carers and ensure they are explicitly involved in the service system.

The initial stage of the roll out of the WWF Program will occur over the next ten months and will include Area Health Service visits to map capacity and adopt the strategy for local application, and staff training workshops.

NSW Health considers the auditing of minimum standards for the involvement and documentation of families and carers is appropriately undertaken at the Area Health Service level, by reviewing and or including the requirements in the mental health services' existing file audit tools. These audits will be reported through the established Tracking Tragedy progress reporting process.

ASSESSING AND MANAGING RISK OF HARM TO OTHERS

Recommendation 8

NSW Health develop an empirically based risk assessment and management framework of risk of harm to others.

(*Implementation timeframe 24 months)*

NSW Health agrees in principle to this recommendation and work in this area has commenced. The Centre for Mental Health anticipates that this work will be completed within the timeframe.

Currently, assessment of risk of violence to others is a core component of any mental health assessment and is highlighted in the comprehensive *Framework for Suicide Risk Assessment and Management for NSW Health Staff* guidelines and protocols. However, further enhanced capacity to assess and manage risk of harm to others is supported.

Consensus opinion is that risk assessment tools used in conjunction with structured risk assessment protocols provide the most reliable approach. Management of risk of violence includes consideration of family, community support and legal issues. The development and adoption of a framework for assessment and management of risk of harm to others requires both the development and testing of the model prior to its adoption.

The Centre for Mental Health will work in close collaboration with Justice Health (Statewide Forensic Mental Health Directorate), to develop the framework for risk of harm to others, drawing on the extensive expertise of the Directorate. The Clinical Safety and Standards Steering Group will be consulted in this process.

Recommendation 9

NSW Health liaise with mental health professional bodies to include in professional development programs defined minimum risk assessment skills.
(*Implementation timeframe 24 months)*

NSW Health supports this recommendation in principle and recognises the need to enhance clinicians' risk assessment skills.

NSW Health has supported the Institute of Psychiatry conducting advanced training in suicide risk assessment for mental health professionals for several years. However, this recommendation particularly relates to the assessment of risk of harm to others.

The Community Forensic Mental Health Service established within Justice Health in 2004 provides specialist consultation, advice and clinical care in complex cases involving risk of violence to others in the context of mental health. As part of its task, Justice Health will assume responsibility for oversighting and facilitating the training for Area Health staff in risk assessment. At this stage there needs to be further exploration of resource requirements for this training role. Progress on implementation of this recommendation will be reported to the Sentinel Events Review Committee.

FORENSIC PATIENTS

Recommendation 10

NSW Health develop a register of forensic patients in community care.
(*Implementation timeframe 6 months)*

NSW Health supports this recommendation and implementation has commenced.

Justice Health, through its Community Forensic Mental Health Service has commenced the development of a database to register forensic patients in the community. The development of this database is proving to be a complex task, however, it is expected to be operating within a 12 month timeframe.

Recommendation 11

NSW Health develop guidelines for the minimum level of care that should be provided to forensic patients in community care.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation and work has commenced on the development of guidelines as recommended.

Justice Health is developing guidelines for the minimum level of care to be provided for forensic patients in the community in conjunction with the database register of forensic patients in the community. Justice Health is currently up-skilling clinical staff. The development and ongoing monitoring of guidelines will be implemented over a two to three year timeframe. The next phase will include capacity building within mainstream mental health services.

The Centre for Mental Health, in collaboration with the Clinical Safety and Standards Steering Group will provide input and advice to the development of the guidelines to ensure the optimal Area Health Service engagement and prioritisation in regard to care for this small but important patient group.

CLINICAL PRACTICE AND CARE

Recommendation 12

NSW Health define standards in relation to the multidisciplinary review of critical points of the patient’s pathway, including:

- new presentations;
- acute exacerbations or relapses of illness;
- changes in the level of risk of harm to self or others; and
- discharge from the mental health service.

These standards should specify the involvement of a treating psychiatrist or most senior attending mental health clinician.

(*Implementation timeframe 12 months)*

This recommendation is supported and will be implemented within the 12 month timeframe. The Centre for Mental Health with reference to the Clinical Safety and Standards Steering Group will oversight the development and implementation of these standards. The Steering Group will take into account current local practices and the protocols and those laid out in recent NSW Health policy documents, the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* and the draft *Discharge and Follow-up Protocols for NSW Mental Health In-patient Services.*

Recommendation 13

NSW Health develop minimum standards for consultation with, and/or direct contact by, consultant psychiatrists:

- in the assessment of emergency presentations to mental health services and emergency departments;
- in the care of inpatients of mental health units; and
  for the recording of such contact.

(*Implementation timeframe 12 months)*

This recommendation is supported and will be implemented within the 12 month timeframe. The Centre for Mental Health will oversight the development of standards with reference to the Clinical Safety and Standards Steering Group.

Current local policies and practices together with consideration of resources and reasonable workload limits for consultants will be taken into consideration. The standards will be developed in consultation with Area Health Services to determine resources and change management practices required to implement this recommendation, in collaboration with the Clinical Services Redesign Units in Area Health Services, as required.

Recommendation 14

NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation, which will be implemented within the timeframe. The Centre for Mental Health will oversight the development of these standards with reference to the Clinical Safety and Standards Steering Group. Current NSW mental health practices, policies and protocols addressing the use and documentation of telephone contact during assessment, treatment and post discharge follow-up will be considered in this process.

Whilst there is a need for clear policy and direction on telephone contact in high risk situations, NSW Health considers that telephone contact with patients plays an important part of the clinical relationship.

Clinical management decisions, including the frequency and method of contact with the patient, should be based on an individual comprehensive mental state assessment, including risk of harm to self and others and suicide risk. The NSW Health *Framework for Suicide Risk Assessment and Management for NSW Health Staff* recommends face-to-face reassessment following discharge from a mental health service or unit.

In rural and remote communities, mental health professionals may have to rely on the use of the telephone for contact with the patient, general practitioner family and other services. In such situations phone contact is an important adjunct to providing quality care and is often the only way to provide timely advice and support.

The draft *Discharge and Follow-up Protocols for NSW Mental Health In-patient Services* describe the minimum requirements for follow-up after discharge. The protocols stipulate that the relevant health provider with whom the post-discharge appointment has been made must make all reasonable attempts to contact the person, including include telephone calls, contacting family/carer/general practitioner, visits to the person's residence and follow-up letter.

Recommendation 15

NSW Health implement a procedure for flagging and reviewing patients who are failing to improve.

(*Implementation timeframe 24 months)*

NSW Health supports this recommendation which will be implemented within the timeframe. The Centre for Mental Health will oversight the development and implementation of this procedure with reference to the Clinical Safety and Standards Steering Group.

Monitoring the progress of a patient is a core clinical task. This can present challenges within mental health services due to factors relating to the patient, their illness and the treatment setting. Many patients experience illness over many years, either continuously or episodically. Continuity of care may be disrupted if patients move their place of residence and hence change local mental health service providers or when there are staff changes within a mental health service. On occasions, all these factors may occur at the same time. As a result systems embedded into Mental Health care systems are needed to minimise the risk of poor outcomes due to such factors.

The new Clinical Services Redesign program in NSW Health will be consulted to provide advice to implement the changes required.

Recommendation 16

NSW Health ensure that risk assessments and risk management plans are routinely documented in the medical record, and that changes to the level of risk are documented and are accompanied by a specific and appropriate management plan.

(*Implementation timeframe 24months)*

NSW Health supports this recommendation and will work to promote its implementation within the timeframe.

The Centre for Mental Health will take the lead on this clinical issue, with reference to the Clinical Safety and Standards Steering Group. Scope of work will be to determine the best approach to ensure that risk assessment and appropriate management plans are routinely documented in medical records.

The practice principles inherent in this recommendation are recognised essential procedures for clinical management of risk. The MH-OAT protocols initiative was developed to address this issue. The review of the use of the MH-OAT clinical modules, which is currently being carried out, will canvas the current practices across NSW and point to improvements for the training and use of MH-OAT.

Other recent initiatives yet to be fully implemented across the NSW Mental Health Services which emphasise the responsibility for documenting key clinical decisions, risk assessment and management plans, include the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* and the soon to be released *Discharge and Follow-up Protocols for NSW Mental Health In-patient Services.* Staff training being developed to support these initiatives will demonstrate the importance of sound documentation in medical records at key points in the assessment and management process.

An interactive training package is being developed to support implementation of the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* in Area Health Services. The importance of proper documentation is emphasised in the training package, illustrated by case studies in the module. The package will be piloted in July 2005. Implementation of the training module will commence in the 2005/06 financial year. Several Area Health Services have commenced local training around the Framework.

DISCHARGE AND FOLLOW-UP

Recommendation 17

NSW Health develop minimum standards for the frequency and duration of follow-up after discharge from an inpatient mental health unit. This should be linked to the level of clinical risk.

(*Implementation timeframe 12 months)*

This recommendation is supported and will be implemented within the timeframe. The Centre for Mental Health will lead the development of these standards, with reference to Clinical Safety and Standards Steering Group. These standards will be informed by the work already underway in this area, described below.

It must be acknowledged that not all mental health patients will be discharged from hospital with a 'low' level of clinical risk given the nature of their illness, and broader societal considerations balancing the right to treatment, the right to personal freedom and the acknowledgement of the roles and responsibilities of individuals, families and carers, and non-government agencies in the safe care of individuals with mental illness.

The *Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units* require that a discharge plan be developed and documented which articulates roles, responsibilities and timeframes for the period between assessments as well as explicit plans for responding to non-compliance and missed contact by the patient.

Discharge and Follow-up Protocols for NSW Mental Health In-patient Services due for release in 2005, provide greater detail on minimum practices for discharge planning and post-discharge follow-up.

The schedule for re-assessment after discharge is clearly set out in both of the protocols and is based on the person's level of suicide risk. They recognise that the first 28 days after discharge from a mental health in-patient unit is a period of elevated suicide risk.

Recommendation 18

NSW Health ensure that people with a first episode of psychosis or major mood disorder receive active follow up by the senior attending mental health clinician for at least 12 months following first service contact, in keeping with the National Psychosis Guidelines. Where this is impossible or unnecessary, the case should be reviewed and adequately documented.

(*Implementation timeframe 12 months)*

This recommendation is supported in principle and is current practice for early psychosis within many parts of New South Wales.

Continued follow-up by the senior attending mental health clinician, may not always be directly possible particularly in rural areas, given the large geographic regions across which Mental Health Services are provided.

In circumstances where ongoing direct service provision cannot be provided, NSW Health accepts that a senior attending mental health clinician should be available for consultation at all times for less senior staff providing ongoing care to the patient. Supervision is available to Mental Health staff across NSW for example clinical supervision has been established as a priority in mental health nursing. Supervision by consultant psychiatrists is mandatory for psychiatry trainees, and clinical supervision of psychologists and social workers is standard practice.

Early psychosis practice in NSW uses the *Australian Clinical Guidelines for Early Psychosis*. Early psychosis service development has been guided by *Getting in Early: A Framework for Early Intervention and Prevention in Mental Health in NSW* (2000). In NSW, the establishment of early psychosis services range from specialist early psychosis teams through to integrated services in which all staff are trained in the principles of early intervention.

One well-developed approach is the Southern Area First Episode (SAFE) which is a model for a comprehensive early psychosis service in a rural area that has been piloted in other rural areas. It accesses visiting psychiatrists and telepsychiatry consultation. Psychiatric services are provided by child and adolescent and adult mental health early intervention specialists, who work as a single team. They are also responsible for educating other staff in the mental health service.

The development of the service requirements within this recommendation will be led by the Centre for Mental Health with reference to the Clinical Safety and Standards Steering Group to ensure that achievable service standards will be developed within the 12 month timeframe for implementation by Area Health Services.

Recommendation 19

NSW Health develop mandatory procedures for response to loss of contact or non-attendance at planned follow-up for people who may be at risk of suicide or risk of harm to others. If loss of contact occurs within 28 days of discharge for any patient, or at any time if a person remains at significant risk, then:

- immediate consultation should occur with a senior mental health clinician; and
- a considered action plan should be documented by the service.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation and recognises that good risk management needs to be consistently practiced.

The *Framework for Suicide Risk Assessment and Management for NSW Health Staff* and the associated site-specific protocols, including *Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units* were released in November 2004. They have been disseminated widely throughout the NSW Health system. Implementation rests with the Area Health Services, through the development of supporting local protocols and education and training of staff. This will be supported by an interactive training package which will be implemented in the 2005/06 financial year. Some Area Health Services have commenced local training around the Framework.

The *Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units* require that a discharge plan be developed and documented which articulates roles, responsibilities and timeframes for the period between assessments as well as explicit plans for responding to non-compliance and missed contact by the patient.

Discharge and Follow-up Protocols for NSW Mental Health In-patient Services have also been drafted which detail minimum practices for discharge planning and post-discharge follow-up, including the necessity for urgent contact if an appointment is not kept or the level of risk escalates. The Discharge Protocols are due for release in 2005.

All protocols emphasise that patients who have been at risk of suicide require close follow-up when discharged from hospital and recognises that the first 28 days after discharge from a mental health in-patient unit is a period of elevated suicide risk.

The Centre for Mental Health will lead the development of the procedures with reference to the Clinical Safety and Standards Steering Group. Building on Circular 98/31 - policy guidelines for suicide risk assessment and management, the *Framework* and *Discharge and Follow Up Protocols*, the Clinical Safety and Standards Steering Group will determine what additional measures are required to fully meet this recommendation within the identified timeframe.

SERVICE PARTNERSHIPS

Recommendation 20

NSW Health ensure that where multiple health providers (e.g. general practitioner, private psychiatrist, psychologist, non-government organisation) are involved in a shared management plan that there is effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information there is review by the senior clinician.

(*Implementation timeframe 12 months)*

NSW Health supports this recommendation, subject to legal requirements as discussed below.

The Centre for Mental Health will lead the development of policies required to address this recommendation within the timeframe, with reference to the Clinical Safety and Standards Steering Group.

The Steering Group's activity will be supported by the privacy legislation, policy initiatives and local protocols. For example, the Health Records and Information Privacy Act 2002 and the NSW Health Privacy Manual 2005 (Version 2) enable the exchange of information between service providers for the on-going care of a person without the expressed consent of the patient. In particular, the issue of sharing of information for ongoing treatment purposes, and how to address situations where the patient refuses or withholds consent for sharing of information is dealt with in depth at paragraph 11.2.1.3 of that Manual. These provisions apply equally to mental health and non-mental health information.

The draft *Discharge and Follow-up Protocols for NSW Mental Health In-patient Services* direct relevant hospital and community mental health staff to have access to file information concerning people in the care of both service components. The draft document has been reviewed within the Cross Agency Mental Health Strategy and revised to assist with identifying mutual patients, facilitating exchange of appropriate information and being included in the collaborative discharge planning process. Agencies will need to make local agreements on what information can be exchanged in accordance with the Privacy legislation. The patient should be informed of the substance of these agreements.

The protocols set out minimum standards for health services to follow in relation to the timing, type and recipients of discharge summaries and reports. They also deal with consent in relation to information where safety or a deteriorating clinical state become an issue after discharge, and recommend that the senior clinician should make decisions regarding the release of information in such situations.

All protocols emphasis that patients who have been at risk of suicide require close follow-up when discharged from hospital and recognises that the first 28 days after discharge from a mental health in-patient unit is a period of elevated suicide risk.

Recommendation 21

NSW Health ensure the development of policies and training for suicide risk assessment in Alcohol and Drug services.

(*Implementation timeframe 24 months)*

NSW Health supports this recommendation and is in agreement with the timeframe given. The Circular 98/31 *Policy guidelines for the management of patients with possible suicidal behaviour* is mandatory for all NSW Health staff. Training programs supporting its implementation currently take place in

Area Health Services. A multimedia training program that is being developed to support the implementation of the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* will promote training opportunities for drug and alcohol staff working in both inpatient settings and in community settings.

In addition, NSW Health is currently undertaking a survey of all Drug and Alcohol agencies across NSW to determine the level of psychological health assessment conducted on the drug and alcohol treatment population, including suicide risk assessment. Area Health Services will report on current questions and screening tools used to identify patients at risk of suicide and results will be used to develop a statewide policy and any additional training tools for clinicians as required for suicide risk assessment.

A comorbidity module relating to adolescents with mental health and drug and alcohol issues is being developed for the School-Link Training program. It is an advanced module for school and TAFE counsellors, adolescent mental health workers and drug and alcohol workers which will be implemented across NSW during 2005-2007.

RESOURCES AND DEVELOPMENT

Recommendation 22

NSW Health establish clear timeframes for delivering on its previously made commitment to reach acute mental health bed targets, to ensure Area Health Services meet their population bed needs in terms of Department of Health accepted planning models. Clear timeframes and targets should also be set for the provision of community mental health services.

(Implementation timeframe 6 months)

NSW Health agrees with this recommendation and it is being implemented. Since 2001, new acute mental health beds have opened throughout New South Wales and development for further beds and associated clinical staff are underway or are planned to the 2007/08 year. The Mental Health Clinical Care and Prevention Model (MH-CCP) is a valuable planning tool and NSW Health has planned to meet 80% of the acute bed need predicted by 2007/08.

These beds cannot be viewed in isolation and appropriate use of acute mental health beds requires effective access to non-acute beds and supported accommodation. More that 70 new non-acute beds have been opened since 2003 and a further 80 non-acute beds are being planned. The Housing and Accommodation Support Initiative (HASI) had rolled out 118 places of high support accommodation across NSW. A further 460 low outreach supported accommodation places for people living in public and community housing will be established in 2005/06. An additional 126 high support places are currently going to tender.

Further increases will be targeted to increase community based mental health services over 2005/06 – 2006/07. These include a comprehensive Mental Health Family and Carer Program across New South Wales and additional community mental health rehabilitation services.

NSW Health will continue to monitor the performance of services and aims to develop the mix of acute and community mental health services in a balanced manner.

Recommendation 23

NSW Health develop a mental health workforce strategy to build the necessary mental health workforce to meet service and quality goals across the life span, by the end of 2006.

(*Implementation timeframe 6 months)*

Mental health workforce planning and development is a key priority for NSW Health, in the context of current vacancies and future projected demand. A wide range of initiatives and actions are currently underway as part of a coherent Workforce Strategy that has 4 main elements:

- To identify and use creative means to recruit and retain people in the workforce, including strategies within the 2005/06 Mental Health Nursing Workforce and Skills Acquisition Project;
- To facilitate new ways of working across professional boundaries, including the identification of service models which are linked to required skills and competencies;
- To develop the workforce through revised education and training at both pre- and post-qualification levels, including the provision of funded educational supports; and
- To develop leadership and change management skills, including participation in the NSW Health Clinical Leadership Program.

Specific initiatives, including timeframes, are as follows:

- April 2005: Launch of the 2005/06 Mental Health Nursing Workforce and Skills Acquisition Project. The initial phase resulted in 450 expressions of interest from nurses, 220 of which were referred to Area Health Services with a view to employment.
- May 2005: Expansion of mental health participation in the NSW Health Clinical Leadership Program.
- July 2005: Workforce projections completed for the period 2005/08.
- August 2005: Provision of financial support to doctors undertaking post-graduate training in psychiatry with view to College fellowship.
- September 2005: Completed review of best practice service models for each component of the integrated mental health service, including necessary skills and competencies required for meeting the needs of patients.

- March - July 2005: Medical Training and Education Committee (MTEC) review of trainee psychiatrist training across New South Wales. A final report has been released including recommendations for strengthened and better facilitated training program across five training zones with greater support provided to trainees. MTEC has now amalgamated with Postgraduate Medical Council to form the Institute of Medical Education and Training (IMET).

Recommendation 24

In order to maximise the effectiveness of existing strategies to build workforce capacity (including resources, policies and protocols), NSW Health develop in partnership with the Institute of Psychiatry, other professional bodies and Area Health Services an educational agenda to progress skill and knowledge development. This collaborative process should identify priorities and set learning goals for each year over the next five years.

(*Implementation timeframe 6 months)*

NSW Health supports the direction of this recommendation and is engaged in a planned, systematised workforce capacity building strategy.

NSW Health is committed to a mental health program that learns and encourages learning among its staff. This includes promoting exchange of information between staff, hence creating a more knowledgeable workforce. This produces a flexible organisation where people will accept and adapt to new ideas and changes through a shared vision.

Specific initiatives are as follows:

- NSW Health participation in the review of psychiatry training by the Medical Education and Training Council (MTEC), final report expected by August 2005.
- Mental Health participation in the Clinical Leadership Program, an initiative under the auspice of the Chief Nursing Officer; this initiative is ongoing.
- Staff from the Centre for Mental Health and the NSW Institute of Psychiatry working together to map out educational needs for mental health staff, including requirements for the future direction of the Institute; a submission is expected from the Institute in June 2005.
- NSW Health currently funds the NSW Institute of Psychiatry for the provision of a range of mental health education and training programs for health workers.
- Provision of scholarships for mental health nurses, allowing for a range of educational options targeting individual and organisational requirements; providers include universities and other educational bodies, with commencement in second half of 2005.