

NSW Government's Final Response Tracking Tragedy (2008)

4th REPORT OF THE NSW MENTAL HEALTH SENTINEL EVENTS REVIEW COMMITTEE

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Foreword

The Minister for Health established the Mental Health Sentinel Events Review Committee in 2002 as a ministerial advisory committee to provide an independent review of deaths in which consumers of public mental health services were involved as suicide victims or as suspected perpetrators of homicide.

The Committee's objectives are to identify systemic problems and advise on opportunities for improving the safety and quality of service delivery for consumers of mental health services and the wider community. It produced its first Tracking Tragedy report in 2003, its second report in 2005 and its third report in 2007.

The Committee has now produced its 4th Tracking Tragedy report – *A systemic look at homicide and non-fatal serious injury by mental health patients, and suicide death of mental health inpatients.*

We would like to take this opportunity to thank the Committee for its work in reviewing often complex and confronting cases in order to meet its objectives. The NSW Government acknowledges this work and the significant role it plays in improving the effectiveness and safety of mental health services in NSW.

The 4th Tracking Tragedy report focuses on suspected suicide deaths reported by NSW Mental Health Services between 2003 and 2006, where the person was an inpatient of a NSW public mental health unit. These include suspected suicide deaths occurring within the unit, after absconding from the unit or being on unauthorised leave, or while on authorised leave. The Committee also looked at homicides that occurred during 2005 and 2006 as well as six serious non-fatal injuries caused by patients of mental health services in the years 2004 to 2006.

In its 4th report, the Committee acknowledges that suicides are infrequent events and there is an overall downward trend in the number of inpatient suicide deaths and an apparent reduction in suicide deaths of consumers on unauthorised leave. Twelve recommendations are made, with major themes across the recommendations noted as risk assessment, inclusion of carers and families, and care in the community.

The NSW Government's Final Response agrees with the principles of all of these recommendations and it is encouraging to note that many of the core components of the recommendations are already being actioned or addressed through current or planned strategies and initiatives.

The 4th Tracking Tragedy report is an important document that highlights the improvements that can be made to the mental health system in NSW and the changes that have already occurred. In responding to this report, the NSW Government recognises the value of the Mental Health Sentinel Review Committee to the community and to the key stakeholders who use or are involved with the mental health system in this State.



John Della Bosca MLC
Minister for Health



Barbara Perry MP
Minister Assisting the Minister for Health (Mental Health)

Summary of Recommendations and Final Response

RECOMMENDATION NO.	RECOMMENDATION	NSW GOVERNMENT FINAL RESPONSE
1	<p>NSW Health review and modify the <i>Access to Means of Suicide and Deliberate Self-harm Facility Checklist</i>, to ensure that it addresses, but is not limited to, the following:</p> <ul style="list-style-type: none"> ▪ cupboard door handles ▪ fixed shower rails ▪ hand basin fittings ▪ wardrobe rails ▪ all supposed “non-weight bearing” rails ▪ potential hanging points within courtyards 	<p><i>Recommendation 1 is supported, and consultation will be undertaken with the relevant NSW Health agencies to ensure implementation.</i></p>
2	<p>NSW Health establish a co-ordinated, consistent and ongoing statewide audit process of mental health inpatient units that includes but is not limited to:</p> <ul style="list-style-type: none"> ▪ access to means of suicide and risk of violence ▪ security of the ward entrance/admission environment ▪ physical security and monitoring of inpatient unit perimeters and courtyards ▪ optimal functioning of duress alarms ▪ procedures for the use of and response to duress alarms in inpatient units and emergency departments. 	<p><i>The principles of Recommendation 2 are supported. Further consultation will be undertaken with Area Health Services regarding the development and implementation of a statewide audit process.</i></p>
3	<p>NSW Health provide clinicians with standards for the documentation of risk assessment:</p> <ul style="list-style-type: none"> ▪ during ongoing inpatient care ▪ prior to changes in leave status 	<p><i>The principles of Recommendation 3 are supported, and initiatives to address the core components are being implemented.</i></p>
4	<p>Within the Family and Carer Mental Health Program, NSW Health ensure that particular attention is given to the role of the family in planning for leave. This should include:</p> <ul style="list-style-type: none"> ▪ involvement in ongoing monitoring of clinical progress and risk ▪ appropriate involvement in decisions to grant leave ▪ contingency planning and support for families and carers during periods of leave 	<p><i>The principles of Recommendation 4 are supported, and mechanisms to address the core components are in place.</i></p>
5	<p>NSW Health develop and implement a communication strategy that ensures that family members and carers are properly informed of the risks of untreated mental illness. This strategy would include, but not be limited to, a sensitive information brochure in relation to the risk of relapse and the possibility of risk to others when a person suffering from a psychosis becomes unwell.</p>	<p><i>The principles of Recommendation 5 are supported. Some mechanisms to address the core components of this recommendation are in place and consultation will be undertaken with key stakeholders around the appropriateness and requirement for additional initiatives.</i></p>

RECOMMENDATION NO.	RECOMMENDATION	NSW GOVERNMENT FINAL RESPONSE
6	<p>NSW Health develop and implement a standard of care planning which includes documenting:</p> <ul style="list-style-type: none"> ▪ the regular review of care, including consideration of a second opinion for prolonged acute admissions ▪ the identification and management of substance abuse co-morbidity 	<p><i>The principles of Recommendation 6 are supported. Mechanisms to address the core components of this recommendation are in place and additional initiatives are planned.</i></p>
7	<p>NSW Health develop and implement guidelines to ensure the safe and effective management of patients with a history of high risk who are managed in “shared-care” or in the primary care of a general practitioner and other service providers. These arrangements should include regular review and communication with a psychiatrist or senior mental health clinician.</p>	<p><i>The principles of Recommendation 7 are supported. Mechanisms to address some of the core components of this recommendation are in place and consultation will be undertaken with key stakeholders to determine the appropriateness and requirement for any additional initiatives.</i></p>
8	<p>NSW Health develop guidelines for the indication for and implementation of Community Treatment Orders to ensure that people of high risk retain contact with mental health services.</p>	<p><i>The principles of Recommendation 8 are supported, and mechanisms to address the core components are in place.</i></p>
9	<p>NSW Health define and implement minimal resource levels for inpatient and assertive community care of persons with complex and challenging anti-social behaviours.</p>	<p><i>Recommendation 9 is supported, and consultation will be undertaken with key stakeholders to ensure implementation.</i></p>
10	<p>NSW Health put in place systems to ensure that Area Health Services facilitate the early access by clinicians to expert forensic assessment services for selected high risk general psychiatric patients. These services should extend to the assessment of patients judged to present extreme risk of violence who have not been involved in a serious injury incident.</p>	<p><i>The principles of Recommendation 10 are supported, and mechanisms to address the core components are already in place.</i></p>
11	<p>NSW Health develop additional specialised environments and procedures within acute health facilities for managing the medical care of aggressive elderly patients with behavioural disturbance associated with dementia.</p>	<p><i>The principles of Recommendation 11 are supported. Initiatives to address the core components of this recommendation have been implemented and further initiatives are planned.</i></p>
12	<p>NSW Health put in place systems to monitor the implementation of recommendations made by the NSW Mental Health Sentinel Events Review Committee to facilitate the reporting of progress with implementation and the auditing of compliance with the recommendations.</p>	<p><i>The principles of Recommendation 12 are supported, and mechanisms to address the core components are in place.</i></p>

Final Response Detail

SAFETY AUDITS

Recommendation 1

NSW Health review and modify the *Access to Means of Suicide and Deliberate Self-harm Facility Checklist*, to ensure that it addresses, but is not limited to, the following:

- cupboard door handles
- fixed shower rails
- hand basin fittings
- wardrobe rails
- all supposed “non-weight bearing” rails
- potential hanging points within courtyards

Commencement: Immediate; Implementation timeframe: 6 months

NSW Government Response

Recommendation 1 is supported, and consultation will be undertaken with the relevant NSW Health agencies to ensure implementation.

The NSW Government agrees that a safe and secure environment for mental health consumers is fundamental to their care, and NSW Area Mental Health Services (AMHS) are very aware of their duty to ensure the safety of this vulnerable group as far as possible. This duty includes adherence to initial facility design standards for acute mental health units and their environs and also requires regular audits of environmental risks to support maximum safety within the mental health inpatient facility. This is considered part of the management planning necessary for consumers at risk of suicide.

The existing *Access to Means of Suicide and Deliberate Self-harm Facility (AMSDSF) Checklist* is part of the Suicide Risk Assessment and Management Protocols for mental health inpatient units. It is a comprehensive audit tool to assess level of current environmental risk, and note the action required to redress identified risk for mental health inpatient units. The checklist notes suicide and other potential risks for consumers, such as the safe storage of poisonous substances and hazardous materials. A preliminary review of the existing *AMSDSF Checklist* reveals that many of the areas within this Recommendation are already included, such as ‘non-collapsible shower frames’ and ‘clothes rod in room wardrobes’.

As the Sentinel Events Review Committee commented in its 4th Tracking Tragedy Report, the regular audits of access to means conducted in mental health units have had the effect of reducing a range of ligature points and other environmental risks, with the remaining risks points being difficult to restrict or control. For mental health inpatient services there remains the difficulty of providing an environment that controls or excludes all potential risks and one that provides a degree of comfort and normality for the consumers.

Accordingly, review and, if required, modification of the checklist will be carried out in consultation with AMHS staff.

Recommendation 2

NSW Health establish a co-ordinated, consistent and ongoing statewide audit process of mental health inpatient units that includes but is not limited to:

- access to means of suicide and risk of violence
- security of the ward entrance/admission environment
- physical security and monitoring of inpatient unit perimeters and courtyards
- optimal functioning of duress alarms
- procedures for the use of and response to duress alarms in inpatient units and emergency departments.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 2 are supported. Further consultation will be undertaken with Area Health Services regarding the development and implementation of a statewide audit process.

As noted in the response to Recommendation 1, the NSW Government supports the review and modification, where appropriate, of the *Access to Means of Suicide and Deliberate Self-harm Facility (AMSDSF) Checklist*. The consideration of environmental issues where there is a risk of violence will be included in the review of this tool.

However, the development of a state-wide process for auditing specific environmental risks and hazards will need to consider and build on current audit processes, such as those associated with Australian Council of Healthcare Standards (ACHS) accreditation or Occupational Health & Safety (OH&S) reviews. Accordingly, consultation will be required with Area Health Services (AHS) to gain an understanding of the audit processes that already exist, how these may be utilised to support the auditing of mental health inpatient environments and what new or additional audit processes may be required.

RISK ASSESSMENT

Recommendation 3

NSW Health provide clinicians with standards for the documentation of risk assessment:

- during ongoing inpatient care
- prior to changes in leave status

Commencement: 6 months; Implementation timeframe: 12 months

NSW Government Response

The principles of Recommendation 3 are supported, and initiatives to address the core components are being implemented.

The NSW Government recognises the need for clear risk assessment processes. One of the ways in which this is being addressed is through the release of the redesigned NSW Health Mental Health-Outcomes and Assessment Tools (MH-OAT) Clinical Modules in September 2008.

These standardised modules were developed to support comprehensive clinical assessments and accurate documentation for all mental health consumers of NSW Area Mental Health Services.

A principle change to the modules as a result of the redesign includes a revised risk assessment approach to include specific support regarding the risk of violence/aggression as well as consistent screening questions in all core modules linked to a more detailed risk assessment module.

In addition, funding has been provided to Justice Health to support them to develop a Statewide Risk Assessment & Management Training Program for Area Mental Health professionals working with consumers who may be at risk of violence towards others. The aim of the Program is to enable clinicians in mental health services to develop knowledge and skills relevant to risk assessment and management within inpatient and community settings. The Program's first training session took place on 28th and 29th April 2008 in Greater Western Area Health Service and continued throughout 2008 at other sites. Further training is also scheduled for 2009.

While this training relates specifically to risk assessment regarding consumers who may be at risk of violence towards others, candidates will receive advanced training in the development and documentation of risk assessment and management plans and the theoretical principles that underpin them. This knowledge will enable AMHS to develop their own local protocols around risk assessment and management and support the appropriate use of the redesigned MHCD.

In relation to standards of documentation specifically for suicide risk assessment, the NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff has been developed to link with the Mental Health Clinical Documentation assessment and management protocols. The framework provides detailed information on conducting suicide risk assessments and the roles and responsibilities of generalist and mental health services as well as the standards of practice that must be met in key treatment settings. An important component of the framework is the requirement to clearly document risk assessment outcomes using the MHDC as well as conduct and document regular reviews, including re-assessment of risks and response to clinician interventions.

COMMUNICATION SYSTEMS

Recommendation 4

Within the Family and Carer Mental Health Program, NSW Health ensure that particular attention is given to the role of the family in planning for leave. This should include:

- involvement in ongoing monitoring of clinical progress and risk
- appropriate involvement in decisions to grant leave
- contingency planning and support for families and carers during periods of leave

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 4 are supported, and mechanisms to address the core components are in place.

The majority of care for people with a mental illness occurs in the community, making carers and families of a consumer an integral part of the care team.

The NSW Government has formally recognised carers and the critical role they play in improving the quality of life and the health outcomes for consumers in a range of ways. Specifically in relation to planning for leave, this includes the release of the NSW Health *Discharge Planning for Adult Mental Health Inpatient Services Policy Directive* (PD2008_005) in January 2008.

An important component of the Discharge Planning Policy is the requirement for AMHS to discuss and explain the arrangements and responsibilities of leave to the consumer and their family or carer.

This includes providing 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.

The Discharge Planning Policy also provides a set of principles for good clinical practice for the management of leave, which includes the following points:

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

A review and evaluation of the Discharge Planning Policy and its implementation will be undertaken during 2009/10, which will provide an opportunity to further promote the importance of the points listed above.

The role of carers is also recognised through the Mental Health Act 2007. The Act outlines the requirement for services to include carers by giving them greater access to information about the consumer while still allowing consumers to have some control regarding who is to be provided with information about them. Training for services on these and other new requirements of the Act was carried out by the Institute of Psychiatry during 2008.

Recommendation 5

NSW Health develop and implement a communication strategy that ensures that family members and carers are properly informed of the risks of untreated mental illness. This strategy would include, but not be limited to, a sensitive information brochure in relation to the risk of relapse and the possibility of risk to others when a person suffering from a psychosis becomes unwell.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 5 are supported. Some mechanisms to address the core components of this recommendation are in place and consultation will be undertaken with key stakeholders around the appropriateness and requirement for additional initiatives.

The NSW Health *Discharge Planning for Adult Mental Health Inpatient Services Policy Directive* (PD2008_005) 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.

An important component of the Discharge Policy is the requirement for a Discharge Care Plan to be developed in consultation with the service, the consumer and the consumer's family or carer. This plan 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, with indicators of risk to 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 MHCD modules.

The Discharge Planning process also includes the development and documentation of a Contingency & Relapse Response Plan. 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 as well as contact information for support persons and agencies, and what to do and who to contact in an emergency. As noted above, a review and evaluation of the Discharge Planning Policy and its implementation will be undertaken during 2009/10.

The Statewide Risk Assessment & Management Training Program (see response to Recommendation 3) will support this process by giving guidance to clinicians on the assessment and management of risk of harm to others.

In relation to the development of additional and specific communication strategies or information brochures regarding risk to families, limited consultation has been undertaken with the Family and Carer Mental Health Program (F&CMHP) Steering Committee regarding this issue. The consultation focused on the viability of providing information of this nature as a component of information sharing within the parameters of the F&CMHP. The F&CMHP Steering Committee acknowledged that information and advice for carers and families about the risks associated with untreated mental illness is important, for both consumers and families, and written information may already exist that could be expanded to include a reference to this.

However, the F&CMHP Steering Committee expressed a level of concern regarding the way in which a 'campaign' or dissemination of specific written information about the 'possibility of risk to others' may be interpreted by the community and the impact of this interpretation on consumers, who already face a significant level of stigma.

Accordingly, further exploration will be undertaken through more extensive consultation with the F&CMHP Steering Committee and other stakeholders regarding appropriate ways to address this recommendation.

CARE PLANNING

Recommendation 6

NSW Health develop and implement a standard of care planning which includes documenting:

- the regular review of care, including consideration of a second opinion for prolonged acute admissions
- the identification and management of substance abuse co-morbidity

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 6 are supported. Mechanisms to address the core components of this recommendation are in place and additional initiatives are planned.

The NSW Government agrees that care planning is a critical factor in ensuring the delivery of quality mental health care. Accordingly, all consumers are required to have a Care Plan while in care as well as a Discharge Care Plan at discharge from care.

A Care Plan is a component of the Mental Health Clinical Documentation. It is used to record 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 also identifies the person who is responsible to assist in this process.

The NSW Health *Discharge Planning for Adult Mental Health Inpatient Services* Policy Directive requires the development and documentation of a comprehensive plan for the ongoing care and needs of a consumer after their discharge from hospital. The Discharge Care 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 is provided to the consumer and family, and relevant community agencies (with the consumer's consent) and a copy placed in the consumer's medical record.

In relation to management of co-morbidity issues, the NSW Health Mental Health and Drug and Alcohol Office (MHDAO) Co-morbidity Framework for Action provides the strategic direction for NSW Health to manage co-morbidity of mental health and drug and alcohol in the State's health settings. The Framework's main objective is to ensure that new approaches to providing equitable and effective health services to assist people with co-morbid mental health and drug and alcohol problems are trialled in NSW.

MHDAO are also in the process of developing clinical guidelines for the assessment and management of people with a co-existing mental health and substance use disorder in acute care settings and reviewing the existing Mental Health and Substance Use Disorder Delivery Guidelines with a view to their refinement.

SHARED CARE

Recommendation 7

NSW Health develop and implement guidelines to ensure the safe and effective management of patients with a history of high risk who are managed in "shared-care" or in the primary care of a general practitioner and other service providers. These arrangements should include regular review and communication with a psychiatrist or senior mental health clinician.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 7 are supported. Mechanisms to address some of the core components of this recommendation are in place and consultation will be undertaken with key stakeholders to determine the appropriateness and requirement for any additional initiatives.

Improving communication and care arrangements between General Practitioners (GPs) and mental health services has been a priority for the NSW Government since 1999, when the Partnerships Program was launched.

This Program utilised a range of initiatives, both local and state-based, to strengthen partnerships between mental health services and general practitioners. At a local level, the Program proposed that AMHS establish, as a minimum, a strategy to improve general practitioners' access to acute mental health assessments for their patients as well as a process for continued monitoring and improvement in communication between mental health services and general practitioners.

The Teams of Two project, a state-wide component of the Program, has been instrumental in supporting enhanced cooperation and collaboration between mental health services and GPs.

Teams of Two was a joint project of General Practice NSW (formerly the Alliance of NSW Divisions of General Practice) and MHDAAO and was launched in 2003. Essentially a learning initiative that combined learning with local practice, Teams of Two invited GPs and mental health professionals to consider and discuss the practical aspects of providing quality and continuous mental health care in partnership.

The learning modules, available on CD-Rom from General Practice NSW, include pre-prepared case scenarios that can be used as the basis for discussion about issues such as access, referral, information sharing, feedback and the boundaries of service provision.

Many NSW Divisions of General Practice are already working with NSW Health services on a number of successful programs, such as Better Outcomes in Mental Health Care and NSW Health has signed a Memorandum of Understanding (MOU) with General Practice NSW to provide a foundation for collaborative effort.

The importance of close collaboration between GPs and mental health services is also acknowledged within the NSW Health *Physical Health Care for Mental Health Consumers* Guidelines (GL2009_007), which provide practical strategies that AMHS can use to build better partnerships with local GPs and examples of initiatives that other services have used to achieve this. These Guidelines were released in May 2009 in conjunction with the *Physical Health Care within Mental Health Services* Policy Directive (PD2009_027) that requires AMHS to develop and implement a strategy to improve partnerships with GPs at a local level.

Additionally, the NSW Government recognises that providing integrated, high quality services across NSW is dependent on a consistent, effective planning process. The NSW Health *Integrated Primary and Community Health Policy (IPaCH) 2007 – 2012* (PD2006_106) provides a framework for the development of consistent processes and structures regarding integrated primary and community health services.

IPaCH is a five-year plan to provide comprehensive and well-coordinated primary and community health services for the people of NSW. It aims to ensure that the activities of the primary and community health sector are integrated, both internally and with other parts of the NSW health system. The IPaCH Policy is an “enabling plan” that will assist NSW Health in achieving the aims of both the State Plan and the State Health Plan. It contains a range of priority areas, one of which is integrated planning. This notes the need to:

- Work with Area Health Services and other key stakeholders to design and implement a consistent process for integrated service planning for primary and community health services across NSW; and
- Work with Area Health Services and other key stakeholders to develop processes and structures for integrated service planning at Area, regional and local levels.

Implementation of the IPaCH Policy is monitored by the Chronic, Aged and Community Health Priority Taskforce (CACH HPT) and the NSW General Practice Council. Implementation of the NSW IPaCH Policy and the MOU will enable NSW Health and the Divisions network to work effectively in partnership.

During the latter half of 2008, work was also commenced to scope the existing interface between primary care and mental health services in NSW. This will support the development of a strategy during 2009/10 that will build a seamless continuum of primary health care for consumers as they move between general practice and mental health and drug and alcohol community and inpatient services.

All of these initiatives support the principle of good communication between primary and secondary health care being a critical component to providing quality mental health care to consumers. These initiatives also support the concept of formal shared-care arrangements. The Partnerships Program in particular provided services and GPs with a tool to enable them to discuss and agree on how shared care in their area will work.

However, the NSW Government acknowledges that a definitive set of standards or guidelines does not exist to provide guidance around the establishment and operation of shared care arrangements specifically for mental health consumers. Accordingly, consultation with both AMHS and General Practice NSW will be undertaken regarding the development and implementation of such guidelines.

LOSS OF CONTACT

Recommendation 8

NSW Health develop guidelines for the indication for and implementation of Community Treatment Orders to ensure that people of high risk retain contact with mental health services.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 8 are supported, and mechanisms to address the core components are in place.

The NSW Government recognises that people with a mental illness whose care is managed within the community under a Community Treatment Order (CTO) must retain contact with their mental health service, for their own well being as well as that of the community.

The Mental Health Act 2007 provides clear guidelines regarding when CTOs are required and how they should be implemented. Specifically, *Part 3 - Involuntary Treatment in the Community*, Division 1 – *Applications for making of community treatment orders*, Division 2 – *Operation of community treatment orders* and Division 3 – *Revocation, variation and review of community treatment orders*.

During the extensive consultation undertaken as part of the revision of the Mental Health Act 1990, there was a strong consensus of opinion among stakeholders that the guidelines around the application of CTOs struck an appropriate balance between respect for civil rights and the right to provide enforced treatment in the interests of the person and the community. Further, it was felt that any additional parameters would potentially upset this balance and limit the application of CTOs.

The Statewide Risk Assessment & Management Training Program (see response to Recommendation 3), which is currently being rolled out to inpatient and community services, will also support AMHS to develop risk assessment and management plans for high risk consumers. Such plans will include key risk management activities around supervision and monitoring to mitigate and ultimately prevent identified risks, such as lack of appropriate contact with mental health services by consumers under a CTO.

RESOURCES TO MANAGE COMPLEX RISK

Recommendation 9

NSW Health define and implement minimal resource levels for inpatient and assertive community care of persons with complex and challenging anti-social behaviours.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

Recommendation 9 is supported, and consultation will be undertaken with key stakeholders to ensure implementation.

Managing consumers with complex and challenging anti-social behaviours is recognised by the NSW Government as an issue that requires careful consideration.

MHDAO is currently conducting a review of service planning and appropriate models of resources, revenue and performance through a cost benchmarking exercise.

Such an exercise will update and improve on the current funding benchmarks for inpatient mental health services (and child & adolescent day services). Importantly it will also identify components of expected (new and emerging) service provision that align with best practice, but which are not currently budgeted, and seek to cost them and provide appropriate benchmarks.

Additionally, the project provides an opportunity for an “in principle” agreement on core service models within the mental health program. This work will be further considered during the review of the Mental Health – Clinical Care & Prevention model.

Consultation will be undertaken with the MHDAO team managing this project as well as other key stakeholders regarding the feasibility of establishing minimum resource levels as part of the review process.

FORENSIC SERVICES

Recommendation 10

NSW Health put in place systems to ensure that Area Health Services facilitate the early access by clinicians to expert forensic assessment services for selected high risk general psychiatric patients. These services should extend to the assessment of patients judged to present extreme risk of violence who have not been involved in a serious injury incident.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 10 are supported, and mechanisms to address the core components are already in place.

The NSW Government agrees that access to expert forensic assessment for high risk consumers is critical to the safe and effective management of their care.

The Justice Health Community Forensic Mental Health Service (CFMHS) has responsibility for clinical oversight of formal forensic consumers, and also provides forensic expertise on ‘high-risk civilian patients’ and offenders under Community Offender Service. In addition, the CFMHS is working in collaboration with the Department of Corrective Services to provide treatment to a small group of sex offenders who are residing in the community, of which a large percentage have a co-morbid mental illness or disorder.

The Statewide Risk Assessment & Management Training Program (see response to Recommendation 3) will support clinicians to identify high risk consumers and know when to seek support from the CFMHS regarding forensic assessment.

SPECIALISED ENVIRONMENTS

Recommendation 11

NSW Health develop additional specialised environments and procedures within acute health facilities for managing the medical care of aggressive elderly patients with behavioural disturbance associated with dementia.

Commencement: immediate; Implementation timeframe: ongoing

NSW Government Response

The principles of Recommendation 11 are supported. Initiatives to address the core components of this recommendation have been implemented and further initiatives are planned.

The NSW Government recognises that pressure on specialist services will grow as the population ages and the number of older people with complex mental health problems increase. Accordingly, the principles of appropriate environments, procedures and practices, specialist clinical support and staff training for effective management of aggressive elderly consumers with behavioural disturbance associated with dementia is supported. This support is reflected in the range of initiatives and strategies already in train in relation to managing care for elderly consumers with complex mental health issues.

These include:

SMHSOP acute inpatient facilities

A new Specialist Mental Health Service for Older People (SMHSOP) acute inpatient unit was opened at Wollongong hospital in September 2008, and another is being established at Bloomfield hospital, to address the inpatient care needs of older people with acute mental illness, including severe behavioural and psychological symptoms of dementia. A SMHSOP acute inpatient unit is also to be established in Newcastle as part of the relocation of services to the Mater Hospital site.

Dementia Clinical Nurse Consultants in acute hospitals

Under the *NSW Dementia Action Plan*, Dementia Clinical Nurse Consultant positions have been funded in a number of acute hospitals across NSW to improve responses to dementia and delirium in acute hospital settings.

Benchmarking work with SMHSOP acute inpatient units

SMHSOP benchmarking forums commenced in February 2007, with the aim of supporting services to improve their understanding of each other, models of SMHSOP service delivery currently practiced in NSW, and how to use data, including national Mental Health Key Performance Indicators and routine outcome measurement data, to understand and improve their services.

Further forums and work in 2008 will focus on identifying and describing evidence-based care and good practice in key areas, application of national performance indicators, and identifying, supporting and implementing improvements in practice and information. The SMHSOP benchmarking project is expected to inform clinical practice, service models and planning for SMHSOP acute inpatient units.

Transitional Behavioural Assessment and Intervention Service (T-BASIS)

The T-BASIS model is a transitional care model, aligned with the non-acute inpatient component of the SMHSOP service model outlined in the *SMHSOP Service Plan*.

It complements aged care rehabilitation models (including services funded under the NSW Transitional Aged Care Program), but is focussed on the assessment and management of older people with severe behavioural and psychological symptoms of dementia. Seven T-BASIS Units are being implemented in four Area Health Services through clinical service redesign of existing units.

MH-Aged Care Partnership Special Care Programs

NSW Health is developing specialist community residential partnership services (Special Care Units and Programs) that aim to address the long term care and support needs of older people with complex mental health needs, including people with severe behavioural and psychological symptoms of dementia (BPSD). One service opened in November 2007, operated by Hammond Care, a residential aged care provider, and another service is being piloted by Catholic Health Care. Both are in partnership with Sydney South West Area Health Service. Both services are being reviewed as part of a two-year evaluation.

Adapting the Ward for People with Dementia resource

The *Adapting the Ward for People with Dementia* resource, developed with funding from NSW Health, recognises that people with dementia will either be helped or harmed by the environment in which they live. It includes an Audit Tool and was developed to assist staff of small hospitals caring for people with dementia for lengthy periods to identify and address the shortcomings of the care environment.

Development of SMHSOP acute inpatient facility planning guidelines

NSW Health has commissioned the Centre for Health Assets Australia (University of NSW) to develop SMHSOP acute inpatient facility planning guidelines to assist in the development of appropriate physical facilities and environments for the management of older people with acute mental illness, including people with severe behavioural and psychological symptoms of dementia (BPSD).

In relation to the development of additional specialised environments for managing the medical care of elderly consumers with behavioural disturbance associated with dementia, the NSW Government recognises that an appropriate response to this recommendation requires developments in both NSW Health mental health and aged care services as both SMHSOP and aged care services provide medical care for elderly consumers with behavioural disturbance associated with dementia.

Further development and adaptation of geriatric medical units and SMHSOP acute inpatient units (with attention to the management of this group) is proposed as the best approach. Consideration of this issue is already underway within SMHSOP planning, benchmarking and service development activities.

IMPLEMENTATION OF RECOMMENDATIONS

Recommendation 12

NSW Health put in place systems to monitor the implementation of recommendations made by the NSW Mental Health Sentinel Events Review Committee to facilitate the reporting of progress with implementation and the auditing of compliance with the recommendations.

Commencement: immediate; Implementation timeframe: 6 months

NSW Government Response

The principles of Recommendation 12 are supported, and mechanisms to address the core components are in place.

The NSW Government agrees that a system to monitor implementation of the recommendations made by the NSW Mental Health Sentinel Events Review Committee (SERC) in its Tracking Tragedy reports is essential. Current monitoring of the implementation of the recommendations sits with the Mental Health Priority Taskforce (MHPT).

MHPT is one of 12 Health Priority Taskforces set up in 2005 as part of the Health Advisory Network to provide advice to the Minister and the Department.

It provides direction and leadership for the development of integrated mental health services for NSW, reflecting best practice national and international standards, and its workplan includes monitoring the implementation of SERC Tracking Tragedy recommendations as a priority.

The newly created MHDAO Clinical Governance Team has as part of its portfolio responsibility for overseeing implementation of the SERC Tracking Tragedy report recommendations and will be providing progress reports on this to MHPT.

MHDAO recognises that implementing the SERC Tracking Tragedy recommendations is a complex process that often involves a wide range of stakeholders, all with their own individual interests and concerns. Development of implementation plans that take account of the views of these stakeholders, while also being realistic and achievable, will involve planning processes that are clear, systematic and structured. Accordingly, the Clinical Governance Team intends to build on the work undertaken to date in relation to implementing the SERC Tracking Tragedy recommendations through a range of strategies, including:

- Earliest possible consultation with target clinicians and other stakeholders regarding how best to implement the core components of the recommendations
- Assessment and consideration of the costs associated with implementation of the recommendations
- Use of project planning methodology, with set goals and milestones, to strengthen the current recommendation implementation process
- Consideration of how AHS can translate plans into effective actions tailored to needs at the local level
- Adequate promotion of new initiatives or regulatory mechanisms to raise awareness and encourage commitment and buy-in from AHS
- Development and documentation of clear lines of accountability to support sustainability of new initiatives or regulatory mechanisms
- Monitoring and evaluation of new initiatives or regulatory mechanisms and their impact on the health care system in NSW