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# CHAPTER 13 – MENTAL HEALTH

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Last updated 21/11/19
AGGRESSION, SECLUSION & RESTRAINT IN MENTAL HEALTH FACILITIES IN NSW (PD2012_035)

PD2012_035 rescinds PD2007_054.

PURPOSE

This document outlines the position of NSW Health about how staff working in mental health facilities manage behaviour that can potentially cause harm.

Consumers with mental illness are sometimes admitted to mental health inpatient units to keep them and those around them safe. Mental health staff use a variety of different methods to maintain a safe environment including options such as counselling, time out, seclusion and a range of physical holds. Mechanical restraints involving equipment are rarely used.

Mental health units demonstrate preferences in the use of these interventions, e.g. some use mechanical restraint while others would never consider this practice; some use seclusion while others do not (Bowers et al, 2007).

While seclusion and restraint are used in some mental health facilities to manage disturbed behaviour, others have found that these strategies can be safely avoided.

The NSW Mental Health Act 2007 [Section 68 (f)] states that “any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.”

It is the position of NSW Health that clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint. When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not put themselves, their colleagues or mental health consumers at unnecessary risk.

MANDATORY REQUIREMENTS

This document applies to mental health intensive care, high dependency, acute and non-acute inpatient units that service all age groups of mental health consumers. It also applies to the care of mental health consumers in Emergency Departments that are declared mental health facilities.

The principles and processes in the attached procedure are recommended for the care of all inpatients. Particular population groups may require additional care (see GL2012_005).

In non-declared mental health units such as Transitional Behavioural Assessment and Intervention Service (T-BASIS) Units, consent must be obtained for the use of restraint that is consistent with the NSW Guardianship Act 1987.

Local Health District policies, procedures, protocols, guidelines or other documents relating to the management of disturbed behaviour, including the use of seclusion and restraint, must be consistent with this policy and procedure and include an electronic reference to or hard copy of this document.
IMPLEMENTATION

Chief Executives must:
- Ensure that the principles and requirements of this policy and procedure are applied, achieved and sustained
- Ensure that all staff are made aware of their obligations regarding this policy and procedure through staff education
- Ensure that documented procedures and adequate controls are in place to monitor use of this policy and procedure
- Ensure that there are documented procedures in place to effectively respond to and investigate alleged breaches of this policy and procedure.

Managers must:
- Promote a recovery oriented, patient-centred culture within the mental health service
- Ensure that all mental health staff read and understand this document
- Monitor this document and ensure staff comply with its requirements
- Implement review mechanisms as outlined in this procedure on all mental health units
- Ensure audits on compliance with this document are conducted in the mental health service at least once each year.

Clinical staff in mental health facilities must:
- Read, understand and comply with the requirements of this policy and procedure
- Provide leadership in any interventions designed to manage disturbed or aggressive behaviour.

Non-clinical staff in mental health facilities must:
- Comply with the requirements of this policy and procedure
- Follow the direction of clinical staff in the management of disturbed or aggressive behaviour.


AGGRESSION, SECLUSION & RESTRAINT IN MENTAL HEALTH FACILITIES – GUIDELINE FOCUSED UPON OLDER PEOPLE (GL2012_005)

PURPOSE
This document provides guidance about caring for older people whose behaviour can potentially cause harm.

KEY PRINCIPLES

Principle 1: Protection of fundamental human rights
Principle 2: Protection against inhumane or degrading treatment
Principle 3: Right to highest attainable standards of care
Principle 4: Right to medical examination
Principle 5: Documentation and notification
Principle 6: Right to appropriate review mechanisms
Principle 7: Compliance with legislation and regulations
USE OF THE GUIDELINE

This guideline may be used in mental health facilities in NSW focussed upon older consumers. It can be applied to the care of older people in all mental health units.

It is designed to be read in conjunction with PD2012_035 Aggression, seclusion and restraint: Preventing, minimising and managing disturbed behaviour in mental health facilities in NSW.


NSW HEALTH MENTAL HEALTH SUPPORTING PLAN TO NSW - (HEALTHPLAN) (GL2012_006)

PURPOSE

The plan is the NSW Health Mental Health Services Supporting Plan to the NSW Health Services Functional Area Disaster Plan (NSW HEALTHPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

This plan identifies the emergency management arrangements necessary for the coordination of mental health services at State level when HEALTHPLAN is activated in response to a range of Emergency situations.

The arrangements in this plan will also provide guidance for the preparation of the Local Health Districts.

KEY PRINCIPLES

The plan outlines the agreed roles and functions for the mental health services component of NSW Health being one of the five major contributing health service components that constitutes a whole of health response incorporating an all hazards approach.

The plan identifies recommended actions under four emergency management phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases are recommended to be carried out once the Mental Health Services Supporting Plan has been activated by the State Health Services Functional Area Coordinator (HSFAC).

USE OF THE GUIDELINE

Responsibilities of key parties are detailed in Part Two of the Mental Health Services Supporting Plan. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

CLINICAL CARE OF PEOPLE WHO MAY BE SUICIDAL (PD2016_007)

PURPOSE
A significant proportion of people who die by suicide have had contact with a health professional in the weeks prior to their suicide. It is therefore essential that health staff identify people at risk of suicide and prevent suicide by implementing effective management strategies including referral to relevant services for further assessment and expert supports.

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies to prevent suicide including facilitating access to appropriate care. This policy has been specifically developed for the specialist mental health workforce providing care across community, inpatient and emergency settings and in collaboration with other health professionals and the individual’s support network.

This policy directive is intended to:

- Support the provision of timely evidence-based clinical care of people at risk of suicide to ensure people remain safe and are supported in their recovery
- Outline the role and responsibilities of mental health services and clinicians to inform local policies and procedures, and
- Support a consistent and coordinated evidence informed approach to support application of clinical guidelines and training.

MANDATORY REQUIREMENTS
This policy and its directives the Clinical Care Of People Who May Be Suicidal (Attachment 1), establishes minimum standards that NSW mental health services and clinicians are required to meet in the identification, assessment and management of people with suicidal behaviour and ideation in all care settings.

IMPLEMENTATION
Local Health District, Specialty Network Chief Executives, Health Service Executives need to:

- Assign responsibility, personnel and resources to implement this policy
- Provide line managers with support to mandate this policy in their areas
- Ensure local protocols are in place in each facility to support implementation
- Ensure mental health clinicians undertake training in suicide risk assessment and management
- Work together with the Mental Health and Drug Alcohol Office to ensure Local Health District (LHD) policies, procedures and standards are consistent with statewide policies, procedures referred to in the attached Clinical Care Of People Who May Be Suicidal policy directive and those NSW Heath policies and guidelines referenced within that document
- Report compliance with this policy to the NSW Ministry of Health as required
- NSW Health Service staff and visiting practitioners providing relevant services need to comply with this policy.
13. MENTAL HEALTH

1 ABOUT THIS POLICY DIRECTIVE

Suicide is the leading cause of death due to injury in Australia. Most people who go on to die by suicide do so because of overwhelming and unbearable psychological distress - if people are safely helped through this period of high risk they can usually recover their equilibrium and do well.

It is important mental health clinicians are able to recognise the presentation of possible suicidal behaviour in different age groups and diagnostic categories and to respond effectively.

Education and training is available to all NSW Health staff through the Health Education and Training Institute (HETI) to support clinical skill training in suicide prevention.

2 IDENTIFICATION AND CARE OF PEOPLE WITH SUICIDAL BEHAVIOUR OR IDEATION

Mental health service clinicians in all settings have a responsibility to undertake assessment of people presenting with suicidal behaviour or ideation. Settings may include emergency departments, mental health telephone triage services, community mental health services, mental health inpatient facilities and general health facilities. When undertaken by assertive community teams these will extend to other settings such as the home or school.

People at risk of suicide, including those presenting to health services with self-harm and those admitted to a mental health facility, should receive a comprehensive mental health assessment incorporating a psychiatric evaluation, a culturally and developmentally appropriate psychosocial assessment including current stressors and a detailed assessment of suicide risk.

2.1 Comprehensive mental health assessment

The comprehensive mental health assessment should be conducted by a mental health clinician in collaboration with the person at risk, their family and carers and other relevant people related to the presenting situation such as specialist mental health services.

Risk measurement checklists or tools should not be used in isolation to determine treatment decisions. Use of suicide risk factor checklists or screening tools alone cannot be recommended for use in clinical practice as a means of accurately predicting a person’s risk of suicide as no rating scale or clinical algorithm has proven predictive value in the clinical assessment of suicide. There is moderate to low quality evidence for their use; they have insufficient sensitivity and specificity; and therefore lack reliability for predictive purposes.

The goal of a suicide risk assessment is to determine the level of suicide risk at a given time, including an assessment of changeability and impulsivity in the person, quality of informal support networks, level of engagement in care planning and wider support network, to provide the appropriate clinical care and management plan.

A comprehensive assessment should be sensitive to the distress of the person and the fact that assessment involves significant disclosure. This should be carried out in a manner that is recovery-orientated and trauma-informed.

2.2 Psychiatric assessment

A psychiatric assessment evaluates recent symptoms, current mental state and past history, and seeks to determine if a relapsed, untreated, or previously undiagnosed psychiatric disorder may be the cause of the clinical presentation.
2.3 Psychosocial assessment

A psychosocial assessment evaluates external factors that may contribute to the person’s current distressed state. This may include stressors, any significant changes in life circumstances or challenging life events including significant loss, and the use of alcohol or drugs which may increase risks of impulsive behaviour. Protective factors inclusive of strong social supports, good coping and problem-solving skills, and an ability to seek and access help should also be explored as these may protect the person from suicide.

2.4 Assessment of suicide risk

Assessment of risk determines the severity of self-harm, suicidal thoughts or behaviour including identifying any specific plans for suicide, access to means, potential lethality of the chosen method, persistence of ideation, what precautions against discovery were planned, impulsivity and distorted thinking, and details of any previous suicide attemptsvi.

The Mental Health Triage Policy (PD2012_053) defines and outlines the clinical processes to identify the presenting factors that suggest risk, the appropriate response required, and how to manage call situations including callers who threaten to harm themselves. (http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_053.pdf)

Local Health Districts (LHDs) and Health Networks that implement electronic medical records (EMRs) for inpatient and community mental health services should avoid the use of risk assessment checklists or forms as the sole predictive or decision-making tools.
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<td>• Provide clinical management and care in accordance with the <em>NSW Mental Health Act (2007)</em></td>
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<tr>
<td>• Undertake a comprehensive mental health assessment inclusive of risk for people with suicidal behaviour or ideation and not use risk measurement tools or checklists in isolation to determine treatment decisions</td>
</tr>
<tr>
<td>• Undertake a comprehensive mental health assessment inclusive of risk on entry to any mental health service, and monitor the status of this throughout the patient’s care episode through regular reassessment, particularly in response to changes in personal circumstances or care</td>
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<tr>
<td>• Develop a management plan with the involvement of the person, their family / principal carers and key stakeholders</td>
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<tr>
<td>• Ensure clinical records include documentation of ongoing mental state, assessments of risk, and actions and precautions taken as an outcome of those assessments including consultation with supervisors and person’s key carer network where management plans change to support ongoing communication across the care system</td>
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<tr>
<td>• Complete a Notification to NSW Police and Firearms Registry Form (Appendix B) if the person is known to have access to a firearm, and there is an assessed level of risk to self or others</td>
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<tr>
<td>Mental Health Services have an obligation to:</td>
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<td>• Ensure locally developed protocols are in place at all entry points to health care including emergency departments that support the:</td>
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<tr>
<td> − Appropriate triage of at risk patients and interim observational management pending handover to mental health</td>
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<tr>
<td> − Consultation with persons with suspected suicidal risk, and referral for comprehensive mental health assessments</td>
</tr>
<tr>
<td> − Person’s immediate safety and notify mental health services of the risk of imminent departure from the emergency department by a patient known to be at risk of self-harm</td>
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<tr>
<td> − Establish pathways to care to assist in early identification and access for people with suicidal behaviour or ideation.</td>
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3. CLINICAL CARE OF THE SUICIDAL PERSON

Of utmost importance is the safety and wellbeing of people at risk of suicide regardless of health setting. The management plan should:

- Be recovery oriented, trauma-informed and inclusive of the persons perceptions as well as of family and carers
- Be informed by consideration of the person’s capacity to make decisions about their treatment and safety
- Ensures continuity of care and provision of essential information across settings and service providers
- Ensure care in a public health facility includes a safe physical environment
- Ensure clinical management and care is in accordance with the Mental Health Act (2007)

Chiefly:

- People receive care and treatment in the least restrictive environment possible enabling the care and treatment to be effectively given.
- Every effort that is reasonably practicable is made to seek the person’s views and consent to treatment and care. The person’s expressed wishes should be incorporated into their recovery plan to the fullest extent that is possible.
- The views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about treatment and whether interventions are provided as voluntary or involuntary under the Act.

Clinical judgment of mental health professionals is central to the assessment and management of a person at risk of suicide, and is based on their clinical experience, the person’s clinical presentation, the assessment and management options available and, information from relevant others. Consultation with, or the advice of, a senior colleague should be sought - particularly where the decision to not admit someone with a suicide risk is made. Appropriate community follow up should also be arranged. Consultation outcomes should be clearly documented as part of the assessment formulation.

4. RESPONDING TO PEOPLE WITH ONGOING SUICIDALITY

People with recurring or ongoing risk from suicide ideation or behaviours require particular consideration. These include the incorporation of clear strategies to support the person’s recovery, to respond to changes in risk over time and to ensure that services have strategies to contain emotional distress. This will necessitate review of the historical and dynamic nature of risk and the capacity of the person and their support network to utilise personal coping strategies. Reviews should involve all relevant parties (including case conferencing) and include regular reviews of the management plan. Some overarching principles include:

- Establish a team approach to risk formulation and response
- Acknowledge the underlying distress that drives self-harm ideation and assess the risk at each presentation
- Actively respond to all co-existing conditions
- Set clear expectations of the assessment and support process, including a clear management plan and guidelines on expected behaviour of the person
- Facilitate the person’s engagement with / linkage to programs that promote emotional self-mastery and problem solving skills.
Ongoing management of a person’s mental health treatment requires mental health professionals regardless of their setting to:

- Consider decisions about care and treatment in accordance with the NSW Mental Health Act (2007)
- Consider the person’s preferences and capacity to consent to treatment as indicated in Section 68 of the NSW Mental Health Act (2007)
- Engage designated carers and/or principal care providers and key stakeholders in ongoing discussions with the person about treatment and care planning including management of risk of harm and management plans.

5. TRANSFER OF CARE AND DISCHARGE

Transitions in the care of a person with mental health issues should be identified as points of potential increase in risk.

PD2012_060 (Transfer of Care from Inpatient Mental Health Services) refers to situations where the mental health consumer’s care is transferred from a mental health inpatient unit across health settings including to another inpatient service, to the community, or during periods of approved leave. The policy sets out the treating team's responsibilities in relation to advice, information sharing, and documentation to ensure continuity of care and safety are maintained during the transfer process (http://www0.health.nsw.gov.au/policies/pdf/PD2012_060.pdf).

The period immediately following discharge from an acute psychiatric admission is a period of greatly increased risk. Discharge planning must include early engagement with relevant supports well ahead of the proposed transfer date. Suicide risk assessments and management plans should be regularly revised and updated.

Safe discharge requires Mental Health clinicians to deliver assertive and coordinated follow-up through direct contact as soon as possible following discharge from psychiatric inpatient units or emergency departments. This contact needs to assess the success of initial transition back into the community and therefore must include both direct contact with the person and, where possible, discussion with the person’s principal carer. Discharge must be accompanied by:

- Written information for the person with details of discharge plans including referrals to other treatment teams or community services, and
- Information about access to the 24/7 Mental Health Line 1800 011 511.

All mental health professionals regardless of their setting have an obligation to:

- Ensure the requirements outlined in Transfer of Care from Inpatient Mental Health Services PD2012_060 are followed for the care of people with suicidal intent and behaviours
- Revise and update suicide risk assessments and management plans at points of significant transitions in care as these represent times of potential increase in risk
- Make direct contact with mental health consumers discharged from an acute psychiatric admission to the community within the timeframe indicated in the Transfer of Care Plan or within a maximum of 7 days.
6. CLINICAL SUPERVISION AND SUPPORT

Mental Health Services need to ensure clear local protocols are in place to support less experienced clinicians to seek advice on clinical matters from more senior clinicians regarding the assessment or management of patients who are suicidal and support the implementation of protocols for clinical supervision and support.

Mental Health clinicians should understand the meaning of recovery based care, capacity and consent within the Mental Health Act (2007). They should also understand their responsibilities and procedures to work collaboratively with relevant support agencies, essential to supporting a person’s recovery and safety.

Minimum requirements
All mental health services regardless of the setting have an obligation to:

- Ensure that mental health clinicians have access to appropriate clinical supervision, consultation or advice from a senior clinician at all times.

7. CLINICAL DOCUMENTATION

Mental health clinicians have a professional and legal responsibility to maintain clear, accurate and timely records.


Any locally developed electronic medical records (EMRs) for inpatient or community mental health services should avoid the use of risk assessment checklists or forms as the sole predictive or decision-making tools.

Minimum requirements
All mental health professionals regardless of their setting have an obligation to:

- Ensure that mental health clinicians use the Mental Health Clinical Documentation modules to document care as mandated in the Mental Health Clinical Documentation Policy Directive PD2010_018
- Ensure mental health clinicians complete clinical documentation training
8. ENVIRONMENTAL HAZARDS

Mental health inpatient facilities can reduce environmental hazards for patients with suicidal behaviour and ideation. Conducting regular environmental safety audits is recommended for LHD and Speciality Network mental health services.

The Access to Means of Suicide and Deliberate Self-harm Facility Checklist (Appendix C) has been developed to specifically address safety issues in mental health inpatient facilities and may be a useful tool.

Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Develop and implement standardised practices intended to improve patient safety, eliminate hazards and reduce the likelihood of adverse incidents occurring including:
  - Each shift changeover incorporating a patient’s risk assessment
  - Undertaking annual environmental safety audits that identify and ameliorate the risks presented by low-lying ligature points and non-collapsible curtain rails
  - Undertaking annual environmental safety audits that identify any obstructions to the observation of high risk patients in mental health inpatient facilities
  - Strategies to monitor and prevent potentially dangerous items being brought into the inpatient unit by patients, family, carers or friends. This needs to be conducted in a respectful and trauma-informed manner
  - Using processes to escalate and address safety issues, and for this to include the use of tools and checklists that are specifically developed in the mental health inpatient facility, and
  - Designating a staff member responsible for undertaking the environmental audit which is to be dated, signed and retained as a formal record (refer Appendix C).
9. EDUCATION AND TRAINING

Maintaining effective and current clinical skills and practice in assessing and managing suicidal behaviour and ideation are core requirements of all mental health clinicians.

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<tr>
<td>All mental health professionals regardless of their setting have an obligation to:</td>
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<tr>
<td>• Recognise the need to respond respectfully and in a non-stigmatising manner to those who attempt suicide and who self-harm</td>
</tr>
<tr>
<td>• Understand current clinical and legal responsibilities in the delivery of mental healthcare</td>
</tr>
<tr>
<td>• Know the minimum requirements mental health services and clinicians are required to observe in the assessment and management of people with suicidal behaviour and ideation, in accordance with this policy</td>
</tr>
<tr>
<td>• Integrate the key principles outlined in this policy directive in the delivery of clinical management and care of people with suicidal behaviour and ideation</td>
</tr>
<tr>
<td>• Deliver evidence-based clinical practice in the assessment and management of people with suicidal behaviour and ideation</td>
</tr>
<tr>
<td>• Recognise the differing presentations of possible suicidal behaviour in different age groups and diagnostic categories to respond effectively and efficiently in the provision of ongoing care</td>
</tr>
<tr>
<td>• Possess competency in undertaking detailed evaluations of suicidal behaviour and ideation.</td>
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Mental Health Services have an obligation to:

• Ensure mental health clinicians regardless of setting undertake training in suicide risk assessment and management.

288(3/3/16)
10. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE

The suspected suicide of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from a health service requires an internal review and referral for investigation to NSW Police if the death occurs within seven (7) days of the person’s last contact with the health service, or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the health service.

At the discretion of NSW Police the incident may be referred to the NSW Coroner.

The suspected suicide of a person (meeting the circumstances outlined in the preceding paragraph) falls in the highest severity assessment category, a SAC 1 and requires the submission of a reportable incident brief (RIB) to the Ministry of Health (MoH): within 24 hours of notification.

The Incident Management Policy PD2014_004 provides direction to health services regarding the management of clinical (and corporate) incidents and includes the provision of appropriate feedback to patients, families, support persons and clinicians.

Policy PD2014_004 outlines the reporting of specific healthcare incidents to the NSW MoH reportable incident brief (RIB) system.

The Open Disclosure Policy PD2014_028 outlines a standardised approach in communicating with families and other carers after an incident in care and includes acknowledgement of a patient safety incident to the patient’s support person(s) as soon as possible; the provision of truthful, clear and timely communication; and an apology to the patient’s carers as early as possible, including the words “I am sorry” or “we are sorry”.

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### Minimum requirements

All mental health professionals regardless of their setting have an obligation to:

- Demonstrate compassion, openness, respect and empathy to the family and carers of a person who has died where it is a suspected suicide
- Ensure an offer of ongoing support to family, carers and others
- Be aware of and observe a standardised approach in communicating with families and other support people after an incident in care that is consistent with the [Open Disclosure Policy PD2014_028](http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_028.pdf)
- Advise any clinician who has been managing care of the deceased in the community (including private psychiatrists, general practitioners) of the death as soon as possible

### Mental Health Services

Mental Health Services are responsible for ensuring:

- Effective local incident management systems are consistent with the [Incident Management Policy PD2014_004](http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_004.pdf)
- Any mental health clinician affected by a suicide death is offered support from their team manager, clinical supervisor and the Employment Assistance Program (EAP).
APPENDIX A - RELEVANT NSW HEALTH LEGISLATION, POLICY DIRECTIVES, GUIDELINES AND INFORMATION BULLETINS

NSW Health Legislation


2. Disability Services Act 1993 No. 3
3. Guardianship Act 1987 No. 257
4. Health Administration Act 1982 No. 135
5. Health Administration Regulation 2010
7. Health Records and Information Privacy Act 2002 No. 71
8. Health Records and Information Privacy Regulation 2012
9. Health Services Act 1997 No. 154
10. Mental Health Act 2007 No. 8
11. Mental Health Amendment (Statutory Review) Act 2014 No. 85

NSW Health Policy Directives and Guidelines


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</tr>
<tr>
<td>Coroners Cases and the Coroners Act 2009</td>
<td>PD2010_054</td>
</tr>
<tr>
<td>Departure of Emergency Department Patients</td>
<td>PD2014_025</td>
</tr>
<tr>
<td>Electronic Information Security Policy - NSW Health</td>
<td>PD2013_033</td>
</tr>
<tr>
<td>Incident Management Policy</td>
<td>PD2014_004</td>
</tr>
<tr>
<td>Medication Handling in NSW Public Health Facilities</td>
<td>PD2013_043</td>
</tr>
<tr>
<td>Mental Health Clinical Documentation</td>
<td>PD2010_018</td>
</tr>
<tr>
<td>Mental Health Clinical Documentation Guidelines</td>
<td>GL2014_002</td>
</tr>
<tr>
<td>Mental Health Triage Policy</td>
<td>PD2012_053</td>
</tr>
<tr>
<td>NSW Health Privacy Manual (Version 2)</td>
<td>PD2005_593</td>
</tr>
<tr>
<td>NSW Clinical Guidelines - For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (2008)</td>
<td>PD2014_028</td>
</tr>
</tbody>
</table>

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APPENDIX B – NSW POLICE FORCE – FIREARMS REGISTRY

NSW POLICE FORCE - FIREARMS REGISTRY

Disclosure of Information by Health Professionals
Section 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998

Section 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998 protect disclosures of information to the NSW Commissioner of Police by health professionals where they are of the opinion that a person they are treating may pose a risk to public safety or to the person’s own safety if in possession of a firearm or prohibited weapon. Of particular interest are high risk mental health patients known to have access to firearms.

Sections 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998 provide protection from civil or criminal liability, that may otherwise arise including a breach of confidentiality, when disclosing information to the Commissioner of Police.

A health professional is defined in S79 of the Firearms Act 1996 and for the purposes of section 38 of the Weapons Prohibition Act 1998, as any of the following persons: a medical practitioner, psychologist, nurse, social worker or professional counsellor.

PROCESS TO FOLLOW
1. Complete the form and Fax to: 02 9876 3000 and mark Attention: Team Leader Licensing; AND
2. Fax this form to the police station nearest the residential address of the patient. If you are unsure of the nearest police station, ring the Police Assistance Line on 131444.

PATIENT INFORMATION

LAST NAME
FIRST NAME

DATE OF BIRTH
TELEPHONE

HOME ADDRESS

Where is the patient currently located? eg. inpatient, Accident and Emergency, at residential address etc.

If in hospital, anticipated date of discharge. To ensure safety issues can be addressed, please give at least 6 hours notice to Police.

DATE OF DISCHARGE

ADDRESS WHERE PATIENT WILL BE DISCHARGED (if different from residential address).

Describe the circumstances that lead you to believe that the person may pose a threat if in possession of a firearm/prohibited weapon. Include relevant conversation, observations, circumstances, effect of medical condition or treatment on person’s capacity etc.

Does the person have access to their own firearms/prohibited weapons? 
YES
NO
UNKNOWN

Does the person have access to other firearms/prohibited weapons?

YES
NO
UNKNOWN

If “YES” indicate below the address where the firearms/prohibited weapons are located. For example, with friends, neighbours, spouse or other relative.

HEALTH PROVIDER INFORMATION

Medical Practitioner
Psychologist
Reg/Enrolled Nurse
Social Worker
Counsellor

NAME
CONTACT NUMBER

SIGNATURE
DATE

Reporting Location (eg hospital, mental health hotline, private clinic, facility etc)

ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE

Vers 3.0 February 2013

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APPENDIX C - ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF-HARM FACILITY CHECKLIST

All services should review the physical structure of the mental health inpatient unit to identify:

i. Any obstructions to the observation of high risk patients

ii. Structures that could be used in suicide by hanging.

Inpatient units should remove (or make inaccessible) all likely ligature points

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Review Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Vulnerability Points</td>
<td>Reviewed</td>
</tr>
<tr>
<td><strong>Hanging points</strong></td>
<td></td>
</tr>
<tr>
<td>Non-collapsible curtain rails</td>
<td></td>
</tr>
<tr>
<td>Non-collapsible bed frames</td>
<td></td>
</tr>
<tr>
<td>Non-collapsible shower frames</td>
<td></td>
</tr>
<tr>
<td>Internal piping</td>
<td></td>
</tr>
<tr>
<td>Shower fittings</td>
<td></td>
</tr>
<tr>
<td>Clothes rod in room wardrobes</td>
<td></td>
</tr>
<tr>
<td>Shower curtains</td>
<td></td>
</tr>
<tr>
<td>Light fittings</td>
<td></td>
</tr>
<tr>
<td>Ceiling fan</td>
<td></td>
</tr>
<tr>
<td>Bedroom and bathroom door handles and knobs</td>
<td></td>
</tr>
<tr>
<td><strong>Blind spots</strong></td>
<td></td>
</tr>
<tr>
<td>Corners</td>
<td></td>
</tr>
<tr>
<td>Alcoves</td>
<td></td>
</tr>
<tr>
<td>Under stairways</td>
<td></td>
</tr>
<tr>
<td>Power-board rooms</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td><strong>Access to facility</strong></td>
<td></td>
</tr>
<tr>
<td>Exit points</td>
<td></td>
</tr>
<tr>
<td><strong>Location of unit</strong></td>
<td></td>
</tr>
<tr>
<td>Busy road</td>
<td></td>
</tr>
<tr>
<td>Railway line</td>
<td></td>
</tr>
<tr>
<td>River, ocean</td>
<td></td>
</tr>
<tr>
<td>Cliffs</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

288(3/3/16)
<table>
<thead>
<tr>
<th>Risk Vulnerability Points</th>
<th>Reviewed</th>
<th>Current Safety Risk (Nil, Low, Med, High)</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisonous substances kept in locked cupboard or storeroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reagents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning fluids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other hazardous material</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Windows – structure and design</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are windows in the facility made of full glass, meshed glass or small panes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety policy and procedures</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Routine search of patient on admission and return from any period of leave off the unit</td>
<td></td>
<td></td>
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<tr>
<td>Further search of patient when there are grounds for suspicion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Monitoring of items conveyed from relatives, friends and family to patients and information provided on the safety of items bought in to the unit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to areas of particular risk –bathrooms, kitchens, toilets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Careful observation of cutlery, removal of linen from patients bedroom where there are concerns around self-harm, power cords, tools, plastic bags and any other potentially dangerous implements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident reporting, investigating and reviewing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Actions required to reduce risk:**

Implementation procedure:

Completed by: ____________________________

Signature: ____________________________

Name: ____________________________

Next Review Date/Time: ____________

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APPENDIX D - RECOMMENDED RESOURCES

Literature


A series of three articles on suicide from The Lancet Psychiatry, Vol. 1 Issue 1 available online at http://www.thelancet.com/journals/lanpsy/onlinefirst

• The neurobiology of suicide
  Prof Kees van Heeringen PhD, Prof J John Mann MD
  The Lancet Psychiatry 2014 Vol. 1 Issue 1; Pages 63 - 72, June 2014 doi: http://dx.doi.org/10.1016/S2215-0366(14)70220-2

• The psychology of suicidal behaviour
  Prof Rory C O'Connor PhD, Prof Matthew K Nock PhD
  The Lancet Psychiatry, June 2014 Vol. 1 No. 1 pp 73-85. doi: http://dx.doi.org/10.1016/S2215-0366(14)70222-6

• Effects of suicide bereavement on mental health and suicide risk
  Dr Alexandra Pitman MSc[Econ], David Osborn PhD, Prof Michael King PhD, Annette Erlangsen PhD

Guidelines and Resources for mental health professionals

The 1800 011 511 NSW Mental Health Line

The 1800 011 511 NSW Mental Health Line aims to facilitate universal and equitable access to mental health care through a 24/7 mental health telephone triage, referral and advice service staffed by mental health professionals. The line is also a resource for service partners seeking advice about an individual’s clinical symptoms, the urgency of their need for care and local treatment options. The 1800 011 511 number is accessible Australia-wide and links to LHD mental health telephone triage services.

Mental Health for Emergency Departments - A Reference Guide

Mental Health and Drug and Alcohol Office, NSW Ministry of Health. Sydney, Amended March 2015.

This Reference Guide is intended to assist emergency department staff and other clinicians in their care of people experiencing emergency mental health problems. This resource is a reference guide for clinicians working as first responders to mental health presentations, particularly for emergency and acute presentations. The purpose of the guide is to provide practical guidance in the initial clinical assessment and management of mental health presentations. This Reference Guide builds upon the earlier versions of the reference guide (2001; 2002; 2009) and is available in electronic format at http://www.health.nsw.gov.au/mhdao/publications/Publications/mental-health-ed-guide.pdf
Clinical Practice Guidelines

*Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm*

Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm

[https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_DSH-pdf.aspx](https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_DSH-pdf.aspx)

**Framework for Suicide Risk Assessment and Management for NSW Health Staff**

The Framework provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of generalist and mental health services to guide the suicide risk assessment and management process. The Framework is suite of resources released in 2005 and includes:

- Framework for Suicide Risk Assessment and Management for Health Staff
- Suicide Risk Assessment and Management – Emergency Department
- Suicide Risk Assessment and Management Protocols – General Hospital Ward
- Suicide Risk Assessment and Management Protocols – General Community Health Service
- Suicide Risk Assessment and Management Protocols – Community Mental Health Service
- Suicide Risk Assessment and Management Protocols – Mental Health In-Patient Unit


**SANE Australia – The Suicide Prevention and Recovery Guide**

The SANE Australia Suicide Prevention and Recovery Guide aims to help mental health professionals support people who are experiencing suicidal thoughts and behaviours – through the prevention of suicide, and in crisis management.


**Aboriginal and Torres Strait Islander mental health care**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed new online resources to support the work of health professionals and improve knowledge and understanding of Aboriginal and Torres Strait Islander mental health care.

The resources include a new Aboriginal and Torres Strait Islander mental health web page, as well as four competency based training and Continuing Professional Development modules addressing key factors to be considered when working and engaging with Aboriginal and Torres Strait Islander peoples and/or communities.

The four e-learning modules are accessible online to College members and cover:

1) Interviewing an Aboriginal or Torres Strait Islander patient
2) Developing a mental health management plan for an Aboriginal or Torres Strait Islander patient
3) Formulation of a case involving an Aboriginal or Torres Strait Islander patient
4) Review of a model of mental health service delivery in an Aboriginal or Torres Strait Islander community.

The resource is accessed at [https://www.ranzcp.org/News-policy/News/New-resources-on-Aboriginal-and-Torres-Strait-Isla.aspx](https://www.ranzcp.org/News-policy/News/New-resources-on-Aboriginal-and-Torres-Strait-Isla.aspx)
Cultural Considerations & Communication Techniques: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person.
Aboriginal Mental Health First Aid Training and Research Program. Melbourne: Mental Health First Aid Australia and beyondblue; 2008. This resource is accessed at

Resources for Aboriginal and Torres Strait Islanders

*Finding your way back* – A resource for people who have attempted suicide has been written to guide you through some of the physical, social and emotional issues that often come up after a suicide attempt. http://resources.beyondblue.org.au/prism/file?token=BL/1289

Resources for Emergency Departments, Teachers, Communities

i. Mental Health for Emergency Departments A Reference Guide 2015
iii. *Seeking Solutions to Self-Injury: A Guide for Emergency Departments*
iv. *Conversations Matter*
   Conversations Matter is a new suite of online resources developed to support community discussion about suicide. The resources provide practical information for communities and professionals to guide conversations about suicide. The professional resources have been developed in separate modules that provide advice about prevention-focused conversations, intervention-focused conversations and postvention-focused conversations occurring in the community. http://www.conversationsmatter.com.au/professional-resources

Suicide Postvention Guidelines
A framework to assist staff in supporting their school communities in responding to suspected, attempted or completed suicide (2010). South Australia: Government of South Australia, Department of Education and Children’s Services. South Australia Department of Education and Children’s Services, Catholic Education South Australia and Association of Independent Schools.

Resources for individuals and families

i. Lifeline’s 13 11 14
   The NSW Government has extended and increased its support for Lifeline Australia with a $10.5 million funding commitment over four years (from 2015-16 to 2018-19) to support Lifeline NSW Centres to operate 24/7 crisis telephone service.
ii. beyondblue https://www.beyondblue.org.au/
   A range of resources are available on the beyondblue website on suicide. This includes for individuals, families and friends, workplaces, schools and universities.
REFERENCES


2 Ibid

3 Ibid

4 Ibid


7 [http://www.nice.org.uk/guidance/cg16/resources](http://www.nice.org.uk/guidance/cg16/resources)


9 Suicide Risk Assessment and Management Protocols : Mental Health In-Patient Unit SHPN: 040183 ISBN: 0 7347 3720 3 from the Framework for Suicide Risk Assessment and Management for NSW Health Staff SHPN (MH) 040184, ISBN 0 7347 3721 1

SEXUAL SAFETY – RESPONSIBILITIES AND MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES (PD2013_038)

PURPOSE

This Policy Directive outlines the minimum requirements to be met in relation to establishing and maintaining the sexual safety of mental health consumers and responding appropriately to incidents that breach or compromise this safety.

It should be read in conjunction with the NSW Health *Sexual Safety of Mental Health Consumers Guidelines* GL2013_012. The Guidelines, which support this Policy Directive, provide comprehensive information and advice regarding how mental health services can improve the sexual safety of consumers. The Guidelines should be used to ensure the broad, overarching responsibilities of mental health services outlined within this Policy are met.
MANDATORY REQUIREMENTS

Attachment 1 nominates those requirements that are mandatory for mental health services to meet in relation to the sexual safety of mental health consumers.

These requirements provide clear direction to mental health services regarding a baseline for the establishment and maintenance of the sexual safety of the consumers who use their service. All services are required to build on this baseline utilising the Sexual Safety of Mental Health Consumers Guidelines GL2013_012.

IMPLEMENTATION

Implementation of this policy and its requirements will be an iterative process over two years, with six-monthly milestones and reporting should occur as per the requirements outlined at 5.2 in the Responsibilities and Minimum Requirements for Mental Health Services.

The Local Health District (LHD) has responsibility for ensuring that:

BY JUNE 2014
- All line managers clearly understand they are accountable for effective implementation of the processes required to meet the outlined responsibilities of this Policy Directive.
- Structures are established to appropriately implement this Policy Directive.
- Lead staff member and champions nominated to drive implementation of the Guidelines and Policy Directive at LHD level.
- Consultation is undertaken with staff, consumers and carers to identify training/education needs and this information is provided to the Mental Health and Drug & Alcohol Office (MHDAO).

BY JUNE 2015
- This Policy Directive is successfully implemented within the LHD, as per the requirements outlined in this Policy Directive at 6 - Implementation.
- Policies and procedures are developed to ensure the requirements of this Policy Directive are met.
- Regular file audits are undertaken to monitor compliance with this Policy Directive.

The Mental Health and Drug and Alcohol Office (MHDAO) has responsibility for ensuring that:

BY JUNE 2014
- Hard copies of the Sexual Safety of Mental Health Consumers Guidelines GL2013_038 are printed and readily available.
- The availability of the above Guidelines, any associated resources and training is promoted to Local Health Districts.
- A training needs assessment is completed with LHDs to support the implementation of this Policy.

BY JUNE 2015
- A training framework is developed and implemented, in consultation with LHDs, to support mental health staff to implement this Policy Directive.
- Implementation of this Policy Directive is monitored, in accordance with the reporting requirements for LHDs.
## 1. DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute inpatient mental health setting</td>
<td>Service setting in which care is provided to individuals with acute mental health conditions. Acute inpatient mental health services operate 24 hours a day, are short-term, and care is provided by a multidisciplinary team, often within general hospitals. The primary goals of acute inpatient services are to provide a comprehensive evaluation; rapidly stabilise acute symptoms; address the individual’s health and safety needs; and develop a comprehensive discharge/transfer of care plan that allows the individual to quickly return to the community or other appropriate levels of care.</td>
</tr>
<tr>
<td>Community mental health setting</td>
<td>Service setting in which care and support is provided that assists individuals with a mental health condition to develop skills in self-care and independent living in their own environment. Community mental health services may operate from hospital-based ambulatory care environments, such as outpatient clinics, or be attached to community health centres, and outside of crisis-care, are generally day programs.</td>
</tr>
<tr>
<td>Consensual sexual activity</td>
<td>Sexual activity that occurs after mutual sexual consent has been provided by those involved. Also see ‘sexual consent’.</td>
</tr>
<tr>
<td>Consumer</td>
<td>Someone with a mental illness or disorder that uses a mental health service.</td>
</tr>
<tr>
<td>Gender sensitive practices</td>
<td>The different needs of men and women are considered in all aspects of service planning and service delivery.</td>
</tr>
<tr>
<td>Informed decision</td>
<td>A decision made by a consumer who understands the nature, extent, or probable consequences of the decision, and can make a rational evaluation of the risks and benefits of alternatives. The decision cannot be considered informed unless the consumer is mentally competent and the decision made voluntarily.</td>
</tr>
<tr>
<td>Mental health service</td>
<td>Any establishment or any unit of an establishment that has the primary function of providing mental health care.</td>
</tr>
<tr>
<td>Mental health workers/staff</td>
<td>Any person working in a permanent, temporary, casual, termed appointment or honorary capacity within a NSW Health mental health organisation. This includes volunteers, consumer advocates, contractors, visiting practitioners, students, consultants and researchers performing work within NSW Health facilities.</td>
</tr>
<tr>
<td>Non-acute and residential mental health settings</td>
<td>Service setting in which care is provided for individuals with a mental health condition that is moderate to severe in complexity. Non-acute inpatient and residential mental health services can be secure, for people with a serious mental illness whose behaviours may put themselves or others at risk or for those who have unremitting and severe symptoms which inhibit their capacity to live in the community. Alternatively, services can provide intensive psychosocial rehabilitation and supports in group accommodation prior to residents living independently.</td>
</tr>
<tr>
<td>Perpetrator/offender</td>
<td>Someone who has breached the sexual safety of a consumer.</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>Activity of a sexual nature with oneself (masturbation) or another (sexual touching, sexual intercourse, oral sex).</td>
</tr>
</tbody>
</table>
| Sexual assault                                         | Sexual assault occurs when:                                                                                                                       | a) a person is forced, coerced or tricked into sexual acts against their will or without their consent, or  
|                                                        | b) a child or young person under 16 years of age is exposed to sexual activities, or  
|                                                        | c) a young person over 16 and under 18 years of age is exposed to sexual activities by a person with whom they have a relationship of ‘special care’ e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc. |
**Sexually disinhibited behaviour**
Poorly controlled behaviour of a sexual nature, where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations; at the wrong time; or with the wrong person.

**Sexual harassment**
Unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Can involve physical, visual, verbal or non-verbal conduct.

**Sexual health**
A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons. (World Health Organisation)

**Sexual safety**
The recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.

**Sexual safety ‘champions’**
Individuals who work in mental health who have an interest in or responsibility for sexual safety, or sexual assault prevention and response, as it relates to mental health consumers, and are willing to act as advocates for the implementation of the NSW Ministry of Health Sexual Safety of Mental Health Consumers Guidelines and this policy directive.

**Sexual safety incident**
The term used to refer to an incident that breaches or compromises the sexual safety of a consumer, and which is recognised as either sexual assault or harassment, consensual sexual activity in an inappropriate setting or sexually disinhibited behaviour.

**Trauma informed care**
Mental health treatment that is directed by:
- a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual; and
- an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. (Jennings, 2004)

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### 2. INTRODUCTION

Sexual assault and violence are crimes that have long term consequences for their victims. While these types of crimes potentially affect all members of the community, research confirms that people with a mental illness or impairment are at a considerably higher risk. Sexual or other abuse or violence can also be a significant contributing factor in the development or compounding of mental health issues.

This makes sexual safety critical for people who use a mental health service – whether the consumer is receiving treatment in a hospital setting, a rehabilitation or residential setting, or within the community.

**Sexual safety**

Sexual safety refers to the respect and maintenance of an individual’s physical (including sexual) and psychological boundaries.

---

13. MENTAL HEALTH

Sexual safety incidents

The types of behaviour that can breach and/or compromise the sexual safety of a mental health consumer have been split into the following three incident types:

- Sexual assault and harassment.
- Consensual sexual activity in an inappropriate context or setting.
- Sexually disinhibited behaviour.

Within the context of this Policy Directive, each of these behaviours is referred to as a ‘sexual safety incident’.

3. POLICY CONTEXT

This Policy Directive responds to feedback provided to the Mental Health and Drug and Alcohol Office (MHDAO) and the Clinical Advisory Council (CAC) indicating the need for clear and mandated direction for mental health services regarding their responsibilities in relation to the sexual safety of mental health consumers in all care settings.

To date, mental health services have been guided by the NSW Health Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services, which were first released in 1999 and revised and re-released in 2005. However, these guidelines were only applicable to inpatient settings and insufficient information was provided regarding how staff should respond to particular sexual safety issues (e.g. prior sexual assault trauma; consensual sex; disinhibited behaviour etc). Accordingly, these guidelines have now been superseded by the Sexual Safety of Mental Health Consumers Guidelines GL2013_012, which should be read in conjunction with this Policy Directive.

The objectives of this Policy Directive have linkages to the State Plan – A New Direction for NSW, specifically F3(a-c): Improved outcomes in Mental Health, as well as the State Health Plan, Towards 2010 – A New Direction for NSW, specifically Strategic Direction 2: Create better experiences for people using health services.

Other Australian and NSW government strategies, legislation and NSW Ministry of Health Policy Directives that should be considered when implementing this Policy Directive are noted within the Sexual Safety of Mental Health Consumers Guidelines.

4. AIM AND OBJECTIVES

4.1 Aim

The aim of this Policy Directive is to provide direction to NSW mental health services regarding the establishment and maintenance of the sexual safety of mental health consumers who use their service. It should be read in conjunction with the NSW Health Sexual Safety of Mental Health Consumers Guidelines GL2013_012. The Guidelines, which support this Policy Directive, provide practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers.

The Guidelines should be used to ensure the broad, overarching responsibilities of mental health services outlined within this Policy are met.

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4.2 Objectives

The objectives of this Policy Directive are to:

a. Establish expected standards for the sexual safety of mental health consumers in all care settings;
b. Clearly outline the responsibilities of mental health services in relation to establishing and maintaining the sexual safety of mental health consumers;
c. Develop a consistent, co-ordinated, approach to the promotion of sexual safety and the prevention of and response to sexual safety incidents; and
d. Improve the sexual safety of consumers of mental health services.

4.3 Principles

The following principles have been developed to provide a clear foundation for the establishment and maintenance of the sexual safety of consumers in all mental health service settings.

1. All mental health consumers are entitled to be sexually safe.
2. All mental health services are responsible for taking appropriate action to prevent and appropriately respond to sexual safety incidents.
3. All mental health services are responsible for supporting mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. All mental health services are responsible for developing individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service – staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer’s rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant’s privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
   a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment; and
   b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community; and
   c. Integrate trauma-informed care principles into all aspects of treatment.
10. Mental health consumers are provided with opportunities to undertake education to enable them to:
    a. Effectively recognise and respond to behaviours, both their own and other people’s, that may compromise or breach their own or another person’s sexual safety;
    b. Develop self-protective behaviours; and
    c. Establish and maintain good sexual health.
5. RESPONSIBILITIES AND MINIMUM REQUIREMENTS

5.1 All services

5.1.1 Responsibilities

Mental health services in all settings have a responsibility to:

5.1.1.1 Implement and monitor observance of the NSW Health Sexual Safety of Mental Health Consumers - Guidelines to establish and maintain the sexual safety of the consumers who use their service.

5.1.1.2 Define and promote the appropriate standard of behaviour expected of consumers and staff involved with the service.

5.1.1.3 Promote the rights and responsibilities of members of the service in relation to sexual safety.

5.1.1.4 Ensure information about sexual safety, and available support services in particular, is provided to consumers and their families and carers and is readily accessible by all members of the service.

5.1.1.5 Ensure the requirements of the NSW Health Code of Conduct and other relevant policies, standards and legislation is promoted to and readily accessible by all members of the service and particularly by service staff.

5.1.1.6 Foster a culture that supports and understands the importance of sexual safety through leadership, promotion and training.

5.1.1.7 Work collaboratively with local relevant sexual assault and other services to ensure the most appropriate support is available to consumers who disclose a sexual assault.

5.1.1.8 Take account of the sexual vulnerability of a consumer and any history of prior assault, trauma or disinhibited behaviour in the planning and provision of mental health interventions.

5.1.1.9 Recognise gender differences within their care provision.

5.1.1.10 Respect the consumer’s right to privacy and confidentiality, within the limits of legislation, when they have experienced a sexual assault.

5.1.1.11 Support staff to whom a disclosure of sexual assault or harassment is made, or when a staff member witnesses an assault.

5.1.1.12 Appropriately report and record any sexual safety incident, taking account of the incident type, whether the alleged perpetrator is a consumer or staff member, and the age of the consumer who has disclosed the incident.

5.1.2 Minimum Requirements

Mental health services in all settings must:

5.1.2.1 Ensure all staff have access to the NSW Health Sexual Safety of Mental Health Consumers Guidelines.

5.1.2.2 Develop sexual safety standards that define appropriate behaviour for the service setting in consultation with all members of the service, including consumers and their families and carers – see Appendix A in the Sexual Safety of Mental Health Consumers Guidelines for example standards.
5.1.2.3 Provide clear information and advice to consumers that takes account their cultural background, gender, age, sexual orientation, and personal experiences regarding:
- their rights and responsibilities in relation to sexual safety
- the sexual safety standards that exist in the service setting
- the process for addressing a sexual safety incident
- the support services available should they experience sexual assault or harassment
- how to manage sexual health issues, such as contraception, sexually transmitted diseases (STDs) and pregnancy.

5.1.2.4 Organise for relevant frontline staff and managers, and consumer workers and representatives involved with the service, to undertake training to enable them to effectively prevent and respond to sexual safety incidents, and increase the confidence of staff to discuss sexual health and safety issues with consumers. Such training must include:
- How to assess a consumer’s vulnerability and take a sexual assault history
- Consider gender sensitive and trauma informed care principles
- Be undertaken as part of an orientation process where practicable, with refresher training considered annually or biannually.

5.1.2.5 Build or strengthen partnerships with local key stakeholders such as the NSW Health Sexual Assault Service (SAS) and other sexual assault support agencies, the NSW Police Force, General Practitioners (GPs) etc.

5.1.2.6 Conduct an audit to assess the current level of gender sensitivity within the service so that priorities for action can be determined to increase safety and gender sensitivity, and repeat this audit every two years.

5.1.2.7 Assess the vulnerability of each consumer on their admission to the service, which should include any history of sexual assault or incidences of sexual disinhibition, and ensure care plans take account of this. (Note: this assessment can be part of any existing violence screening e.g. domestic violence, elder abuse etc).

5.1.2.8 Respond to a disclosure of sexual assault in accordance with the key actions at Appendix I of this policy directive until assessment of the consumer’s clinical mental state determines otherwise (as detailed within the Sexual Safety of Mental Health Consumers Guidelines).

5.1.2.9 Ensure any information regarding a sexual safety incident is not disclosed without the consent of the consumer involved, except for the purpose for which the information was collected or the incident is identified as a sexual assault and:
- The alleged perpetrator is a staff member.
- The consumer who has been assaulted is under 16 years of age.
- The consumer who has been assaulted is over 16 but under 17 years of age and in a care relationship with the alleged perpetrator in which case the incident must be reported to the NSW Police Force (see 5.1.2.11).

5.1.2.10 Provide staff with an opportunity to de-brief as required when a consumer discloses an incident of sexual assault or harassment to them, or they witness a sexual safety incident.

5.1.2.11 Report a sexual safety incident identified as a sexual assault as per the process outlined within the Sexual Safety of Mental Health Consumers Guidelines, and summarised at Appendix II of this policy directive.
5.2 Acute Inpatient Mental Health Setting

5.2.1 Responsibilities

*Within this setting mental health services have an additional responsibility to:*

5.2.1.1 Support consumers to be free from pressure to engage in sexual activity with another person, including the consumer’s partner or spouse, while in the service environment.

5.2.1.2 Offer sexuality and sexual health education to consumers that is sensitive to each individual’s culture, age and sexual orientation and is relevant to non-acute and residential settings.

5.2.1.3 Consider how changes to the physical environment of the service may improve sexual safety for consumers.

5.2.1.4 Respond to all disclosures of sexual assault or harassment according to the key actions as outlined in the *Sexual Safety of Mental Health Consumers Guidelines* and summarised at Appendix I, until assessment of the consumer’s clinical mental state determines otherwise.

5.2.2 Minimum Requirements

*Within this setting, mental health services must also:*

5.2.2.1 Ensure the sexual safety standards for the service highlight that sexual activity, regardless of its consensual nature, is not supported in an acute inpatient setting due to the extreme vulnerability of the consumer/s involved, as well as the vulnerability of the consumers that may witness any such activity, and reiterate this to consumers and their families, carers and partners.

5.2.2.2 Consult with consumers and carers involved with the service around the requirement for sexual safety and sexual health education for consumers and ensure that consumers are able to contribute to determining the topics such education should involve.

5.2.2.3 Work towards improving the physical environment of existing services, where practicable, and ensure new services are planned, to take account of sexual safety in accordance with the *Sexual Safety of Mental Health Consumers Guidelines*, which are supported by and aligned with the current Australasian Health Facility Guidelines for Adult Acute Mental Health Inpatient Units.

5.2.2.4 Organise for the senior clinician (where not involved in the allegation) to carry out an assessment of the clinical mental state of the consumer who has disclosed an assault or harassment within 24 hours.

5.3 Non-acute and residential mental health settings

5.3.1 Responsibilities

*Within this setting mental health services have an additional responsibility to:*

5.3.1.1 Consider how to appropriately and safely address the sexuality needs of consumers.

5.3.1.2 Ensure access to sexuality and sexual health education for consumers that is sensitive to an individual’s culture, age and sexual orientation on topics relevant to non-acute and residential settings.

5.3.1.3 Consider how changes to the physical environment of the service may improve sexual safety for consumers.

5.3.1.4 Respond to all disclosures of sexual assault or harassment according to the key actions as outlined in the *Sexual Safety of Mental Health Consumers Guidelines* and summarised at Appendix I of this policy directive, until assessment of the consumer’s clinical mental state determines otherwise.
5.3.2 Minimum Requirements

Within this setting, mental health services must also:

5.3.2.1 Ensure the sexual safety standards for the service recognise that sexual activity is a normal and healthy part of life and can be supported in a non-acute and residential setting provided that consent, capacity and safety issues are taken into account.

5.3.2.2 Have an understanding of the capacity of the consumers under their care to consent to sexual activity and if this capacity is in doubt, conduct an assessment of the consumer’s clinical mental health status, communication skills and current level of knowledge and understanding regarding sexual and personal relationships. This assessment must be recorded in the consumer’s collaborative care plan and reviewed on a regular basis.

5.3.2.3 Work with those consumers who lack the capacity to consent to sexual activity to explore solutions should they wish to engage in such activity.

5.3.2.4 Ensure consumers have access to condoms and sexual health information and advice.

5.3.2.5 Monitor the general wellbeing of a consumer or consumers involved in a sexual relationship and attempt to obtain an understanding of how this relationship may be impacting upon their wellbeing.

5.3.2.6 Consult with consumers and carers involved with the service around the requirement for sexual safety and sexual health education for consumers and ensure that consumers are able to contribute to determining the topics such education should involve.

5.3.2.7 Work towards improving the physical environment of existing services, where practicable, and ensure new services are planned, to take account of sexual safety in accordance with the Sexual Safety of Mental Health Consumers Guidelines, which are supported by and aligned with the current Australasian Health Facility Guidelines for Adult Acute Mental Health Inpatient Units.

5.3.2.8 Organise for the senior clinician (where not involved in the allegation) to carry out an assessment of the clinical mental state of the consumer who has disclosed an assault or harassment within 48 hours.

5.4 Community mental health setting

5.4.1 Responsibilities

Within this setting mental health services have an additional responsibility to:

5.4.1.1 Help consumers to access education that is sensitive to their culture, age and sexual orientation on topics relevant to the community setting if required.

5.4.1.2 Protect consumers from further contact with the alleged perpetrator if this is a staff member of the service and provide access to appropriate support if the alleged perpetrator is the consumer’s family member, carer or friend or another consumer involved with the service.

5.4.2 Minimum Requirements

Within this setting, mental health services must also:

5.4.2.1 Consult with consumers around education needs and identify and advise consumers about existing educational materials or courses that may satisfy such a need.

5.4.2.2 Protect consumers from further contact with the alleged perpetrator if this is a staff member of the service and provide access to appropriate support if the alleged perpetrator is the consumer’s family member, carer or friend or another consumer involved with the service.

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6. IMPLEMENTATION

6.1 Process and timing

Implementation of this policy directive must be undertaken according to the implementation plan outlined at Appendix III. In recognition of the significant changes to current practice that must be made at a LHD level, and the investment required at a Ministry level to develop an appropriate and consistent training framework, implementation will need to be staged over a two year period. Implementation must be completed by June of 2014.

6.2 Monitoring and verification

Implementation by individual services should be monitored by each Local Health District via the Individual Service Implementation Monitoring Form at Appendix IV. Progress with implementation must be reported annually to the NSW Ministry of Health Mental Health and Drug and Alcohol Office until implementation is completed, in accordance with the following timeline.

- First progress report due: December 2013
- Second progress report due: June 2014
- Third progress report due: December 2014
- Final progress report due: June 2015

The template form at Appendix V will support this process. This form must be signed by the Local Health District Mental Health Director and submitted to the NSW Ministry of Health Mental Health and Drug and Alcohol Office.

7. ATTACHMENTS

APPENDIX I - Key actions when responding to a sexual assault
APPENDIX II - Reporting process for an incident of sexual assault
APPENDIX III - Broad implementation plan
APPENDIX IV - Mental Health Service Implementation Monitoring Form
APPENDIX V - Local Health District Implementation Verification Form

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## APPENDIX I - Key actions when responding to a sexual assault

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acknowledge and affirm the disclosure</td>
<td>Be non-judgemental, compassionate and understanding when a consumer discloses their experience of sexual assault or harassment and respond promptly, in accordance with the <em>Sexual Safety of Mental Health Consumers Guidelines</em>, whether the assault occurred prior to or after the consumer’s admission.</td>
</tr>
<tr>
<td>2</td>
<td>Explore the disclosure</td>
<td>Provide the consumer with a safe, quiet, private space and gently encourage them to provide information about the assault. Ensure an assessment of the consumer’s clinical mental state is undertaken within 24 hours in an acute inpatient setting and within 48 hours in all other settings before proceeding with next steps.</td>
</tr>
<tr>
<td>3</td>
<td>Establish and maintain safety</td>
<td>Assess whether the consumer is in current danger and the need for special accommodations to make the consumer feel safe, being mindful that it is the alleged perpetrator and not the consumer who has been assaulted that should be moved from the facility if required, unless the consumer who has disclosed the assault specifically requests otherwise or there are other extenuating circumstances.</td>
</tr>
<tr>
<td>4</td>
<td>Secure any evidence</td>
<td>Keep any clothing worn by the consumer at the time of the assault, ensure only the consumer handles these clothes, and secure the location of the assault if possible along with any CCTV footage of the area in which the incident occurred.</td>
</tr>
<tr>
<td>5</td>
<td>Offer support and options</td>
<td>Provide the consumer with advice and information regarding their options (Appendix D of the <em>Sexual Safety of Mental Health Consumers Guidelines</em>) so they can decide how they want to proceed. The consumer’s wishes regarding how to proceed must be respected unless legislatively prohibited or they lack the capacity to make an informed decision (see Step 6).</td>
</tr>
<tr>
<td>6</td>
<td>Organise medical care</td>
<td>Encourage the consumer to seek immediate medical care to identify and treat any physical injuries and to discuss issues such as the risk of infection or pregnancy. Offer counselling as required and ensure consent is obtained for any forensic exam.</td>
</tr>
<tr>
<td>7</td>
<td>Assess capacity to make informed decisions</td>
<td>This assessment will need to include an evaluation of the consumer’s capacity to understand their options, process and communicate information and effectively exercise their rights. If they are assessed as not having the capacity to make an informed decision regarding their options, any such decision should be delayed if possible until the consumer’s capacity is restored. Alternatively, urgent application can be made for a Guardian to make some decisions.</td>
</tr>
</tbody>
</table>
APPENDIX II - Reporting process for an incident of sexual assault

**Internally**

- To the Team Leader/Nursing Unit Manager, who must inform the Senior Manager.
- Through the Reportable Incident Brief (RIB) system – RIB must be submitted within 24 hours when:
  - the alleged perpetrator is a staff member; or
  - the consumer who has been assaulted is under 16 years of age; or
  - the consumer who has been assaulted is over 16 but under 17 years of age and is in a care relationship with the alleged perpetrator.
- Through the Root Cause Analysis (RCA) investigation process.

**Externally**

- To the NSW Police Force when:
  - the consumer requests this and an assessment of the consumer’s clinical mental state does not preclude this as a relevant step;
  - the alleged perpetrator is a staff member; or
  - the consumer is under 16 years of age; or
  - the consumer is over 16 but under 18 years of age and in a care relationship with the alleged perpetrator; or
  - the consumer does not have the capacity to make an informed decision, and the senior clinician has a duty of care to formally report the assault.
- To the Child Protection Helpline (13 36 27) when:
  - the consumer is a child under 16 years of age. The Helpline must also be contacted if the consumer is a child at risk of significant harm (which includes when they have had consensual sexual intercourse); or
  - the consumer is over 16 but under 17 years of age and in a care relationship with the alleged perpetrator.
### APPENDIX III - Broad implementation plan

<table>
<thead>
<tr>
<th>Local Health District (LHD)</th>
<th>Individual service</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be completed by June 2014</td>
<td>To be completed by June 2014</td>
</tr>
<tr>
<td>• Nominate a lead staff member to be responsible for driving implementation of the Guidelines and Policy Directive at LHD level</td>
<td>• Nominate a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a local level</td>
</tr>
<tr>
<td>• Identify at least 2 ‘champions’ who will work with the lead staff member to promote and support staff to implement the Guidelines and Policy Directive</td>
<td></td>
</tr>
<tr>
<td>• Promote the availability of the Guidelines and Policy Directive and encourage services to order adequate hard copies</td>
<td>• Order adequate hard copies of Guidelines to support ready access by staff, consumers and carers</td>
</tr>
<tr>
<td>• Provide clear advice to services and key staff regarding the changes required in order to meet the <em>Sexual Safety of Mental Health Consumers Guidelines</em> and Policy Directive</td>
<td>• Introduce the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicate about implementation process</td>
</tr>
<tr>
<td></td>
<td>• Develop and implement a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service</td>
</tr>
<tr>
<td></td>
<td>• Develop and implement a strategy to establish or build on local partnerships with key stakeholders, such as the local Sexual Assault Service and other sexual assault agencies, GPs, NSW Police Force, relevant Community Managed Organisations etc</td>
</tr>
<tr>
<td>• Consult with services regarding training requirements and feed outcomes up to MHDAO</td>
<td>• Consult with staff, consumers and carers regarding training/education needs and feed information up to identified lead staff and champions</td>
</tr>
<tr>
<td>• Provide feedback to MHDAO on any draft training framework or materials developed</td>
<td>• Develop plan that identifies individual staff members to participate in training and consumers interested in education</td>
</tr>
<tr>
<td>• Communicate with services to determine progress with implementation and request completion of the Individual Service Implementation Monitoring Form</td>
<td>• Complete Individual Service Implementation Monitoring Form</td>
</tr>
<tr>
<td>• Complete and submit the Implementation Verification Form to MHDAO, according to specified timeline</td>
<td></td>
</tr>
</tbody>
</table>

192(14/11/13)
<table>
<thead>
<tr>
<th>Local Health District (LHD)</th>
<th>Individual service</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Develop local policies and procedures to support services to meet the requirements of the Sexual Safety of Mental Health Consumers Guidelines and Policy Directive</td>
<td>▪ Review the following areas of service practice and assess against the Guidelines:</td>
</tr>
<tr>
<td>▪ Develop processes and documentation to support services to review and assess their:</td>
<td>○ level of gender sensitivity</td>
</tr>
<tr>
<td>○ level of gender sensitivity</td>
<td>○ physical environment</td>
</tr>
<tr>
<td>○ physical environment</td>
<td>○ violence screening and admission processes</td>
</tr>
<tr>
<td>○ violence screening and admission processes</td>
<td>○ reporting processes</td>
</tr>
<tr>
<td>▪ Promote the availability of the training once it is released by MHDAO and advise of the need for staff to participate</td>
<td>▪ Based on the outcomes of the above assessment, develop and implement plans to improve these areas to support compliance with the Guidelines and Policy Directive</td>
</tr>
<tr>
<td>▪ Communicate with services to determine progress with implementation and request completion of the Individual Service Implementation Monitoring Form</td>
<td>▪ Implement training/education plan for staff and consumers</td>
</tr>
<tr>
<td>▪ Complete and submit the Implementation Verification Form to MHDAO, according to specified timeline</td>
<td>▪ Ensure future training plans factor in the need for refresher training</td>
</tr>
<tr>
<td></td>
<td>▪ Complete Individual Service Implementation Monitoring Form</td>
</tr>
</tbody>
</table>
# APPENDIX IV - Mental Health Service Implementation Monitoring Form

**Policy Directive:**  
**SEXUAL SAFETY – RESPONSIBILITIES & MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES**

<table>
<thead>
<tr>
<th>Mental Health Service Name</th>
<th>Date</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
</table>

**Authorised by Service Manager**

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
</tr>
</thead>
</table>

**First progress report**  
**Second progress report**  
**Third progress report**  
**Final progress report**

<table>
<thead>
<tr>
<th>Has your service…….</th>
<th>NOT COMMENCED</th>
<th>UNDERWAY</th>
<th>COMPLETED</th>
</tr>
</thead>
</table>

1. **Nominated a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a service level?**

   - [x] NOT COMMENCED  
   - [ ] UNDERWAY  
   - [x] COMPLETED

2. **Ordered adequate hard copies of Guidelines to support ready access by staff, consumers and carers?**

   - [x] NOT COMMENCED  
   - [ ] UNDERWAY  
   - [x] COMPLETED

3. **Introduced the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicated about the implementation process?**

   - [x] NOT COMMENCED  
   - [ ] UNDERWAY  
   - [x] COMPLETED

4. **Developed and implemented a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service?**

   - [ ] NOT COMMENCED  
   - [x] UNDERWAY  
   - [x] COMPLETED

5. **Developed and implemented a strategy to establish or build on local partnerships with key stakeholders, such as the local Sexual Assault Service and other sexual assault agencies, GPs, NSW Police Force, relevant Community Managed Organisations etc?**

   - [x] NOT COMMENCED  
   - [ ] UNDERWAY  
   - [x] COMPLETED

6. **Reviewed the following areas and assessed against the Guidelines?**

   - [ ] The level of gender sensitivity within the service  
   - [ ] The practical environment or layout of the service  
   - [ ] The service’s violence screening and admission processes  
   - [ ] The service’s reporting processes

   - [ ] NOT COMMENCED  
   - [x] UNDERWAY  
   - [x] COMPLETED

7. **Developed and implemented plans to improve these areas, based on the outcomes of the above assessment, to support compliance with the Guidelines and Policy Directive?**

   - [ ] NOT COMMENCED  
   - [x] UNDERWAY  
   - [x] COMPLETED

8. **Consulted with staff, consumers and carers re training/education needs and provided this feedback to identified LHD champions?**

   - [ ] NOT COMMENCED  
   - [x] UNDERWAY  
   - [x] COMPLETED

9. **Developed a training and education plan that identifies which staff must participate in training and which consumers are interested in education?**

   - [ ] NOT COMMENCED  
   - [x] UNDERWAY  
   - [x] COMPLETED

10. **Implemented your training and education plan for staff and consumers upon the release of the new training based on the Guidelines?**

    - [x] NOT COMMENCED  
    - [ ] UNDERWAY  
    - [x] COMPLETED

---

**SUBMIT COMPLETED FORM TO THE MENTAL HEALTH DIRECTOR AT LOCAL HEALTH DISTRICT**

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13. MENTAL HEALTH

APPENDIX V - Local Health District Implementation Verification Form

Policy Directive: SEXUAL SAFETY – RESPONSIBILITIES & MINIMUM REQUIREMENTS FOR MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT</th>
<th>Date</th>
<th>/</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verified by Mental Health Director</td>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signature</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First progress report ☐ Second progress report ☐ Third progress report ☐ Final progress report ☑

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lead staff member and champions nominated to drive implementation of the Guidelines and Policy Directive at LHD level</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy Directive</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>4. Review undertaken by services regarding the changes required to service delivery and practices to meet the Guidelines and Policy Directive</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>5. Plans developed and implemented by services to support compliance with the Guidelines and Policy Directive</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>6. Services consulted regarding training requirements and outcomes communicated to MHDAO</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>7. Available training and requirement to attend promoted to services</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

Notes:

SUBMIT COMPLETED FORM TO MHDAO BY EMAIL AT MHDAO@doh.health.nsw.gov.au

192(14/11/13)
SEXUAL SAFETY OF MENTAL HEALTH CONSUMERS GUIDELINES
(GL2013_012)


PURPOSE

The Sexual Safety of Mental Health Consumers Guidelines provide practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers and respond appropriately to incidents that breach or compromise this safety. Sexual safety refers to the recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people.

These Guidelines should be read in conjunction with Policy Directive PD2013_038, which mandates the minimum requirements that must be met in this regard.

KEY PRINCIPLES

The key principles in these Guidelines, and the associated Policy Directive, are listed below.

1. All mental health consumers are entitled to be sexually safe.
2. Mental health services take appropriate action to prevent and appropriately respond to sexual safety incidents.
3. Mental health services support mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. Mental health services develop individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service including staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer’s rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant’s privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
   a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment.
   b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community.
   c. Integrate trauma-informed care principles into all aspects of treatment.

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10. Mental health consumers are supported to access education to enable them to:
   a. Effectively recognise and respond to behaviours, both their own and other people’s, that may compromise or breach their own or another person’s sexual safety.
   b. Develop self-protective behaviours.
   c. Establish and maintain good sexual health.

USE OF THE GUIDELINE

These Guidelines apply to NSW Health services providing specialist mental health care in all settings including acute inpatient, non-acute inpatient, rehabilitation and community and staff working for such services.

Where a service has a mix of acute and non-acute consumers in the one unit or facility, it is the responsibility of the service to ensure they implement these Guidelines and the associated Policy Directive in a way that addresses this mix.

The scope of the Guidelines does not extend to providing practical and detailed guidance about how services can best manage issues relating to sexual activity involving consumers. Services are encouraged to develop their own local policies and protocols in relation to this area, being mindful of the policy approach advocated within these Guidelines regarding the right of consumers to express their sexuality safely and respectfully in the appropriate settings.

The Policy Directive outlines a number of Responsibilities and Minimum Requirements for:
   • all Mental Health Services, (pg 11)

with additional Responsibilities and Minimum Requirements specific to:
   • acute inpatient mental health settings (pg 13)
   • non-acute and residential mental health settings (pg 14)
   • community mental health settings (pg 15).

Implementation will be staged over a two year period, and must be completed by June of 2014. Implementation by individual services should be monitored by each Local Health District via the Individual Service Implementation Monitoring Form at Appendix IV of the associated Policy Directive.

To download the Guidelines please go to
ABORIGINAL MENTAL HEALTH AND WELL-BEING POLICY 2006-2010 (PD2007_059)


The NSW Aboriginal Mental Health and Well Being Policy 2006-2010 (the Policy) is a framework to guide NSW Health and NSW Area Mental Health Services (AMHSs) in the provision of culturally sensitive and appropriate mental health and social and emotional well being services to the Aboriginal community of NSW.

The Policy will improve the coordination of care for Aboriginal people in NSW by ensuring:

- partnerships are formed with other relevant organisations relating in strong working relationships;
- accessible and responsive mental health services that cater for all ages and enable targeted priority areas; and
- a supported and skilled workforce in Aboriginal mental health and well being and increasing the expertise and knowledge base in this area.


NSW OLDER PEOPLE’S MENTAL HEALTH SERVICES SERVICE PLAN 2017-2027 (GL2017_022)

GL2017_022 rescinds GL2006_013

This plan is intended to guide NSW older people’s mental health (OPMH) services over the next ten years. Pressure on these specialist services will grow as the population ages and the number of older people with complex mental health problems increases. The Plan outlines the purpose, scope, target group and key elements of OPMH services, the context in which they operate and current developments in the service environment. It identifies evidence-based service models and key strategic priorities for the development, delivery and improvement of OPMH services.

This document can be accessed at the following link:

SPECIALIST MENTAL HEALTH SERVICES FOR OLDER PEOPLE (SMHSOP) COMMUNITY SERVICES MODEL OF CARE GUIDELINE  (GL2017_003)

PURPOSE
The purpose of this Guideline is to outline a good practice model of care for NSW Specialist Mental Health Services for Older People (SMHSOP) community services.

This model of care explains how community mental health services for older people should be delivered. The aims involve providing the right care to people at the right time, by the right team in the right place, with care directed by the consumer and carer with expert clinician assistance alongside. It is intended to guide policy makers, service planners, service managers and clinicians in improving and re-orienting SMHSOP community services in a manner that is evidence-based, recovery-oriented and responds to key themes identified from consumer, carer, clinician and stakeholder consultations.

Both the SMHSOP community and Behavioural Assessment and Intervention Services (BASIS) teams across NSW are in the primary scope of the model of care.

The Guideline focuses on the model of care and relevant recommendations for SMHSOP community teams. Additional detailed information is available in the SMHSOP Community Model of Care Project Report.

KEY PRINCIPLES
This Guideline is guided by the principles of recovery, consumer-directed care and partnering with the consumer, carer(s), GP, and other key services and supports.

The SMHSOP community model of care has been informed by work being done at the state and national level in the mental health and / or aged care space. It aligns with key national and state standards and policy frameworks.

USE OF THE GUIDELINE
This Guideline should be used by SMHSOP community services to assist them to make improvements in service delivery which are based upon the best available evidence. It is to be developed in collaboration with consumers, carers, clinicians, managers, health care partners and other key stakeholders. It will also provide guidance to existing community services and new services, to inform planning and promote the best use of available resources.

This document can be accessed at the following link:
TRANSFER OF CARE FROM MENTAL HEALTH INPATIENT SERVICES (PD2019_045)

PD2019_045 rescinds PD2016_056

PURPOSE

This Policy provides direction to NSW Health mental health services. It applies to NSW Health mental health staff involved in the assessment, care, discharge planning or transfer of care of a mental health consumer.

The Policy Directive

- Establishes minimum standards to support effective and safe discharge planning and transfer of care for consumers of NSW Health mental health services.
- Sets out a consistent, coordinated approach to ensure continuity of care and support for the consumer and for their family/carers at the point of transfer of their care.
- Clarifies the role and responsibility of mental health services in discharge planning and transfer of care including their linkages with other health care providers and support services, to meet the needs of mental health consumers and their family/carers.

Key Performance Indicators

This Policy Directive aims to address three key performance indicators to improvemental health outcomes:

- reduce re-admissions within 28 days to any acute mental health unit
- increase community follow-up within 7 days post discharge from an acute mental health unit
- reduce the number of involuntary patients who abscond (Types 1 and 2) from inpatient mental health units.

This Policy Directive supersedes PD2016_056 Transfer of care from mental health inpatient services.

MANDATORY REQUIREMENTS

Local Health Districts (LHDs)/Specialty Health Networks (SHNs) have responsibility to ensure that:

- mental health staff are aware of the requirements of this Policy Directive
- mental health staff are trained and supported to implement the requirements of this Policy Directive
- local relevant policies and procedures align to the key principles and procedures in this Policy Directive
- mental health staff are familiar with local procedures, communication and documentation standards for discharge planning and transfer of care within their setting
- discharge planning and transfer of care processes and documentation are routinely monitored and subject to clinical review processes, and the results are provided to clinical staff
- processes are in place to monitor the post-discharge community care indicator (7-day follow up), rates of re-admission to an acute mental health service within 28 days, and the number of involuntary patients who abscond from inpatient mental health units.
IMPLEMENTATION

Roles and Responsibilities

**The Ministry**
- provides mandatory requirements for mental health discharge planning and transfer of care
- reviews and takes appropriate follow up action on the implementation reports submitted by Local Health Districts and Specialty Health Networks.

**Chief Executives**
Ensure that:
- the principles and requirements of this Policy Directive are applied, achieved and sustained
- all relevant staff understand and comply with the requirements of this Policy Directive
- all relevant staff receive education and training to enable them to carry out their roles and responsibilities in relation to the Policy Directive
- the LHD or SHN submits a report on the Policy Directive’s implementation for the initial six and 12 month periods. The reports are to be submitted to the Mental Health Branch, Ministry of Health, on the templates provided (see Procedures document Appendix C and D).

**Mental Health Staff**
- Read, understand and comply with the requirements of this Policy Directive.

Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services Procedures

1 BACKGROUND

1.1 About this document

Transitions between services and care providers are times of significant risk for mental health consumers and their families/carers. Collaborative and comprehensive discharge planning and transfer of care improves safety for the consumer, their family/carer and the wider community.

1.2 Scope of policy

This Policy Directive applies to NSW Health mental health staff involved in the assessment, care, discharge planning and/or transfer of care of a mental health consumer. It sets out the principles and essential requirements for effective and safe discharge planning and transfer of care for consumers of all ages (younger people, adults and older persons) to services including but not limited to:
- public mental health inpatient units
- community mental health services
- medical wards
- Local Health Districts (LHDs) and Specialty Health Networks (SHNs)
- private psychiatric hospitals
- general practitioners
- private psychiatrists, psychologists and other health professionals
- community managed organisations (CMOs)
- drug and alcohol inpatient units
- community drug and alcohol services
- government agencies and service providers (for example, Community Living Supports, Housing and Accommodation Support Initiatives, National Disability Insurance Agency/National Disability Insurance Schemes, Police and Correctional facilities)
- aboriginal community controlled health services (ACCHS)
- residential aged care facilities

314(26/09/19)
1.3 Key definitions

<table>
<thead>
<tr>
<th>Carer/s</th>
<th>Refers to a family member, friend or guardian who is identified as a designated carer and/or a principal care provider under the Mental Health Act 2007.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer</td>
<td>Refers to a person with lived experience of a mental health condition who is accessing or has previously accessed a mental health service. For children and younger people, their caregivers may sometimes be described as consumers (Mental Health Coordinating Council, 2018). In this document the term ‘patient’ is used when associated with legal status.</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>This term is usually associated with assessments, referrals and recovery plans put in place to support continuity of care for a consumer returning to the community after a hospital admission. It links hospital treatment with community based health care and support services. In this document the term ‘discharge planning’ also refers and extends to the planning, coordination and continuity of care process involved when a mental health consumer moves between any of the settings identified under section 1.2 Scope of the policy.</td>
</tr>
<tr>
<td>Multidisciplinary team</td>
<td>Refers to the treating team including psychiatrist, doctors, nursing, allied health professionals and other support staff including peer workers.</td>
</tr>
<tr>
<td>Telehealth</td>
<td>Telehealth is the secure transmission of images, voice and data between two or more units via telecommunication channels, to provide clinical advice, consultation, monitoring, education and training and administrative services (Agency for Clinical Innovation, Guidelines for the use of Telehealth for Clinical and Non Clinical Settings in NSW, 2015, p4).</td>
</tr>
<tr>
<td>Transfer of care</td>
<td>Refers to the transfer of professional responsibility and accountability for the care of a mental health consumer to another person or professional group.</td>
</tr>
</tbody>
</table>

1.4 Legal and legislative framework

The NSW Mental Health Act 2007 (the Act) has informed this Policy Directive. If there are any inconsistencies between this Policy and the Act, the provisions of the Act take precedence.

This Policy Directive has also been informed by:
- National Mental Health Service Standards (2010)
- National practice standards for the mental health workforce (2013)
- National Safety and Quality Health Service Standards (second edition-2017)
- recommendations from New South Wales Auditor-General’s Report (Performance Audit), Mental Health Post Discharge Care (2015)

Recommendations from coronial inquests and findings from Root Cause Analysis investigations have also informed this Policy Directive.

The NSW Health policy for PD2011_015 Care Coordination: Planning from Admission to Discharge in NSW Public Hospitals provides key requirements for all inpatients discharged to the community.

Other relevant legislation, related policies and guidelines are listed at Appendix E.
2. **KEY PRINCIPLES**

Effective discharge planning and transfer of care relies upon active, collaborative planning involving consumers and their families/carers, the treating team and the receiving team. This will support seamless and coordinated delivery of care.

Timely, clear verbal communication and documentation are essential elements of safe and effective discharge planning and transfer of care for mental health consumers. **The following key principles underpin this policy:**

2.1 Care planning including discharge planning and transfer of care practices are based on trauma-informed and recovery oriented principles and practices. These practices prioritise the safety and wellbeing of the consumer, and their family/carer including children.

2.2 Consumers and carers are partners in care planning including discharge planning and transfer of care. They must be listened to and involved, as appropriate, throughout care planning from admission through to discharge and transfer of care to another service provider.

2.3 Planning for transfer of care commences as soon as practicable after the consumer’s admission to the service.

2.4 There is both autonomy and treatment collaboration in the context of safe and comprehensive care. Staff are to make every effort to support and maintain the consumer’s rights, choice and self-determination.

2.5 This process is an active one. There is comprehensive assessment and timely reviews of a consumer’s mental state, their physical health, strengths, vulnerabilities, and consideration of any parenting and family responsibilities, and available supports to enhance effective planning for discharge and/or transfer of care. As with any clinical review, it should be age appropriate and consider cognitive function e.g. psychogeriatric assessment), developmental stage, and co-existing disabilities.

2.6 There is continuity of care following transfer. Effective coordination and continuity of care following transfer of care relies on clear and timely verbal communication and documentation between the treating team, the consumer, their family/carer and the receiving service.

2.7 Consumers are not discharged without issues of homelessness being addressed. Consumers are to be discharged into appropriate accommodation and/or referred to local homelessness services.

2.8 To maximise opportunities to support the consumer, all modalities of service delivery should be employed. Consider the use of telehealth (where clinically appropriate) as an effective and efficient modality to support discharge planning and transfer of care.

2.9 Discharge planning and transfer of care must take into account a consumer’s language, culture, and diversity (i.e. Aboriginal and Torres Strait Islander background), gender and/or sexual orientation.

2.10 The Clinical Excellence Commission (CEC) recommends the use of ISBAR(Introduction; Situation; Background; Assessment; and Recommendation) as a key communication guide to achieve a standardised handover procedure that is thorough and person-centered. [http://www.cec.health.nsw.gov.au/qualityimprovement/team-effectiveness/insafehands/clinical-handover](http://www.cec.health.nsw.gov.au/qualityimprovement/team-effectiveness/insafehands/clinical-handover)
3 DISCHARGE PLANNING AND TRANSFER OF CARE

The following guidelines will assist LHDs and SHNs to develop local written procedures which address and manage key aspects of mental health discharge planning and transfer of care. These local procedures must set out requirements and practices applicable for all service settings.

3.1 Discharge Planning: Working with consumers, families and carers

Mental health services must:

- **Identify a key contact/coordinator from the multidisciplinary treating team**, who is responsible for ensuring that each step of the discharge planning process is completed.

- **Estimate the date of discharge (EDD) in collaboration with the consumer and their family/carer**, based on mental state and other assessments. Regular review of this date must consider current events and clinical advice. The EDD supports timely transfer of care planning and is helpful for the consumer and carer.

- **Carry out regular mental state examinations and assessments of the consumer’s personal strengths and vulnerabilities, social supports, safety and practical needs.** These assessments should consider factors such as:
  - harm to self or harm to others (including children in contact with the consumer)
  - risk from others
  - parenting and family responsibilities
  - housing, homelessness or risk of homelessness
  - medication history (including non-adherence with psychiatric medication)
  - history of trauma
  - history of substance use or misuse
  - co-existing physical health and other disabilities
  - history of domestic violence as a victim or perpetrator
  - vulnerability to elder abuse
  - access to firearms or weapons
  - existing and planned support services and their location.

- **Develop and document management strategies for identified risks** in the consumer's Mental Health Care Plan in their medical record and consider the need for documenting any appropriate ‘Alerts’ and ‘Problems’.

- Services should **facilitate the use of risk assessment processes and management strategies** that respond to violence, abuse and neglect and prioritise the safety and wellbeing of consumers, regardless of whether the consumer is identified as the victim or the perpetrator.

- **Consider the need for a Community Treatment Order** (Part 3 Involuntary treatment in the community of the Act), where appropriate.

- **Consider child protection and wellbeing issues** and respond accordingly (refer to the Child Wellbeing and Child Protection policies and procedures for NSW Health).

- **For consumers with long inpatient stays** who are being discharged under the Pathways to Community Living initiative, refer to local Pathways to Community Living procedures and processes.

- **Support the consumer to update or develop their Wellness Plan**, which will include contingency plans for changes in circumstances including:
  - deteriorating mental or physical health and
  - emergency contacts.

- Ensure all relevant information for safe discharge are discussed with the consumer and family as well as provided in writing.
3.2 Discharge Planning: Working with other services

Mental health services must:

- **Engage the receiving service**, for example the community mental health team, other health provider or support service, in discharge planning.

- **Establish mechanisms to enhance the transition experience and reduce the risk of the consumer being lost to care**, for example:
  - Facilitate the consumer’s engagement with the receiving community mental health team, other health provider and support service. This could be an introduction by phone, videoconference/telehealth or face-to-face prior to discharge.
  - Use mental health peer workers, if the consumer requests this, to support the consumer transitioning from inpatient to community based services.
  - Offer input from Aboriginal Health Workers or culturally diverse workers in discharge planning.
  - Offer the consumer and their family/carer access to translating and interpreting services where appropriate.

- **For consumers who live in social or community housing**, make early contact with Family and Community Services (FACS) or the relevant community housing provider to ensure that rental obligations are considered and occupancy is maintained.

- Services involved in current and ongoing treatment must **establish a follow-up procedure** for consumers who do not keep or are reluctant to engage with the planned follow-up arrangements as part of discharge planning.

3.3 Transfer of care

Mental health services must establish a standard procedure for transferring a consumer’s care that includes both verbal and written handover. See section 3.5 Documentation for guidance on the provision of documentation and mechanisms for the treating (referring) team to confirm that the written information has been received by the receiving service provider.

3.3.1 Planning for transfer of care

- **Transfer of care discussions are to include the consumer’s goals and practical considerations such as:**
  - estimated time and date of discharge (EDD)
  - transportation needs
  - access to suitable services
  - supports post-discharge
  - other responsibilities such as parenting and family issues
  - safety planning where the consumer is a victim of domestic and/or family violence or other abuse. Safety planning should be undertaken by, or with a psychosocially trained health worker in consultation with the consumer
  - appropriate referrals for ongoing care and supports.

- Ensure that the local Transfer of Care Checklist in the electronic medical record or its equivalent is completed for all consumers.

- Discuss the *Your Experience of Service (YES)* with the consumer and give them supporting documentation (e.g. brochure) and a paper copy or the online link with the service code identifier, to complete.

- Discuss the *Carers Experience Survey (CES)* with the carer and give them supporting documentation and a paper copy or the online link with service code identifier, to complete.
3.3.2 Transferring care

From a community mental health service:

- When a community mental health service is transferring a consumer’s care to an external service provider, including a general practitioner, private psychiatrist or psychologist, they must include the Discharge/Transfer Summary from any recent inpatient admission. This summary document offers important information about recent treatment and care of a psychiatric or medical condition, including changes in medication.

- When transitioning from a community mental health service, the multidisciplinary team should review all prior discharges/transfers. This review should confirm in writing that discharge/transfer is indicated and that the care plan is comprehensive.

From an inpatient service:

- When an inpatient service is transferring a consumer’s care to the community, ensure that the treating Psychiatrist or their delegate authorises in writing the arrangements for a consumer’s discharge/transfer of care to the community under the discharge plan section of the Discharge/Transfer Summary document. If the consumer is an involuntary patient, the authorising Psychiatrist must be an Authorised Medical Officer (AMO) under the Act.

To a medical or other ward:

- When transferring to a medical or other ward, discuss the transfer with the consumer and carer/s. Ensure that risk assessments and tailored management strategies are conducted.

- Ensure all relevant information for safe transfer of care are included in the verbal clinical handover to the ward’s treating team as well as provided in writing.

When discharging to the community from other Health settings where the Mental Health Service has been involved in the person’s assessment or care, the responsible mental health staff member should collaborate with the treating team in relation to discharge planning/transfer of care.

This includes clarity about each staff group’s responsibilities in providing both clear verbal and written advice to the consumer and their family/carer on post discharge care as well as referral to community-based services if appropriate.

3.3.3 At the time of discharge/transfer:

With consumers and families/carers:

- The Discharge/Transfer Summary document or (if unavailable at discharge) the Information Handout is a crucial document for consumers and their families providing information on care and safety of consumers.

- It is imperative that the Discharge/Transfer Summary or Information Handout is given to the consumer and their family/carer at the time of discharge and a copy kept in their medical record.

- The nominated mental health key contact/coordinator must take time to go through the Discharge/Transfer Summary with the consumer and their family/carer, and ensure they understand it and answer any questions.

- Section 3.5 Documentation provides detailed guidance on information to be included in the Discharge/Transfer Summary.

- The consumer must also receive a copy of their Wellness Plan.

With receiving service provider/s:

- The Discharge/Transfer Summary document must be forwarded to the receiving service provider and other support services within 12 hours of discharge/transfer, or earlier as clinically indicated.

- The discharging (referring) service must phone the receiving service provider and other support services to advise that the consumer has been discharged, where the consumer’s follow up appointment is within 24 hours of discharge.
3.4 Follow-up in the community

- Timing of follow up contact should be based on clinical need/priority and discussed at the time of discharge with the consumer/family as part of the discharge planning process.

- **The receiving community mental health service** must contact the consumer within seven (7) days of discharge from an acute inpatient mental health unit including a Psychiatric Emergency Care Centre. This contact must include clear plans for next actions/follow-up. Identification of clinical deterioration should be escalated and managed as appropriate.

- Where the team is unable to contact the consumer, (or the consumer is a young person), they must contact the consumer’s family/carer to gain their perspective on how well the consumer is settling in the community and to identify any concerns that need to be addressed, or to identify additional referrals that could assist this process.

3.5 Documentation

Discharge documentation, including the *Discharge/Transfer Summary*, gives essential information to support continuity of care for the consumer in the initial transition period. It should be given to the consumer at the time of discharge, and to their family/carer, where appropriate.

- Discharge documentation must be **clearly written and summarise care provided with sufficient information for the intended audience**. It must be understood according to the consumer’s culture and language. Information should include, but not be limited to:
  - correctly entered diagnosis
  - current medications and any side effects
  - agreed care plan
  - identified risks and contingency plans relapse prevention strategies as discussed, and steps to take if relapse is likely,
  - telephone contacts for access/re-entry to the mental health service
  - contact numbers and appointment details of health professionals or support services to which the consumer has been referred for ongoing care
  - treatment and other therapeutic interventions
  - physical health care follow up
  - description of any parenting or family responsibilities
  - include mental health outcome measures as appropriate
  - family and carer information/contact details

- Information that is auto populated in the discharge summary in the electronic medical record (e.g. phone numbers, GP details, medications, diagnosis), should be routinely checked for accuracy.

**If the Discharge/Transfer Summary is not available at the time of discharge, an Information Handout is to be given to the consumer and their family/carer (refer to Appendix B). A dated copy of this information handout is to be kept in the consumer’s medical record together with details of who completed it and to whom it was given.**

- NSW Health mental health clinicians are to follow the requirements under *Mental Health Clinical Documentation* which specifies the mandatory implementation of standardised mental health clinical documentation within NSW public mental health services.

4 THE ROLE OF LEAVE TO SUPPORT DISCHARGE PLANNING AND RECOVERY

Many of the requirements for assessment, communication, documentation and transfer of care as set out in this document also support the planning and management of approved leave.
Graduated leave provides the consumer and the treating team with the opportunity to assess readiness for discharge to the community. Leave periods may present increased risk for the consumer and for others, however leave should be designed to provide opportunities for a strengths-based approach geared towards a consumer’s identified goals for discharge.

Approved leave plays an important part in preparation for discharge from mental health inpatient units. The purpose of leave is in the context of treatment goals and strategies. Periods of leave help the consumer maintain links with their life outside hospital and supports their recovery. Consumers detained under the Act are granted leave under Section 47 of the Act.

4.1 Leave Procedures

LHDs and, SHNs must develop local written inpatient leave procedures to ensure consistent and safe leave planning, management and review practices for both voluntary and involuntary mental health inpatients.

4.1.1 The leave plan: Development and communication essentials

If the family/carer is unwilling or unable to participate in the leave plan, it must be reviewed and the outcome documented. Where the outcome of assessment prior to leave raises concern, leave arrangements may be altered or cancelled by the assessing clinician.

Local leave procedures must ensure that leave plans:

• are developed in discussion with the consumer (when a young person, with their carer/parent)
• are discussed, understood and agreed upon with family, friends or care providers who are expected to support and/or supervise the consumer during leave
• prioritise the safety and wellbeing of the consumer, carers, and family members including children
• consider and set out the requirements for voluntary and involuntary patients under the Act
• referrals to the community mental health service to provide clinical care during leave, must be agreed with that service

Details of these discussions/referrals must be recorded in the consumer’s leave plan/medical record.

4.1.2 Approval of the written leave plan

• is subject to the multidisciplinary team’s consideration of the consumer’s improved assessment including risk of harm to self and others and risk of absconding
• is the outcome of the multidisciplinary team’s discussion and is recorded in the consumer’s medical record
• has the written approval of the treating psychiatrist, or their delegate, who must be an authorised medical officer (AMO) under the Act if the consumer is an involuntary patient

4.1.3 Provision of written leave information

The consumer and the family/carer, or other care provider, must be given written advice for the leave period. This document should detail relevant matters such as:

• purpose of leave
• departure and return times
• medication and supervision requirements
• guidance on measures to manage risks during leave
• contact details for the inpatient unit
• arrangements for crisis support
• any restrictions on the consumer’s activities and agreed responsibilities.
4.1.4 Post leave follow up requirements include:
• discussion with the consumer, family / carer / community mental health service about the success of leave
• mechanisms for post leave reports to inform clinical reviews
• local safety and security practices to ensure that the consumer has not brought materials to the unit following leave that could pose a threat to themselves or others.

4.1.5 Failure to return from leave or absent from the unit
Steps to follow if a consumer;
  o does not return from leave as arranged
  o is missing
  o has absconded from the unit (i.e. involuntary patients under the Act).
• If there are concerns about a voluntary patient’s vulnerability or risk of harm to themselves or others, consider initiating detention processes under Section 19 of the Act or provide guidance about notifying the police to request a welfare check.
• If an involuntary inpatient has not returned from approved leave (or has absconded from the unit), procedures must take into account requirements under the Act including notifying the police (also refer to section 3.4.7 of the NSW Health-NSW Police Memorandum of Understanding 2018).
• Services must complete incident reporting requirements in line with NSW Health PD2014_004 Incident Management Policy and local procedures.

Mental health inpatient units must implement processes to review incidents where an involuntary patient absconds from the unit or during approved leave, to identify areas for improvement and to promote the delivery of responsive and effective care.

5 PRIVACY AND INFORMATION SHARING
To ensure a safe and effective transfer of care, information about the consumer gathered during the episode of care may need to be disclosed to a range of people. This may include health providers, Community Managed Organisations (CMOs), families/carers, the Appointed Guardian and government agencies.

The collection, use or disclosure of a consumer’s personal or personal health information must comply with the following legislation:
• The Privacy and Personal Information Protection Act 1998 (NSW)
• The Health Records and Information Privacy Act 2002 (NSW)
In essence, the disclosure of the consumer’s information must be:
• directly related to the purpose for which the information was collected
• relevant to the treatment, care or support provided by the third party
• for statutory provisions for mandatory notification purposes (see Appendix A)

Consumers must be consulted about who will be provided with their personal health information and the reasons why. This consultation should take into account the consumer’s age, maturity, safety needs, capacity and obligations under the Act and NSW Privacy Manual for Health Information. It may be particularly important to seek input from culturally diverse workers.

The consumer may refuse their consent, however, the senior treating clinician must make every effort to explain to the consumer the value of providing certain information to identified people to ensure the best possible care and support is provided. This is especially important if the person is residing with a family member or other carer.

The outcome of these discussions must be clearly documented in the consumer’s medical record. Ensure the consumer is given a copy of the Privacy Leaflet for Patients.
6 MONITORING AND REPORTING

LHDs and SHNs must develop local monitoring, reporting and compliance processes for discharge planning and transfer of care which support quality, continuity of care and system-wide improvement.

The following key performance indicators are included in Service Performance Agreements between LHDs/SHNs and the Secretary, NSW Health, to support an integrated system which delivers connected care:

- the rates of the post discharge 7-day follow up in community for consumers discharged from acute mental health inpatient units
- the rates of re-admission to acute mental health units within 28 days
- the number of involuntary inpatients who abscond from an inpatient unit or who abscond while on approved leave (Incident types 1 and 2).

LHDs/SHNs should also implement other monitoring processes which include, but are not limited to clinical audits and other quality assurance mechanisms to assess:

- level of participation of the consumer, their family/carer, receiving health care professionals and other support services, in discharge planning and transfer of care
- the timeliness and quality of information in the discharge documentation
- evidence that discharge/transfer of care documentation has been received by the receiving health service provider and other support services
- the submission of six and twelve month policy directive implementation reports to the Mental Health Branch of the NSW Ministry of Health (Appendix C and D).

7 APPENDICES

Appendix A: Privacy and Information Sharing

There is a range of people with whom information may need to be shared to ensure a consumer’s safe and effective transfer of care. They include:

- **Health Providers**

  Under the *Health Records and Information Privacy Act 2002 (NSW)* – relevant information may be provided to other health professionals providing care, so long as the disclosure is directly related to the primary purpose for which the information was collected and the patient has a reasonable expectation that their information will be used in such a manner.

- **Community Managed Organisations (CMOs)**

  Information exchange supports a continuum of care. When sharing information with CMO service providers the information must be either for a directly related purpose (depending on the service provision) or occur where the consumer consents to receiving the support service. Either way, the consumer must have a reasonable expectation that their information will be used for this purpose, or have consented to the service provision. If there is serious concern about imminent risk to the safety of the consumer or others, relevant risk assessment information may be released to the CMO if it is reasonably necessary for the CMO to provide the relevant service.

- **Family and Carer**

  Carers identified under the *Mental Health Act 2007* must be included in transfer of care planning. However, with consent of the consumer, it may be good practice to involve other members of the family or carer network. A person who is over the age of 14 and under 18 years may not exclude a parent from being given information about them (Section 72(3) of the Act).
Where a consumer is being discharged into the care of their family and/or carers, and with the consumer’s consent, they should have sufficient information to properly support the consumer’s ongoing health care needs. This may include providing a written copy of transfer of care documents that provide easy access to critical information such as advice about the medication regimen and the management of suicide risk. The consumer must also have a reasonable expectation that their information will meet this requirement. This expectation is best met by communicating with the consumer about relevant discharge planning and ensuring consumers receive a copy of the Privacy Leaflet for Patients.

In some circumstances, provision of generic information about general matters relating to mental health care and treatment options may be appropriate.

If the consumer has not consented, it is important that any disclosure to family or care providers is directly related to the primary purpose for which the information was collected.

- **Role of Appointed Guardian**

  If a consumer has a guardian, the guardian will be the consumer’s designated carer and therefore all the provisions of the Act relating to designated carers will apply.

  If the consumer under guardianship lacks capacity, then under the *Health Records and Information Privacy Act*, the guardian essentially stands in the shoes of the consumer and all information can be provided to the guardian.

- **Mandatory notification and exchange of information between prescribed bodies**

  Appropriate information must be provided to prescribed agencies for statutory provisions for mandatory notification (as occurs in relation to suspected child abuse, and certain notifiable diseases), such as mandatory notification obligations imposed on registered practitioners.

  The law also allows for personal health information to be disclosed to prescribed agencies/bodies in certain circumstances, for example:

  - to law enforcement agencies, such as the Police, in order to provide information relating to a serious crime, including assault, domestic violence, child abuse
  - to comply with a subpoena or search warrant if your personal information is required as evidence in court
  - To prevent or lessen a domestic violence threat in accordance with Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* and associated Information Sharing Protocols.
  - to exchange information about the safety, welfare or wellbeing of children and young people in accordance with the *Children and Young Persons (Care and Protection) Act 1998*.

  Please refer to the *Privacy Manual for Health Information* for guidance on these requests (see Appendix E).
APPENDIX B: Sample Information Handout for consumers returning to the community

If the Discharge/Transfer Summary and other documentation is not available at the time of discharge to the community, the consumer and their family/carer must be given an Information Handout in plain language.

A dated copy of the handout is to be kept in the consumer’s clinical record and should identify who completed it and to whom it was given (i.e. the consumer/carers name).

The content of this handout will vary according to the consumer’s clinical needs, the setting and other local factors, but should include:
- the consumer’s name and current contact details
- date of discharge from service/facility
- carer’s name and contact details
- current medication/s, regimen, advice about possible side effects and safety measures
- current medical concerns/treatment/follow-up
- follow up health care arrangements or details of support services, such as:
  - community mental health service: name, address, telephone contact details, name of contact person and appointment details
  - GP phone number and appointment details
- early warning signs of relapse, identification of risks and strategies to reduce each risk identified
- contingency plans and relapse prevention strategies
- emergency telephone contacts for access/re-entry to the mental health service
- information or standard handouts about educational or community support services
- information on family and carer support services.

314(26/09/19)
Appendix C: LHD/SHN 6-month implementation reporting form
Mental Health Discharge Planning and Transfer of Care 6-month Implementation Verification Form

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH</th>
<th>Date</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Verified by Mental Health Director</td>
<td>Name</td>
<td>Signature</td>
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</table>

First 6 month progress report  

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nomination of a staff member responsible for implementing the policy within the organisation</td>
<td></td>
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</tr>
<tr>
<td>2. Access to the Policy Statement and Procedures is promoted throughout the organisation</td>
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<tr>
<td>3. Review undertaken by services regarding the changes required to service delivery and practices to meet the Policy Statement and Procedures</td>
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<tr>
<td>4. Local protocols developed and disseminated to support services to understand and meet the requirements of the Policy Statement and Procedures</td>
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<tr>
<td>5. Implementation plans, including education strategy developed by the service to support compliance with Policy Statement and Procedures</td>
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<td></td>
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</tbody>
</table>

Notes:

SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO:
MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)

314(26/09/19)
Appendix D: LHD/SHN 12-month implementation reporting form
Mental Health Discharge Planning and Transfer of Care LHD/SHN 12-month Implementation Verification Form

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH</th>
<th>Date</th>
<th>/</th>
<th>/</th>
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</thead>
<tbody>
<tr>
<td>Verified by Mental Health Director</td>
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<td></td>
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<tr>
<td>Name</td>
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<tr>
<td>Signature</td>
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</tbody>
</table>

Second 12 month progress report ☐

**IMPLEMENTATION REQUIREMENTS**

<table>
<thead>
<tr>
<th>Review process has been established to:</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Measure the percentage of discharged consumers and their family/carer who were included in the discharge planning and transfer of care process</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>b) Measure the percentage of discharged consumers and their family/carer who received the relevant discharge information at discharge.</td>
<td>☐</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>c) Measure the percentage of discharged consumers whose discharge planning and transfer was discussed with the receiving service provider/s prior to transfer of care</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Notes:</td>
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<tr>
<td>d) Documentation that referral / discharge information has been received by the receiving health and/support service providers</td>
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<tr>
<td>Notes:</td>
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</tbody>
</table>

Submit completed form to Mental Health Branch by email to:
MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)
Appendix E: Legislative framework, policy and guidelines

Legislation
1. Mental Health Act 2007
2. Guardianship Act 1987
3. Health Records and Information Privacy Act 2002
5. Children and Young Persons (Care and Protection) Act 1998

Related polices, guidelines, manuals, and other related documents


References


DRUG AND ALCOHOL PSYCHOSOCIAL INTERVENTIONS PROFESSIONAL PRACTICE GUIDELINES (GL2008_009)

These guidelines aim to provide a benchmark for the delivery of quality psychosocial interventions to drug and alcohol treatment services. They recognise the value of such interventions within the D&A field, and support professional implementation of them. They emphasise the need for better understanding about the purpose and benefits of the interventions.


MENTAL HEALTH CLINICAL DOCUMENTATION GUIDELINES (GL2014_002)


PURPOSE

This Guideline supports the Policy Directive Mental Health Clinical Documentation (PD2010_018) by outlining the suite of Mental Health Clinical Documentation to be used by NSW Mental Health Services. The primary aim of this Guideline is to provide broad guidance for the use of the modules to document the episode of care from triage through to transfer/discharge. It is not intended as a script or text for conducting a clinical assessment, deciding upon interventions to be undertaken or the application of care.

KEY PRINCIPLES

Mental Health Clinical Documentation is separated into Core (required in all circumstances and clinical settings) and Additional modules (to be undertaken when clinically indicated) to be applied across the episode of care. The modules interrelate such that completion of the Core modules informs what Additional modules to document further assessments are required and such that the clinical record as documented through the clinical documentation forms a coherent narrative about the episode of care.

The suite of Clinical Documentation Modules are to be viewed as a tool for recording assessments and care provided and are not a script for undertaking these procedures. The modules are a place to document clinical information and are not a substitute for clinical skills, training, supervision or judgement.

USE OF THE GUIDELINE

This Guideline should inform the use of the suite by clinicians in mental health and other settings and provides advice on the intent and process of the development of the documents. The Guideline provides advice on when to complete individual Clinical Documents and where the results of a thorough clinical assessment should be recorded to allow consistency across episodes of care and between clinical records.

PHYSICAL HEALTH CARE WITHIN MENTAL HEALTH SERVICES (PD2017_033)

PD2017_033 rescinds PD2009_027

PURPOSE

This policy supersedes PD2009_027 Physical Health Care within Mental Health Services, which was first released in 2009.

It should be read in conjunction with the NSW Health Physical Health Care of Mental Health Consumers – Guideline (GL2017_019).

The policy provides direction to NSW mental health services in improving the provision of physical health care to mental health consumers by:

1. Establishing expected standards for the physical health care.
2. Clarifying the role of mental health services, and appropriate linkages with other health care providers, to meet physical health care needs.
3. Developing a consistent, co-ordinated, approach to the physical health care of mental health consumers.

MANDATORY REQUIREMENTS

Mental health services in all settings have responsibility to ensure that:

- Staff are trained and supported to implement the NSW Health Physical Health Care within Mental Health Services.
- Provision and access to physical health care for mental health consumers; or facilitating or advocating for the provision of such care; is recognised as the responsibility of the mental health service.
- Organic causes must be excluded or appropriately treated at first presentation of mental illness or in the event of major changes in mental health presentation.
- Adverse physical health outcomes from mental health treatment are minimised and options discussed with the consumer.

Services are required to develop their own local policies and protocols for mental health settings such as inpatient units, community mental health services and psychiatric emergency care centres.

IMPLEMENTATION

Chief Executives are required to ensure:

- The principles and requirements of this policy and guidelines are applied, achieved and sustained.
- All appropriate staff are made aware of their roles and responsibilities in relation to this policy.
- All appropriate staff receive education and training to enable them to carry out their roles and responsibilities in relation to the policy.

Managers must:

- Ensure that all mental health staff read and understand this document.
- Monitor compliance with this policy.

Clinicians are required to:

- Read, understand and comply with the requirements of this policy.

NSW Ministry of Health will:

- Review this policy directive at 5 years following the date of publication.
13. MENTAL HEALTH

BACKGROUND

All consumers of mental health services have the right to expect health care that is responsive and in line with the care provided to the general population.

According to available research, both national and international, the physical health of people with a mental illness is poor, and poor physical health is associated with impaired mental health. People with severe mental illness have high rates of mortality and reduced life expectancy as well as decreased access to healthcare.

Mental health services are uniquely placed to support improvement in the physical health of mental health consumers through the adoption of a holistic approach to the care and treatment provided.

Appropriate support provided by well-trained mental health staff can assist consumers to identify and seek treatment for physical illnesses or disease.

Working collaboratively with primary health providers, such as General Practitioners (GPs), Primary Health Networks and non-government organisations play a critical role in the initiation of preventative measures for consumers.

KEY PRINCIPLES

1. Mental health consumers are entitled to quality, evidence based education, care, and treatment for all aspects of health, including physical health.

2. Physical health for mental health consumers is considered by mental health services in planning, education, access, health promotion, screening and preventative activities.

3. Physical health care for mental health consumers must:
   a) recognise consumers as critical partners in the care team
   b) appropriately involve consumers, their families and carers
   c) discuss with the consumer and be delivered in a respectful, non-judgemental and culturally sensitive way
   d) support the consumer to make informed choices.

4. Mental health services work collaboratively with other key health providers in providing quality physical health care for mental health consumers. GPs, Primary Health Networks and non-government organisations have a pivotal role in the provision of care.

5. Physical health care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

PHYSICAL ASSESSMENT CORE COMPONENTS

Core components of a physical assessment of a consumer admitted to inpatient or community mental health care include a relevant history and physical examination.

The core components of a relevant history at first assessment are:

- current prescribed, over the counter or alternative medications
- drug and alcohol use assessment, including smoking
• the presence of any new physical problems or symptoms that are concerning the consumer, their carer or family
• known presence of
  o diabetes
  o high blood pressure
  o high cholesterol
  o asthma or other respiratory illness
  o ‘other’ illness
• relevant family history

If the assessment is being conducted as part of a review it should also include information about:
• diet
• physical activity
• the consumer’s wish to discuss any relevant health issues
• the consumer’s participation in relevant preventative health care

History may be obtained as part of a broader mental health assessment, or using a form completed by the consumer, with the assistance of carer or family if appropriate.

The core components of a physical examination are:
• observations - BP; pulse and respiratory rate; temperature
• weight and waist circumference
• height (if not already recorded from previous contact)
• examination of respiratory, cardiovascular and gastrointestinal systems
• initial examination of the neurological system including at least notation regarding presence or absence of marked abnormality of key features such as:
  o equality of pupil size, or eye movement
  o facial symmetry
  o limb and hand power
  o gait
  o limb tone
  o orientation and alertness
  o involuntary movement or akathisia (the Abnormal Involuntary Movement Scale may be used to assist this if clinically appropriate)

RELEVANT HEALTH INTERVENTIONS

Health interventions particularly relevant to the long term health status of mental health consumers are listed below. ‘List A’ includes those that are particularly relevant to cardiovascular health and ‘List B’ are other potentially indirect interventions.
List A – Cardiovascular Health
- Smoking cessation (if relevant)
- Weight control interventions, including dietary and life-style advice, if BMI > 25 or abdominal obesity
- Regular exercise
- BP monitoring

List B – Potentially Indicated Interventions
- Contraceptive advice (if of reproductive age) and sexual safety/sexual health advice
- Visual acuity and clinical hearing evaluation, with referral to secondary care if any abnormalities
- Dental review if not conducted in previous 12 months or a need is identified prior to this
- Education on breast (women) or testicular self-examination and symptoms of prostatism (men over 55 years)
- Provision of information regarding HPV vaccination (females <27yo)
- Influenza vaccination when indicated
- Examination for skin malignancies
- Education on risks related to alcohol and illicit drug abuse

MONITORING AND REPORTING
Monitoring the implementation of this policy will occur in part through analysis of the physical health related questions developed for the NSW mental health version of the National Your Experience Survey. Other potential mechanisms to assess service quality and monitor progress against desired outcomes will continue to be explored and Local Health Districts will be consulted regarding any additional proposed mechanisms to support the reporting and monitoring process.
**APPENDIX**

**Attachment 1: Equipment checklist**

<table>
<thead>
<tr>
<th>ITEM</th>
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<tbody>
<tr>
<td>• A private, warm, well lit area with an examination couch or bed suitable for conducting of physical examinations, together with sheets or towels</td>
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<tr>
<td>• Stethoscope</td>
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<td>• Sphygmomanometer</td>
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<td>• Thermometer</td>
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<td>• Tendon hammer</td>
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<tr>
<td>• Non-stretchable measuring tape</td>
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<tr>
<td>• Tuning fork (256 Hz)</td>
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<tr>
<td>• Weighing scales</td>
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<tr>
<td>• Urinalysis sticks</td>
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<tr>
<td>• Auriscope and ophthalmoscope</td>
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<tr>
<td>• Examination torch</td>
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<td>• Snellen chart</td>
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<td>• Height measure</td>
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<tr>
<td>• Disposable gloves</td>
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<td>• Examination lubricant</td>
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<td>• Neurological testing pins</td>
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<tr>
<td>• Peakflow monitor</td>
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<tr>
<td>• Glucometer</td>
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<td>• Alcometer/breathalyser</td>
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<tr>
<td>• Oximeter</td>
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<tr>
<td>• X-ray box or electronic substitute</td>
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<tr>
<td>• Pathology venipuncture and associated collection equipment</td>
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<tr>
<td>• Pathology specimen containers</td>
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</tbody>
</table>
Attachment 2: Implementation checklist

<table>
<thead>
<tr>
<th>LHD/Facility:</th>
</tr>
</thead>
</table>

**Assessed by:**

**Date of Assessment:**

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assign responsibility, personnel and resources to implement the principles and procedures in mental health service settings.</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy.</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>3. Develop and implement a strategy to establish or build on local partnerships with GPs, Primary Health Networks, Community Managed Organisations and other health providers</td>
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<tr>
<td>4. Undertake a review of current staff skills, identify gaps in knowledge and factor these into future training plans.</td>
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<tr>
<td>5. Identify, develop and implement strategies to address at risk populations.</td>
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</table>

**Notes:**

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**PHYSICAL HEALTH CARE OF MENTAL HEALTH CONSUMERS (GL2017_019)**

GL2017_019 supersedes GL2009_007

**PURPOSE**

This guideline supersedes GL2009 007 *Physical Health Care of Mental Health Consumers – Guidelines*, which were first released in 2009.

The document has been revised with the involvement of consumers, carers and clinicians. It aims to improve clarity in expectations as well as improve consumer focus. Clinical guidance on the physical observation for specific mental health settings has been revised and updated.

The Guideline recognises the role of mental health services in the physical health care of consumers; clarifies appropriate linkages with other health care providers; proposes the building of stronger partnerships with key stakeholders; and establishes minimum expectations for the physical health care of consumers.

314(26/09/17)
**KEY PRINCIPLES**

1. Mental health consumers are entitled to quality, evidence based education, care, and treatment for all aspects of health, including physical health.

2. Physical health for mental health consumers is considered by mental health services in planning, education, access, health promotion, screening and preventative activities.

3. Physical health care for mental health consumers must:
   a. Recognise consumers as critical partners in the care team
   b. Appropriately involve consumers, their families and carers
   c. Discuss with the consumer and be delivered in a respectful, non-judgemental and culturally sensitive way
   d. Support the consumer to make informed choices.

4. Mental health services work collaboratively with other key health providers in providing quality physical health care for mental health consumers. GPs and non-government organisations have a pivotal role in the provision of care.

5. Physical health care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

**USE OF THE GUIDELINE**

The guidelines provide a framework and, where available, evidence based guidance to assist NSW Health mental health services to:

1. Recognise their role in the physical health care of consumers, including advocacy;
2. Clarify appropriate linkages with other health care providers;
3. Build stronger partnerships with key stakeholders, including GPs, mental health consumers and families and carers;
4. Establish minimum expectations for the physical health care of consumers, together with a program to improve standards; and
5. Improve the physical health care of mental health consumers.

The scope of the Guidelines does not extend to providing practical and detailed guidance about how services can best manage issues relating to mental health and physical health care.

Services are encouraged to develop their own local policies and protocols in considering the rights of consumers.

These Guidelines outline a number of Responsibilities and Minimum Requirements for:

- Clinical guidance for all Mental Health Settings (Section 4),
- Clinical guidance for Specific mental health settings (Section 5),
- Clinical guidance for Special populations (Section 6); and
- Supporting chapters.

The Guidelines can be downloaded at:

314(26/09/17)
PSYCHIATRIC MALINGERING – DETECTION AND MANAGEMENT (GL2009_016)

Guideline provides direction to Area mental health service clinicians and emergency department medical staff in relation to standards for the diagnosis and management of psychiatric malingering.

Malingering is the conscious feigning, exaggeration or self induction of illness for personal gain, other than merely gaining the status of a patient. In the context of the psychiatric assessment in the emergency department, it may involve a patient who presents with a range of symptoms and signs, who may seek to achieve gains diverse as accommodation, financial assistance, avoidance of criminal charges, or prescription medications.

SAFE START STRATEGIC POLICY (PD2010_016)

(A component of the NSW Health/Families NSW Supporting Families Early Package)

PURPOSE

This policy provides direction for the provision of coordinated and planned responses by health workers involved in the identification of families at risk of adverse outcomes during the perinatal period. It outlines the core structure and components required by NSW Health services to implement the SAFE START model of universal psychosocial assessment, depression screening and follow-up care and support during the perinatal period.

MANDATORY REQUIREMENTS

All Area Health Services are to develop multidisciplinary and multi-agency systems of family-focused health care for pregnant women and families with infants up to two years age. Implementation of the SAFE START model in each Area Health Service must be focused on early identification of psychosocial risk and depressive symptoms and timely access to appropriate interventions for pregnant women and families with infants up to two years age. Area Health Services will implement strategies outlined in the policy to enhance the knowledge and skills of health and related workers to deliver psychosocial assessment and depression screening; and in the provision of early mental health interventions for mothers, infants and their families.

IMPLEMENTATION

Chief Executives are to ensure a written local SAFE START action plan, as described in this policy and its associated documents, is in place. Local SAFE START action plans should be developed by local executive lead governance groups comprising representation from maternity, child and family health, mental health, drug & alcohol, Aboriginal and multicultural health services. Local executive lead governance groups will guide development and implementation of multidisciplinary and multi-agency systems of family-focused health care for pregnant women and families with infants up to two years age. Ongoing performance monitoring of the SAFE START model and related reporting will be the responsibility of the local executive lead governance groups and will demonstrate that pregnant women and families with infants up to two years age identified as vulnerable are engaged with appropriate specialist assessment and access to family-focused, integrated health care.

This policy must be read in conjunction with the following documents that comprise the NSW Health/ Families NSW Supporting Families Early Package.


SAFE START GUIDELINES: IMPROVING MENTAL HEALTH OUTCOMES FOR PARENTS & INFANTS (GL2010_004)

(A component of the NSW Health/Families NSW Supporting Families Early Package)

PURPOSE

The SAFE START Guidelines outline the rationale for psychosocial assessment, risk prevention and early intervention during pregnancy and the postnatal period. The Guidelines propose a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment and depression screening in the antenatal and postnatal (perinatal) period. The Guidelines add value to the companion documents that comprise the NSW Supporting Families Early Package: Maternal and Child Health Primary Health Care Policy and SAFE START Strategic Policy. The importance of the broader specialist roles of mental health and drug & alcohol services in addressing the needs of parents at risk of developing, or with, mental health and drug & alcohol problems, are outlined in the Guidelines.

KEY PRINCIPLES

The key principles of the SAFE START model are that NSW Area Health Service staff should:

1. Promote continuity of family care throughout pregnancy, postnatal and early childhood periods;
2. Recognise the significance of risk and protective factors in health. The complex interaction between risk and resilience is acknowledged as well as the strengths and diversity of local communities in the determinants of health;
3. Acknowledge the role of parents and family systems in providing sound foundations for the healthy development of children. The vital role of support systems, especially fathers or partners, is identified and opportunities to include them and participate in care;
4. Ensure interventions are undertaken as early as possible and are flexible enough to respond to variations in individual and family circumstances;
5. Participate in a comprehensive network of local government and non-government resources and services including hospital and community health services, general practitioners, primary health and specialist health services such as mental health and drug & alcohol services and community agencies;
6. Facilitate ongoing partnerships for service delivery based on communication, collaboration and cooperation between the mother, her family and various professionals across the spectrum of care.

USE OF THE GUIDELINE

The SAFE START Guidelines provide support material for local executive lead governance groups and front-line health professionals from maternity, child and family health, mental health, drug & alcohol, Aboriginal and multicultural health services to promote an integrated approach to the care of women, their infants and families in the perinatal period.

This guideline must be read in conjunction with the following documents that comprise the NSW Health/Families NSW Supporting Families Early Package.


SCHOOL-LINK INITIATIVE MEMORANDUM OF UNDERSTANDING (PD2010_020)

PURPOSE

This policy:
1) Introduces the NSW School-Link Initiative Memorandum of Understanding between NSW Department of Health and the NSW Department of Education and Training.
2) Outlines what is required by NSW health services to implement the NSW School-Link Initiative Memorandum of Understanding.

MANDATORY REQUIREMENTS

The Memorandum of Understanding provides a framework for a collaborative approach by NSW Department of Health and NSW Department of Education and Training in improving the mental health of children and young people in NSW.

The framework will facilitate the interaction between NSW Department of Health and the NSW Department of Education and Training on:
- the roles and responsibilities of the two Departments in meeting the mental health needs of children and young people in NSW government schools.
- issues relevant to the management of children and young people with mental health problems and the provision of shared care and collaborative support to students with mental health problems.
- the provision of ongoing joint training in the assessment and management of identified mental health problems for school and TAFE counsellors and mental health staff.
- the process for identification and development of new School-Link Initiatives.
- promoting information sharing about each Department’s programs, services and other resources, to facilitate better outcomes for children and young people coping with mental health problems.
- specifying joint funding arrangements.
- the development and delivery of mental health prevention, promotion and early intervention programs for children and young people.

IMPLEMENTATION

Area Health Services

All Area Health Services are required to establish local School-Link Steering Committees to assist in the implementation of the Memorandum of Understanding.

All Area Directors of Mental Health (or their nominees) together with Regional Directors from the Department of Education and Training (DET) (or their nominees) are responsible for establishing and maintaining local arrangements for the implementation of agreed activities as contained in the memorandum of understanding (additional schedules are currently being developed).

Local direction

Local direction in School-Link matters will be provided by Area Health School-Link Steering Committees which will include Area Health School-Link Coordinators, District Guidance Officers, NSW Department of Education and Training regional personnel, other representatives from Area Mental Health Services and non government school representatives. The School-Link Steering Committees will report regularly to the NSW School-Link Management Committee.

82(04/03/10) & 84(25/03/10)
13. MENTAL HEALTH

NSW Department of Health

NSW Department of Health has established a NSW School-Link Management Committee comprising senior officers from NSW Health MH-Kids and the NSW Department of Education and Training Student Welfare Directorate. This committee will lead the implementation of the Memorandum of Understanding, setting the strategic directions, developing and overseeing the schedules and activities and the management of the NSW School-Link Initiative. Liaison with other individuals, groups or agencies will occur from time to time as required.


NSW CHILDREN OF PARENTS WITH A MENTAL ILLNESS (COPMI) FRAMEWORK FOR MENTAL HEALTH SERVICES 2010 – 2015 (PD2010_037)

PURPOSE

The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services is a new publication that aims to:
1. Foster the continuing development of Area Mental Health Services for children of parents with a mental illness and their families.
2. Assist Area Mental Health Services in the ongoing development of collaborative approaches with key partners and agencies working with children and their families.

MANDATORY REQUIREMENTS

The NSW COPMI Framework identifies and sets out strategic directions for an integrated approach for Area Mental Health Services in collaboration with NSW Health partners to improve the mental health and well-being of children and young people in NSW who have a parent with a mental illness. The four key strategic directions are:
1. Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.
2. Identify and provide responsive services for families where a parent has a mental illness.
3. Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.
4. Support the workforce to provide appropriate family focused interventions and care to parents with a mental illness, their children and families.

IMPLEMENTATION

Area Mental Health Services are required to provide a range of services consistent with the strategic directions to foster and improve the mental health and wellbeing of children whose parents have a mental illness, their parents and families. The major focus of the NSW COPMI Framework is on reducing the impact of parental mental illness on all family members through a timely, coordinated preventative, family focused approach.

The NSW COPMI Framework identifies some key outcomes associated with the implementation of COPMI framework for mental health services. These include:
- Early and better identification of the difficulties parents may face when they have mental illness and of the possible or actual risks for their children.
- Assessment of level and type of need and appropriate interventions required to enhance optimal functioning for the children, parents and families.

84(25/03/10) & 91(17/06/10)
• Support and intervention and recovery that is multi-faceted, targeting the children, the parent experiencing mental health problems and the family to promote resilience, coping skills and improve parental mental health and parenting capacity to meet their children’s need and ensure their safety.

Part Two of the NSW COPMI Framework is a Support Document that provides information and resources to support the framework and to facilitate the implementation of the framework process.

ELECTROCONVULSIVE THERAPY: ECT MINIMUM STANDARD OF PRACTICE IN NSW (PD2011_003)

PD2011_003 rescinds PD2010_068.

PURPOSE

This Policy Statement defines minimum requirements that must be met in the delivery of electroconvulsive therapy (ECT) in New South Wales.

These requirements apply to all facets of care, including the indications for treatment, potential risks and strategies to minimise them, issues of consent, facilities, anaesthesia, application of the procedure, and the required quality improvement framework.

MANDATORY REQUIREMENTS

The minimum requirements that must be met by health care providers and the health care system are detailed in Minimum Requirements in the delivery of ECT in NSW.

This policy statement is to be read in conjunction with the Guidelines: ECT Minimum Standards of Practice in NSW.

IMPLEMENTATION

Roles and responsibilities of the NSW Department of Health:
• Provide advice and assistance for the implementation of this policy.
• Monitor and evaluates the health system implementation of standards for ECT.

Roles and responsibilities of Chief Executives:
• Assign responsibility, personnel and resources to implement the standards for ECT.
• Report on the implementation and evaluation of ECT standards of Practice to the NSW Department of Health.

Roles and responsibilities of the health service executives responsible for clinical operations and governance:
• Ensure successful implementation of the ECT standards.
• Monitor and evaluate the implementation of ECT standards across their services and feedback evaluation results to staff.
• Ensure the ECT standards are incorporated into orientation programs for relevant clinical staff.
• Educate relevant clinical staff in the use of the ECT standards.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:
• Locally implement the ECT standards.
• Evaluate compliance with the ECT standards.
• Annually monitor and evaluate local ECT practices and processes in line with the ECT standards.

Roles and responsibilities of all clinicians:
• Ensure their work practices are consistent with the standard for ECT.
CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH PROBLEMS REQUIRING INPATIENT CARE (PD2011_016)

PURPOSE

This policy provides a framework to guide decision making regarding inpatient care for children and adolescents with mental health problems.

MANDATORY REQUIREMENTS

Health Service Implementation

NSW mental health services must have local plans for bed management in place that are consistent with this Framework.

Mental Health Service Evaluation

Mental health services must audit, monitor and evaluate their local bed management practices on an annual basis.

IMPLEMENTATION

Roles and responsibilities of the NSW Department of Health:

- Provide advice and assistance for the implementation of this policy.
- Monitor the statewide implementation of the Access Framework for Children and Adolescents with Mental Health Problems Requiring Inpatient Care.

Roles and responsibilities of Chief Executives:

- Assign responsibility, personnel and resources to implement the framework.

Roles and responsibilities of the Director of Mental Health responsible for clinical operations and governance:

- Facilitate development of patient flow protocol/policy consistent with the statewide Policy’s framework.
- Ensure bed management practices are regularly audited across their services and feedback on results is provided to staff.
- Educate clinical staff in the application of the framework.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:

- Implement the local policy for mental health patient flow.
- Ensure that the child/adolescent and their family participate in the process as appropriate.
- Evaluate compliance with the framework.
- Annually monitor bed management processes in line with the principles outlined in the framework.

Roles and responsibilities of all clinicians:

- Ensure their work practices are consistent with the principles outlined in the framework.
1. BACKGROUND

1.1 About this document

Mental health problems in children and adolescents are growing in prevalence and complexity with an earlier age of onset. These factors impact on the access and care arrangements for children and adolescents requiring mental health care. While the majority of children and adolescents with mental health problems continue to be cared for in the community there will be some who require inpatient care.

This policy defines the key principles and provides a framework for determining the most appropriate treatment facility for those children and adolescents with mental health problems who require inpatient treatment. This includes admission into the following inpatient units:

- Specialist Child and Adolescent Mental Health units
- Paediatric hospitals and paediatric wards in general hospitals
- Adult Acute Mental Health wards
- PECCs (Psychiatric Emergency Care Centre)

To ensure optimal consumer outcomes for children and adolescents there is a need to improve integration between specialist Child and Adolescent Mental Health Services (CAMHS) and the other inpatient units.

In this framework “Children” refers to 0-11 year olds and “Adolescents” refers to 12-17 year olds. The age definition varies from the definition used in other paediatric policies due to the different focus of care. The adolescent age group in this framework is consistent with the Mental Health-Clinical Care and Prevention Model (MH-CCP version 1.11) for service planning.

This policy replaces the guidelines Mentally Ill Young People – Severely Disturbed – Interim Guidelines for Acute Care GL2005_006.

1.2 Legal and legislative framework

Key aspects of the following government legislation and plans informed the development of this policy.

The Mental Health Act 2007 requires least restrictive care, consistent with safe and effective care that is appropriately and reasonably available to the person.


The Mental Health (Forensic Provisions) Act 1990, especially Section 33 which refer to a Magistrate’s ability to order a defendant to be taken to and detained in a mental health facility.

1.3 Policy context

In 2009 Caring Together: The Health Action Plan for NSW was released in response to the recommendations made by Commissioner Garling following his inquiry into acute care services in NSW Public Hospitals. Recommendation 9b relates to the provision of hospital care for children and adolescents, recommending where possible to provide care in facilities designated and set aside for children and young people.
While there has been an expansion of specialist CAMHS beds recently, the Mental Health – Clinical Care and Prevention (MH-CCP) model predicts that NSW will require more specialist CAMHS beds than are currently available. There are currently plans for three new specialist CAMHS declared units in NSW at Orange, Shellharbour and Hornsby with an upgrade of the service at Sydney Children’s Hospital.

The draft Building a Secure Base for the Future: NSW Mental Health Service Plan for Children, Adolescents and the People Who Care for Them acknowledges that the establishment of and planning for new specialist child and adolescent mental health inpatient units provides an opportunity to more clearly delineate the roles of specialist acute CAMHS inpatient units and to improve integration across the statewide service spectrum.

MH-Kids with the Child & Adolescent Mental Health Sub-Committee will develop clinical service guidelines for roles and responsibilities of existing and planned acute inpatient CAMHS with respect to their local populations, their positions as statewide units and their areas of sub-specialist expertise. This will assist in matching patients to appropriate services and in prioritising those children, adolescents and families at highest risk for current or future impairment and those with the greatest need for specialist assessment and treatment.

2. ACCESS TO MENTAL HEALTH INPATIENT SERVICES FOR CHILDREN AND ADOLESCENTS

Mental health services have responsibility for assessing and determining the care needs of children and adolescents with mental health problems. The following framework outlines the key principles and factors that should be taken into account when identifying the most appropriate inpatient care when required.

2.1 Key Principles

Decisions regarding type of and urgency of admission to an inpatient setting require consideration of age, severity and complexity of condition and degree of risk and are also contingent on the availability of services and the capacity of the family or other carers to use them.

All local community care options should be considered prior to arranging an inpatient admission. Transfers of care should be negotiated with the receiving clinical team and occur in a planned and coordinated way. The patient and family should also be provided with support in preparation for the transfer to the hospital.

Inpatient services for children and adolescents, if required, should be selected based on the following overarching key principles. Inpatient care must be the:
- least restrictive alternative, and must consider their safety and that of others;
- closest available to home and usual supports wherever possible, especially for younger children and Aboriginal families;
- most developmentally and clinically appropriate care given available resources.

2.2 Spectrum of Care

The NSW spectrum of child and adolescent mental health care (Figure 1.) includes a number of service settings and may be delivered directly by local health services or through clear cross-health service agreements. The great majority of children and young people with mental health problems who receive treatment do so in a community setting. It is imperative to provide mental health care in the
least restrictive setting, as close to home as possible and with minimal disruption to the child or young person’s community supports, networks and relationships. Hospital-based assessment and treatment is usually only provided where the problems have been resistant to specialist community-based treatment or where less restrictive treatment is not feasible. Due to the limited number of specialist CAMH inpatient beds all CAMH inpatient units currently have a statewide role. As more child and adolescent units are established, mental health services will be able to provide more comprehensive care for local populations and there will be evolution and differentiation of cross-health service and statewide sub-specialty expertise and roles.

In comprehensive services, these service settings are not discrete and care transitions are characterised by continuity in care planning and delivery, which improves service delivery and risk management. CAMHS positions, such as the consultation liaison nurse positions, bridge inpatient and community-based services and improve coordination and continuity of care.

To achieve continuity of care the following should occur as part of good practice:

- Community care teams should be engaged prior to or at the time of an acute admission
- Admissions to inpatient units should be carefully negotiated and planned with clear goals
- Community care teams should remain involved throughout the episode of inpatient care to facilitate timely discharge.
Figure 1. The spectrum of mental health care for 0-17 year olds and their families in NSW is shown in the following diagram.

COMMUNITY BASED CAMHS

DAY PROGRAMS

- Rivendell
  - Redbank House
  - Coral Tree
  - Pine Lodge (Orange)
  - Shellharbour

NON-ACUTE INPATIENT UNIT

- NON-ACUTE CAMH INPATIENT UNITS
  - Redbank House (AFU) (Westmead), Rivendell (Concord)

- INTENSIVE FAMILY INTERVENTIONS
  - Redbank House (CFU) (Westmead), Coral tree (Ryde)

- NON-ACUTE CAMH SUPPORT FOR NON-SPECIALIST INPATIENT UNITS
  - Paediatric wards in general hospitals

ACUTE INPATIENT UNITS

- ACUTE CAMH INPATIENT UNITS
  - Redbank House (AAU) (Westmead), Gna Ka Loo
    (Campbelltown), Sydney Children’s Hospital (Randwick)
  - Children’s Hospital Westmead (Hall Ward), Nexus (Newcastle),
    Lismore
  - Shellharbour*, Orange*, Hornsby*

- ACUTE CAMH SUPPORT FOR NON-SPECIALIST INPATIENT UNITS
  - Paediatric wards in general hospitals, PECCs, Adult acute wards

SPECIALIST STATEWIDE

- Forensic Hospital (Justice Health)
  - High intensity, Longer Stay Unit (Concord – Walker Unit)

* Planned units
Children and adolescents with mental health problems in NSW are admitted into inpatient units under three broad categories:

1. Non-acute CAMH specialist units and paediatric hospitals or paediatric wards in general hospitals
2. Acute units
   a. CAMHS specialist
   b. Non-specialist units (e.g. adult mental health units and paediatric units) with CAMHS support
3. Highly specialised statewide units

2.2.1 Non-acute admissions

**Specialist non-acute CAMH units** *(12 – 17 year olds)*

Specialist CAMH inpatient units including Redbank House(AFU) and Rivendell provide intensive assessment and treatment targeting recovery, rehabilitation and relapse prevention for adolescents (apart from the family units which admit children). These units are not declared under the *Mental Health Act* and therefore cannot detain patients involuntarily. They operate five days a week and not during school terms so are not suitable for acute presentations.

**Family admissions** *(up to 12 year olds)*

Both Redbank House and Coral Tree Family Service provide “family admissions”. This type of program provides more intensive family-oriented assessment and treatment, particularly where there are associated mental health and parenting problems.

**Paediatric hospitals or paediatric wards in general hospitals** *(up to 16 year olds)*

Admission to local paediatric hospital, paediatric wards or local paediatric safe beds can lead to care being delivered closer to home in a developmentally appropriate setting with CAMHS consultation-liaison support. This requires a strong partnership between paediatric and CAMHS services.

The range of specialist staff available in paediatric hospitals means that paediatric wards in these specialist hospitals are the most appropriate for some children and adolescents with severe and complex problems or physical presentations requiring investigation and/or treatment. Note: The age cut-off for paediatric wards is below that for CAMHS units. The exception to this may be paediatric hospitals admitting older adolescents of school age who are continuing patients of that hospital.
2.2.2 Acute admissions

Consultation with CAMHS should occur to determine the most appropriate site for acute inpatient care of a child or adolescent.

For most children under 12 years of age who require individual admission (i.e. not family admission), care in a paediatric ward is indicated, with access to mental health consultation-liaison support to the treating paediatric team. The few who require more specialised inpatient mental health care than that available on a paediatric ward are likely to be best treated in a combined child and adolescent mental health unit in a paediatric hospital. The number of admissions required statewide for children in this category is relatively small; however these children are likely to have more severe and complex problems and high needs.

Acute admissions can be planned or can come in directly through avenues including, Emergency Departments or under Section 33 of the Mental Health (Forensic Provisions) Act 1990 where the Magistrate can send the patient directly to a declared unit. Local guidelines for the assessment and management of adolescents with acute mental health presentations to emergency departments should clearly identify admission criteria and the process for admission.

**Specialist Acute CAMHS units** (generally 12-17 year olds, except SCH and Hall Ward up to 16 years)

The current units are:
- Redbank House (AAU) at Westmead Hospital – 9 beds;
- Gna Ka Lun at Campbelltown Hospital – 10 beds;
- Sydney Children’s Hospital (SCH) at Randwick – 8 beds;
- Hall Ward at The Children’s Hospital at Westmead – 8 beds;
- Nexus at John Hunter Hospital in Newcastle – 12 beds; and
- Lismore Adolescent Mental Health Unit – 8 beds.

With few specialist beds available, most of those children and adolescents who are currently prioritised for admission to acute CAMH inpatient units have problems of high complexity and severity. With the exception of the unit at Sydney Children’s Hospital these are declared units. Planning is underway for higher activity and acuity at Sydney Children’s Hospital and new units at Orange, Shellharbour and Hornsby.

Admission policies and procedures for CAMHS inpatient units should reflect their Statewide role to ensure equity of access and prioritisation according to clinical need.
Non CAMHS acute care

The flexibility to admit to a non-CAMHS unit allows children and adolescents with mental health presentations to access treatment closer to home. When young people are admitted for mental health assessment and treatment to a setting other than a specialist child and adolescent mental health inpatient unit, there should be liaison with the supporting CAMHS. The clinical arrangements will vary according to local staffing profiles. Where child and adolescent psychiatrists are available in a Network, children or adolescents could be admitted under their care. In many sites, this arrangement is not feasible and it is more appropriate for patients to be admitted under the care of paediatricians or general (adult) psychiatrists with identified CAMHS consultation. Local protocols need to be in place outlining arrangements for access to appropriate specialist advice. Some local protocols may include shared care arrangements. Given the potential for confusion any shared care protocols must clearly delineate responsibilities including after hours roles.

As with non-acute admissions, paediatric wards with CAMHS consultation liaison may be appropriate setting for children and adolescents up to 16 year olds. Note: The age cut-off for paediatric wards is below that for CAMHS units. The exception to this may be paediatric hospitals admitting older adolescents of school age who are continuing patients of that hospital.

Admission to adult acute wards or PECCs is usually for stays of much shorter duration than admission to specialist CAMH units. These units facilitate options for short term care close to home. In some Networks, adult mental health units have pods which can be used to provide space for adolescents away from other adult patients. These must be appropriately staffed.

A formal risk assessment of a unit which is not specifically CAMH assists with identifying the challenges and risks of the operational environment of the unit and the suitability of that environment for patient groups. The risk assessment should include a rating of the likelihood of risks occurring and the impact or consequence of that risk if it were to occur. It is recommended that a team conduct the Site risk assessment. The team ideally should include representatives from CAMHS, NUM of the unit, Health and Safety or Risk Manager, and a consumer and carer.

Following a unit risk assessment, staff can then plan for any change and additional support that may be required when young patients are admitted to these units. In some instances, 1:1 nursing care (sometimes known as “nurse specialling”) may be indicated, depending on the patient mix, staffing profile and ward configuration. One-to-one specialling time could be rotated across disciplines and should be used in a therapeutic way, as an opportunity for more intensive intervention, minimising an adverse “guarding” relationship between staff and patients.

Local CAMHS should develop clear agreements and joint protocols with local adult mental health services, emergency departments, paediatric services and PECCs regarding access to specialist CAMHS advice in-hours and after-hours. In some sites, CAMHS may be able to offer community-based extended hours or other after-hours direct care.

Clear pathways to care should be developed in each health service in consultation with the services mentioned above.

2.2.3 Admission to the highly specialised statewide units

The adolescent unit at the forensic hospital at Malabar (Bronte Unit) and the specialist high intensity longer stay CAMHS inpatient unit at Concord (Walker Unit) are each unique and have a statewide specialist role.
**Walker Unit (12-17 year olds)**

The Walker Unit is a specialist declared high-intensity longer stay unit designed to improve care for young people with significant impairment who require treatment in an inpatient setting due to continuing risk or unremitting symptoms that are slower to respond to treatment.

Admission criteria for the Walker Unit include the presence of severe mental illness, with evidence of significant functional impairment and demonstrated treatment resistance. All patients considered for admission will have had treatment at a secondary health care service and will be referred from a child and adolescent mental health service. The referring agency is expected to have ongoing participation in the treatment process, before, during and after the admission.

**Bronte Unit (14-21 year olds)**

The Forensic unit has the capacity to treat both forensic (mostly transferees from juvenile justice custody) and civilian patients who present significant risk to others. The emphasis is on effective, evidence based treatment of mental disorders alongside risk management. The service model is multidisciplinary and recovery-based, with strong community partnerships to achieve ongoing safe care. Patients will be considered eligible for admission if they:

- are over 14 and under 21 years of age at the time of referral;
- are detainable under the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990*;
- present a risk of harm to others; and
- require treatment in a secure facility.

Patients for whom there are concerns about self-harm or suicide risk, vulnerability, risk of exploitation, or poor treatment adherence but who do not present a significant risk to others are expected to be managed in local Mental Health Service units rather than a high security facility.

In regard to civilian patients from health services, the referral must provide evidence as to how the patient meets the admission criteria of the Bronte unit and why care in conditions of lower security is not suitable. The mental health service must provide an assurance, in writing, that they intend to remain involved in the patient’s ongoing care through attendance at ward rounds and case conferences (via teleconference if unable to attend in person), and that the mental health service will receive the patient back into its care upon transfer of care from The Forensic Hospital. In addition, the referrer must submit a letter of referral that has been endorsed by the local Director for Child and Adolescent Mental Health (CAMHS) or the Director of Mental Health indicating that the referrer has support for the referral.

### 2.3 Key decision making factors

In their decision making, Mental Health Services are required to balance the needs of the children, adolescents and their families with the available infrastructure and resources.

Prioritisation must be made on the basis of clinical need and a commitment to a safe environment. Each patient should be individually evaluated and placed to optimise clinical outcomes. The ward milieu and patient mix is important for all inpatient units but is even more critical for children and adolescents.
The aims of hospitalisation should be clearly defined when admission is being considered. Hospital admission should not be a strategy solely for providing supervised care placements for children and adolescents. Children and adolescents in the predicaments of homelessness or breakdown in care should only be admitted if there are specialist mental health assessment requirements or therapeutic goals that are best achieved by inpatient care.

When assessing the child or adolescent for admission, other care options should also be considered as part of the assessment. The following must also be taken into account in the assessment:

- severity (including levels of distress or impairment)
- complexity (including comorbidities)
- impact (on the child and others)
- persistence
- age and developmental stage
- risk of harm
- care required.

In making the decision to transport a patient to a facility away from home the pros and cons associated with transportation and distance care must be considered. Financial and accommodation costs for the family and disruption with schooling are some of the factors to be considered. For Aboriginal children, adolescents and families, issues around travel away from home and separation require culturally sensitive attention.

Aboriginal children and adolescents continue to experience high levels of distress and poor emotional and social wellbeing compared with the non-Aboriginal community, and experience high level of readmission to hospital.

Local protocols should demonstrate a commitment to ensuring culturally accessible and appropriate referral by including the following when assessing the most appropriate care:

- Aboriginality must be identified on assessment
- Consultation should occur with Aboriginal mental health workers and liaison officers (or the Aboriginal community controlled sector)
- Assess cultural integrity of the service to which the child or adolescent is to be referred
- Incorporate Aboriginal concepts of health and wellbeing through the assessment, referral and treatment process

There is little evidence to suggest that treatments delivered during inpatient care are effective for children and adolescents with uncomplicated disruptive behaviour disorders however admission may be required to clarify diagnoses and to treat comorbid problems.

Although it rarely occurs in children, chronic suicidal and/or self-harming behaviour can become a more frequent presentation for adolescents. Specialist CAMHS assessment and involvement in treatment planning is essential. Repeated or extended inpatient admission can be counter-therapeutic for some adolescents with chronic suicidal and/or self-harming behaviour.

Justice Health is developing consultation services to provide advice to specialist child and adolescent mental health inpatient units. This will enhance capacity to assess and treat young people appropriately in these settings across the state.
2.4 Escalation process

Each mental health service must have an escalation protocol to address the immediate situation of an adolescent patient urgently requiring admission. This must include an articulated local plan for patient flow (for an example from SESIAHS see Attachment 1).

Local clinical governance arrangements should inform documented local escalation pathways for seeking an urgent admission of an adolescent to a specialty CAMH acute unit. An example of an escalation pathway could include the following:

It is important that at each stage of the referral process outlined above that the unit receiving the referral maintains communication with the referring unit or service (e.g. providing information on the likelihood of admission, progress while in hospital, transfer of care arrangements).

At a state level the Operational Management Working Group of the Complex Needs Patients Subcommittee is responsible for accepting referrals from local Mental Health Programs regarding patients assessed as being at persistent high risk of harm to self or others, and where current/proposed accommodation or inpatient placement is deemed unsuitable or problematic. Referral to this committee is made by the Directors of Mental Health. See Attachment 2 for Terms of Reference.
The Operational Management Working Group of the Subcommittee will review and will provide recommendations to the Director of the Mental Health and Alcohol Office on the care and management of individual patients with complex needs referred by representatives of the mental health service responsible for the patient’s current and/or ongoing care. MH-Kids is involved when children and adolescents are referred.

For patients referred to a specialised facility through the Operational Management Working Group, the initiating mental health service must have an exit plan in place for the patient’s placement and care in the longer term.
## 13. MENTAL HEALTH

### Attachment 1 - SESIMHS Extraordinary Event Management and Demand Plan for Acute Inpatient Beds –2009-2010

<table>
<thead>
<tr>
<th>Level</th>
<th>Threshold</th>
<th>Demand Indicator</th>
<th>Authority to Invoke Resource Mobilizing Capacity</th>
<th>Actions</th>
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<tbody>
<tr>
<td>0</td>
<td>Proactive Routine Practice</td>
<td>Facility Mental Health Beds Available</td>
<td>Site Senior Nursing Manager/ Operations Manager and Site Service Directors</td>
<td>Transport and Escort Duties&lt;br&gt;• Resource list of medical, nursing and support staff available for overtime and/or transport/escort duties. Resource bases to include community MH, MH Consultation Liaison, Nursing Allocations Office and other SESIMHS Network Hospital’s workforce.&lt;br&gt;• Workforce Planning with Nursing Agencies to secure sufficient numbers of agency personnel with appropriate skills sets&lt;br&gt;• Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport&lt;br&gt;&lt;br&gt;Community Team Presentations&lt;br&gt;• Standardise a Triage Assessment Process where all Community Referrals to the SESIMHS MHS are triaged via the CMT Leader and individually discussed with the Patient Flow Coordinator in consultation with the Duty Consultant.&lt;br&gt;&lt;br&gt;Demand Capacity&lt;br&gt;• Predictive Bed Model and capacity planning with identified inpatient discharges, planned leave and contingency leave for each day&lt;br&gt;• Identify OOA Clients and commence repatriation planning&lt;br&gt;• Identify Private patients and commence private facility negotiations&lt;br&gt;• Suitable ECT procedures to be mobilised to Day Only&lt;br&gt;• Mobilise Non Acute Referrals/LLOS Meeting and Second Opinion Processes/Assertive Care Progression Model of Care&lt;br&gt;&lt;br&gt;Emergency Department&lt;br&gt;• Key MH/ED CNC KPIs around completion of A1 with purposeful admission plan/projected LOS, bed finding negotiations&lt;br&gt;• Assertive planning around comprehensive ED discharge planning including standard community information packs/AODS/Sexual Assault/support agency information/pre packs of medications/pharmacy dispensing medications after hour’s information/NGO support services&lt;br&gt;• Emergency Department escalation plan for managing multiple presentations, co morbid AODS/Clinical Pharmacology/Sexual Assault cases/Non English Speaking presentations or surges in MH emergency assessments to be formalised and circulated to all operational teams</td>
</tr>
<tr>
<td>1</td>
<td>Patients requiring Mental Health inpatient admission and no local mental health beds available</td>
<td>No Facility Mental Health Beds Available&lt;br&gt;&lt; 2 Facility Emergency Department Beds Available&lt;br&gt;Predicted Discharges less than predicted Emergency &amp; Planned</td>
<td>Site Senior Nursing Manager/ Operations Manager and Site Service Directors in Consultation with Area Mental Health Access Team and Local Patient Flow Coordinator, Staff Specialist or Registrar</td>
<td>Transport and Escort Duties&lt;br&gt;• Circulate standardised briefings to SVH Transport, SESIAHS Community Transport Drivers and NSW Ambulance to increase staff awareness/preparedness and support for increased service demands.&lt;br&gt;&lt;br&gt;Community Team Presentations&lt;br&gt;• Standardise a Triage Assessment Process where all Community Referrals to the Network MHS are triaged directly by Network/Facility CMT Leader and individually discussed with the Nursing Manager/Operations Manager&lt;br&gt;&lt;br&gt;Demand Capacity&lt;br&gt;• Brief local Private Mental Health Facility Operations Mx to increase staff awareness/preparedness and support for increased service demands. Mobilize suitable current inpatients that have private MH insurance.&lt;br&gt;• Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport&lt;br&gt;• Review Numbers of Leave Clients and redirect daily reviews to assertive Out Patient Review Clinics/Community Care&lt;br&gt;• Review patients on leave for potential to remain on extended leave</td>
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## 13. MENTAL HEALTH

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<tr>
<td>2</td>
<td>All local Network and SESIAHS Mental Health Beds full + &gt; 8 hrs unplaced mental health patients in a SESIAHS Emergency Department.</td>
<td>Facility ED full and unable to off load ambulances &gt; 5 MH patients waiting to be seen or waiting for MH review &gt; 3 admitted MH patients awaiting transfer to MH Bed or Delay in discharges from Ward &gt; 4 hours</td>
<td>Site Senior Nursing Manager/Operations Manager and Site Service Directors in Consultation with Area Mental Health Access Team and Local Patient Flow Coordinator, Staff Specialist or Registrar, Area Director Mental Health</td>
<td>Transport and Escort Duties&lt;br&gt;Contingency planning around escort resources to be negotiated with Facility Corporate Services Manager who has governance over site employed community transport service drivers.&lt;br&gt;Contingency planning around access to hospital vehicles for the purpose of non acute transport.&lt;br&gt;Contingency Planning with NSW Non Acute Transport Services around extended access to non acute transport services.&lt;br&gt;Circulate standardised briefings to NSW Police to increase staff awareness/preparedness and support for transport and potential service limitations. Community Team Presentations&lt;br&gt;Restrict CMT admissions to psychiatric emergencies only. Patients will need to meet the requirements for involuntary admission under the MHA.&lt;br&gt;CMT Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director Demand Capacity&lt;br&gt;ECT and/or elective outpatient appointments restricted to Psychiatric Emergencies Only.&lt;br&gt;Investigate clinically appropriate alternative accommodation options/Hotels for all accommodation challenged patients who are occupying an acute MH bed inappropriately&lt;br&gt;Situational escalation that may include deployment of MH skilled observation staff, patient transfer, occupation of regional or rural beds within NSW, occupation of local MH over census beds for limited &amp; definitive periods, resource dependant&lt;br&gt;Suspend all repatriation requests from other AHS to admit local client into an available bed within SESIMHS&lt;br&gt;Admissions restricted to psychiatric emergencies in all SESIMHS services&lt;br&gt;Patients will need to meet the requirements for involuntary admission under the MHA.&lt;br&gt;Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director&lt;br&gt;Redirect or defer elective admissions, consider non acute network partner Bloomfield accommodation ( i.e. Clozapine trials)&lt;br&gt;Suspend tertiary referral admissions to identified tertiary referral beds including NPI beds Emergency Department&lt;br&gt;Invoke Emergency Department escalation plan for managing multiple presentations, co morbid AODS/Clinical Pharmacology/Sexual Assault cases/Non English Speaking presentations or surges in MH emergency assessments including redeployment of C/L, Rehabilitation, Community medical resources and support teams.</td>
</tr>
</tbody>
</table>
### Extraordinary Event

As identified by the DCO and Area Director Mental Health

**As above. Situational escalation process inclusive of Area Mental Health Service Director & Director of Clinical Operations. The repertoire of options may include specific risk mitigation strategies that may include the following actions for limited & definitive periods, resource dependant**

- Suspend all non SESIMHS admissions into available beds within SESIMHS + NSW Health
- Circulate standardised briefings to Other Area Health Facility to increase awareness/preparedness and support for increased service demands.
- Suspend SESIMHS MHRS Program and return MHRS patients to community
- Negotiate SESIMHS MHRS Program pts as Non Acute Admission with Network Partner/Bloomfield
- Co manage Older Adult MH pts on General Hospital Aged Care Units/Behaviour Disturbed Units
- Co Manage Older Adult MH pts in MAU/War Memorial Hospital/Garrawarra Hospital respite beds
- Suspend all Justice Health Presentations/Schedule to SESIMHS.
- NSW Health to Circulate standardised briefings to Long Bay Gaol to increase awareness/preparedness and support for transfer of pts to adjacent area

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Attachment 2 - Operational Management Working Group (Complex Needs Patients Subcommittee) Terms of Reference

The Operational Management Working Group of the Complex Needs Patients Subcommittee is responsible for accepting referrals from Area Mental Health Programs regarding patients assessed as being at persistent high risk of harm to self or others, and where current/proposed accommodation or inpatient placement is deemed unsuitable or problematic. Membership includes senior mental health professionals with significant clinical leadership experience, and with delegated authority from their respective Area Health Service to undertake negotiations with respect to the transfer and placement of these identified patients.

Terms of Reference

The Operational Management Working Group of the Subcommittee will:
1. using the decision-making criteria, review and provide recommendations to the Director of the Mental Health and Alcohol Office on the care and management of individual patients with complex needs referred by representatives of the Area Health Service responsible for the patient’s current and/or ongoing care; and
2. review emerging trends in patterns of referral, systemic problems identified and outcomes achieved in relation to the ‘Complex Needs Patients’ group and report back to the CAC through the Subcommittee.

Target Group
A sub group of the Operational Management Working Group will consider and provide advice on individual patients meeting the following criteria:
1. (a) Where the patient has been diagnosed with a mental illness, or exhibits significant behavioural disturbance, the character of which strongly suggests the presence of an underlying mental illness AND
   (b) where the clinical presentation includes a persistent high level of risk of harm to themselves or others irrespective of where they are located within the health system; AND
   (c) where the current or proposed inpatient or community placement is deemed sub-optimal and problematic.
2. Mental health patients with coexisting brain injury, cognitive impairment or intellectual disability who meet other eligibility criteria will be included in the Operational Management Working Group’s target population.
3. There is no exclusion on the basis of age.

Referrals to the Operational Management Working Group will be through the Area Health Service’s nominated representative on the working group, the Area Clinical Director or Area Mental Health Director’ to the Secretariat. Each Area Health Service needs to establish internal processes for managing referrals from frontline clinicians.

Membership
- Chair of the Complex Needs Patients Subcommittee or delegate
- Director/Clinical Director (or delegate), Mental Health, Greater Southern AHS
- Director/Clinical Director (or delegate), Mental Health, Greater Western AHS
- Director/Clinical Director (or delegate), Mental Health, Hunter New England AHS
- Director/Clinical Director (or delegate), Mental Health, Justice Health
- Director/Clinical Director (or delegate), Mental Health, North Coast AHS
- Director/Clinical Director (or delegate), Mental Health, Northern Sydney Central Coast AHS
- Director/Clinical Director (or delegate), Mental Health, South Eastern Sydney Illawarra AHS
- Director/Clinical Director (or delegate), Mental Health, Sydney West Area Health Service
- Director/Clinical Director (or delegate), Mental Health, Sydney South West AHS
13. MENTAL HEALTH

In addition to identified members of the Working Group relevant to the referred patient, other persons nominated by such identified members, will participate in ad hoc meetings focused on the management of the specific patient.

Secretariat
Clinical Governance Team, Mental Health and Drug and Alcohol Office

Frequency of meetings
Quarterly meetings, with additional ad hoc meetings as required. Meetings may be held via teleconference where appropriate.

Quorum
50% of membership for scheduled meeting; three members (clinicians) for ad hoc meetings.

Timeframe for Review
Reviewed annually

CHIEF PSYCHIATRIST PANEL REVIEW OF COMPLEX MENTAL HEALTH TREATMENT PLANS (PD2011_055)

PURPOSE

The purpose of this Policy Directive is:
1. To provide an independent high level clinical review of treatment plans that lie outside of usual clinical practice where there is an urgent need.
2. To establish an expert panel chaired by the Chief Psychiatrist that will convene for the purpose of reviewing the treatment plan.
3. To set out a formal procedure to address concerns that have been raised about the clinical management of patients which have been considered to be highly complex and may lie outside usual clinical practice.

MANDATORY REQUIREMENTS

That the attached protocols are established and complied with in all Local Health District Mental Health Services.

IMPLEMENTATION

Chief Executives, Local Health Districts are to ensure that this Policy Directive is implemented in accordance with the attached ‘Protocols for the Chief Psychiatrist Panel Review of Complex Mental Health Treatment Plans’.

Any local protocols currently in place must be consistent with the principles contained in the attached Protocols.

The Policy Directive is to be trialled for 2 years and re-assessed in December 2013.
INTRODUCTION

This document outlines the process for a Panel, to be led by the Chief Psychiatrist, to review complex mental health treatment plans that are not typical or standard. This includes plans which require additional clinical oversight when there is an urgent need for treatment that is clinically indicated and to prevent injury or prolonged suffering of the consumer.

MEMBERSHIP

The panel will consist of the Chief Psychiatrist plus at least one Senior Mental Health Clinician who is not associated with the referring Local Health District (LHD). The Chief Psychiatrist will decide on the membership of the panel based upon requirements and availability, but will be a minimum of two people with sufficient and appropriate expertise.

The Chief Psychiatrist will keep a list of potential panel members.

Membership of the panel will be determined in the context of the circumstances of each case. This is due to the fact that each case is likely to present different diagnoses, proposed treatment options and varying complex medical histories. It should also be noted that the composition of each panel may vary according to the Local Health District involved, to ensure independence.

The Chief Psychiatrist will facilitate the review process. In the event that the Chief Psychiatrist is unavailable, the panel is to be chaired by a LHD Mental Health Director or Clinical Director who is a neutral party to the referral.

REFERRAL PROCESS

Only the following positions have the responsibility for referring treatment plans directly to the Chief Psychiatrist:

- LHD Mental Health Service Clinical Directors
- LHD Directors of Mental Health
- LHD Health Service Chief Executives
- Director, Mental Health and Drug & Alcohol Programs
- NSW Health Deputy Director-General
- Director-General.

The Panel will then consider the treatment plan as soon as is practicable, bearing in mind that these treatment plans may need urgent review given the gravity of the situation. The patient’s medical condition may be such that any delay in treatment is likely to result in injury, prolonged suffering or be potentially life threatening.

The review may be either written and/or by verbal submission considering the timeframes.

Circumstances for making a referral:

Mental Health Clinicians are able to seek approval from their Clinical Director and Chief Executive to invoke a review of proposed treatment in the following circumstances:

- all other treatments have already been tried with unsatisfactory results, and the situation is so problematic that the treating team considers this treatment is urgently required
- the treating team has sought at least one second opinion and has undertaken peer review which has included the LHD Clinical Director and other appropriate Senior Clinicians.
The treatment plan should be referred for the consideration of the panel once it is endorsed by the District Executive.

Appropriate referrals would include treatment plans where:

- Two or more conventional treatments are used together in a way not previously combined and/or
- A standard treatment is used outside the regular setting and/or
- A particular person presents with an unusual and highly complex set of presentations.

Because it is difficult to define every possible scenario, the LHD Clinical Director will need to use clinical judgment in deciding which treatment plans to refer for a panel decision. However, all treatment plans that involve the continuation of anaesthesia for treatment or control of psychiatric/behavioural problems beyond what is usually required for the administration of ECT must be referred.

It is important to note that the trial of new medication or experimental treatment remains an ethical consideration and is outside the scope of this policy. The panel will only give consideration to treatment plans for individuals which include currently available treatment options available in clinical settings.

**ROLE OF THE PANEL**

1. To consider the proposed treatment plan based on the clinical findings and plan of care to be provided and to give an opinion as to:
   a. Whether this treatment is reasonable for this patient and that,
   b. All aspects of safety and patient, family and staff welfare have been considered.
2. To offer any further advice to the treating team that the panel feels is necessary.
3. To advise relevant bodies e.g. Mental Health Review Tribunal (MHRT) or Official Visitors of the decision made on the treatment plan. The advice given to the MHRT is to be provided prior to, or during any relevant hearing which considers this emergency treatment.
4. The panel should reach a consensus on the treatment plan. In the event that a consensus is not able to be reached, the authorised medical officer from the referring LHD is required to consider the advice given by the Chief Psychiatrist.

**RESPONSIBILITIES**

**Chief Psychiatrist’s responsibilities:**

To provide a record of decisions and rationale on each case to the Director of Mental Health and Drug & Alcohol Programs (MHDAO) once the panel has reached a resolution. A copy of the decision is to be provided to the Director-General.

To provide advice to the MHRT, Official Visitors and other relevant bodies on the decision made by the panel.

A de-identified report of the work of the panel will be provided to the NSW Mental Health Clinical Advisory Council (CAC) at least yearly or more often if need arises.

**Panel member’s responsibilities:**

To assist in determining a resolution on the treatment plan as a member of the panel.
Local Health District staff responsibilities:

That the LHD Clinical Director or their delegate make a timely referral to this panel in the instance where their clinical judgement determines that such a referral is required.

The LHD should provide a report on the treatment and clinical outcome to the Chief Psychiatrist within one month.

RIGHT OF APPEAL

The rights of appeal for mental health consumers and their carers are outlined in the Statement of Rights (Schedule 3 Mental Health Act 2007) as such:

“You (or a carer or friend or relative) may at any time ask the medical superintendent or another authorised medical officer to discharge you. If the medical superintendent or authorised medical officer refuses or does not respond to your request within 3 working days you (or a carer or friend or relative) may lodge an appeal with the Mental Health Review Tribunal. You will be given a notice setting out your appeal rights.”

Consumers and their carers should be made aware of their right of appeal and information on how to undertake an appeal should be provided.

TIMELINES

The panel will be convened as soon as practicable, and no longer than 48 hours, in order to make an urgent decision on an arising treatment plan.

The Chief Psychiatrist will provide the panel’s record of decisions and rationale on each case to the Director, Mental Health and Drug & Alcohol Programs (MHDAO) within a two week period. This will be copied to the Director-General, NSW Health.

The Policy Directive is to be trialled for 2 years and re-assessed in December 2013.
CLOZAPINE-INDUCED MYOCARDITIS – MONITORING PROTOCOL (PD2012_005)

PURPOSE

The protocol put forward in this policy recommends a way to actively monitor mental health patients on Clozapine.

Clozapine is an effective antipsychotic for the management of treatment-resistant schizophrenia. All patients taking Clozapine are registered at an approved Clozapine monitoring service where ongoing monitoring is required for the detection of neutropenia and agranulocytosis.

The policy encourages the continuation of Clozapine in the presence of mild illness, but defines a threshold for cessation and how to manage this.

MANDATORY REQUIREMENTS

Gaining a better understanding of the potential risks associated with Clozapine will enable NSW Health staff to ensure that appropriate protocols and guidelines for the effective monitoring and management of patients taking Clozapine are in place.

IMPLEMENTATION

Implementation of this Policy Directive will be guided by the NSW Health Monitoring Protocol for Clozapine Induced Myocarditis Procedures.

The document outlines a range of cardiac disorders that has been associated with the use of Clozapine, recommends the typical clinical course of myocarditis and puts forward the recommended monitoring protocol for the detection of neutropenia and agranulocytosis.

Local Health Districts and other NSW Health organisations will be required to regularly report on the progress of the monitoring protocol.

1. BACKGROUND

Clozapine is an effective antipsychotic for the management of treatment-resistant schizophrenia. All patients taking clozapine are registered at an approved clozapine monitoring service where ongoing monitoring primarily occurs for the detection of neutropenia and agranulocytosis.

A range of cardiac disorders has been associated with the use of clozapine, the most serious being myocarditis, cardiomyopathy and death. Myocarditis is most commonly observed early in treatment.

This procedure recommends active monitoring for the first 4 weeks, relying on assessing clinical symptoms and signs, as well as investigations such as troponin and C-reactive protein results. It encourages continuation of clozapine in the presence of mild illness, but defines a threshold for cessation.

Recommended ongoing monitoring for cardiac disorders should include:

- BP - admission at week 6, week 18, 6 months and thereafter unless problematic
- ECG - 6 months and annually thereafter unless clinically indicated
- ECHO - 6 months, then thereafter if clinically indicated
13. MENTAL HEALTH

• Troponin & CRP – Pre, first 4 weeks, week 6, week 18, at 6 months and thereafter 6 monthly unless clinically indicated
• CK-MB and NT-proBNP also advised should myocarditis be suspected.

2. DEFINITIONS

Troponin I or T - The troponin test measures the levels of one of two proteins, troponin T or troponin I, in a blood sample. These proteins are released when the heart muscle has been damaged, such as during a heart attack. The more damage there is to the heart, the greater the amount of troponin T and I there will be in the blood. **Range:** <14ng/L

CRP - ‘C-reactive protein’ - is produced by the liver. The level of CRP rises when there is inflammation throughout the body. **Range:** <5mg/L

NT-proBNP - ‘N-terminal B-type natriuretic peptide’ is released by the ventricular wall in response to increased wall stress and reflects the haemodynamic status of the heart. Useful for detecting early and initially asymptomatic myocarditis.

CK-MB - ‘Creatine Kinase’ - Myocardial Band’ is a cardiac marker used to assist diagnoses of an acute myocardial injury.

ULN - Upper Limit of Normal

LV - Left Ventricular

3. TYPICAL CLINICAL COURSE OF MYOCARDITIS

• The first indications of the onset of myocarditis are non-specific symptoms of illness such as fever with features commonly associated with influenza, but symptoms may include severe diarrhoea and vomiting or dysuria (point 2, Figure 1).
• C reactive protein (CRP) usually begins to increase around this time (point 2, Figure 1).
• Troponin I or T typically increases with a delay of as much as 5 days after both the onset of symptoms and commencement in the rise of CRP (Point 3, Figure 1).
• A sudden drop in systolic blood pressure may occur around this time and the patient may report chest pain (Point 3, Figure 1).
• The first appearance of non-specific electrocardiogram (ECG) changes also occurs at this point (Point 3, Figure 1).
• Basal crepitations, third heart sounds, peripheral oedema and raised jugular venous pressure also may develop (Point 3, Figure 1).
• An ECHO may show impairment of left ventricular function (Point 3, Figure 1).
• Heart rate typically increases a few days following initiation of clozapine in all patients including those not developing myocarditis.
• It may increase again with the onset of fever and elevation in CRP (Point 2, Figure 1) or it may suddenly increase with the first development of high troponin (Point 3, Figure 10).
• In some cases myocarditis may develop without accompanying symptoms.
4. MONITORING PROTOCOL

- The monitoring protocol recommends obtaining baseline troponin I or T, CRP, ECG and ECHO.
- Subsequently CRP and troponin should be monitored weekly for the first four weeks of treatment.
- During the first four weeks, vital signs and direct enquiry regarding symptoms ought to be assessed at least every alternate day whilst the patient is an inpatient and weekly if the patient has been transferred to an outpatient clinic.
- In the presence of relevant symptoms, an abnormally increased heart rate or raised CRP (50 mg/L), it is recommended that troponin and CRP be measured daily and the patient monitored for developing illness.
- If troponin levels are only slightly raised (less than twice the upper limit of normal) and CRP remains less than 100 mg/L, clozapine may be continued.
- Discontinuation of clozapine and investigation by echocardiography is advised if either troponin is in excess of twice the normal maximum or CRP is more than 100 mg/L.
- Routine monitoring for myocarditis up to day 28 is recommended, in comparison to the previous guidelines which extend monitoring only to day 14.
- With a high proportion of cases of myocarditis occurring during week 3, this recommendation for actively monitoring for myocarditis during the first 4 weeks proposes that this regime will have sufficient sensitivity to pick up all symptomatic cases of myocarditis developing between days 14 and 21.

Heart rate as an indicator of myocarditis

- Clozapine frequently causes benign tachycardia.
- Monitoring heart rate on at least alternate days (as inpatient) and weekly (as outpatient) from baseline during first 4 weeks will mean that trends and tendencies for the individual patient can be identified and an abnormal increase associated with the onset of myocarditis is more likely to be correctly interpreted.
C-reactive protein in early diagnosis

- This protocol suggests measuring CRP along with troponin measurements in the routine monitoring for myocarditis.
- CRP is generally a non-specific marker of inflammation; however, studies indicate that elevated CRP is an early diagnostic indicator of the presence of myocarditis where other cardiac biomarkers are elevated.
- A CRP of more than 50mg/L may foreshadow the onset of myocarditis.

ECG and Echocardiography (ECHO)

- Monitoring guidelines do not recommend using ECG as a means of detecting the development of myocarditis.
- Clinicians may choose to monitor heart rate by ECG and may find diagnostic benefit in monitoring the evolving ECG changes.
- In order to use an ECHO as a diagnostic tool in suspected myocarditis, a baseline ECHO prior to clozapine treatment is advisable to exclude pre-existing dysfunction.

Eosinophilia

- Raised eosinophils should not be used to monitor for myocarditis occurring following clozapine initiation.
Figure 2: Proposed protocol for monitoring patients commenced on clozapine for clozapine-induced myocarditis. (Ronaldson, KJ, et al)
5. CONTINUATION OF CLOZAPINE WITH MILD DISEASE

- Given the potential success of clozapine, every opportunity for continuation of clozapine should be taken provided it can occur safely.
- It has been suggested that the continuation of clozapine may be contemplated if troponin I or T is no more than twice the upper limit of normal, provided CRP is less than 100mg/L.
- If deciding to continue clozapine treatment, certainty that cardiac function is not at risk, can be further assessed by checking CK-MB, Pro-BNP and/or ECHO and requested a cardiologist assessment.
- Slow titration of clozapine dose is advised.

6. MANAGING MYOCARDITIS

- Once clozapine-related myocarditis has been suspected or diagnosed, clozapine treatment must cease.
- There is evidence that the early cessation of clozapine treatment with the onset of myocarditis improves clinical outcomes.
- Where myocarditis is suspected, investigation for clozapine-induced impairment should be conducted promptly following the withdrawal of clozapine. A cardiologist should be consulted about the need for referral.
- If no significant impairment of cardiac function is measured, no specific therapy apart from cessation of Clozapine is required.
- However, where the echocardiography reveals moderate or severe left ventricular impairment a cardiology consult should be sought to further assess the need for drug or mechanical intervention.

7. ADDITIONAL INFORMATION

FORENSIC MENTAL HEALTH SERVICES (PD2012_050)

PURPOSE

Forensic mental health services provide assessment, care, treatment, and other services to people with mental illness who are, or have been, in contact with the criminal justice system. The provision of health care services for forensic and correctional patients, and for civil patients who are a high risk of harm to others, requires the coordination of specialist and general mental health services.

The purpose of this policy is to ensure that there are appropriate standards for forensic mental health services and general mental health services that provide care and treatment to forensic patients.

Forensic mental health services are underpinned by the same principles that underpin general mental health services with the addition of specific principles, legislation and processes that are applicable to forensic and correctional patients, including the Mental Health (Forensic Provisions) Act 1990. The general principles include those such as the Charter for Mental Health Services in NSW. Forensic mental health services in NSW aim to adhere to the National Statement of Principles for Forensic Mental Health.2

As with the broader NSW mental health system, an effective and efficient forensic mental health system involves a strong collaborative approach between service providers.

MANDATORY REQUIREMENTS

This policy applies to all Public Health Organisations which provide services to correctional patients, or forensic patients detained in mental health facilities or other places, or conditionally released in the community, and to high risk civil patients that come into, or who are referred to, the forensic mental health system.

IMPLEMENTATION

Local Health District Chief Executives, Health Service Executives, Managers:
- Assign responsibility, personnel and resources to implement this policy.
- Provide line managers with support to mandate this policy in their areas.
- Ensure that local protocols are in place in each facility to support implementation.
- Work together with the Justice and Forensic Mental Health Network (JFMHN) to ensure that Local Health District (LHD) policies, procedures and standards are consistent with statewide policies, procedures and standards set out for the forensic system.
- Report compliance with this policy to the NSW Ministry of Health as required.

Chief Executive and Managers, Justice and Forensic Mental Health Network
- Ensure that the Guidelines for Forensic and Correctional Patient Ground Access, Leave, Handover, Transfer, and Release are reviewed and updated at intervals of no greater than three years.
- Work together with LHDs, and provide leadership and expertise in relation to the development of system wide policies, procedures and standards for forensic mental health services.

NSW Health Service staff and visiting practitioners providing relevant services:
- Comply with this policy.

To access the attachment to this Policy Directive please go to

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MENTAL HEALTH TRIAGE POLICY (PD2012_053)

PURPOSE

An efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

This policy has been developed by the NSW Ministry of Health in collaboration with Local Health Districts (LHD)/Health Networks. It defines mental health triage, the mental health triage process and the Standards for NSW Health mental health telephone triage services. It also briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of public mental health triage services.

The 1800 011 511 NSW Mental Health Line is a single number, state-wide mental health telephone service operating 24 hours a day, 7 days a week and is staffed by mental health professionals. The Mental Health Line provides universal and equitable access to mental health triage and referral to the most appropriate point of care.

The NSW Mental Health Line is one component of the State Mental Health Telephone Access Line (SMHTAL) Program. The other component of the SMHTAL Program is to improve the operation of public mental health telephone triage services so that they meet the Standards for NSW Health mental health triage services (the Standards) (see section 12.3).

MANDATORY REQUIREMENTS

This policy applies to all public mental health telephone triage services operated by Local Health Districts/Health Networks or their equivalent and by private providers contracted to deliver mental health telephone triage services on behalf of Local Health Districts/Health Networks.

This policy is underpinned by the National Standards for Mental Health Services 2010, in particular Standard 10.2 ‘Access: The mental health service is accessible to the individual and meets the needs of the community in a timely manner’; and Standard 10.3 ‘Entry: The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment’, as well as the Standards.

Local Health District/Health Network policies, procedures, protocols, guidelines or other documents relating to mental health triage must be consistent with this policy.

IMPLEMENTATION

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.
• Funding the development and delivery of standardised mental health telephone triage training to mental health clinicians who undertake the mental health telephone triage function.
• Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
• Monitoring and quality improving the operation of the SMHTAL Improvement Project.

Local Health Districts/Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:
• Implementing the State Mental Health Triage Policy.
• Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline ‘Call Handling Guidelines for Mental Health Telephone Triage Services’ GL2012_008).
• Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
• Ensuring staff undertaking the triage function receive relevant training and ongoing support.
• Ensuring adequate resource allocation for human resource costs, minor capital works activity and other costs associated with the delivery of triage services.
• Implementing routine evaluation and clinical practice improvement processes, including complaint/incident management.
• Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services.

Clinical staff are responsible for reading, understanding and complying with the requirements of this policy. (Refer Section 2 ‘Roles and Responsibilities’ for additional information).

1. BACKGROUND

1.1 About this document

In NSW: a new direction for mental health (June 2006), a commitment was made to establish a 24 hour state-wide mental health telephone advice, triage and referral service, staffed by mental health clinicians and linked into the National Health Call Centre Network (agreed to by the Council of Australian Governments). The NSW Ministry of Health developed the State Mental Health Telephone Access Line (SMHTAL) Program to fulfil this commitment.

The aim of the SMHTAL Program is to facilitate access to appropriate mental health services by the people of New South Wales.

The SMHTAL Program is being implemented via an Improvement Project. The Improvement Project will facilitate access to appropriate mental health services through the establishment of a 1800 state-wide mental health telephone number operating 24 hours a day, 7 days a week (the NSW Mental Health Line); and by improving the operation of Local Health District (LHD)/Health Network mental health telephone triage services so that they meet state-wide performance Standards.

NSW Health recognises that an efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.
1.2 Key definitions (for the purpose of this policy)

**Triage** – Mental Health triage is a clinical process conducted by a mental health clinician and documented using the NSW Health Mental Health Clinical Documentation triage module. Triage prioritises service type, need and urgency based on assessed risk, need, disability and dysfunction.

**Assessment** – A comprehensive mental health assessment conducted by a mental health clinician and documented using NSW Health Mental Health Clinical Documentation standardised assessment module.

**Alerts/Clinical Risk Assessment** – Alerts/clinical risk assessment is the process used to identify and evaluate potential and imminent risk of harm to self and others.

**Action Plan/Risk Management** – The formulation of the Action Plan should take into consideration the clinical risk assessment and any other relevant information gathered during the triage process.

**Local Health Districts/Health Networks** - The organisations within the New South Wales public health system that provide public sector health services.

**Mental Health Service** – refers to New South Wales public sector mental health services.

1.3 Aim of this document

To define mental health triage, the mental health triage process, the Standards, and Local Health District/Health Network responsibilities with regard to the delivery of mental health triage services.

1.4 Key principles

- Effective and equitable access to mental health services for the people of New South Wales.
- As an entry point to mental health support and treatment, mental health triage services must take responsibility for the management of a caller until transfer to the appropriate agency or person for follow up. This includes:
  - Delivery of timely and consistent services for all people seeking assistance for a mental illness.
  - Facilitation of access to advice and information on other services where a public mental health service intervention is not required.
- Local Health District/Health Network mental health telephone triage services are staffed by appropriately trained and experienced mental health clinicians.
- The triage process will determine urgency of response based on an assessment of risk, distress, dysfunction and disability.
- Triage can be completed face-to-face or by telephone.
- Where a mental health triage indicates that a specialist mental health assessment is likely to be required, the Local Health District/Health Network is responsible for ensuring that a mental health assessment is provided within the urgency of response time frame.
- Where possible local information including relevant consumer care plans should be accessible to triage services.
- Professional interpreter services are engaged in accordance with Ministry of Health policy requirements.
- Triage services will adhere to the principles identified in the National Standards for Mental Health Services 2010: Standard 10.2 Access ‘The mental health service is accessible to the individual and meets the needs of the community in a timely manner’; Standard 10.3 Entry ‘The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment’.
2. **ROLES AND RESPONSIBILITIES**

This section briefly outlines the main roles and responsibilities of the key stakeholders in supporting the delivery of effective and efficient triage services.

### 2.1 NSW Ministry of Health

The NSW Ministry of Health is responsible for the state-wide development and implementation of the SMHTAL Program, including:

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program, including development of marketing collateral.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards, and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.
- Funding the development and delivery of standardised mental health telephone triage training to mental health telephone triage clinicians.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

### 2.2 Local Health Districts/Health Networks

Local Health Districts/Health Networks and Mental Health Services are responsible for the clinical governance and local corporate governance of the triage policy and associated mental health telephone triage service/s. This includes:

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline ‘Call Handling Guidelines for Mental Health Telephone Triage Services’ **GL.2012_008**).
- Monitoring the operation of its mental health telephone triage service/s to achieve the Standards and meeting Ministry of Health reporting requirements.
- Ensuring staff undertaking the triage function receive relevant training and ongoing support.
- Ensuring adequate resource allocation for human resource costs, capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint/incident management.
- Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services

### 2.3 Mental Health Telephone Triage Service Clinicians

The primary role of a mental health clinician undertaking the telephone triage function is to offer assistance to all callers at the first point of contact.
Mental health clinicians undertaking the telephone triage function will be experienced mental health clinicians with current registration or professional affiliation in the disciplines of nursing, social work, psychology, occupational therapy. While there is no explicit definition of “experienced mental health clinicians”, for the purposes of the SMHTAL Program “experienced” means having at least three years’ experience working in acute mental health settings conducting initial mental health assessments.

The NSW Health Mental Health Clinical Documentation triage module (triage module) must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

The triage module must also be completed when referring to another service such as:
- Health service (not mental health)
- General Practitioner
- Another Local Health District/Health Network
- Non-Government Organisation
- Specialist mental health services
- Information for possible future referral i.e. client may be escalating.

Mental Health clinicians undertaking the telephone triage function must manage callers in line with Local Health District/Health Network protocols, and must ensure that triage referrals are forwarded to the most appropriate service within the Urgency of Response scale timeframe.

Mental Health clinicians will complete, but not be limited to, the State mental health telephone triage training program or equivalent training programs, in addition to completing local orientation and induction programs.

Mental Health clinicians will have access to appropriate supervision and will have ready access to senior staff for consultation, training and support.

2.4 Mental Health Clinician/Team Receiving Triage

Local Health District/Health Network and Mental Health Service clinical staff are expected to respond to triage referrals within the Urgency of Response scale timeframe.

When there is a resource issue impacting on the ability of the receiving team to respond within the Urgency of Response scale timeframe, this should be clearly communicated to the patient/consumer and duly documented on the patient’s file. Refer to section 9.1, “Responding to urgency of response”.

Clinicians receiving the triage referral are expected to complete a comprehensive assessment within the urgency of response timeframe.

When a Mental Health Service provides a consumer with the 1800 011 511 NSW Mental Health Line number as part of their treatment plan, the Mental Health Service must forward information about the consumer, including a Consumer Wellness Plan, to the triage service.

Clinicians receiving the triage referral are expected to appropriately provide ongoing feedback and evaluation regarding triage practices. Any concerns regarding the quality of the triage are to be documented on the Incident Information Management System (IIMS).
3. THE TRIAGE PROCESS

Triage is a clinical process to assess and identify the needs of the person and the appropriate response required.

The most important element of triage is the identification of risk.

Following this brief assessment, a recommendation for treatment and an interim management plan is formulated including a response timeframe for those accepted for care in public mental health services.

Triage can be completed for all prospective consumers, existing consumers whose condition may have deteriorated and who require further assessment and intervention, and other service users.

Mental health triage can be conducted in person (face-to-face) or on the telephone. Telephone contact is often more timely and convenient for many service users. Telephone triage has the additional consideration of limited observation capacity, not being able to physically assess the person’s behaviour, mannerisms, body language, demeanour or distress.

Frequently referrals are made by third parties (concerned friends, carers, and health professionals). Every attempt should be made to speak to the referred party in order to complete the triage assessment process.

All triages are to be completed using the NSW Health Mental Health Clinical Documentation triage protocol and module.

The triage clinician must collect and document sufficient demographic, social and clinical information to determine whether there is a need, or potential need, for further intervention by the Mental Health Service, particularly face to face follow up, or whether referral to another service should be considered. The aim of the triage process is to obtain sufficient information from the person making the referral (including self-referral) to:

- Determine whether the person requires a mental health service intervention;
- Identify symptoms of acute psychosis;
- Identify possible suicidal behaviour or thoughts;
- Determine the level of risk of harm to self or others;
- Determine the level of risk of harm to children including pregnancy;
- Initiate emergency response where extreme and high urgency is identified;
- When a public mental health service intervention is not required, identify the service most likely to meet the needs of the person (e.g. refer to ServiceLink);
- Identify local community health services and other relevant services (e.g. refer to ServiceLink);
- Give the person clear and concise information about the services available and options for further assessment or treatment including to call back should the situation escalate;
- Refer the person to the service likely to meet the identified need for further assessment or treatment;
- Ensure inclusion of explanatory models which may be culture bound;
- Ensure that the client/consumer has a clear understanding of the triage process and subsequent follow up actions.
4. RISK ASSESSMENT

4.1 Clinical Risk Assessment

Triage clinical risk assessment encompasses two components: initial alerts; and a specific clinical risk assessment.

A brief risk assessment screening tool is incorporated in the triage document.

Possible risk factors include:
- Significant past history of risk.
- Recent thoughts, plans, symptoms indicating risk.
- Recent behaviour suggesting risk.
- Concern from others about risk.
- Current problems with alcohol or substance misuse.
- Major mental illness or disorder.
- At risk mental state:
  - Deterioration due to untreated illness
  - Non-adherence to treatment
  - Lack of support systems
  - Emergence of early warning signs
- Unrecognised acute medical illness presenting as delirium (esp. older people).
- Significant circumstances that create volatile behaviour.
- Concern that a child or young person is being abused or neglected.
- Refugee experience, migration and acculturation stressors, minority ethnic status, intergenerational conflict and concerns with multiple identity issues.

Alerts/risks identified are to be recorded on the front page of the triage document in the Alerts/Risks section.

Clinical risk is rated as Low, Medium or High, and includes but is not limited to:

- Child Wellbeing
- Suicide
- Harm to others
- Elder abuse
- Absconding/wandering
- Falls risk
- Accommodation
- Sexual abuse
- Exploitation
- Cultural risks and barriers
- Isolation
- Aboriginality/"Stolen Generation"
- Member of minority group
- Immigrant/refugee status
- Acute Psychosis
- Self-harm
- Domestic Violence
- Substance use
- Fire risk
- Drug reaction/medical/allergy
- Domestic safety issues
- Physical abuse
- Reputation
- Access to firearms
- Sexual identity conflicts
- Stress related to significant life stage transition
- Unemployment
4.2 Occupational Health and Safety Risk Assessment

Triage OHS risk assessment encompasses initial alerts recorded, and must be incorporated within any action plan undertaken to facilitate information to community services relating to possible risk during home visit identified at point of triage.

Alerts include:

- Animals on premises
- Location issues
- Weapons
- Poor lighting
- Unwanted visit
- Other: …………

5. Completing the Triage Document

As a minimum, the NSW Health Mental Health Clinical Documentation Triage module (see Appendix 12.1) is to be used as a basis upon which to complete a triage. Local Health Districts/Health Networks may elect to incorporate the triage document within an electronic medical record or equivalent.

A triage form must be completed whenever it is indicated that the caller may need further mental health service intervention, including but not limited to: referral to community mental health services or other health provider, admission to a hospital, ongoing phone contact or gathering information for future referral.

All sections of the triage document must be completed. When it is not possible to gather all the requisite information on the first point of contact, clinicians must document this on the triage document.

Consumer demographics:
All consumer demographic details should be completed. This information is essential for current and future contact with the consumer. It must be noted if the consumer is a current client of mental health services.

Alerts/Risks:
Any alerts/risks identified during the triage must be clearly documented, including examples/evidence, and summarised in this section. Some examples: ‘High risk for suicide’, ‘Child at risk’, ‘Fire risk – smokes in bed’.

Alerts identified during the triage must be addressed in the Action Plan.

Triage Details:
Includes date, time, location, communication issues, referrer details and reason for referral.

‘Location’ refers to the place where the triage is delivered and is described at Ward, Clinic, or Unit level, e.g. emergency department.

‘Location’ and ‘Site’ information complement each other - for example an ambulatory mental health facility can be described as: Site: XYZ Community Health Centre, Location: Adult Mental Health.

‘Communication issues’ includes issues such as preferred language required or cultural and gender considerations or any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example, ‘Arabic interpreter is required’. Where cultural issues are present, a brief summary should be noted, for example: ‘Cultural issues may be present, Aboriginal Liaison Officer may be required’.
Reason for referral (include whether client is opposed to referral):
Summarise reason for service being sought by self or other, including a brief outline of what is happening in their current situation that has caused them to call.

History:
History of mental illness or disorders (including Behavioural and Psychological Symptoms of Dementia (BPSD)), family history of mental illness or disorders and past treatments, experience of torture and trauma (post traumatic stress disorder (PTSD)). If there are problems that may be BPSD, family history of dementia is relevant. History of treatment/s including any alternative, traditional or culturally relevant treatments.

Medical Issues:
Medical history of significant illness, drug reactions, current medical concerns. Consider whether any issues suggesting delirium may be present (e.g. especially in older people; sudden onset of change in behaviour, cognition, or ability to care for self, fluctuating symptoms or level of alertness, possible acute medical problems).

Current Treatments:
Service providers, prescribed medication, therapy. Have these had any effect or side effects? Is GP aware of, or supporting the referral? If possible BPSD, have any triggers been identified, or behavioural strategies attempted?

D & A use:
Past and current (include current intoxication), treatment, type substance, frequency.

Current functioning and supports:
Family and carer supports or responsibilities, (including children), accommodation issues (if in residential aged care, note if high or low level).

If a carer or support person is present, it is important to check with that person that they are capable of providing the support to the consumer for the level of distress the consumer is in until the mental health service is able to make face-to-face contact with the consumer.

Legal status/Forensic issues:
Current legal issues, charges, convictions, custodial sentences, Guardianship Orders, visa/migration status.

Mental State impressions:
A brief description of the person’s current state, e.g. upset, cheery, crying, calm, verbally aggressive.

Possible Risks
Thoughts of harming self and/or others, neglect, at risk behaviours, acute medical illness.

All tick boxes in this section of the triage document must be completed.

Overall Risk
Suicide, violence and other risks including child safety, self-harm, absconding, exploitation, domestic violence, abuse, neglect, environmental risks.

Summary:
Formulation of presentation including reason for referral, current reported concerns, risk issues, and indications for further assessment and treatment.

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**Action Plan:**
Action plan/interventions includes assigning the Urgency of Response and an overview of all services provided and follow up services being arranged during triage process. Include any actions initiated that address risks and needs previously identified. Include details of interim management plan negotiated with the caller.

- Community Services/Child Wellbeing Unit notified
- Police notified
- Ambulance notified
- Referred to Inpatient Mental Health Service
- Referred to Community Mental Health Service
- Referred to specialist mental health services
- Referred to Emergency Department
- Referred to Community Health
- Interpreter booked
- Aboriginal Liaison Officer notified
- Consult with bilingual/bicultural mental health clinicians (local or state-wide pool)
- Other:

Consumers who are accepted for care into the mental health service should be advised of the anticipated timeframe for response by the receiving mental health team including the option to call back if the situation changes or escalates.

**Contacts:**
Clinicians should document details of any communications undertaken during the triage to identify any corroborated undertaken, as well as provide contact details to aid any subsequent communication. The prompts provided in the ‘Contacts’ table are not meant to be definitive or exhaustive and provision is made for clinicians to specify ‘Other’ contacts.

6. **CRISIS TRIAGE RATING SCALE**

The Crisis Triage Rating Scale (CTRS) (see Appendix 12.2) is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). NSW Health has adopted this tool to be used within ambulatory services to indicate Urgency of Response (UoR).

The scale evaluates the consumer according to three factors: (1) whether they are a danger to themselves or others, (2) their support system, and (3) their ability to cooperate.

The CTRS is available to assist decision-making regarding the determination of the UoR at triage once the clinician has gathered **ALL** the required information and has made the determination that a consumer requires mental health care. The guidelines regarding the completion of the UoR is that the clinician should use **ALL** available information (including the assistance availed by the CTRS), to inform their decisions regarding the UoR and the resulting action plan. A clinician can make a decision on the UoR on the basis of available information, without having to use the CTRS.

**Rating A: Dangerousness**

1) Expresses or hallucinates suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive and violent.

2) Expresses or hallucinates suicidal/homicidal ideas without conviction. History of violent or impulsive behaviour but no current signs of this.
3) Expresses suicidal/homicidal ideas with ambivalence or made only ineffectual gestures. Questionable impulse control.
4) Some suicidal/homicidal ideation or behaviour or history of same, but clearly wishes to control behaviour.
5) No suicidal/homicidal ideation/behaviour. No history of violence or impulsive behaviour.

**Rating B: Support System**

1) No family, friends or others. Agencies cannot provide immediate support needed.
2) Some support can be mobilised but its effectiveness will be limited.
3) Support systems potentially available but significant difficulties exist in mobilising it.
4) Interested family/friends, or others but some question exists of ability or willingness to provide support needed.
5) Interested family, friends, or others able and willing to provide support needed.

**Rating C: Ability to Cooperate**

1) Unable to cooperate or actively refuses.
2) Shows little interest in or comprehension of efforts made on her/his behalf.
3) Passively accepts intervention strategies.
4) Wants help but is ambivalent or motivation is not strong.
5) Actively seeks treatment, willing to cooperate.

**Ascertainment guidelines**
The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to a client is of extreme urgency and should be followed with appropriate indication on the urgency of response scale and appropriate action. Note that if in residential aged care, Rating B can still be in range 2 to 5.

<table>
<thead>
<tr>
<th>Crisis triage rating scale</th>
<th>CTRS: A + B + C</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Dangerousness =</td>
<td>Scores are:</td>
</tr>
<tr>
<td>B. Support System =</td>
<td>Category A = 3 – 9</td>
</tr>
<tr>
<td>C. Ability to Cope =</td>
<td>Category B = 10</td>
</tr>
<tr>
<td>Triage Rating (A+B+C) =</td>
<td>Category C = 11</td>
</tr>
<tr>
<td></td>
<td>Category D = 12 – 13</td>
</tr>
<tr>
<td></td>
<td>Category E = 14 – 15</td>
</tr>
<tr>
<td></td>
<td>Category F = NA</td>
</tr>
<tr>
<td></td>
<td>Category G = NA</td>
</tr>
</tbody>
</table>

The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It differentiates between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984) subsequently determining required level of response.

The following minimum action/interventions have been compiled to assist the triage clinician respond to consumer/referrer needs:

**Category A Extreme Urgency**: Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence).
13. MENTAL HEALTH

**Category B High Urgency:** See within 2 hours/present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress).

**Category C Medium Urgency:** See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).

**Category D Low Urgency:** See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous).

**Category E Non Urgent:** See within 2 weeks.

**Category F:** Requires further triage contact/follow up.

**Category G:** No further action required.

### 6.1 Responding to Urgency of Response

The mental health triage should clearly indicate which service is required to act on the Urgency of Response (UoR), e.g. the receiving mental health team.

**The receiving mental health team at the time of referral, will be responsible for follow up of non-presenting consumers,** e.g. consumer fails to present to Emergency Department or is not present on home visit.

There may be occasions when the receiving mental health team is unable to respond within the assessed UoR timeframe. In these instances it is the responsibility of the Mental Health Service to ensure that local processes are in place to manage and support the consumer until such time as the local mental health team is able to assume responsibility and make face-to-face contact with the consumer.

The key principle is to ensure, as much as is practicable, that the consumer is safe until face-to-face contact is made by the local mental health team clinician.

### 6.2 Crisis Triage Rating Scale/Urgency of Response Review

Confidence of assessment may indicate the need to review the CTRS either increasing or decreasing the urgency of response. Any changes to the CTRS/UoR must be comprehensively and clearly documented as to the reason for the change.

### 7. CLINICAL DOCUMENTATION

Mental health care is especially dependent on good clinical documentation.

Ministry of Health Policy Directive PD2010_018 specifies the mandatory implementation of standardised mental health clinical documentation within public mental health services.

Clinicians must complete the Ministry of Health Mental Health Clinical Documentation Triage document, or equivalent electronic medical record file.

All records of calls, including clinical documentation, form part of the patient’s medical record and can be used in courts of law.
13. MENTAL HEALTH

The use of the triage document should always be guided by the clinician’s informed judgement regarding the consumer’s clinical status and needs at the time.

The bottom of every page of the triage document must be signed off by the clinician completing the document including the name (PRINT), signature, designation (PRINT) and date.

If a section is unable to be completed, the clinician should document why the information has not been collected. For example, the clinician can document that ‘the information was unavailable at triage’. If the information was not available at the time of triage, clinicians should document any follow up actions planned to obtain that information.

Clinicians must also meet other requirements of record keeping as outlined by:

- Australian Standard AS2828-1999 Paper-based health care records
- PD2012_069 Health Care Records - Documentation and Management

8. REFERRAL PATHWAYS

8.1 Mental Health Service

The Mental Health Service must identify clear referral pathways that facilitate adherence to achieving CTRS and UoR and standardise clinical information so that it can be shared across multiple sites, where applicable.

Pathways should include linkages to the NSW Dementia Behaviour Management Advisory Service (DBMAS) State Telephone Assistance Line 1800 699 799; and Mental Health DBMAS and/or Behavioural Assessment and Intervention Services (BASIS).

8.2 Emergency Department Referral – General Hospital

When a consumer has been asked to self-present to an emergency department, or is to be brought to an emergency department by police or ambulance, the triage clinician is to ensure that the emergency department staff are notified by telephone of the expected presentation and provided with a copy of the completed triage. The responsible local mental health team is also to be notified of the presentation.

8.3 Health Service other than Mental Health

Clear referral pathways are to be identified that facilitate the sharing of clinical information and linkage of triage processes to other relevant services within the Local Health District/Health Network. These may be dependent upon local delineation of service responsibilities, but may include services for older or younger people, intellectual disability or community health.

In the event that a child, young person and their family has been identified as being at risk of harm, it is important to engage with services that provide advice on the need for statutory child protection intervention (Child Wellbeing Units), or services that can assess the needs of vulnerable children, young people and families that present with complex issues (Family Referral Services).
Services must be aware of local interpretation of Ministry of Health Guideline GL2006_013 that defines a collaborative role for NSW Health Aged Care services and SMHSOP for older people who present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from SMHSOP. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:
- major depression,
- severe physical and/or verbal aggression,
- severe agitation,
- screaming,
- psychosis.

8.4 Specialist Mental Health Services

Mental health presentations often include a range of complexities and sensitivities that are exacerbated by the prevalence of additional cultural, language and mental health literacy barriers. The availability of specialist cross cultural clinical consultants is aimed at addressing these complexities and facilitating culturally responsive early intervention for the purpose of increasing service use, compliance and improved clinical outcomes. Use of specialist assessment tools developed for indigenous and culturally and linguistically diverse populations are used for determining appropriate referral pathways for clients.

8.5 Managing callers from other Local Health Districts/Health Networks or other States and Territories

All callers to a Local Health District/Health Network mental health telephone triage service are handled at the first point of contact and will receive a triage (using the NSW Health Mental Health Clinical Documentation Triage module) and a risk assessment.

If there is an immediate risk, emergency services are to be activated to take the person to a place of safety where a comprehensive mental health assessment can be conducted.

If the situation does not require an immediate 000 response, the completed triage document is to be made available to the relevant Local Health District/Health Network mental health telephone triage service immediately and the receiving service must be advised by telephone that the triage referral is being forwarded. All Local Health District/Health Network MHTTS have a landline number, details of which are available to all Local Health District/Health Network MHTTSs.

Callers who are making general enquiries and are not seeking assistance for themselves or others may not require referral to their local service but must be treated appropriately and provided with appropriate information.

9. MONITORING AND REPORTING

All Mental Health Telephone Triage Services are to ensure that there are quality assurance processes in place to review and improve triage practices. This should include an ongoing system of data reporting; analysis and action, linked to the Standards for Mental Health Telephone Triage Services (see Appendix 12.3).

Opportunities to identify the experience of consumers, carers and other users of the service, including the appropriateness of the response process are acknowledged as important elements of ongoing performance monitoring processes.
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All Local Health Districts/Health Networks are required to provide routine reports to the NSW Ministry of Health via the Mental Health and Drug and Alcohol Office, as set out in the SMHTAL Reporting Template (see Appendix 12.4), at three monthly intervals, which report on the operation of their mental health telephone triage service in complying with the Standards.

10. RELATED DOCUMENTS

2006: NSW Health Identifying and Responding to Domestic Violence. See also Policy and Procedures for responding to Domestic Violence PD2006_084.
2007: Mental Health Act (NSW) 2007.
2011: NSW Health Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines PD2011_001.

11. REFERENCES


National Standards for Mental Health Services (2010).


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12. APPENDICES
13. MENTAL HEALTH

12.1 NSW Health Mental Health Triage Module

**NSW HEALTH**

**Mental Health**

**TRIAGE**

**CONSUMER CONTACT NUMBERS:**

**ALERTS/RISKS?** □ No □ Yes □ Summary (summary after triage completed)

**TRIAGE DETAILS**

Date: ___________________ Time: ___________________

Location: ___________________

Communication issues (e.g. language or cultural barriers, sensory impairment)

Information taken by: Face to face □ Phone □ Other □

Purpose of contact (tick appropriate option): □ Seeking assistance/referral □ Information □

Is client/primary carer aware of referral? □ Referred by: ___________________

Reason for referral (include whether client is opposed to referral)

**HISTORY** (e.g. past diagnoses, interventions, information on family history)

**MEDICAL ISSUES** (e.g. significant illnesses, allergies, adverse drug reactions, obesity, etc., pregnancy)

**CURRENT TREATMENTS** (e.g. medications, psychological interventions, complementary/alternative interventions, providers/services involved)

**DRUG AND ALCOHOL USE**

**CURRENT FUNCTIONING AND SUPPORTS** (e.g. concerns regarding living situation, supports or other care responsibilities, note name, age, current whereabouts of dependents)

Staff Name: ___________________ Signature: ___________________

Designation: ___________________ Date: ___________________

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## 13. MENTAL HEALTH

### MANDATORY

<table>
<thead>
<tr>
<th>First Name</th>
<th>Surname</th>
<th>DOB</th>
<th>MRN</th>
</tr>
</thead>
</table>

### LEGAL STATUS/FORENSIC ISSUES
- e.g. Mental Health Act involuntary patient orders, Guardianships

### MENTAL STATE IMPRESSIONS
(consider information provided by client and other sources)

### POSSIBLE RISKS

<table>
<thead>
<tr>
<th>Suicide</th>
<th>Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

- Significant past history of risk
- Recent thoughts, plans, symptoms indicating risk
- Recent behaviour suggesting risk
- Concern from others about risk (assessment should include corroboration where possible)
- Current problems with alcohol or substance misuse
- Major mental illness or disorder
- At risk mental state (e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)
- Person's level of risk appears to be highly changeable
- Significant uncertainty in the assessment of the level of risk

#### Overall Risk
- (current/immediate)

<table>
<thead>
<tr>
<th>High</th>
<th>Med</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### SUMMARY
(overall stress impression, including possible risk; please also document any "risk factors" on Page 1)

### ACTION PLAN

**Urgency of response**  (see CTRS Guidelines)

- A Immediate
- B Within 2 hours
- C Within 12 hours
- D Within 48 hours
- E Within 2 weeks
- F Requires further triage contact/follow up
- G No further action required

- Department of Community Services notified
- Police notified
- Ambulance notified
- Referred to Inpatient Mental Health service
- Referred to Community Mental Health service

**Details of Action Plan:**

### CONTACTS

Communication undertaken with

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact details</th>
<th>Comments/Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Name</th>
<th>Signature</th>
<th>Designation</th>
<th>Date</th>
</tr>
</thead>
</table>

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12.2 Crisis Triage Rating Scale

The Crisis Triage Rating Scale (CTRS) may be used by clinicians as a guide in the determination of urgency of response.

**Definition:** The CTRS is a brief rating scale developed to screen emergency psychiatric consumers rapidly. It helps differentiate between consumers who require hospitalisation from those who are suitable for outpatient crisis intervention treatment (Bengelsdorf et al., 1984). The scale evaluates the consumers according to three factors: (A) whether they are a danger to themselves or others, (B) their support system and (C) their ability to cooperate. The clinician chooses the appropriate number under each scale that best describes the consumer's presentation. The total score (A+B+C) can be useful in predicting whether hospitalisation would be required. For example, a consumer scoring below 9 requires hospitalisation, whereas for those scoring above 9 another intervention could be recommended. The Scale was originally based on a telephone triage scale and has been modified and expanded to cover a broader range of response options in inpatient and community services. This Scale should be used by a clinician in conjunction with the available triage information to make an informed decision about the urgency of response.

**RATING A: Dangerousness**
1. Expresses or hallucinates (hears commands) suicidal/homicidal ideas or has made a serious attempt in present episode of illness. Unpredictable, impulsive, violent.
2. Expresses or hallucinates suicidal/homicidal ideas, without conviction, or the behaviour is somewhat dependent on the stress in the environment. History of violence or impulsive behaviour, but no current signs of this.
3. Expresses suicidal/homicidal ideas with ambivalence, or made only ineffective gestures. Questionable impulse control.
4. Some suicidal/homicidal ideation or behaviour, or history of same, but dearly wishes and is able to control behaviour.
5. No suicidal/homicidal ideation or behaviour. No history of violence or impulsive behaviour.

**RATING B: Support system**
1. No family, friends or others. Agencies cannot provide the immediate support needed.
2. Some support can be mobilised, but its effectiveness will be limited.
3. Support system potentially available, but significant difficulties exist in mobilising it.
4. Interested family, friends or others, but some question exists of ability or willingness to provide support needed.
5. Interested family, friends or others able and willing to provide support needed.

**RATING C: Ability to cooperate**
1. Unable to cooperate or actively refuses.
2. Shows little interest or comprehension of efforts made on their behalf.
4. Wants help but is ambivalent or motivation is not strong.
5. Actively seeks treatment, willing and able to cooperate.

**Ascertainment guidelines:** The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to the consumer should be one of extreme urgency, with appropriate documentation in the Triage's 'Action Plan' and 'Urgency of response' on page 2.

**URGENCY OF RESPONSE SCALE (CTRS: A+B+C)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Extreme Urgency</th>
<th>Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A 3 — 9</td>
<td>High Urgency</td>
<td>See within 2 hours/present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress)</td>
</tr>
<tr>
<td>Category B 10</td>
<td>Medium Urgency</td>
<td>See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour)</td>
</tr>
<tr>
<td>Category C 11</td>
<td>Low Urgency</td>
<td>See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous)</td>
</tr>
<tr>
<td>Category D 12 — 13</td>
<td>Non Urgent</td>
<td>See within 2 weeks</td>
</tr>
<tr>
<td>Category E 14 — 15</td>
<td></td>
<td>Requires further triage contact/follow up</td>
</tr>
<tr>
<td>Category F</td>
<td></td>
<td>No further action required</td>
</tr>
</tbody>
</table>

164(27/09/12)
12.3 Standards for NSW Health Mental Health Telephone Triage Services

1) Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.

2) Mental Health Telephone Triage Service (MHTTS) operators are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage and have a working knowledge of the operating protocols of the service.

3) MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients’ previous contact with the MHTTS.

4) Each MHTTS is governed by detailed local polices and operational protocols which can be reliably interpreted.

5) Each MHTTS systematically monitors the accuracy of the telephone triage decision.

6) Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe.

7) Each MHTTS is able to:
   a. Provide advice and information relating to the availability of public or private MH services.
   b. Provide direction to callers who raise non-MH concerns.

8) Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available.

9) Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency.

10) Calls to MHTTS are answered promptly. Benchmark figures are set for:

<table>
<thead>
<tr>
<th>Grade of Service: Average time to answer calls on average over a calendar month</th>
<th>70% of Calls, answered within 30 seconds, when averaged over a calendar month.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Speed to Answer (MSA)</td>
<td>Not more than 1% of calls wait more than 2 minutes prior to being answered by a MH clinician. The 1% standard will be consistently achieved regardless of time of day or day of week. (The time to answer a call is measured from the time the call starts ringing to when it is answered by a MH clinician; not from the time a call is answered by a voice recording or placed in a queue.)</td>
</tr>
<tr>
<td>Call Abandonment rate</td>
<td>Not more than 5% of calls are abandoned. A call is “abandoned” if the caller terminates the call having waited at least 10 seconds from the completion of an announcement message.</td>
</tr>
</tbody>
</table>
13. MENTAL HEALTH

12.4 SMHTAL Reporting Template

The following report is to be completed each three months and sent to the Mental Health and Drug and Alcohol Office of the NSW Ministry of Health.

Reporting periods and their due dates are shown below:

<table>
<thead>
<tr>
<th>Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 January – 31 March</td>
<td>14 April</td>
</tr>
<tr>
<td>1 April – 30 June</td>
<td>14 July</td>
</tr>
<tr>
<td>1 July – 30 September</td>
<td>14 October</td>
</tr>
<tr>
<td>1 October – 31 December</td>
<td>14 January</td>
</tr>
</tbody>
</table>

.............................................................LOCAL HEALTH DISTRICT/HEALTH NETWORK

FOR THE PERIOD: .................................................. TO .....................................................

1. Call Activity

(a) In-call volume x month
   Only includes calls received by the LHD/Health Network Mental Health telephone triage service from the 1800 011 511 NSW Mental Health Line.

(b) Calls received (i.e. call volume – abandoned calls) per month

(c) Calls received during business hours (i.e. 8.30am – 5pm M to F)

(d) Calls received outside business hours

(e) Average duration of calls

Call Activity Summary

<table>
<thead>
<tr>
<th>Month</th>
<th>In-bound call volume</th>
<th>In-bound calls handled</th>
<th>Bus Hours</th>
<th>Outside Bus Hours</th>
<th>Average duration of calls handled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month XX</td>
<td></td>
<td></td>
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<tr>
<td>Month XX</td>
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<td>Month XX</td>
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<tr>
<td>TOTAL</td>
<td></td>
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</tbody>
</table>

Comments
2. Compliance with the Standards

(a) Telephony Standards

i. Grade of Service
(70% of calls answered in 30 seconds averaged over a calendar month)

Percent of calls answered in 30 seconds or less x month.

ii. Maximum speed to answer (MSA)
(Not more than 1% of calls waiting over 2 minutes. The time to answer a call is measured from
the time the call starts ringing to when it is answered by a MH clinician; not from the time a call
is answered by a voice recording or placed in a queue)

Percent of calls waiting over 2 minutes per month.

iii. Call Abandonment rate
(Not more than 5% of calls are abandoned. A call is “abandoned” if the caller terminates the call
having waited at least 10 seconds from the completion of an announcement message).

Percent of calls abandoned.

<table>
<thead>
<tr>
<th>Telephony Standards Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
<tr>
<td>Month 1</td>
</tr>
<tr>
<td>Month 2</td>
</tr>
<tr>
<td>Month 3</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Comments
(b) Non–telephony standards
Comment on the performance of the non-telephony Standards.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Comments on adherence to Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Callers across NSW are able to access mental health (MH) services by calling a one number, state-wide MH telephone triage service. This service is to operate 24/7.</td>
<td></td>
</tr>
</tbody>
</table>
| 2. Mental Health Telephone Triage Service (MHTTS) operators:  
- are experienced MH clinicians who are appropriately trained in conducting standardised telephone mental health triage; and  
- Have a working knowledge of the operating protocols of the service. |  
- Number of MHTAL clinicians who have received specialist MH telephone triage training YTD.  
- % of all MHTAL clinicians who have received specialist MH telephone triage training. |
| 3. MHTTS operators have, when possible, access to the history and recent status of current and past clients of the MH service and access to resources about referral points. In the interim and as a minimum, MHTTS operators are to have access to a record of clients’ previous contact with the MHTTS. |  |
| 4. Each MHTTS is governed by detailed polices and operational protocols which can be reliably interpreted. |  |
| 5. Each MHTTS systematically monitors the accuracy of the telephone triage decision. |  |
| 6. Each MHTTS is integrated with local services and permitted to mobilise emergency assistance, and local MH assessments within the specified urgency of response timeframe. |  |
| 7(a) Each MHTTS is able to provide advice and information relating to the availability of public or private MH services.  
7(b) Each MHTTS is able to provide direction to callers who raise non-MH concerns. |  |
| 1.1 Each MHTTS conducts routine quality monitoring and improvement processes. Performance against standards, complaints monitoring and outcomes, benchmarks and other quality improvement activities made publicly available. |  |
| 9. Each MHTTS is subject to sophisticated cost and output determination to determine its efficiency. |  |
3. **Quality Monitoring**

(a) **Complaints**
Number of complaints x Source of Complaint (e.g. Client/Carer, GP, MH staff, Other Health staff, Emergency Services, Other) x Month

**Summary Number of Complaints**

<table>
<thead>
<tr>
<th>Month</th>
<th>Source of Complaint</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Client/Carer</td>
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<tr>
<td>Month 1</td>
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<tr>
<td>Month 2</td>
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<tr>
<td>Month 3</td>
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<tr>
<td>TOTAL</td>
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</tbody>
</table>

Briefly describe the more serious or common complaints received and how they were resolved

<table>
<thead>
<tr>
<th>Nature of the Complaint</th>
<th>Resolution</th>
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<tbody>
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</table>

(b) **Incidents**
Reporting and resolution of incidents. (Incidents should be reported in IIMS)
Number of incidents x IIMS SAC Severity Rating x Month

**Summary Number of Incidents**

<table>
<thead>
<tr>
<th>Month</th>
<th>Severity rating (SAC)</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<td>Month 1</td>
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<td>Month 2</td>
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<td>Month 3</td>
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<tr>
<td>TOTAL</td>
<td></td>
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</tbody>
</table>
Briefly describe the more serious incidents or common incidents and how they were resolved

<table>
<thead>
<tr>
<th>Nature of the Incident</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
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</table>

(c) **Quality Monitoring and Improvement Activities**

Describe other quality monitoring or improvement activities conducted, e.g. file audits, staff supervision.

<table>
<thead>
<tr>
<th>Other quality monitoring or improvement activity</th>
<th>Description</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
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</table>
CALL HANDLING GUIDELINES FOR NSW HEALTH MENTAL HEALTH TELEPHONE TRIAGE SERVICES (GL2012_008)

PURPOSE

In *NSW: a new direction for mental health (June 2006)*, a commitment was made to establish a 24 hour state wide mental health telephone advice, triage and referral service, staffed by mental health clinicians and which would link with the National Health Call Centre Network, operating as *healthdirect* Australia. The NSW Ministry of Health developed the State Mental Health Telephone Access Line (SMHTAL) Program to fulfil this commitment.

The aim of the SMHTAL Program is to facilitate access to appropriate mental health services by the people of New South Wales.

The SMHTAL Program is being implemented via an Improvement Project. The Improvement Project will facilitate access to appropriate mental health services through the establishment of a 1800 state wide mental health telephone number operating 24 hours a day, 7 days a week (the 1800 011 511 *NSW Mental health Line*); and by improving the operation of Local Health District/Health Network mental health telephone triage services so that they meet state-wide performance Standards.

The 1800 011 511 *NSW Mental Health Line* provides universal and equitable access to mental health triage and referral to the most appropriate point of care.

This Guideline will assist clinicians undertaking the mental health telephone triage function to manage particular call situations. This Guideline is to be read in conjunction with the Mental Health Triage Policy (PD2012_053). Both the Policy and this Guideline have been developed in collaboration with Local Health Districts/Health Networks.

KEY PRINCIPLES

- Effective and equitable access to mental health services for the people of New South Wales.
- All callers are managed at first point of contact.
- Where a mental health triage indicates that a specialist mental health assessment is required, the Local Health District/Health Network is responsible for ensuring that a mental health assessment is provided within the urgency of response timeframe.
- As an entry point to mental health support and treatment, triage services are to take responsibility for the management of a caller until transfer to the appropriate agency or person for follow-up. This includes:
  - Delivery of timely and consistent services for all people seeking assistance for a mental illness or mental disorder.
  - Facilitation of access to advice and information on other services where a public mental health service intervention is not required.
- To facilitate effective responses across a culturally and linguistically diverse NSW, professional interpreter services are engaged in accordance with Ministry of Health policy requirements.

USE OF THE GUIDELINE

- Local Health District/Health Network policies, procedures, protocols, guidelines and other documents relating to mental health telephone triage must be consistent with the Mental Health Triage Policy (PD2012_053) and this Guideline.
- Staff undertaking the mental health telephone triage function are responsible for reading and understanding these guidelines and for complying with Local Health District/Health Network protocols and guidelines in relation to telephone triage services.

PRINCIPLES FOR SAFE MANAGEMENT OF DISTURBED AND/OR AGGRESSIVE BEHAVIOUR AND THE USE OF RESTRAINT (PD2015_004)

PURPOSE

This document outlines the principles for safe management of disturbed and/or aggressive behaviour in NSW public health facilities with the view to promoting:

- The reduction and, where possible, elimination of the use of manual/mechanical restraint in NSW public health facilities.
- The safety of staff, patients and members of the public in a situation where disturbed and/or aggressive behaviour occurs in inpatient clinical areas.

This policy does not cover:

- The use of pharmacological restraint.
- The management of mental health patients and the use of seclusion in declared mental health services and mental health facilities, which is covered by PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW.

MANDATORY REQUIREMENTS

This document applies to staff who work in NSW public health facilities and may be exposed to disturbed and/or aggressive behaviour.

Public health organisations must ensure that:

- Local processes and procedures are in place for the prevention and management of disturbed and/or aggressive behaviour, including the appropriate use of manual/mechanical restraint consistent with the principles outlined in this document.
- Staff have appropriate skills to apply manual/mechanical restraint appropriately and, where necessary, access to appropriate training as specified in the Policy Directive: Violence Prevention and Management Training Framework for the NSW Public Health System (PD2012_008).

IMPLEMENTATION

Chief Executives of Local Health Districts and Specialty Health Networks are required to:

- Provide the overall direction for the implementation of the principles, early identification of disturbed and/or aggressive behaviour, the use of de-escalation strategies and the minimisation of the use of manual and mechanical restraint.
- Ensure the implementation of risk management practices to identify, assess and manage risks associated with a) the use of manual/mechanical restraint and b) hospital clinical care areas that are at high risk of the occurrence of disturbed and/or aggressive behaviour.
- Ensure local processes and procedures are in place for the management of disturbed and/or aggressive behaviour, consistent with the principles outlined in the policy.
- Ensure staff working in high-risk clinical care areas have the appropriate skills and supervision to facilitate prevention, early identification and management of disturbed or aggressive behaviour.

Directors of Clinical Governance are required to:

- Review local restraint practices to ensure the compliance of the principles outlined in this policy.
- Ensure processes and procedures are in place for adequate monitoring of the patient in manual/mechanical restraint including accurate documentation and incident notification (of aggressive episode) and management.
13. MENTAL HEALTH

- Monitor and evaluate the strategies utilised to prevent escalation of disturbed and/or aggressive behaviour.
- Provide regular evaluation reports to the respective committees summarising the number of incidents of aggressive episode; the effectiveness of the prevention strategies; and recommendations for training, environment and strategy to promote ongoing reduction in incidence.

Staff are required to:
- Follow local clinical processes and procedures for dealing with disturbed and/or aggressive behaviour.
- Undertake relevant training relating to the management of disturbed and/or aggressive behaviour and restraint procedure.
- Discuss identified risk(s) and develop management plan with patients, families and carers.
- Take notice of early signs of disturbed and/or aggressive behaviour and take any threat seriously.
- Seek assistance as early as possible and preferably before the situation escalates.
- Implement de-escalation strategies as part of the process of engaging with the patient, family/carer to reduce the likelihood of disturbed and/or aggressive behaviour.
- Closely monitor the patient’s physical and mental condition when he/she is restrained (manual/mechanical restraint is to be used as an option of the last resort).
- Clearly document the reason and the type of restraint use, the start and end time of restraint, and patient’s physical condition and clinical assessment in patient record.
- Follow local processes and procedures to manage, report and record the incident.

1 BACKGROUND

1.1 About this document

This policy provides the principles underpinning the prevention strategies and the management of disturbed and/or aggressive behaviour, and the use of manual/mechanical restraint (as the last resort) for NSW public health facilities.

This policy does not cover:
- The use of pharmacological restraint.
- The management of mental health patients in declared mental health services and mental health facilities, which is covered by PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW.

In a health context, in limited circumstances, it may be necessary to use restraint (as the last resort) in a public health facility, when:
1. Dealing with disturbed and/or aggressive patients or other individuals who pose a risk of harm to themselves or others.
2. As an incidental part of treatment to a patient.

This policy mainly focuses on the issue relating to dealing with disturbed and/or aggressive patients or other individuals who pose a risk of harm to themselves or others in NSW public health facilities.

1.2 Introduction

Staff working in NSW public health facilities may be involved in managing patients or other individuals who may exhibit disturbed and/or aggressive behaviour.

Some hospital clinical care areas are at high risk of the occurrence of disturbed and/or aggressive behaviour. These areas are to be identified through risk assessment and local processes and procedures are to be developed for these areas.
There may be other clinical areas where patients with specific medical conditions also pose a high risk. These patients should be identified through a clinical risk assessment.

For the purpose of this policy, restraint refers to manual or mechanical restraint only. Restraint is only to be used as the last resort in managing a disturbed and/or aggressive patient or other individual who poses a risk of harm to themselves or others.

There is an international shift towards the reduction and, where possible, elimination of the use of restraint in health facilities. NSW Health supports this approach. A safer approach to managing the care of patients who exhibit disturbed and/or aggressive behaviour is one that focuses on prevention strategies especially communication, engagement, situation awareness and appropriate case management. This approach is likely to have a better outcome for staff, patients and members of the public.

These prevention strategies include:
- Risk assessment and management of triggers or stimuli.
- Ongoing communication and engagement with the patient and their family/carer as a part of the patient’s care.
- Case management involving the patient and their family/carer.
- Situation awareness.
- Assessment of situation, self capacity, engagement and de-escalation.

A summary of strategies for prevention, management of behavioural escalation and aggressive behaviour is provided in Section 5.3 (a).

1.3 Key definitions

Restraint

In this policy, restraint refers to the use of manual force and/or a mechanical device to restrict a person’s movement in an emergency situation of aggressive behaviour, where that person is deemed to be at an immediate risk of harm to self or others.

The two types of restraint covered by this policy are:

A) Manual restraint refers to the use of a minimal amount of manual force (human to human) to restrict a person’s movement in an emergency situation of aggressive behaviour, where the person is at an immediate risk of harm to self or others.

B) Mechanical restraint refers to the use of mechanical device/s to restrict a person’s movement in an emergency situation of aggressive behaviour, where the person is at an immediate risk of harm to self or others.

Examples of manufactured mechanical restraint devices include (but are not limited to) belts, harnesses, manacles, straps and mittens.

Note: Handcuffs are not an acceptable form of restraint used in NSW Health facilities. Patients (with handcuffs) brought in by Police or Corrective Services are to be transferred to clinicians for assessment. Handcuffs should be removed unless the patient remains under custody of an accompanying Police or Corrective Services officer.
13. MENTAL HEALTH

Appropriate mechanical restraints must:\n- Be adjustable to reflect the physical frailty of the patient.
- Allow the patient to be placed in a sitting or lying position.
- Have a wide cuff to prevent tightening and reduced circulation.
- Have no sharp edges or not be made from material that is sharp or abrasive.
- Be made of a material that is easy to clean.
- Be easy to apply, i.e. when the patient is moving.
- Be difficult for the patient to remove.
- Be able to be secured to furniture i.e. a bed or chair. It is appropriate to pre-prepare a bed with restraints.

Human rights

Human rights are often defined in different ways. Simple definitions that are often given (Australian Human Rights Commission) include:\n- The recognition and respect of people’s dignity.
- A set of moral and legal guidelines that promote and protect recognition of our values, our identity and ability to ensure an adequate standard of living.
- The basic standards by which we can identify and measure inequality and fairness.
- Those rights associated with the Universal Declaration of Human Rights.

1.4 Legal and legislative framework

The use of restraint is potentially an assault (at both criminal and civil law) if it occurs without legal justification.

Where a patient or other individual in a public health facility is behaving in a violent or aggressive manner and is posing an immediate risk of harm to themselves or another person, it will be lawful to restrain the patient or other individual to prevent the risk of harm eventuating. However, any use of restraint must be reasonable in the circumstances and the minimum amount of force required to respond to the threat. That is, the legal justification of the restraint is self-defence, or defence of others.

A lawful restraint is a restraint that is used to respond to an immediate risk of harm with no more force used than is reasonable and necessary to deal with the risk of harm.

Restraint should only ever be used as the last resort to deal with a risk of harm. A public health facility owes a duty of care to any patient or individual they restrain and should take all reasonable steps to minimise any harm occurring to the patient/individual under restraint.

2 PREVENTION OF DISTURBED AND/OR AGGRESSIVE BEHAVIOUR

Successful prevention of an escalation of a disturbed behaviour can minimise or eliminate the use of restraints in health care facilities. Prevention strategies include:
- Embedding risk identification and management education routinely for relevant health care team.
13. MENTAL HEALTH

- Maintaining ongoing team communications between staff and the patient and their family/carer.
- Building staff capacity to recognise and identify triggers/stressors, and to apply appropriate responses including de-escalation strategies, through education and training.
- Discussing the identified risk(s) and developing the management plan with the patient, family/carer.

2.1 Assessment of stressors or triggers

Aggression is often an escalation of a disturbed behaviour triggered by a range of contributing factors, including:
- Clinical conditions (e.g. mental health illness, brain disorder, intellectual disability and cognitive impairment)/
- Undesired interpersonal interactions/
- Personally interpreted stress.
- Environmental disturbances (e.g. noise, confined space).

The most important role in regards to assessment is to identify the contributing factors, to understand why aggression is occurring and to treat the underlying cause(s) or condition(s). A common cause of aggression in older people is their misinterpretation of the environment and miscommunication, where aggressive behaviour is often triggered by fear.

On-going engagement with the patient and their family/carer through clear, respectful and open communication allows early detection, identification and appropriate management of triggers that may lead to aggressive behaviour.

Where necessary, input should be sought from staff who have expertise and knowledge in identifying precursors to aggressive behaviour during the clinical risk assessment, as part of a multidisciplinary approach to the care of the patient.

When a disturbed behaviour occurs, do not enter the patient’s/individual’s personal space without their permission (unless there is an immediate risk of self-harm or harm to others) as this could escalate their distress, anger and/or behavioural disturbance.

Key points to note:
1. Engage with the patient, their family/carer and other health professionals (using a team approach) to identify stressors/triggers for disturbed behaviour as part of the initial and ongoing patient care.
2. Undertake appropriate clinical assessment to obtain information on the patient’s condition. For example, cognitive screening tools for older persons, medical assessment of mental health patients and Drug and Alcohol assessment tools.
3. Develop ways to manage stressors/triggers of disturbed behaviour and document a management plan for health care teams to follow.

2.2 Guiding principles for prevention strategies

Key principles to guide prevention strategies are as follows:
- Positive and proactive care is the main approach to patient care.
- Reduce excessive reliance upon restrictive interventions.
- Restrictive interventions are to be used as the last resort.

Examples of assessment tool hyperlinks:
- Cognitive screening tools for older persons
- Medical assessment for mental health patients in emergency department
13. MENTAL HEALTH

- People must be treated with compassion, respect, dignity and kindness. Staff are to comply with the NSW CORE (Collaboration, Openness, Respect and Empowerment) values.
- Health services must support people’s rights to balance safety from harm and freedom of choice.
- Positive relationships between the people who deliver services and the people they support must be protected, preserved and promoted at all times.

These key points are summarised as PANEL (Participation, Accountability, Non-discriminatory, Empowerment and Legality) principles, which underpin the prevention strategies and the management of disturbed and aggressive behaviour.

The PANEL principles provide a human rights-based approach for prevention strategies to avoid restrictive care practices.

<table>
<thead>
<tr>
<th>Key Principle</th>
<th>What it means</th>
<th>What it looks like in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTICIPATION</td>
<td>Enabling participation of all key people and stakeholders</td>
<td>Consulting with the person, staff and other stakeholders; involving the person, carers and support staff in developing risk assessments and management plans where possible; identifying and reducing barriers to the person accessing services.</td>
</tr>
<tr>
<td>ACCOUNTABILITY</td>
<td>Ensuring clear accountability, identifying who has legal duties and practical responsibility</td>
<td>Clearly outlining responsibilities under relevant legislative Acts and ensuring staff are aware of their obligations to respect human rights.</td>
</tr>
<tr>
<td>NON-DISCRIMINATORY</td>
<td>Avoiding discrimination and ensuring attention is paid to groups who are vulnerable</td>
<td>Using person centred care planning approaches that are non-discriminatory and ensuring all staff are sensitive to cultural diversity and the stigma associated with mental illness.</td>
</tr>
<tr>
<td>EMPOWERMENT</td>
<td>Empowering staff and people who use services with the knowledge and skills to understand their rights</td>
<td>Raising awareness of the rights of persons who use services and empowering people through appropriate and timely interventions.</td>
</tr>
<tr>
<td>LEGALITY</td>
<td>Complying with all relevant legislation</td>
<td>Identifying the human rights implications in restrictive management and continually considering the principles of fairness, respect, equality, dignity and autonomy.</td>
</tr>
</tbody>
</table>

2.3 De-escalation of verbal aggression

In situations when a patient or an individual demonstrates signs of escalating verbal aggression, all reasonable steps are to be taken to seek resolution without physical contact.

In dealing with a patient or an individual who is verbally aggressive, staff should remain calm and use effective communication skills to de-escalate the situation through:
- Respecting personal space.
- Appropriate body language using a non-confronting manner.
- Establishing appropriate verbal contact to engage with the person.
- Communicating in a clear and concise manner, avoiding repetition.
- Listening and acknowledging the person’s concerns.
- Identifying the person’s needs and feelings.
- Setting clear limits and boundaries.
- Being respectful.
- Expressing an intention to help the person.

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• Offering choices that are realistic.
• Working with their family/carer/relatives to calm the person if safe and appropriate to do so.
• Providing the person time and space to settle/calm down.

3 MANAGEMENT OF AGGRESSIVE BEHAVIOUR

3.1 Retreat and back-up options

If all reasonable steps have failed to resolve or de-escalate the situation and the situation continues to escalate (with immediate risk of self-harm or harm to others), staff should seek help and back-up support to ensure the appropriate clinical management of the aggressive behaviour and the safety of those involved. Staff may decide to retreat to a safe place if necessary, but must ensure that back-up support is arranged to control the situation and to protect others. The back-up support staff should also be advised that the staff member is retreating.

Staff are to be familiar with the following back-up options, such as:
• Calling for support from senior staff or clinician.
• Use of a duress alarm (where such system is available) or initiation of the duress response.
• Activation of the local emergency response (i.e. Code Black).

3.2 Use of restraint

Where possible, the patient or the individual is to be assessed for any underlying causes or conditions that trigger the aggressive behaviour and activate an appropriate treatment plan or management strategies.

The use of manual/mechanical restraint should only be considered (and used only as the last resort) when the patient or the individual is at immediate risk of self-harm or harm to others and all reasonable steps have failed to seek resolution without physical contact.

Restraint carries risks of physical and mental harm to staff, patients and other members of public. If the use of restraint (manual/mechanical) is considered, it must be undertaken by staff who have the necessary skills to apply manual/mechanical restraint, in accordance with the minimum training standards set out in PD2012_008 Violence Prevention and Management Training Framework for the NSW Public Health System.

Local Health Districts (LHD)/Specialty Health Networks (SHN) must ensure staff have appropriate training and skills in de-escalating and managing disturbed and/ or aggressive behaviour (e.g. the Violence Prevention and Management suite of courses developed by the Health Education and Training Institute or other appropriate courses in use within Local Health Districts).

If restraint is used (as the last resort when all other strategies have failed), it must take into account the specific considerations outlined in Section 3.2.4.

Restraint must be discontinued as soon as the patient/individual has regained behavioural control, the immediate risk of harm has passed or police assistance has arrived.
3.2.1 Key principles for the use of restraint

| Principle 1 | Protection of fundamental human rights |
| Principle 2 | Protection against inhumane or degrading treatment |
| Principle 3 | Right to highest attainable standards of care |
| Principle 4 | Right to medical examination |
| Principle 5 | Documentation and notification |
| Principle 6 | Right to appropriate review mechanism |
| Principle 7 | Compliance with legislation and regulation |

3.2.2 Specific groups of patients

Specific population groups of patients may be more vulnerable to physical or psychological harm by the restraint procedure. This includes:

- Children and young people.
- Older people.
- Pregnant women.
- Patients with physical health issues (e.g. obesity, diabetes, cardiac disease and metabolic disorders).
- Patients with a history of trauma/detention who may be re-traumatised by the episode of restraint (e.g. refugees, people who have been abused at any stage of their life).
- Patients with an intellectual disability and those with cognitive impairment such as dementia or delirium.
- People who are under influence of drugs or other substances.
- People who have engaged in a physically exhausting combative struggle for longer than two minutes.
- People from culturally and linguistically diverse background.
- Aboriginal and Torres Strait Islander people.

For these groups of patients, it is important to adopt non-restrictive means of managing disturbed and/or aggressive behaviour whenever it is possible.

3.2.3 Team approach for restraint

The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support provided by security staff at the direction of clinical staff if necessary and available.

Applying manual restraint is a team approach and a lead clinician must be identified to lead the supporting staff to undertake the restraint procedure. An appropriate team leader is someone who:

- Has completed training in the safe use of restraint.
- Is confident and competent to lead a restraint procedure, or has the best rapport with the patient.
• Assigns roles for each staff member (one to support or hold each limb) participating in the restraint procedure.
• Positions close to the head of the patient and continues to engage with the patient during the restraint in an effort to reassure and calm the patient.
• Monitors the patient’s airway and physical condition during the restraint procedure.

3.2.4 Specific considerations for manual/mechanical restraint

Restraint should be avoided where possible, as there are serious dangers with continuous restraint in any position. Specific considerations if manual/mechanical restraint is undertaken are listed below.

A) Mechanical restraint equipment

In clinical areas where mechanical restraint is used, the equipment must be reviewed and approved by the relevant local health district (LHD) or specialty health network (SHN) governance committee(s). A specific procedure must be in place to guide the use of mechanical restraint equipment and staff must be trained in the use of the equipment.

The restrictions on the use of mechanical restraint are:
• Restraint devices must be professionally manufactured, not hand-made.
• Restraint devices must meet the requirements set out in Section 1.2 Key definition.
• A person cannot be confined in a mechanical restraint device inside a locked room at any time.
• A person held in a four limb restraint device should be cared for in a designated clinical space/area to protect the patient’s privacy.
• Care must be undertaken to protect the privacy and dignity of any person in any kind of mechanical restraint device.

B) Manual restraint

In the rare circumstance when manual restraint is required, the restraint techniques should be carefully considered and risk assessed to ensure the least restrictive strategy is being utilised.

All restraint techniques pose a risk to the physical health of the patient/individual. Manual restraint that requires holding the patient/individual in a bent over, seated, prone or supine position for a prolonged period of time increases this risk. Manual restraint should be limited to the amount of time necessary to:
• Allow the patient/individual to safely regain control of their behaviour.
• Allow the application of mechanical restraint.
• Administer medication, and/or remove the patient/individual to a safer environment.

C) Restraint position

The restraint position options include standing, sitting, kneeling, supine and prone.
• Prone restraint has been identified as being high risk due to the increased risk of respiratory restriction. There have been instances in which young apparently healthy people have died suddenly while being held in a physical restraint. The prone position has been implicated in these deaths.
• Prone restraint must only be used as the last resort when all other reasonable steps and other restraint positions have failed to appropriately respond to the threat of self harm or harm to others.
3.2.5 Assessment and monitoring a patient/individual who is placed in restraint

It may not be possible to assess the patient/individual before the restraint procedure is being applied. Immediately after the patient/individual is being restrained, a clinical assessment must be undertaken by a medical officer to identify and treat any underlying clinical condition that may have caused the aggressive behaviour.

The team leader is to provide guidance to the staff members who apply the restraint; monitor the patient and ensure that the restraint is maintained for the shortest period possible.

At all times during the restraint, a clinical member must be identified to be responsible to monitor and document the patient’s physical condition while the patient is in restraint. Close clinical monitoring of the patient’s physical condition includes airway, breathing, circulation, level of consciousness and skin integrity where the manual force or device is applied. An example of an assessment checklist is provided in Section 5.3 (b).

Any changes or deterioration of the patient’s condition should trigger urgent action(s) such as reduction of pressure, repositioning the patient and/or mechanical restraint and activation of emergency medical assistance.

The restraint must be used for the shortest period possible to allow the person to safely regain control of their behaviour. Restraint must be ceased when the person has regained behavioural control or the immediate risk of serious harm has passed. Next of kin or primary carer must be notified of aggressive episode and the use of restraint where possible.

3.2.6 Documentation

- Each episode of the use of restraint must be recorded in the patient’s health care record including the reason for restraint, the type of restraint use, the patient’s physical condition, the duration of the restraint and if medication was administered.
- Each incident of aggressive behaviour is to be reported in Incident Information Management System (IIMS) in accordance with the PD2014_004 Incident Management Policy.
- If an episode of restraint use has resulted in injury, this must also be recorded in IIMS.

4 POST-INCIDENT MANAGEMENT

4.1 Post-incident review

The occurrence of an incident of aggressive behaviour is to be reported and reviewed within the required timelines in accordance with the PD2014_004 Incident Management Policy and local procedures. The outcomes of the reviews are to be communicated to the team in the health care unit and through the organisation so that learning from each incident can be shared among health care units.

The Individual patient care plan is to be reviewed by the treating medical team (with the patient and their family/carer) to include/amend prevention strategies for managing identified stressors or stimuli that trigger behavioural escalation.

4.2 Post-incident support

The experience of the use of restraint could be difficult for the patient and staff who are involved in the incident. To minimise the impact, the following strategies should be considered:
13. MENTAL HEALTH

- The patient’s ongoing care plan should include supportive counselling as required.
- The family/carer who is distressed about the situation should be offered supportive counselling which can occur within the inpatient setting or on an outpatient basis.
- Other patients in the clinical area, who may have seen and are distressed about the incident, should also be offered supportive counselling.
- Staff who experience distress may be offered support from their team manager, their clinical supervisor or the Employee Assistance Program (EAP).

4.3 Complaints

In some instances, the patient and/or their family/carer may feel that inappropriate care was provided during the management of the incident. Clinicians should attempt to discuss the incident and resolve the issues at the time using open disclosure (as necessary). The collaborative review process also provides an opportunity to address any concerns through open and honest discussion.

If this is not acceptable to the patient and/or their family/carer, information on how to lodge a formal complaint with the facility must be given to the patient/family/carer.

4.4 Data and review

Each health care unit that uses restraint must have local processes in place to collate data; monitor the use of restraint; report findings from review and audit; and develop/amend strategies to minimise the use of manual/mechanical restraint and to support less restrictive practices.

4.5 Audit

Each health care unit is to undertake an annual audit to identify, detect and monitor the trend of the use of manual and/or mechanical restraint. The recommended measures are:
- Reason for restraint: Dealing with disturbed and/or aggressive patient or other individual who pose a risk of harm to themselves or others.
- Type of restraint: a) Manual, and b) Mechanical (and the type of devices).
- Duration of each restraint.

5 RELATED POLICIES AND RESOURCES

5.1 Related policies

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD2015_xxx</td>
<td>Minimising Restraint Use in Adults</td>
<td>- Mechanical restraint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Older adults in acute and subacute hospital setting including multipurpose services</td>
</tr>
<tr>
<td>PD2015_001</td>
<td>Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach</td>
<td>Requirements for identifying, assessing and eliminating or controlling violence related risks, and for providing an appropriate response when violence occurs</td>
</tr>
<tr>
<td>PD2012_035</td>
<td>Aggression, Seclusion &amp; Restraint in Mental Health Facilities in NSW</td>
<td>Mental health facilities</td>
</tr>
<tr>
<td>PD2012_008</td>
<td>Violence Prevention &amp; Management Training Framework for NSW Public Health System</td>
<td>Minimum standards for training</td>
</tr>
</tbody>
</table>
### 13. MENTAL HEALTH

#### PD2010_033
Children and Adolescents - Safety and Security in NSW Acute Health Facilities
- Protection of children and adolescents from risk of harm to self or others in public health facilities
- Patient groups i.e. mental health patients or those affected by drugs and alcohol

#### GL2012_005
Aggression, Seclusion & Restraint in Mental Health Facilities – Guidelines Focused Upon Older People

#### Policy Manual
Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
Chapter 14: Role of security personnel in NSW Health and the management of all security related risks, including those related to violence and in the clinical environment
Chapter 29: Duress response arrangement

### 5.2 Related resources

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency of Clinical Innovation (ACI) Tools</td>
<td>Cognitive Screening for Older Adults</td>
<td>Assessment tool for Older Adults (combined AMTS, DRAT and CAM),</td>
</tr>
<tr>
<td>Toolkit-Minimising Restraint Use in Adults</td>
<td></td>
<td>Adults in acute and subacute hospital setting including multipurpose services</td>
</tr>
<tr>
<td>Physical Assessment for Mental Health Patients Form</td>
<td></td>
<td>Assessment tool for emergency department</td>
</tr>
<tr>
<td>Health Education Training Institute (HETI) training</td>
<td>Violence Prevention and Management in the workplace training</td>
<td>Training modules include personal safety and team restraint techniques</td>
</tr>
</tbody>
</table>
5.3 Other resources

(a) Strategies for minimisation of the use of manual/mechanical restraint in the clinical area

**Assessment <> Engagement <> Communication <> Review**

**Assessment of stressors/stimuli**
- Patient clinical condition
- Personally interpreted stress
- Environmental disturbance
- Undesired personal interactions

**Strategy built in to patient care plan**
- Principles (i.e. PANEL) applied to avoid restrictive care practice and comply with CORE value
- Strategies developed (together with patient, family / carer and other health professionals) to manage the identified stressors/or stimuli

**Strategy review**
Strategies reviewed (together with patient, family / carer and other health professionals) and adjusted as required

**Assessment <> De-escalation <> Communication <> Review**

**Assessment**
- Assess the risk of harm to the patient / individual
- Assess any risk of danger to staff/others
- Implement strategies to reduce the stressors / stimuli which trigger the behavioural escalation

**De-escalation**
- Undertake all reasonable steps to seek resolution without physical contact
- Staff should remain calm and use effective communication skills to de-escalate situation
- Involve the patient in the plan of care where possible

**Strategy review**
Strategies reviewed (together with patient, family / carer and other health professionals) and adjusted as required

**Assessment <> Restraint <> Monitoring <> Review <> Documentation**

**Assessment**
- Assess risk of harm for patient or other individual
- Assess risk of danger for staff/others
- Retreat and call for back up

**Restraint-only restraint**
- Restraint is undertaken using team approach by trained staff
- Restraint must be limited to the time required to allow patient / individual to safely regain control, to administer medication or to remove the patient to a safer environment
- Restraint position: standing, sitting, kneeling, supine and prone (prone position should be avoided where possible and is only to be considered when all other possible restraint positions have failed)

**Close monitoring of patient’s physical condition - Refer to 5.3 (b)**
- Is patient’s airway clear?
- Is patient breathing?
- Is patient’s circulation (where restraint is applied) normal?
- Is patient conscious?
- Is patient free from risk of injury?
- Does the patient have any existing medical condition / injury?
Any changes / deterioration of patient’s condition should trigger urgent action /s or emergency medical assistance

**Restraint-should only be considered if:**
- If all reasonable steps have failed to seek resolution without physical contact
- If the patient / individual is at immediate risk of harm to self or others
- If it is the safest way to protect the patient / individual and/or others

**Review and Documentation**
- Patient must be assessed and treated for any underlying clinical conditions
- Patient must be reviewed for the mechanical restraint cessation
- Clear documentation in the patient record of the reason for restraint, time of restraint, restraint type and position, patient physical condition while in restraint, clinical assessment undertaken and time of restraint cessation
### Assessing and monitoring patients' condition and risk while they are in restraint (adopted and modified from the dynamic risk assessment process\(^8\))

<table>
<thead>
<tr>
<th>Airway?</th>
<th>Can they get air in?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is there any pressure to their neck?</td>
</tr>
<tr>
<td></td>
<td>• Is there anything covering their face?</td>
</tr>
<tr>
<td></td>
<td>• Is there any other item blocking their airway?</td>
</tr>
<tr>
<td></td>
<td>• Is their mouth or throat free from vomit?</td>
</tr>
<tr>
<td></td>
<td>• Are there any signs of airway obstruction? i.e. Gurgling/gasping sounds; verbal complaints or difficulty speaking.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breathing?</th>
<th>Are they able to breathe?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is their chest free to move?</td>
</tr>
<tr>
<td></td>
<td>• Is their thoracic area free from pressure?</td>
</tr>
<tr>
<td></td>
<td>• Are there signs they are having difficulty breathing? i.e. An increased effort to struggle; or heightened distress/anxiety.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Circulation?</th>
<th>Can blood be circulated efficiently?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Are their limbs free from pressure?</td>
</tr>
<tr>
<td></td>
<td>• Are there any signs of tissue hypoxia? i.e. pale/grey/blue skin colouring to the lips nail beds or earlobes?</td>
</tr>
<tr>
<td></td>
<td>• Are there reported symptoms of compartment syndrome? Pain, pins and needles, unable to feel the pulse and/or paralysis?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of consciousness?</th>
<th>Are they alert?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Are their eyes open?</td>
</tr>
<tr>
<td></td>
<td>• Are they talking?</td>
</tr>
<tr>
<td></td>
<td>• Are they interacting with you?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deformity?</th>
<th>Is there a risk of injuring any joints, limbs, or other skeletal/muscular structures?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is the spine in correct alignment?</td>
</tr>
<tr>
<td></td>
<td>• Are the joints of the upper and lower limbs free from end-of-range stress?</td>
</tr>
<tr>
<td></td>
<td>• Is the patient complaining of discomfort or pain to any part of their body?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Existing medical condition or injury?</th>
<th>Is there anything known about the patient's medical history and/or complication that could influence the risk?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Any known respiratory disease?</td>
</tr>
<tr>
<td></td>
<td>• Any know cardiac or vascular disease?</td>
</tr>
<tr>
<td></td>
<td>• Any other relevant pathology or injury?</td>
</tr>
</tbody>
</table>

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\(^8\) Hollins L. Managing the risks of physical intervention: developing a more inclusion approach. *Journal of Psychiatric and Mental Health Nursing*, 2010;17:369-376
PSYCHIATRIC EMERGENCY CARE CENTRE MODEL OF CARE GUIDELINE
(GL2015_009)

PURPOSE
Psychiatric Emergency Care Centres (PECCs) were introduced in NSW from 2005 as one component of a series of strategies designed to enhance Mental Health (MH) Emergency Care services alongside community mental health teams, Emergency Department mental health clinicians, consultation liaison psychiatry services, psychiatry registrars and consultant psychiatrists.

The earlier version of the PECC Operational Model of Care Guideline attempted to articulate a consensus regarding detailed aspects of PECC operations. The facilities in which PECCs operate differ from each other including with regards to governance, overall mental health resources and how these resources are configured and managed and the physical location and design of the PECC and it has become apparent that it is neither desirable nor possible to standardise resourcing or service delivery arrangements for managing the care of people with mental health problems including those presenting to Emergency Departments (ED).

This updated PECC Model of Care Guideline provides high level guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services’ model of care.

KEY PRINCIPLES
MH care in the ED is a collaborative process, with shared responsibility between Emergency Department and MH clinicians and managers and other specialities (e.g. Toxicology, Drug and Alcohol), where relevant. The relative portion of this shared responsibility varies according to individual patient needs and local service arrangements.

PECCs are integrated with a range of community-based and inpatient care options and represent the least restrictive hospital-based inpatient care option. It is intended to be utilised by consumers with low to medium acuity mental health problems for whom less restrictive care (e.g. community based care), is considered inappropriate and unsafe and who are likely to require only a brief (up to 48 hours) period of time in hospital.

The guiding principles for PECCs are:
1. Collaborative decision-making
2. Least restrictive, short-term inpatient care
3. Outcome based monitoring.

USE OF THE GUIDELINE
It is the intention of this guideline that individual PECCs represent a locally determined service collaboration and configuration, based on the guided principles contained within this document. Services should monitor, evaluate and if necessary re-design these agreements by way of carefully chosen outcome and process data reflective of important aspects of mental health emergency care.

This document will assist in the process of establishing, monitoring or reviewing PECC services, their role in the emergency space and in relation to the remainder of community - inpatient MH services.


314(03/09/15)
NSW SMHSOP ACUTE INPATIENT UNIT MODEL OF CARE GUIDELINE (GL2016_016)

PURPOSE
This Guideline supplements the larger Specialist Mental Health Services for Older People (SMHSOP) Acute Inpatient Unit Model of Care Project Report and is intended to guide service improvement and service development in existing units and to inform planning for new units. It provides recommendations regarding good practice in relation to the key components of a model of care for SMHSOP acute inpatient units, as well as service development guidelines to inform service planning and service development, recognising that service development may occur over an extended period of time and implementation of the model of care will require consideration of local service context and other factors.

KEY PRINCIPLES
The function of the SMHSOP Acute Inpatient Unit is to provide appropriate facilities for the reception, multidisciplinary assessment, admission, diagnosis and treatment of known or suspected psychiatric conditions and behavioural disorders, along with assessment of physical health and psychosocial issues, for older consumers with mental illness. Episodes of care are usually precipitated by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self or others.

Recovery-focused, person-centred, biopsychosocial care is proposed as the cornerstone of service delivery within the SMHSOP Acute Inpatient Unit, and should underpin the care that is delivered to the older person while an inpatient. This approach also ensures that the services are delivered in collaboration with the older person and their family and / or carers, addresses the consumer’s desire for information regarding their care, and includes sharing the decision making with the consumer, their family and / or carers.

NSW Health recognises that there is a responsibility to assess, achieve and maintain competence at an organisational, team and individual level to ensure the delivery of health care which is safe and effective. This Guideline outlines recommended performance measures and standards for NSW SMHSOP acute inpatient units that are aligned with best practice and statewide SMHSOP benchmarking.

USE OF THE GUIDELINE
Recommendations from the SMHSOP Acute Inpatient Unit Model of Care Project Report have been listed at the end of each section in this guideline and are provided as a succinct practical guide to support state and local service planners, policy managers, and service managers in the development of new SMHSOP acute inpatient units and the review and improvement of existing SMHSOP acute inpatient units.

ENGAGEMENT & OBSERVATION IN MENTAL HEALTH INPATIENT UNITS (PD2017_025)

PURPOSE
The purpose of the policy is to identify the minimum requirements for mental health inpatient units relating to levels of observation. The policy will guide and direct clinicians in relation to their responsibilities pertaining to observation.

The aims of these requirements are to ensure that observation levels and engagement are adequate to assess and address the risk of harm to patients or others.

MANDATORY REQUIREMENTS
The policy mandates the practice of assessments by Medical Officers to provide direction to nursing staff regarding the level and purpose of observation required for individual patients.

Nursing staff actively contribute to this assessment, and may increase the level of observation for a patient if required.

If a patient’s observation level is increased by nursing staff due to clinical deterioration or concern, this must be escalated and result in a medical review as soon as possible.

The policy requires ongoing multidisciplinary reviews of observation and engagement levels for individual patients to ensure they are responsive to the needs of the consumer.

The outcomes of patient observation and engagements must be contemporaneously documented to inform the continuing and regular review of the observation level.

Observation levels must take into account other risk mitigation factors of the mental health inpatient unit such as ward programs, allied health programs and the clinical environment.

Local procedures must include an evaluation process that mandates audits of observation and engagement practice. These audits will include random inpatient unit visits.

Reports on the outcomes of these audits should be reported to the mental health director.

IMPLEMENTATION
Chief Executives ensure that mental health directors are aware of the policy directive and have a timeframe for full implementation.

Mental health directors review local procedures and practices to determine alignment with this policy and if differences are found, local procedures are updated or developed that clearly outline mandated responsibilities for medical and nursing staff in accordance with this statewide policy.

Mental health directors ensure that an evaluation process is adhered to to ensure compliance to this policy.

Mental health directors ensure that all staff are aware of this policy and procedures which must include random inpatient unit visits and documentation audits.
BACKGROUND

About this document

This policy identifies the minimum standards of observation and engagement to consumers within mental health inpatient units.

This policy replaces previous guidance on mental health nursing observations within the Suicide Risk Assessment and Management Protocols – Mental Health Inpatient Unit (NSW Department of Health, 2004).

The policy ensures that engagement and observation levels continue to assess and manage the risk or concern of harm to a consumer or others.

The policy enables a shared definition and understanding across NSW to improve consumer safety and focus upon consumer centred care.

Local procedures should be developed that align with the procedures, definitions and documentation requirements outlined within this policy.

The policy is relevant to all mental health clinicians involved in the engagement, observation, assessment and review of consumer’s within NSW mental health inpatient units.

Key definitions

Observation
Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making. It is the formal and objective assessment of a person’s condition – physical, mental, social. Observation is not passive nor does it predominantly include watching consumers from a distance. Undertaking observations requires nurses to be person centred and engage therapeutically with inpatients.

Observations through engagement are for safety, protection from harm and maintenance of wellbeing. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery.

The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and to ensure safety of the environment in which the care is being provided.

Observation is indelibly linked with clinical assessment. Observation informs ongoing decisions about care and must be a continuous feature of the care of people in mental health inpatient units.

The principles of observation in mental health inpatient care include engaging with people during purposeful observation which actively contributes to comprehensive care. There are several principles that underlie the practice of observation:

- Observation is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the person
- Appreciation of how inpatient environments influence behaviour
- Observations are communicated between colleagues
- There is a clear process of documentation that is timely and descriptive.
13. MENTAL HEALTH

Ongoing engagement with the consumer, family and carers support shared decision making around continued observation and care planning

*Nursing Observation through engagement in psychiatric inpatient care, Victoria Department of Health, 2013.

The following definitions of observation levels are designed to provide a common language and state wide understanding of the differing levels and requirements for the management of each observation level.

**Level 1: Constant Observation**
Arm’s length: The most restrictive form of observation to mitigate the highest risk or concern for a consumer. At all times a nurse must be within one metre of the consumer; or
Visual: A highly restrictive form of observation to mitigate a consumer assessed at high risk of harm. At all times, the consumer must remain under the visual observation of a nurse.

**Level 2: Observation every 15 minutes** – this level of observation is significantly restrictive to mitigate risks for consumers who are assessed as being at a high level of concern. Nurses must regularly engage and randomly observe consumer’s on this level at least every 15 minutes (at a minimum).

**Level 3: Observation every 30 minutes**
This level of observation should include random and regular checks of a consumer’s location and activity within the unit at least every 30 minutes (at a minimum).

**Level 4: Observation every hour**
This level of observation should include random and regular checks of a consumer’s location and activity within the unit at least every 60 minutes (at a minimum).

**Level 5: Observation every two hours**
This level of observation should include random and regular checks of the location and activity of the consumer every two hours (at a minimum).

**Policy context**

This policy aligns with Standard 2 of the *National Standards for Mental Health Services, 2010.*

This policy supports the implementation of Standard 2: Safety which promotes the optimal safety and wellbeing of consumers in all mental health settings.

This Policy identifies the requirements of staff to regularly review the level of risk or concern related to a consumer and their level of observation. This policy does not relate to the Physical health care of consumers and/or physical observations required. Directives and Guidance for the Physical Health care of mental health consumers may be found in the Physical Healthcare within Mental Health Services Policy (PD2009_027).

This policy is supported by the Transfer of Care from Mental Health Inpatients Policy (PD2016_056); Aggression, Seclusion and Restraint in Mental Health Facilities Policy (PD2012_035) and Clinical Care of People who may be Suicidal Policy (PD2016_007).

Responsibilities and minimum requirements relating to observation of consumers during episodes of restraint and seclusion are attended to within the Policy Directive Aggression Seclusion and Restraint in Mental Health Facilities in NSW (PD2012_035).
OBSERVATION AND ENGAGEMENT

2.1 Observation includes engagement with the consumer as well as visual observation.

2.1.1 Consumer observation must be purposeful and include person centred engagement.

2.1.2 Levels of observation must be allocated according to an individual’s assessments and needs and not at set levels for a whole unit or a point of care (e.g. at admission).

2.1.3 Staff allocating and maintaining observations should explain to the consumer their level of observation and the requirements relating to this level of observation to ensure engagement and participation of the consumer in their health care.

2.2 A consumer’s assessment, management and care plan need to reflect the multidisciplinary teams planning and inform the level of observation and engagement required for individual consumers.

Nurses must record the observation and engagement in the medical record. This documentation must include:

- the level of observation
- the observation and engagement undertaken
- assessment of the consumer’s mental state

Consumer’s identified as being at higher levels of concern or changeability require more frequent observation, engagement and assessment.

2.3 Clinical handovers between multidisciplinary teams must include assessments of observation and engagement levels.

2.4 Nursing clinical handover for each consumer must include the level of observation and the engagement and assessments undertaken to ensure a safe transfer of care and clear understanding of the plan for the receiving nurses.

2.5 The Nursing Unit Manager (or delegate), along with the medical director (or delegate) are responsible for determining if the levels of observation set for all consumer’s in that unit are appropriate, and are reviewed.

2.6 Where there are insufficient nursing resources to undertake observation and engagement, the Nursing Unit Manager (or delegate) will escalate to the responsible Nurse Manager. Where avenues for staffing are exhausted a collaborative decision by the Nursing Unit Manager (or delegate) and local nursing administration will direct distribution of current resources while other arrangements are made.

NURSING SPECIFIC RESPONSIBILITIES

3.1 The Nursing Unit Manager or delegate is responsible for ensuring that all nursing staff are aware and able to fulfil their responsibilities for completing the agreed observation of all inpatients within the unit. This includes the prioritisation of observations within the unit and ensuring nurses are allocated and where required (e.g. Observation level 1, fatigue management, etc.) share the observation responsibilities.

3.2 The Nursing Unit Manager or delegate must randomly review throughout a shift that observation levels are being undertaken and documented as prescribed.

3.3 Nurses may at any time increase the level of observation for an individual consumer based on assessment or concern.
3.4 This increase must be escalated to the responsible medical officer and/or through nursing management and result in a medical review as soon as practicable in line with local clinical deterioration procedures.

3.5 Documentation of observations are to be recorded on locally developed forms that align with the requirements of this policy. Each Level of Observation (i.e. 1, 2, 3, 4 and 5) will require a separate form. These forms must form part of the consumer’s medical record when completed.

3.6 Engagement and assessment must be recorded contemporaneously in the medical record in line with the documentation requirements listed within this policy.

3.7 Tick box observation forms must not be used because they do not adequately document the consumer’s level of risk or record the observation.

3.8 The Observation form must allow the nurse to document the actual time the observation took place and clearly identify the nurse completing the observation.

3.9 Minimum observations documented on the observation form must include the consumer’s location and activity at the time of being seen.

3.10 The medical record will reflect the engagement with the consumer and the resulting assessment.

3.11 The documentation of each engagement and assessment must be inclusive of the consumers’ mental state, current risks and concerns (both subjective and objective), interactions with staff and other persons, and be reflective of the targeted rationale for observation.

3.12 Observations must be conducted regularly according to the assessment of the level of risk or concern. It is recommended that staff occasionally undertake additional rounds between the prescribed times so that consumers cannot discern a pattern/set routine. The risk of set routines in observation is that a consumer may harm themselves, or others, between regular and predictable observation times.

3.13 Where an observation has been missed, the reason must be documented on the consumers observation form by the responsible nurse.

3.14 The observation level, engagement and resulting assessments of each consumer must form part of each clinical handover.

MEDICAL OFFICER RESPONSIBILITIES

4.1 Assessments must be conducted and documented by medical officers to determine the level of observation required for individual consumers. Decisions should be made with the multidisciplinary team, consumer and where possible the family and or carers to ensure collective input and decision making.

4.2 Active feedback to the consumer, family and carers regarding observation levels and assessment ensures ongoing and collective engagement of all parties within care planning.

4.3 The level of observation, its rationale and reviews of the level of observation must be clearly documented by the responsible medical officer within the medical record so clinicians may easily identify the level of observation and the ongoing targeted nursing assessments required as part of this observation level.

4.4 Only medical officers may reduce an observation level, this should occur in consultation with the multidisciplinary team.
### 5 LEVELS OF OBSERVATION

<table>
<thead>
<tr>
<th>Level</th>
<th>Description of level of supervision</th>
<th>Documentation requirements</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 - Constant Observations (Arms Length)</td>
<td>At all times a nurse must be within one metre of the consumer. Assessment of the safety of the consumer and nursing staff must be taken into account when allocating this level of observation. The observation of a consumer on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. A consumer on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.</td>
<td>Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.</td>
<td>At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.</td>
</tr>
<tr>
<td>Level 1 - Constant Observations (Visual)</td>
<td>At all times the consumer must be within the line of sight of the nurse responsible for undertaking the observation. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. The observation of consumers on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.</td>
<td>Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.</td>
<td>At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.</td>
</tr>
</tbody>
</table>
Level 2 - 15 Minute Observations

This level of observation should only be used infrequently due to:
- the challenge it poses to regular engagement.
- the pattern of this observation becoming easily identifiable by consumer’s who may use the time between observation opportunistically and impulsively.

Therefore, this level may be used as a step down from Level 1 observations or a step up from Level 3. Should escalation from Level 3 to Level 2 be instigated by nursing staff, discussion with the Nursing Unit Manager (or delegate) and medical officer should occur immediately to assess whether an observation Level 1 is required to mitigate the identified risk or concerns. This level of observation should include random and regular checks of a consumer’s location and activity within the unit at least every 15 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.

Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.

At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
| Level 3 - 30 Minute Observations | This level of observation should include random and regular checks by nursing staff of a consumer’s location and activity within the unit at least every 30 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians. | Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through two contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record. | At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate. |
| Level 4 - Hourly Observations | This level of observation should include random and regular checks by nursing staff of a consumer’s location and action within the unit at least every 60 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians. | Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record. | At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate. |
| Level 5 - Two Hourly Observations | Consumers on this level of observation are considered by the treating team to be at minimal risk. Consumers on this level of | Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a | At least weekly, led by the responsible medical officer in collaboration with |
observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians. The nursing staff should check the location and action of the person preceding and following the point of nursing handover and at least every two hours. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive.

contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient’s respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.

the Nursing Unit Manager or delegate.

SERVICE / DISTRICT LEVEL POLICIES AND REVIEWS OF EFFECTIVENESS

6.1 Local procedures are to be developed which include the directions within this policy.

6.2 The local procedure should clearly outline the importance and purpose of overnight nursing observations and balance the consumer’s need for sleep hygiene with safety.

6.3 The local procedure must outline the minimum standard of documentation relating to night time observations in relation to description and respiration as identified within this policy.

6.4 Services must ensure that observations are undertaken effectively.

6.5 Random inpatient unit visits and documentation audits should be conducted to ensure that observations and regular engagement are being undertaken effectively. The results of these audits will form an ongoing component to the monitoring and evaluation of this Policy Directive. Services must build the capacity of their workforce to ensure that observations are:

a. Grounded in therapeutic engagement that is facilitated through empathy and understanding of a persons lived experience

b. Conducted in a way that fosters a therapeutic relationship between nurses and the people for whom they provide care.

LIST OF ATTACHMENTS

Attachment 1: Implementation Plan – Engagement and Observation within Mental Health Inpatient Units

314(26/07/17)
ADULT MENTAL HEALTH INTENSIVE CARE NETWORKS
(PD2019_024)

PURPOSE

This Policy Directive sets out the NSW Mental Health Intensive Care Unit (MHICU) Referral Networks. It defines the referral pathway for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to access more intensive care for patients experiencing high acuity mental illness and complex needs, within an integrated model of care.

MHICUs are centres of specialist expertise in the management of people presenting with highly acute and complex mental illness. MHICUs operate as supra LHD services, and are state-wide referral facilities. Referral to a MHICU occurs from an inpatient mental health facility as the least restrictive option when the patient can no longer be safely cared for due to the risk that their behaviour poses to themselves or others.

Each MHICU is a part of a local clinical referral Network and the state wide integrated Network of clinical services that provide timely access to appropriate care.

This Policy Directive also sets out the principles and procedures each LHD should develop and monitor for the care of consumers requiring mental health intensive care.

MANDATORY REQUIREMENTS

- All options for consumer placement to other mental health facilities should be explored before seeking a referral to a MHICU.
- LHDs to admit consumers with the highest acuity or most complex clinical needs from their designated zone into the MHICU.
- MHICUs only provide care to those consumers with the highest acuity or most complex clinical needs.
- Referral and transfer to a MHICU is a time-limited episode of care. On stabilisation of symptoms and/or reduction in the level of clinical risk, consumers will be repatriated to the referring LHD.
- The referring LHD will facilitate the transfer to the MHICU.
- The MHICU will facilitate return transfer back to the referring LHD.
- LHDs must inform relevant clinical staff of this policy directive.

IMPLEMENTATION

- This Policy Directive applies to all adult mental health inpatient facilities.
- LHDs/SHNs must have local policies and procedures in place that are consistent with the principles and procedures identified in this policy by August 2019.

Local Health District/Network Chief Executives are responsible for:

- Ensuring implementation of the Policy Directive, with the Chief Executive as the final point of arbitration and escalation.
- Documenting and implementing local governance and escalation plans to ensure the appropriate accommodation of patients who need to access a MHICU bed. This must include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review. Escalation plans must include procedures for clinicians to follow in instances where an appropriate bed is not available within the zone or difficulties are experienced with patient acceptance and placement.
- Meeting the MHICU needs of their LHD and linked LHDs including the provision of clinical advice and ensuring access to appropriate treatment.

314(24/06/19)
Local Health District/Network Mental Health Directors are responsible for:

- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe.
- Ensuring that all options for placement of the referring LHD’s patient within the originating LHD have been explored, and that transfer to a MHICU is clinically appropriate.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring timely repatriation. On stabilisation of symptoms and/or reduction in the level of clinical risk, MHICU patients must be repatriated to the referring LHD. Repatriation is the responsibility of the referring LHD.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Mental Health Intensive Care Units are responsible for:

- Ensuring information in the Patient Flow Portal and/or Emergency Access View is current and correct at each shift handover.

Patient Flow Units/Bed/ After Hours Managers are responsible for:

- Facilitating referrals for Statewide MHICU transfers in consultation with the local MHICU.

**Adult Mental Health Intensive Care Networks Procedures**

1 **BACKGROUND**

1.1 **About this document**

This Policy Directive provides guidance to ensure that patients with high acuity mental illness and complex clinical needs receive timely treatment in the most appropriate setting. Mental Health Intensive Care Units (MHICUs) are units with a small number of beds and high staff to patient ratios that provide a highly specialist and intensive multidisciplinary mental health care to patients who present with clinical complexity and risks that cannot be safely and effectively managed in an acute mental health inpatient unit.

In NSW there are six MHICUs that currently provide tertiary level intensive mental health care and operate as part of a state wide Network.

This procedure describes key processes of MHICUs as follows:

- Inclusion and exclusion criteria for referral
- Referral processes
- Transfer of patients between MHICUs and LHD inpatient mental health units
- Roles and responsibilities of MHICUs and referring inpatient mental health units in relation to the transfer and return transfer of patients
- Roles and responsibilities of referring inpatient mental health units during a patient’s admission to a MHICU

1.2 **Key definitions**

**Complex clinical needs:** Complex clinical needs refers to the care that a patient requires to manage their acute presentation. Complex needs require significant intervention and ongoing support in a range of biomedical, psychological, social and occupational domains.

**High acuity:** A high acuity patient is a patient that is acutely unstable in their clinical presentation and require increased multidisciplinary review, intervention and care.
Mental Health Act 2007

Patient: It is noted that the preferred terminology for people with a lived experience of mental distress and/or mental illness is “consumer”, however for the purposes of this document “patient” has been used to refer to this population. This term is used to identify that the patient is an admitted inpatient and is accessing mental health intensive care services.

Referring inpatient mental health unit: A LHD/SHN based public inpatient mental health unit that has referred a patient to a MHICU for intensive management or stabilisation.

1.3 Legal and legislative framework

This Policy Directive refers to the care of people who are subject to the restrictions and directions of the NSW Mental Health Act, 2007. In cases where this policy and the MHA are in conflict, the directions of the MHA are to be followed in the first instance. Transfer procedures, detainment of patients and communication with designated carers are all included in the MHA.

1.4 Relevant Information

This Policy Directive has been informed by, and is designed to be read in conjunction with the following NSW Health Policy Directives and frameworks:

- Blue Knot Foundation (2012). Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Author, Sydney
- NSW Health. NSW Ministry of Health Demand Escalation Framework.
- NSW Health PD2018_011: NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults)
- NSW Health PD2017_025: Engagement and Observation in Mental Health Inpatient Units
- NSW Health PD2016_056: Transfer of Care from Mental Health Inpatient Services
- NSW Health PD2016_007: Clinical Care of People Who May Be Suicidal
- NSW Health PD2012_035: Aggression, Seclusion and Restraint in Mental Health Facilities in NSW.
- NSW Health PD2011_015: Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
- NSW Health PD2009_060: Clinical Handover- Standard Key Principles
- NSW Health PD2014_025 - Departure of Emergency Department Patients

2 ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

The Adult Mental Health Intensive Care Network defines the links between LHDs/ SHNs and MHICUs. The Networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries.

There are six (6) local mental health intensive care Networks (Networks), each served by one MHICU. In addition, the Forensic Hospital acts as a second tier referral facility where the patient demonstrates a very high risk of harm to themselves or others, or if a patient requires admission to a MHICU and no other beds are available.
## Table 1: State Wide Adult Mental Health Intensive Care Network

<table>
<thead>
<tr>
<th>MHICU</th>
<th>Referring LHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby</td>
<td>Northern Sydney</td>
</tr>
<tr>
<td></td>
<td>Central Coast</td>
</tr>
<tr>
<td>Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)</td>
<td>Hunter New England</td>
</tr>
<tr>
<td></td>
<td>Mid North Coast</td>
</tr>
<tr>
<td></td>
<td>Northern NSW</td>
</tr>
<tr>
<td>Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange</td>
<td>Western NSW</td>
</tr>
<tr>
<td></td>
<td>Far West</td>
</tr>
<tr>
<td></td>
<td>Murrumbidgee</td>
</tr>
<tr>
<td>McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord</td>
<td>Sydney</td>
</tr>
<tr>
<td></td>
<td>South Western Sydney</td>
</tr>
<tr>
<td>Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta</td>
<td>Western Sydney</td>
</tr>
<tr>
<td></td>
<td>Nepean Blue Mountains</td>
</tr>
<tr>
<td></td>
<td>Southern NSW</td>
</tr>
<tr>
<td>Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick</td>
<td>South Eastern Sydney</td>
</tr>
<tr>
<td></td>
<td>Illawarra Shoalhaven</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Health Network</td>
</tr>
<tr>
<td>Forensic Hospital, Justice and Forensic Mental Health Network, Malabar</td>
<td>Second tier referral for all LHDs/SHNs</td>
</tr>
</tbody>
</table>

### 3 OVERARCHING PRINCIPLES OF CARE

#### 3.1 Guiding principles for the Adult MHICU Network

The operation of the Adult MHICU Network, and arrangements for patient referral and transfer between referring inpatient mental health units and MHICUs is to be guided by the following principles:

1. The care of the patient is to be collaborative, recovery oriented, trauma informed and person centred, respecting the patient’s human rights and dignity whilst being provided in the least restrictive environment alongside input from the patient’s family and support people.
2. Referral and transfer to a MHICU is a time-limited episode of care for the intensive management of high acuity and complex symptoms. On the stabilisation of symptoms and/or reduction in the level of clinical risk, the patient is repatriated to the referring inpatient mental health unit as soon as practicable.
3. Admissions are determined with consideration to the existing patient mix in each Network Zone, and then within the broader Adult MHICU Network.
4. In cases of significant distance between the referring inpatient mental health unit and the MHICU, the benefits of admission to the MHICU must outweigh the risks associated with transferring the patient and their separation from family, carers and identified support people.
5. Determination and coordination of safe and timely patient transfer relies on current and accurate clinical handover between senior clinicians at each site. Relevant service executives and patient flow units should be included in all communication.
6. All processes must comply with the Adult Mental Health Intensive Care Network Policy (PD 2019_024).

#### 3.2 Defining the MHICU patient

A MHICU patient is an existing patient of an acute mental health unit, who requires a high level of multidisciplinary care, observation and review to remain safe in the acute inpatient environment. A patient appropriate for a MHICU may demonstrate the following risks or behaviours.
• Significant risk or continued attempts to harm themselves, with the intent of self-harm and/or suicide.
• Significant risk or actions of violence, physical, sexual or verbal abuse and/or harassment towards other patients, visitors or staff.
• Deterioration of mental health, or increasing symptoms of mental illness including disinhibition, disorganisation, disruption of others and/or significant distressing symptoms of psychosis leading to increased vulnerability
• Repeated attempts to leave the unit without authorisation, if detained under the MHA.

Patients admitted to MHICU are generally categorised as the “most unwell”. That is, these patients demonstrate the highest level of risk, are at the most risk and/or whose symptoms are not resolving to a lower level of acuity in acute inpatient wards. These are patients for whom accessing a higher level of care will provide the resources, observation and structure to contain their experience of distress.

4 REFERRAL TO MHICUS

4.1 Referral to a MHICU

4.1.1 Referral Documentation

The referring inpatient unit will provide a comprehensive clinical handover and package of clinical documentation to the MHICU at the time of referral and transfer. Referral documentation will include:

• Referral form
• Current assessment by treating psychiatrist
• A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
• MHA documentation, including designated carer form
• Contact details of family/ carers and support people
• Medication charts
• Risk Assessment
• 7 days of progress notes
• Details of management and medication strategies trialled and outcomes of these

4.1.2 Assessment

Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of the highest acuity patients. Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the Network or difficulties are experienced with patient acceptance and placement.

It is the responsibility of the receiving MHICU to assess whether a referral is appropriate or not, considering the inclusion and exclusion criteria and the current patient population. The receiving MHICU will confirm receipt of referral documentation to the referring inpatient unit, and will assess referrals and respond to referrals within six hours of referral, or next day in business hours if the referral is received after 11am.

If a referral is not accepted for admission, the MHICU will provide a rationale for this. The MHICU clinical team will also be available to provide clinical consultancy to the referring inpatient unit as required to enable safe care and management of the patient.
4.1.3 Inclusion Criteria
Patients admitted to MHICU are:
- Aged 18 or over
- Detained under the NSW Mental Health Act 2007
- Requiring an intensive level of observation and care to manage deterioration of mental health, increased acuity of mental health symptoms and significant risk of violence, suicide or vulnerability
- Presenting with behaviour that severely compromises the patient’s or another person’s physical or psychological wellbeing and safety
- Medically stable

4.1.4 Exclusion Criteria
Patients not appropriate for admission have:
- A diagnosis of dementia, intellectual disability, substance misuse or intoxication in the absence of a primary diagnosis of a mental illness
- Physical frailty that affects the patient’s care in an intensive care environment
- Medical conditions, including intoxication or detoxification from alcohol or other substances that cannot be safely managed in a MHICU

4.1.5 High Risk Presentations from Emergency Departments or Community
A MHICU admission from an Emergency Department or a community mental health team, may occur after a psychiatrist’s assessment in the following exceptional circumstances:
- To avoid further deterioration and in cases of significant and ongoing risk of violence and aggression, patients should not progress through the usual admission pathway of trialling acute unit care.

Where a patient is referred to a MHICU from an Emergency Department the mental health service has a responsibility to assist the Emergency Department in the proactive management of the patient until the patient is able to be transferred.

4.1.6 Local referral
Referrals from inpatient units will be made to the MHICU in their Local Network in the first instance (Table 1). If a referral is considered appropriate, every effort is to be made by the receiving MHICU to facilitate timely access. This may require a patient with less intensive health care needs in the MHICU to be repatriated to the patient’s referring inpatient unit, or another bed in the referring LHD.

4.1.7 State Wide referral
State Wide referrals will only occur when a local MHICU bed is unavailable, and following an assessment of MHICU and referring LHD resources to ensure that only patients meeting the inclusion criteria at the time of assessment are receiving MHICU care. In this case, all patients currently being treated in the Local MHICU will have higher health care needs than the patient being referred. Following consultation with the referring LHD, the Local MHICU is responsible for finding a State Wide MHICU bed for the referred patient. The Local MHICU liaises with the relevant hospital patient flow processes and State Wide MHICU to identify a bed, and forwards the referral to the State Wide MHICU. The Local MHICU will inform the referring inpatient unit of the State Wide referral, and will provide the contact details of the State Wide MHICU.
Once a bed is identified in the state wide Network, the referring inpatient unit will contact the State Wide MHICU and liaise for the transfer of clinical care. The referring inpatient unit remains responsible for the transfer of the patient to a MHICU.

4.1.8 Clinical Handover

The referring inpatient unit will provide a comprehensive clinical handover and package of care documentation to the MHICU at time of transfer. The package of documents will include:

- Original MHA documentation, including a signed Section 78
- Medication Charts (including current PRN medication)
- Contact details of family and carers

If no access to the referred patient’s electronic medical records are available by the MHICU, the package of documents will also include:

- Current assessment by treating psychiatrist
- Patient History
- A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
- Risk Assessment
- 7 days of progress notes
- Details of management strategies trialled and outcomes of these
- Any available allied health assessments and reports

4.2 Transfer to a Mental Health Intensive Care Unit

It is the responsibility of the referring inpatient unit in consultation with MHICU to arrange for the timely and safe transfer of a patient. Transport arrangements should be in accordance with local policy and resources, and may require coordination with hospital security services, the NSW Ambulance Service and NSW Police consistent with the NSW Health- NSW Police Memorandum of Understanding 2018.

Family, carers and designated support people should be involved in any care planning and informed of any referral. PD 2016_056 Transfer of Care from Mental Health Inpatient Services details the principles and requirements for the safe transfer of a patient’s care across settings. The referring inpatient unit must ensure the continued involvement of family and carers by providing information about options for contact and visits.

314(24/06/19)
### Inclusion Criteria

- Aged 18 or over
- Detained under the *NSW Mental Health Act 2007*
- Requires an intensive level of observation and care to manage deterioration in mental health AND significant risk of violence, suicide, absconding or vulnerability

### Exclusion Criteria

- A diagnosis of dementia, intellectual disability, substance misuse or intoxication without a primary diagnosis of a mental illness
- Physical frailty that affects the patient’s care in an intensive care environment
- Medical conditions that cannot be safely managed in a MHICU

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**Figure 1: MHICU Referral Flowchart**

- **Referral**
  - Referring team identifies need for referral
  - Referring psychiatrists contacts local MHICU and advise of referral
  - Referring inpatient mental health unit to provide referral documents to MHICU

- **Assessment**
  - MHICU to assess patient for admission, as advise referring unit within 6 hours of referral
  - If patient is *not* appropriate for admission, MHICU will provide ongoing clinical consultation to support safe and effective management of the patient

- **Clinical Handover**
  - Referring inpatient unit to advise family/carer and support people of patient transfer to MHICU, including contact details and address
  - Provide original MHA documents to MHICU

- **Transfer to MHICU**
  - Referring inpatient unit to arrange transport of patient to MHICU, in consultation with MHICU
4.3 MHICU processes

4.3.1 Daily Multi-disciplinary Team (MDT) Handover

Clinical Handover refers to the safe transfer of professional responsibility and accountability for some or all aspects of a patient’s care to another person or professional group. Consistent with intensive care practices, MHICU teams are to undertake a daily MDT handover, which provides the opportunity to discuss and review the presentation of each patient. Handover meetings will review the EDD, care strategies, clinical incidents and care plans for each patient. Handover meetings must include prioritisation of patients for transfer or return transfer in the case of a higher acuity referral and identification of patients ready for return transfer to referring inpatient units. Following the daily handover meeting, MHICU updates Emergency Access View to accurately reflect bed status and vacancies.

Regular (at least weekly) communication must occur between the MHICU clinical team and the referring inpatient unit clinical team of admitted inpatients. Best practice is to invite a member of the referring inpatient unit team to the MDT clinical review, in person or using videoconference or teleconference facilities. This includes where referrals have been referred from a lower acuity ward in the same facility. If this is not feasible, an identified MHICU clinical team member is to liaise with the referring inpatient team regarding treatment progress, achievement of care plan goals, changes to the EDD and plans for the return transfer of the patient to the referring inpatient unit.

4.3.2 Identification of patients for transfer

Each LHD that hosts a MHICU is responsible for meeting the mental health intensive care needs of that LHD and linked LHDs within their local Network.

It is the responsibility of the MHICU to identify appropriate patients for transfer to LHD inpatient units in order to create capacity for acceptance of higher acuity referrals. Ideally, the identified patient will be transferred to their referring inpatient unit in this instance. If a bed is not available and cannot be made available by the referring inpatient unit, then the patient may be transferred to an available bed within the patient’s host LHD with return transfer to the referring LHD to be expedited.

Patients identified for transfer will be those who:

- Have demonstrated a reduction in the level of clinical risk to themselves and others as assessed by MDT in consultation with the patient
- No longer require intensive supervision and observation

4.4 Return transfer of patients

4.4.1 Roles and responsibilities of MHICU and inpatient units

It is the responsibility of the MHICU senior clinicians, following discussion with the referring LHD senior clinicians, to return transfer a patient when the clinical risk has reduced and/or the exacerbation of mental health symptoms has stabilised. The MHICU is responsible for arranging the timely and safe return transfer of a patient as it is clinically indicated.

The referring inpatient unit will initiate appropriate local patient flow processes to ensure a bed is available to facilitate the return transfer of a patient from a MHICU. The referring inpatient unit will advise MHICU of the appropriate timing of return transfer (of no more than 24 hours from the time of request). MHICU will arrange transport of the patient and advise the inpatient unit of these arrangements, including the anticipated time of arrival.

If no bed is available for return transfer, the MHICU will contact the LHD mental health patient flow manager and identify an alternative bed for transfer within the patient’s host LHD. Once the patient has reached an acute inpatient unit, the process for return transfer and/or discharge of the patient to the referring inpatient unit and/or community mental health team will progress consistent with existing local policies and procedures.
4.4.2 MHICU Clinical Handover

MHICU will provide a comprehensive clinical handover to the inpatient unit, including the following:

- Successful management strategies
- Outcomes of agreed care goals
- Medication changes
- Therapeutic interventions
- Recommendations for ongoing management

MHICU will provide a package of documents to the inpatient unit, including:

- Original MHA documentation
- Medication Charts
- Contact details of family and carers

If no access to the referred patient’s electronic medical records created by MHICU are available by the inpatient unit, the package of documents will also include:

- Current assessment by treating psychiatrist
- Patient History
- Risk Assessment
- 7 days of progress notes

For further information regarding clinical handover, please refer to NSW Health PD2009_060: Clinical Handover- Standard Key Principles.

4.4.3 Discharge from MHICU to a community setting

MHICUs do not usually have access to the full range of service resources for each LHD/region to enact and monitor appropriate community referrals in order to facilitate an effective and sustainable discharge to the community.

It is not usually appropriate for a patient to be discharged from a MHICU to the community. However, in rare situations where patients are discharged from a MHICU to a community setting, it will be with the clear collaboration and consent of the relevant accepting community mental health team.
13. MENTAL HEALTH

Figure 2: Return transfer of patients from MHICU

MHICU determines appropriate to return transfer in collaboration with IPU

MHICU informs IPU of plan to return transfer

IPU initiates patient flow to make a bed available and advises MHICU

* If no bed is available, MHICU to contact patients host L&D Patient Flow Manager and identify a suitable bed for transfer

MHICU arranges transport for patient to be return transferred

MHICU to contact IPU and provide comprehensive clinical handover to IPU

Patient arrives at IPU with required documentation and is discharged from MHICU

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5 PATIENT FLOW THROUGH THE ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

5.1 Use of the Patient Flow Portal and Emergency Access View applications

Patient Flow Portal (PFP) and Electronic Patient Journey Boards (EPJB)
The PFP and EPJB are electronic patient flow tools that support teams to manage their units’ demand and capacity planning by providing a highly visual tool to facilitate multidisciplinary care, standardising inter-facility transfer processes and supporting the implementation of demand escalation.

It is expected that the EPJB is used by all acute mental health inpatient services, including MHICUs.

At a minimum, each MHICU is required to update the EPJB every four hours, including the Estimated Date of Discharge (EDD) and Waiting for Waiting for What (W4W) functions. Patients identified as ready for return transfer to their referring inpatient unit will be highlighted using the Inter Ward Transfer (IWT) or Inter Hospital Transfer (IHT) functions.

The MHICU EPJB includes the “MHICU Bed Status tool”, which is used to provide detail of MHICU bed status (staffed and available beds), the on-call details of the MHICU consultant, and patient acuity to assist in the location and access of beds for patients in the greatest need of higher level care.

A daily “MHICU Bed Status” report can be automatically generated and emailed to LHD mental health executive, patient flow managers and clinical directors.

Emergency Access View
The Emergency Access View (EAV) is a real-time dashboard displaying the live position against a number of patient demand and patient flow measures. The EAV includes a MHICU Dashboard, and is linked to the PFP to draw information from a single source.

The MHICU Dashboard will support MHICU demand through improved visibility of Network beds, highlighting available beds and the contact details to access these beds. The MHICU Dashboard also provides increased visibility of people in “depart ready” beds, and issues of exit block and delays in transfers.

The MHICU Dashboard will be accessible by LHD executive, Patient Flow Managers and MHICU staff to facilitate the timely access to beds.

5.2 Access to MHICU Beds
MHICUs are tertiary, specialised facilities. MHICUs should not be used to assist in the management of patient flow or clinical capacity for patients who do not meet the criteria for a MHICU admission.

The highest acuity patients in the Network will have access to a MHICU, with lower acuity patients to be transferred from MHICUs to referring inpatient units to facilitate the care of people who have greater clinical needs. To do this, inpatient units will access the MHICU Bed Status link on the EPJB, to identify the appropriate contact for referral.

Where the local MHICU is full and unable to identify a lower acuity patient to transfer from the MHICU, that MHICU will use EAV to identify an available MHICU bed outside of the local Network, and then link the referring inpatient unit with the receiving MHICU to facilitate the transfer and care of patients.
5.3 Patient Flow Process

Usual MHICU patient flow processes are outlined in Section 4: Common MHICU Processes. Consistent with the NSW Ministry of Health Demand Escalation Framework, MHICUs will have a demand escalation framework and pathways in place to manage peak variation and changes in patient flow.

As part of a demand escalation framework, MHICUs will require the following plans to be in place to support effective patient flow:

- Short Term Escalation Plan (STEP)
- Facility Demand Escalation Matrix
- Capacity Escalation Plan

These plans will need to interact with facility and LHD demand escalation plans, as well as with regular review by the Zone.

5.3.1 Estimated Date of Discharge

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from MHICU to the referring inpatient unit. It provides everyone involved with the patients care, including the patient and their family with a projected date to coordinate the patient’s care needs. While for some patients the EDD may change due to clinical issues; review of best practice confirms that an accurate EDD can be set for most patients.

The use of an EDD will assist patient flow managers and referring inpatient units to plan the return transfer of patients into appropriate wards, prevent MHICU delays in returning patients to appropriate wards and reduce patients receiving care outside their home mental health service.

5.4 “Depart Ready” and “Good to Go” Identification

5.4.1 Depart Ready

Patients identified as “Depart Ready” will be patients that have been identified for return transfer, have been accepted by the appropriate inpatient unit and have patient transport booked to return the patient to the referring inpatient unit.

Exit block will occur when G2G patients have not been transferred within 24 hours of identification.

5.4.2 Good to Go

Patients identified through the EPJB as “Good to Go” (G2G) are those that have been identified as appropriate for transfer to a lower acuity inpatient unit. These patients should be identified using the G2G cell on the EPJB, and should be flagged with the referring inpatient unit to begin preparing for return transfer, this may include creating appropriate capacity.

5.5 Network Coordination, Escalation and Management of Delays

LHDs and SHNs will develop formal specialist clinical referral Network procedures to guide clinicians and facilitate patient flow, ensuring appropriate, safe and timely patient referrals, return transfers and clinical consultancy to the Network. LHDs and SHNs will establish processes, led by the Clinical Director for the following purposes:
• Patient referral and priority of referrals in relation to the existing Network and MHICU patient mix
• Patient assessment by MHICU
• To support the LHD with clinical consultancy and management strategies in circumstances where there is a delay in transfer, where it is unsafe to transport the patient or when no MHICU bed is available
• To ensure the referring inpatient unit maintains active engagement in the care of the patient following referral and transfer, including clinical review and case conferences
• To arrange return transfer and support patient transfers
• For the operational review of processes to improve collaboration between services and the operation of both the local and statewide Network

Should issues arise in coordinating the care and treatment of a patient within the Network, issues should be escalated to the LHD executive and Chief Executive, following local guidelines. Resolution of issues will occur at this level.
Figure 1: Escalation Pathway

Patient assessed as appropriate by local MHICU for admission, however no bed is available

Local MHICU actively assesses each current MHICU patient against referred patient to see if a current patient may be transferred to create capacity, in consultation with LHD patient flow managers

Local MHICU accesses Emergency Access View and requests transfer to State Wide MHICU via Patient Flow Portal

If no beds are available or referral is declined, referring LHD MH executive contacts referring LHD Chief Executive

LHD Chief Executive contacts State Wide MHICU LHD Chief Executive to request a bed
## 13. MENTAL HEALTH

### 6 LIST OF ATTACHMENTS

1. Implementation Checklist
2. Adult Mental Health Intensive Care Network Flowchart

**Attachment 1: Implementation checklist**

<table>
<thead>
<tr>
<th>LHD/Facility:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessed by:</strong></td>
</tr>
<tr>
<td><strong>IMPLEMENTATION REQUIREMENTS</strong></td>
</tr>
<tr>
<td>6. Development and documentation of LHD clinical governance and escalation pathways and demand escalation frameworks to ensure patient flow</td>
</tr>
<tr>
<td>7. Development of pathways and communication processes between zoned LHDs and MHICUs to ensure streamlined referral and transfer of MHICU patients</td>
</tr>
<tr>
<td>8. Development of local procedures for MHICU referral, care and transfer that are consistent with this policy directive</td>
</tr>
<tr>
<td>4. Appropriate identification and training of clinical and administrative staff in Patient Flow Portal and Emergency Access View applications</td>
</tr>
<tr>
<td>5. Identification of the LHD Chief Executive as the final point of arbitration and decision making</td>
</tr>
<tr>
<td>6. Audits to review compliance with this document are conducted annually (minimum)</td>
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</tbody>
</table>

Notes: 

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Attachment 2: Adult Mental Health Intensive Care Network Flowchart

<table>
<thead>
<tr>
<th>MHICU</th>
<th>Referring LHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby</td>
<td>Northern Sydney, Central Coast</td>
</tr>
<tr>
<td>Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)</td>
<td>Hunter New England, Mid North Coast, Northern NSW</td>
</tr>
<tr>
<td>Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange</td>
<td>Western NSW, Far West, Murrumbidgee</td>
</tr>
<tr>
<td>McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord</td>
<td>Sydney, South Western Sydney</td>
</tr>
<tr>
<td>Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta</td>
<td>Western Sydney, Nepean Blue Mountains, Southern NSW</td>
</tr>
<tr>
<td>Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick</td>
<td>South Eastern Sydney, Illawarra Shoalhaven, St Vincent’s Health Network</td>
</tr>
<tr>
<td>Forensic Hospital, Justice and Forensic Mental Health Network, Malabar</td>
<td>Second tier referral for all LHDs/SHNs</td>
</tr>
</tbody>
</table>

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13. MENTAL HEALTH

MANAGEMENT OF PATIENTS WITH ACUTE SEVERE BEHAVIOURAL DISTURBANCE IN EMERGENCY DEPARTMENTS (GL2015_007)

PURPOSE

The purpose of this Guideline is to address the management and initial sedation requirements of patients who present to emergency departments (ED) with acute severe behavioural disturbance (ASBD). This Guideline includes information for children, adolescents (children and adolescents includes those under 16 years) and adults under 65 years.

Management of older persons over 65 years is not contained in this Guideline as comprehensive management of these patients is available in other NSW Health documents (please see Section 1.1 Key Documents).

KEY PRINCIPLES

The focus for this Guideline is patients, both adult and paediatric, who are unable to have a medical assessment completed due to the ASBD and may require the administration of sedation before initial assessment can occur.

This document is guided by the principles of least restrictive, collaborative, patient centred care and offers guidance on the following aspects of behavioural management and sedation:
1. Assessment of the patient with ASBD in a safe environment.
2. Use of de-escalation techniques that focus on engagement of the person with ASBD to allow for assessment.
3. Ensuring that legal requirements are adhered to, particularly in relation to the Mental Health Act 2007, the Guardianship Act 1987, The Children and Young Persons (Care and Protection) Act 1998 and the clinician’s duty of care to the patient.
4. Sedation of the patient whose behaviour puts them or others at immediate risk of serious harm and which is unable to be contained by other means. There is also reference to physical restraint of the patient if required.
5. Post sedation care of the patient including observations and documentation.
6. Disposition decisions and transport of the patient from the ED to the most appropriate area for continuation of their care.

USE OF THE GUIDELINE

This Guideline supplements PD2015_004 Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint, however focuses on patients who present to EDs with ASBD. This is a Guideline only and the protocol is based on available scientific evidence of drug safety profiles on sedation of acute behaviour disturbance patients in the ED and clinical advice.

This Guideline does not replace clinical judgement; the decision to proceed with emergency sedation is made on clinical grounds and is authorised by appropriately trained medical and/ or nursing staff, depending on the type of intervention being ordered. Local decision making and procedures should be developed in conjunction with this Guideline and local stakeholder groups. Further detail on use of this Guideline can be found in the Guideline document.

To download the Guideline please go to http://www0.health.nsw.gov.au/policies/gl/2015/GL2015_007.html

---

ii ibid
iii ibid
iv ibid
vii http://www.nice.org.uk/guidance/cg16/resources
ix Suicide Risk Assessment and Management Protocols : Mental Health In-Patient Unit SHPN: 040183 ISBN: 0 7347 3720 3 from the Framework for Suicide Risk Assessment and Management for NSW Health Staff SHPN (MH) 040184, ISBN 0 7347 3721 1