## CHAPTER 13 – MENTAL HEALTH

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LEGAL RESPONSIBILITY AND PROFESSIONAL ACCOUNTABILITY OF MENTAL HEALTH PROFESSIONALS (Information Bulletin 92/26)

INTRODUCTION

The following issues have been raised with the Mental Health Branch by mental health professionals, requesting clarification.

The responses have been prepared by the Legal Branch of the Department of Health.

Before addressing specific issues, it is probably useful to outline the basic tenets of legal liability and responsibility.

It must be stressed that “legal responsibility” is not the exclusive privilege of one health professional in relation to one patient. Different professionals may have varying degrees of responsibility for a particular patient, and who is responsible will vary depending on the particular action or event in question.

The tenets of responsibility are set by case law (or the common law) based mainly on civil litigation in negligence and malpractice cases. Legal liability is based on whether a duty of care existed, the standard of the duty, and whether it was breached. In this respect, the fact that a medical practitioner is the only person entitled to write a Schedule under the Mental Health Act is irrelevant. A schedule is merely one mechanism for conveying a mentally ill person to a psychiatric hospital and the Act also contains other mechanisms for this to occur. In any event, writing a schedule does not have any necessary connection with the continued management and treatment of a patient, which are the key factors which will give rise to a “duty of care”.

That stated, any Court asked to address the question of legal liability will look closely at the question of who had primary care of the patient in respect of the complaint before it. Generally, the case manager will have the major role in most decisions on patients in community care.

The only caveat on this advice is the point made above, that legal responsibility is not an exclusive condition, and will vary depending on the event or act a court is trying to establish liability in relation to. For example, in a case management situation where a decision is made to provide medication, “responsibility” for such a decision will vest in the medical practitioner, or the person empowered by statute to prescribe the medication. However, the monitoring of the patient for any side effects etc., will also be the responsibility of the case manager, on a day-to-day basis. In this sense, if some error or oversight were to occur either or both professionals could be found liable.

ISSUES REQUIRING DEFINITION

1. What is the legal responsibility of mental health professionals, whether medical or not, for the treatments administered to clients?

Health professionals are responsible for their own actions. Should the health professional however be acting under the direction or instruction of another, the supervisor will also be responsible or liable for any detriment resulting from the action or in-action of the professional concerned. A court will view these actions on a case-by-case basis, assessing the facts of any given event on its merits.
The only area where a medical practitioner is likely to be primarily responsible is in respect of actions which only they are capable of performing, e.g. prescribing a medication or writing a medical certificate as to examination or observation of a person (Schedule 2, Mental Health Act 1990). Note though, that any primary responsibility only arises in relation to that act. For example, merely writing a schedule will not generally make a practitioner liable for any treatment or injury/loss occurring to a patient in the psychiatric unit, unless there is further evidence to suggest that the practitioner was in some other way implicated in the injury.

2. **Do medical practitioners have legal responsibility for all treatments administered to all patients, irrespective of whether or not they are personally treating them?**

A medical practitioner is only responsible for his/her own patients. In community mental health services, a decision is often made for the primary manager to be a non-medical health professional with no, or only minimal input from a medical practitioner. As such the medical practitioner cannot therefore be “legally responsible” for patients he/she knows little or nothing about or has no input into the care of.

The only variation to this “common law” position would be if the Department, through legislation or administrative arrangements were to alter the current system and, for example direct that all care decisions be made by or under supervision of a medical practitioner.

3. **The Mental Health Act (1990) does not specify that psychiatric case managers, nor Directors of Health Care Agencies, need be medical practitioners. Must case managers who are administering Community Treatment or Community Counselling Orders, or non-medical Directors of Health Care Agencies, be regarded as “medico-legally responsible” to a medical practitioner?**

Again, at common law, and under the Act, this would not be the case. The Act and the arrangements made thereunder demonstrate the intention as to who is to have primary care and responsibility. There is no evidence that it is to be a medical practitioner.

4. **What is the legal responsibility of professional staff in in-patient settings with respect to the treatments they administer to:**

- involuntary patients; and
- informal (voluntary) patients?

In relation to in-patient cases, the circumstances are different in that the medical superintendent is given statutory responsibilities under the Act, and will be primarily responsible in respect of those duties.

Beyond that it is again a factual question as to who has primary responsibility for decisions made in relation to patients, as in any other setting.
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.
13. MENTAL HEALTH

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
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.


157(28/06/12) & 158(05/07/12)
HANDLING OF POSSIBLE EVIDENCE FOLLOWING A PATIENT’S SUICIDE ATTEMPT
(Information Bulletin 2001/2)

This Information Bulletin provides interim advice to all Health Service staff on the procedure of handling possible evidence following a patient’s suicide attempt.

A patient recently died from Hypoxic Brain Injury after an earlier suicide attempt in hospital. A plastic bag used in that attempt was disposed of, albeit innocently, by hospital staff.

Following this incident, the NSW Health Department urges all Area Health Services to review and, if necessary, revise current Clinical Procedure Manual on the following:

Death by suicide

The implement used to cause the death shall be retained for examination by the Police.

Life threatening self inflicted injury

If the patient is resuscitated or requires emergency medical intervention but death is the likely outcome, then:

a) The implement used to cause death or injury shall be retained (including contaminated material) until Police advice has been obtained.

b) Implement is retained so long as patient or staff safety is not compromised. For example, if the patient has been electrocuted and the electricity remains on.

c) The Police may attend to photograph the contaminated implement before disposal according to hospital or Police protocol.

d) Police advice (including the name, rank of the Police Officer and station contacted) shall be documented in the clinical record.

The Centre for Mental Health intends to revise PD2005_121 (Policy guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospital facilities) this year. More extensive information about dealing with death or serious injury from deliberate self harm may be included in the revision. The revision will involve convening an expert reference group to consider the overall contents of the Circular.
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.
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. 

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.
Minimum requirements

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

- Provide clinical management and care in accordance with the *NSW Mental Health Act (2007)*
- 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
- 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
- Develop a management plan with the involvement of the person, their family / principal carers and key stakeholders
- 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
- 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

Mental Health Services have an obligation to:

- Ensure locally developed protocols are in place at all entry points to health care including emergency departments that support the:
  - Appropriate triage of at risk patients and interim observational management pending handover to mental health
  - Consultation with persons with suspected suicidal risk, and referral for comprehensive mental health assessments
  - 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
  - Establish pathways to care to assist in early identification and access for people with suicidal behaviour or ideation.
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\(^\text{ix}\). 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.

Minimum requirements

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\textsuperscript{viii}.

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/pd/2012/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.

Minimum requirements

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 facilitiesix 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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<th>Minimum requirements</th>
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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>
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<tr>
<td>• Understand current clinical and legal responsibilities in the delivery of mental healthcare</td>
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<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>
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<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>
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<td>• Deliver evidence-based clinical practice in the assessment and management of people with suicidal behaviour and ideation</td>
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<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>
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<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. |
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”.

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
• 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 are responsible for ensuring:

• 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

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer of Care from Mental Health Inpatient Services</td>
<td>PD2012_060</td>
</tr>
<tr>
<td>Children and Adolescents with Mental Health Problems Requiring Inpatient Care</td>
<td>PD2011_016</td>
</tr>
<tr>
<td>Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services</td>
<td>PD2010_037</td>
</tr>
<tr>
<td>Clinical Handover – Standard Key Principles</td>
<td>PD2009_060</td>
</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>
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 s59 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 9085 5588 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 131 444.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOME ADDRESS**

Where is the patient currently located? e.g. Inpatient, Accident and Emergency, at residential address etc.

<table>
<thead>
<tr>
<th>ADDRESS WHERE PATIENT WILL BE DISCHARGED (IF DIFFERENT FROM RESIDENTIAL ADDRESS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>ADDRESS WHERE PATIENT WILL BE DISCHARGED (IF DIFFERENT FROM RESIDENTIAL ADDRESS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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.

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

Does the person have access to their own firearms/prohibited weapons?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**HEALTH PROVIDER INFORMATION**

<table>
<thead>
<tr>
<th>Medical Practitioner</th>
<th>Psychologist</th>
<th>Reg/Enrolled Nurse</th>
<th>Social Worker</th>
<th>Counsellor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME**

<table>
<thead>
<tr>
<th>CONTACT NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE**

<table>
<thead>
<tr>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE</th>
</tr>
</thead>
</table>

**Version 3.0 February 2013**

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13. MENTAL HEALTH 13.21

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>
</table>

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

<table>
<thead>
<tr>
<th>Poisonous substances kept in locked cupboard or storeroom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Reagents</td>
</tr>
<tr>
<td>Cleaning fluids</td>
</tr>
<tr>
<td>Any other hazardous material</td>
</tr>
</tbody>
</table>

### Windows – structure and design

<table>
<thead>
<tr>
<th>Are windows in the facility made of full glass, meshed glass or small panes</th>
</tr>
</thead>
</table>

### Safety policy and procedures

<table>
<thead>
<tr>
<th>Routine search of patient on admission and return from any period of leave off the unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further search of patient when there are grounds for suspicion</td>
</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>
</tr>
<tr>
<td>Access to areas of particular risk – bathrooms, kitchens, toilets</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>
</tr>
<tr>
<td>Incident reporting, investigating and reviewing</td>
</tr>
</tbody>
</table>

### Actions required to reduce risk:


---

**Implementation procedure:**

**Completed by:**

**Name:**

**Signature:**

**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 a, Prof J John Mann MD b
  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. 1No. 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

**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
Cultural Considerations & Communication Techniques: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person.

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
   Centre for Suicide Prevention Studies, The University of Queensland, Brisbane.
iii. Seeking Solutions to Self-Injury: A Guide for Emergency Departments
   Centre for Suicide Prevention Studies, The University of Queensland, Brisbane.
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-focussed conversations, intervention-focussed conversations and postvention-focused conversations occurring in the community. http://www.conversationsmatter.com.au/professional-resources

Suicide Postvention Guidelines

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


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
13. MENTAL HEALTH

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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.

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.


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.
13. MENTAL HEALTH

- 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

| **Acute inpatient mental health setting** | 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. |
| **Community mental health setting** | 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. |
| **Consensual sexual activity** | Sexual activity that occurs after mutual sexual consent has been provided by those involved. Also see ‘sexual consent’. |
| **Consumer** | Someone with a mental illness or disorder that uses a mental health service. |
| **Gender sensitive practices** | The different needs of men and women are considered in all aspects of service planning and service delivery. |
Informed decision | 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.

Mental health service | Any establishment or any unit of an establishment that has the primary function of providing mental health care.

Mental health workers/staff | 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.

Non-acute and residential mental health settings | 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.

Perpetrator/offender | Someone who has breached the sexual safety of a consumer.

Sexual activity | Activity of a sexual nature with oneself (masturbation) or another (sexual touching, sexual intercourse, oral sex).

Sexual assault | Sexual assault occurs when:
- a person is forced, coerced or tricked into sexual acts against their will or without their consent, or
- a child or young person under 16 years of age is exposed to sexual activities, or
- 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 infertility; 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)\(^1\)

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.

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-

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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.

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.

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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.

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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.

### 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
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>
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<tbody>
<tr>
<td>To be completed by June 2014</td>
<td></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>▪ 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>
### Local Health District (LHD) | Individual service
---|---
To be completed by June 2015

- Develop local policies and procedures to support services to meet the requirements of the *Sexual Safety of Mental Health Consumers Guidelines* and Policy Directive
- Develop processes and documentation to support services to review and assess their:
  - level of gender sensitivity
  - physical environment
  - violence screening and admission processes
  - reporting processes
- Review the following areas of service practice and assess against the Guidelines:
  - level of gender sensitivity
  - physical environment
  - violence screening and admission processes
  - reporting processes
- 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
- Promote the availability of the training once it is released by MHDAO and advise of the need for staff to participate
- Implement training/education plan for staff and consumers
- Ensure future training plans factor in the need for refresher training
- Communicate with services to determine progress with implementation and request completion of the Individual Service Implementation Monitoring Form
- Complete and submit the Implementation Verification Form to MHDAO, according to specified timeline
- Complete Individual Service Implementation Monitoring Form
## 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>
</tr>
</thead>
<tbody>
<tr>
<td>Authorised by Service Manager</td>
<td>Name</td>
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<tr>
<td></td>
<td>Signature</td>
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</table>

<table>
<thead>
<tr>
<th>First progress report</th>
<th>Second progress report</th>
<th>Third progress report</th>
<th>Final progress report</th>
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<td></td>
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</tbody>
</table>

- **Has your service……..**
  - NOT COMMENCED
  - UNDERWAY
  - COMPLETED

  - Nominated a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a service level?
  - Ordered adequate hard copies of Guidelines to support ready access by staff, consumers and carers?
  - Introduced the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicated about the implementation process?
  - Developed and implemented a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service?
  - 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?
  - 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
  - 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?
  - Consulted with staff, consumers and carers re training/education needs and provided this feedback to identified LHD champions?
  - Developed a training and education plan that identifies which staff must participate in training and which consumers are interested in education?
  - Implemented your training and education plan for staff and consumers upon the release of the new training based on the Guidelines?

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

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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>
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</thead>
<tbody>
<tr>
<td>Verified by Mental Health Director</td>
<td>Name</td>
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<tr>
<td></td>
<td>Signature</td>
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<tr>
<td>First progress report</td>
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<tr>
<td>Second progress report</td>
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<tr>
<td>Third progress report</td>
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<tr>
<td>Final progress report</td>
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</tbody>
</table>

IMPLEMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th></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>Notes:</td>
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<td></td>
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<tr>
<td>Notes:</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>
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<td></td>
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SUBMIT COMPLETED FORM TO MHDAO BY EMAIL AT, MHDAO@doh.health.nsw.gov.au

192(14/11/13)
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.


This document can be accessed at the following link:


AGED CARE – WORKING WITH PEOPLE WITH CHALLENGING BEHAVIOURS IN RESIDENTIAL AGED CARE FACILITIES (GL2006_014)

This document can be accessed at the following link:


TRANSFER OF CARE FROM MENTAL HEALTH INPATIENT SERVICES (PD2016_056)

PD2016_056 rescinds PD2005_121

PURPOSE

This Policy Directive provides amendments to PD2012_060 but retains the title *Transfer of Care from Mental Health Inpatient Services*. The policy has been revised to include the requirement that all patient leave decisions are to be considered by a multidisciplinary team before they are approved by the relevant authorised medical officer in accordance with Safety Notice SN004/16. References to the Mental Health Act 2007 (the Act) have also been updated in line with 2014 amendments to the Act.

This Policy Directive promotes safe and effective transition of all mental health consumers between inpatient treatment settings, and from the hospital to the community. The procedures map a structured process for the transfer of care that will:

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

This Policy Directive and the procedures provide direction and guidance but do not replace the need to exercise clinical judgement for each presentation and recognition of the current workplace environment to maintain safety and continuity of care.

MANDATORY REQUIREMENTS

Local Health District implementation

This Policy Directive applies to all inpatient mental health facilities. Local Health Districts (LHDs) and Specialty Health Networks (SHNs) – the Justice Health and Forensic Mental Health Network, the St Vincent’s Hospital Network and the Sydney Children's Hospital Network, must have local policies and procedures in place that are consistent with the principles and procedures identified in this policy including the updated requirements for leave planning and approval, and for the reporting of absconding incidents.

Mental health service evaluation

LHD and Specialty Health Network (SHN) mental health services must monitor and evaluate their local transfer of care practices on a regular basis.

Training and orientation

LHD / SHN mental health services must be aware of the principles and procedures for safe and effective transfer of care planning including the management of leave.

IMPLEMENTATION

Roles and responsibilities of the NSW Ministry of Health:

- Provide advice and assistance for the implementation of this Policy Directive
- Monitor and review the implementation of this Policy Directive.
Roles and responsibilities of LHD Chief Executives:
- Assign responsibility, personnel and resources to implement the principles and procedures for mental health service settings
- Report annually on the implementation of transfer of care principles and procedures to the NSW Ministry of Health.

Roles and responsibilities of Directors of Mental Health:
- Facilitate development of District-wide transfer of care and leave policy and procedures that:
  - Are consistent with the state-wide policy directive’s principles and procedures
  - Include protocols for managing a consumer’s transfer of care to the community outside of usual working hours, at weekends and during holiday periods.
- Develop a transfer of care checklist to ensure that all steps of the procedure are carried out
- Educate clinical staff in the principles and procedures for transfer of care planning
- Ensure the principles and procedures for transfer of care planning are incorporated into orientation programs for new clinical staff
- Ensure transfer of care practices are regularly monitored across their services and feedback on results is provided to staff
- Report to the NSW Ministry of Health on the key performance indicators and service measure identified in this Policy Directive.

Roles and responsibilities of hospital, facility, clinical stream, unit managers and heads of departments:
- Implement the local policy for mental health transfer of care
- Ensure that designated carers and primary care providers, family members, other health care providers and community support services participate in the process of planning for transfer of care as appropriate (see Procedures)
- Evaluate compliance with the principles and procedures for transfer of care planning
- Annually monitor and evaluate local transfer processes in line with the principles and procedures for transfer of care and report to LHD / Network Director of Mental Health.
- Only Authorised Medial Officers can approve leave for a patient held involuntary under the Mental Health Act.

Roles and responsibilities of all clinicians:
- Ensure their work practices are consistent with the principles and procedures for safe and effective transfer of care processes.

Key Performance Indicators
Transfer of Care as set out in this Policy Directive aims to address two key state targets to improve mental health outcomes:
- Reduce re-admissions within 28 days to any facility
- Increase the rate of community follow-up within seven days from a NSW public mental health unit.

In addition, the following quality and safety service measure has been established:
- The number of involuntary patients absconded from an inpatient mental health unit.
1 BACKGROUND

1.1 About this document

For many mental health consumers, the period after leaving a mental health inpatient unit is a particularly vulnerable time. This document sets out the principles and requirements for safe transfer of a mental health consumer’s care across treatment settings. It particularly focuses on the ongoing care needs of consumers who are returning to the community following an episode of inpatient care or who are on approved leave from an inpatient unit. The document 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.

Transfer of care is a structured, standardised process for ensuring the safe, efficient and effective transition of people with a mental illness between inpatient settings and from hospital to the community. Transfer of care is part of the continuum of care that starts with the person’s admission to hospital.

Effective transfer of care planning is delivered by mental health services that are responsive to consumer needs and inter-linked with other agencies, service providers, carers and the consumer, using a collaborative approach.

The National Standards for Mental Health Services 2010 apply to the range of mental health services, government, non-government and the private sector. A number of consumers under the care of private psychiatry or psychology services may also access public acute services when their private clinicians are not accessible in crisis situations. Therefore partnerships between public, private and non-government sectors in mental health are important.

With increased complexity of mental health presentations, there is a strong need for a multidisciplinary approach. Health professionals from all disciplines need to work closely together to develop and implement a comprehensive transfer plan.

Transfer of care to the community is to be effected in accordance with the principles and requirements of the Mental Health Act 2007 (the Act), and by obtaining and complying with any order of the Mental Health Review Tribunal, such as Community Treatment Orders.

The NSW Health policy and reference manual for Care Coordination from Admission to Transfer of Care in NSW Public Hospitals (PD2011_015) set out standards and a framework for handling the needs of all consumers leaving hospital care which are generally applicable to the mental health inpatient care pathway. This mental health inpatient transfer of care policy expands the standards established in PD2011_015 and provides more detailed direction for clinicians working with people with mental illness to address their specific safety and care needs.

Thorough assessment and management of risks are essential elements of the transfer of care planning process for all mental health consumers.

The procedures support standardised development, implementation and review of local transfer of care processes. Note, this document does not look at the models of care; instead, it specifically refers to the process involved in transfer of care from a mental health inpatient unit.

2 ‘Transfer of care’ replaces the term ‘discharge’ in this document to reflect a continuum of care. Where reference is made to the Mental Health Act 2007, the term ‘discharge’ is used to reflect the Act.
Scope of policy
This policy refers to situations where the mental health consumer’s care is transferred from a mental health inpatient unit to:

1. Another Inpatient Service:
   - Public mental health unit
   - Private psychiatric hospital
   - General hospital ward.

2. The Community:
   - Community mental health service
   - Consumer in conjunction with family / carers
   - General practitioners and private mental health professionals
   - Government and non-government organisations
   - Combinations of the above.

3. Approved leave
   This policy recognises approved leave as a transfer of care situation and identifies the basic requirements for promoting safety during and following a consumer’s period of leave in the community.

When Psychiatric Emergency Care Centres (PECCs) transfer consumers either to an inpatient service, or to the community, the principles and practices required under this policy apply, as far as practicable. Although the principles and procedures set out in this policy are relevant to forensic and correctional patients, transfer of care for these patients has additional requirements that are not addressed in this policy.

Likewise, the additional requirements involved in a consumer’s transfer from a mental health inpatient unit to a general hospital ward are not dealt with in this policy.

Many episodes of inpatient care involve movement between units or wards while continuing as a single episode of care and under the same team. This policy does not include points of transfer of care within the inpatient unit such as between shifts, internal units or teams, as these are covered in the Clinical Handover – Standard Key Principles policy (PD2009_060).

The definitions of ‘discharge’ and ‘leave’ for data reporting purposes remain unchanged as identified in the Admitted Patient Data Dictionary.

1.2 Key definitions

Authorised medical officer as defined in the Mental Health Act 2007.

Carer/s in this document refers to the two categories of carers identified in the Mental Health Act 2007: designated carers (s72) and the principal care provider (s72A)

Consumer refers to a person under the care of a NSW LHD Mental Health Service. The term ‘patient’ is only used in this document when associated with legal status.

Continuity of care involves a consistent, connected and coherent approach that is responsive to the consumer’s health needs and personal context.

Guardian as defined in the Mental Health Act 2007.

Transfer of care involves the transfer of professional responsibility and accountability for care of a mental health consumer to another person or professional or a combination of professionals.
Transfer of Care Plan refers to a tailored package of information setting out details of treatment, referrals, advice and support arrangements for the information the consumer, carers, community based health professionals and NGO support services to promote continuity of care and safety. Components of the Transfer of Care Plan package are given to the consumers and care providers as relevant to their particular role in supporting the consumers care and recovery.

Where a person has an appointed guardian, the guardian will be the designated carer

1.3 Legal and legislative framework

The development of this policy has been informed by key aspects of NSW legislation, government policy and plans. The policy also puts into effect coronial recommendations concerning transfer of care issues and those of other formal enquiries.

See Attachment 7 for further details.

2. SAFE, EFFECTIVE AND EFFICIENT TRANSFER OF CARE

Continuity of care is one of the cornerstones of good clinical practice. It requires clear and agreed governance arrangements within and between services and agencies, supported by competent, confident staff with the necessary resources to work in partnership and to involve consumers and their carers appropriately at all stages in their care. The development of shared understanding and common objectives is crucial. This should involve key staff in different services together with consumers and their carers and/or guardian. Planning is required to ensure that transfer of care between services is conducted in a timely and streamlined way in order to promote optimal outcomes for the consumer.

2.1. Principles for transfer of care

To ensure quality, safety and efficiency, transfer of care is based on the following principles:

- Admission and transfer of care are part of a continuum of care
- The consumer and their family/carer/guardian are at the centre of care and are partners in care
- Collaboration between public and private mental health services, primary care, other government agencies and non-government organisations is more effective in comprehensively addressing consumers’ and carers’ needs
- Clear and timely communication practices supported by efficient information technology minimises risk of harm to the consumer and others
- Standardised and monitored transfer of care processes support continuous system-wide improvement
- Clinicians at all times must comply with the requirements of the Mental Health Act 2007 (the Act). Any inconsistencies between this policy and the Act, the provisions of the Act take precedence. Of note is that the moment a person does not meet the criteria for involuntary detention they should be made voluntary or allowed to leave.

2.2. Summary of essential actions

Essential components for safe, effective transfer of a mental health consumer’s care:

- Undertake admission assessment including assessment of risks (e.g. suicide, harm to others, sexual exploitation, absconding, homelessness)
- Conduct a multidisciplinary review and identify a care coordinator
- Estimate date for transfer
• Communicate estimated date for return to the community to consumer, carers, and other relevant parties

• If care planning includes periods of leave, develop and document plans and conditions for approved leave with the involvement of the multidisciplinary team, the consumer, those caring for the consumer whilst on leave, and where relevant, community based health and recovery support services.

• Develop and document Transfer of Care Plan package with the participation of the consumer, family / carers / guardian, community support agencies, and health professionals providing ongoing treatment.

• Book referral services with consideration of waiting times or waitlist of the receiving service.

• Prior to transfer to the community:
  o Discuss the consumer’s transfer readiness and needs at a multidisciplinary team review
  o Ensure a consultant psychiatrist review has been conducted within 24-48 of transfer
  o Conduct risk assessments, and reconsider consumer’s readiness immediately before transfer to the community
  o Document modifications to management of risks and other changes in the Transfer of Care Plan
  o Provide consumer with prescribed medication
  o Provide relevant components of the Transfer of Care Plan package to the consumer and family / carer / guardian, GP, community mental health service, private health professionals and non-Government support agencies.

The Transfer of Care Plan is a package of documents that together provide comprehensive information for the consumer, family/carers community based health professionals and other service providers involved in the consumers ongoing care and support. Components of the package should be tailored to the recipient’s needs. For example, information provided to another mental health professional who will be resuming the person’s care may not include emergency contact details but this would be important information for the consumer or carers.

When developed for a consumer returning to the community, the consumer’s right to privacy must be considered and any information provided to support services must be directly related to their service role. The package would be expected to set out advice such as emergency contacts, follow up appointments, support service arrangements, detection and management of possible risks and medication details. It should:

• Include the Transfer/Discharge Summary
• Be guided by relapse prevention and recovery focused principles, and
• Take into account ongoing physical health care needs
• Be written in plain language and where necessary include information in community languages
• Ensure that the consumer’s right to privacy is observed
• Outline supports available for consumers and carers.

When transferring to another inpatient service, the transfer of care plan is expected to include a detailed clinical and social history, risk assessment information, relevant psychosocial information.
2.3 Procedure for Transfer of Care to another Inpatient Service

This policy also applies in circumstances where a mental health inpatient’s treatment has been completed in one setting and is being transferred to another inpatient service for ongoing care.

LHDs have the responsibility for ensuring that their local policy and procedures for transfer to another inpatient service comply with the principles set out in section 2.1 above and the standards established in this policy.

It is expected that the transferring unit and receiving units meet all the requirements and criteria of the admitting service and at a minimum address:

- Documentation provided to admitting service:
  - Full information on consumer’s history
  - Transfer / Discharge Summary
  - Relevant reports, case summaries and materials requested as per receiving unit’s admission policy
  - Recent investigations, tests and reports
  - Updated risk assessment and management plan
  - Updated care plan
  - Medication details.

- Requirement to phone the other service to confirm transfer
- Documentation in the transferring unit shows that staff have informed the carer/s, the GP and other agencies involved that the consumer’s care is being transferred to the other inpatient service.
- Completion of K10/HONOS
- Transfer of Care Plan documented in medical record
- Medical entry in file including follow up plan
- Ward clerk notified of discharge
- Consumer’s name removed from white board
- Discharge details recorded in Admission/Discharge Register
- Treatment sheet placed in clinical file
- Valuables transported with consumer
- Copy of Transfer of Care Plan and associated information provided to admitting service at transfer
- Your Experience of Service (YES) survey questionnaire given to consumer
- Transport arranged.

Attachment 4 provides a sample checklist to monitor this process.

2.4 Procedure for transfer of care to the community

Successful transfer of care is facilitated by good admission and pre-discharge planning with consistent senior staff support throughout the process.

The decision to transfer a consumer rests with the treating psychiatrist in discussion with the multidisciplinary team.

Transfers from a mental health inpatient unit to another inpatient service are guided by the Principles set out in section 2.1.

Six stages for effective transfer of care to the community are detailed on the following pages. It is recognised, however, that in some situations, for example for brief acute admissions, the completion of the detailed procedure set out in these six stages may not be practicable. See section 2.4.1 for further advice.

287(8/12/16)
Six stages for effective transfer of care for mental health consumers returning to the community.

**STAGE 1: Initial Planning for Transfer of Care – Inpatient Unit**

- Admission assessment including comprehensive assessment of risks (e.g. suicide, harm to others, homelessness, sexual exploitation, domestic violence, D&A abuse, physical health, absconding, adherence to treatment, cultural and language issues).
- Multidisciplinary review and identify a key clinician / care coordinator responsible for ensuring all steps of the transfer of care process are completed and documented.
- Within 72 hours of admission to an **acute** unit, document an estimated date of transfer (EDT*), taking into account assessment information related to the consumer’s likely needs (e.g. accommodation, support with daily living skills, support with parenting, support to reduce isolation, support with employment) and any risks at that time. For Psychiatric Emergency Care Centres (PECCs) the EDT is to be documented within 24 hours of admission.
- Notify consumer, carers / guardian, GP, community care coordinators and community support providers of the EDT as appropriate.
- Conduct regular reviews of EDT, adjust where appropriate. Keep consumer, carers, community mental health and other relevant parties informed of the progress.
- Make early referrals and seek engagement of new / next care providers in transfer planning.

*‘EDT’ is equivalent to the term EDD (Estimated Day of Discharge) in current operational practices.*

**STAGE 2: Planning for Transfer to the Community**

- Develop a Transfer of Care Plan* with the consumer, the carer/s, community based health professionals and support services.
  - Detail as appropriate:
    - Medication/s frequency, dosage and side effects
    - A schedule of medical follow up appointments
    - Contact details for community mental health service and follow up arrangements
    - Signs of possible relapse and what to do
    - Emergency contact numbers
    - Consumer self - management plan (including coping strategies)
    - Crisis management plan
    - Community support arrangements including referrals to other services / programs.
- Provide a copy of the care plan to the consumer and carers and relevant portions of the transfer of care plan package to community based health professionals, and support services, which identifies their roles and allows them to confirm their willingness and capacity to participate as envisaged. Provide any risk information, which service providers may need to consider in relation to their capacity to respond.
- Where relevant, develop a service coordination plan that clarifies the different roles and responsibilities of each community based service provider and promotes improved communication and safety, and formalises the professional responsibility of each provider towards the consumer. The consumer and carers should be involved in this action. Family members / close friends should be involved as appropriate.

*The Mental Health (MH) Clinical Documentation - Care Plan module and the Consumer Wellness Plan module may be used to document components of this package.*

**Note:** Section 2.5 - Leave from inpatient units; Section 3 - Transfer of Care Planning for Specific Population Groups
STAGE 3: Preparation for Transfer of Care

- Take into account legal status including Community Treatment Order (CTO), Trustee, Guardianship, or Child Protection Issues.
- Where necessary, arrange for the relevant community mental health team to make application to the Mental Health Review Tribunal (the Tribunal) for a CTO. Refer to the Tribunal’s Civil Hearing Kit which details the application process and legal requirements of Tribunal orders.
- Contact and book appointment/s for follow-up with the appropriate health providers (including the GP, community mental health team, relevant private health practitioners).
- Ensure that timing for follow-up appointments is commensurate with the level of risk, mental health acuity and functional capacity of consumer to adhere to the care plan.
- Make referrals to relevant other service providers that clearly outline what the service is being asked to do, and ensure that the other service provider accepts the referral.
- Ensure the consumer completes the MH-OAT consumer-rated outcome measures, unless contraindicated, and the measures are reviewed by a clinician.
- Encourage and support consumer to complete and return the MH-Copes questionnaire. Explain how the questionnaire fits within the quality improvement framework of the service.
- Provide information to consumers on the community consumer worker services and other peer support programs.
- Conduct a physical health assessment and examination in accordance with PD2009_27 and GL2009_007 (and record in the MH-Clinical Documentation Physical Examination module).

Link to MH Clinical Documentation Modules

STAGE 4: Confirming Readiness for Transfer of Care (within 24-48 hours of transfer)

- A consultant review must be undertaken within 24-48 hours prior to transfer of care, by a consultant, either face to face or via telepsychiatry. The review is to be discussed with the carer/s and documented in the clinical record.
- Complete HoNOS/65+/CA and K10+. If HoNOS and K10+ are inconsistent with each other, or your clinical impression, discuss with the senior clinician and the consumer and/or family/carer prior to transfer.
- Ensure medication is available for use during initial period post transfer. In addition, confirm with the consumer if a prescription for nicotine replacement therapy (NRT) is required.
- Ensure that the General Practitioner and where relevant, other health care providers
  - Have community mental health service contact details
  - Agree on follow-up action if a consumer fails to attend the initial or subsequent appointments
  - Know how to seek specialist advice concerning the consumer’s ongoing care
  - In situations where the consumer will be transferred to a hospital without onsite mental health care (e.g. rural hospital), the treating team must ensure that inter-hospital transfer and admission arrangements, including referral to the local community mental health service, have been made.
- Document follow-up and support arrangements in the Transfer/Discharge Summary (MH-Clinical Documentation module) on, or before, the day of transfer. Where relevant include summaries from other members of the treating team. The Transfer/Discharge Summary must:
  - Specify the person/service responsible for ongoing treatment/actions and
Include clear advice about:
- Recent changes to clinical management
- Medication requirements
- Any relevant risks
- The follow up plan
- Contact details of support services / GP involved in ongoing care and whether they were notified of transfer date
- Details of scheduled appointments.

Indicate whether or not a copy the MH Clinical Documentation Transfer/Discharge Summary module was provided to consumer and carer/s.

**Note:** Section 2.4 Consumers at Risk of Harm to Self or Others

**STAGE 5: At the point of Transfer of Care**

- Check medication supply and prescriptions are provided to the consumer or carers in accordance with Transfer/Discharge Summary.
- Discuss arrangements for subsequent medication and supervision of medication with consumer and carers or other family members / care providers, with the consumer’s consent.
- Ensure that consumer / or carers understands and signs the Transfer of Care Plan and the Consumer Wellness Plan. If the consumer is under 16 years old, ensure that both the consumer and their parents/primary carer understand the plan.
- Provide a copy of the care plan for transfer to the consumer and carers. In circumstances where the consumer opposes access to such information being provided to a carer, it may be necessary to negotiate the carers’ access to certain information that is essential to support safe return to living in the community for the consumer and others. (For further guidance see Attachment 2: Disclosure of Information to families and carers). If the consumer is under 16 years old, provide
  - Their own copy of the Transfer of Care Plan or other tailored developmentally appropriate information, to the young consumer and
  - A separate copy of the Transfer of Care Plan directly to the parent and / or carers.
- Provide relevant information leaflets to consumer / carer.
- Provide a verbal handover to the mental health community team at the point of transfer.
- With the consumer’s agreement, provide relevant information to Community Managed Organisation (CMO) involved in providing immediate support. (For further guidance see Attachment 2: Disclosure of Information to recovery support services and other community based service providers).
- Fax / Email a copy of the Transfer / Discharge Summary (within 12 hours) to the general practitioner and other health professionals who will provide care. Where appropriate and in line with Mental Health Clinical Documentation guidelines, attach:
  - Current Care Plan
  - The Transfer of Care Plan
  - Consumer Wellness Plan
  - Physical Examination module.
- Place copies of the Transfer of Care Plan and Transfer / Discharge Summary in consumer’s file.
STAGE 6: Assertive follow-up - Community Mental Health Service

- Make direct contact with the consumer within the timeframe indicated in the Transfer of Care Plan or at a maximum within seven days to:
  - Monitor the consumer’s progress against the plan after leaving hospital; discuss problems arising and commence future management planning
  -Prompt the consumer about appointment(s) and follow-up plans.
  - This contact may be face-to-face, by telephone or videoconference.
  - It may also be worthwhile contacting the consumer’s carers.
- If the consumer does not attend his / her appointment, initiate follow-up according to agreed arrangements.
- Where the consumer does not attend an appointment and there is persistent refusal to do so, discuss at a multidisciplinary team meeting whether a Community Treatment Order (CTO) should be sought from the Tribunal.
2.4.1 Short mental health inpatient stays

An inpatient stay of less than 48 hours, such as an admission to a PECC, is often associated with additional risks and problems such as inability to contact carers, inadequate access to clinical history, corroborating information and existing documentation. Transfer to the community in such situations should be reviewed by a consulting psychiatrist. LHD mental health management may determine some specific circumstances where exceptions can be made. In addition LHD mental health services need to establish a protocol setting out the minimum requirements for transfer of care for these admissions.

2.4.2 Monitoring

Monitoring and evaluation are essential processes to promote the delivery of responsive, effective transfer of care. LHDs should develop a transfer of care checklist to ensure that all steps of the process are carried out as far as practicable. See Attachment 3 for a sample checklist. Transfer of care planning and outcomes for consumers must be routinely monitored and periodically evaluated in conjunction with other mental health continuous improvement processes. See Attachment 4 for a sample of a self-assessment tool to monitor the transfer of care process (developed by the Victorian government).

2.5 Leave from inpatient units

Planned leave can play an important role in a consumer’s gradual return to the community. However, evidence demonstrates that during leave, mental health consumers are at an increased risk of suicide. Decisions to grant leave should be made in the context of multidisciplinary team discussion of treatment goals and strategies in the consumer’s treatment plan. Leave decisions need to take into account the risks and expected benefits of leave, the rights of the consumer, their family and carers. Risks, include, but are not limited to, risk of harm to self and others (including any child protection issues), and the likelihood and consequences of substance abuse.

287(8/12/16)
LHD / SHN mental health services must re-examine leave protocols to ensure they address:

- Specific criteria and purpose for granting leave
- Development and documentation of a leave plan
- Engagement and consultation with family / carer / CMO
- Requirement for all consumers to have documented risk assessments and risk management plans which are considered in consultation with the multidisciplinary team and referenced in documentation of all leave decisions.

- Procedures to follow where:
  - Newly admitted persons request leave
  - Voluntary consumers seek unplanned leave and
  - Requests for leave are made after hours, at short notice, or on weekends when the treating team is not present.

- Documentation requirements for:
  - The leave plan
  - Post-leave feedback from the consumer, family / staff about any issues of concern arising during the leave
  - Mechanism for post-leave report to inform clinical reviews
  - Post-leave consumer search procedures, in accordance with local search and safety policies
  - Steps to be taken by health staff when any consumer
    - Does not return from leave as agreed
    - Is missing/absent without leave from the unit, and
    - The circumstances and procedures for when Police should be notified.

Processes for monitoring unit leave practices.

It is expected that each LHD will develop checklist/s in regard to inpatient leave from, and return to, units that take into account the nature of the unit.

Note, the additional transfer of care requirements for a mental health inpatient on leave to a general hospital ward are not set out in this policy, and must comply with the hospital’s inter-ward transfer procedures.
2.5.1 Management of planned leave

Leave planning

Where possible, leave should be planned well in advance in the context of treatment goals and discussed by the multidisciplinary team, in consultation with the consumer and carers (where this is relevant).

The leave plan will:

- Document
  - A statement of its purpose
  - The consumer’s departure and return times
  - Any special conditions (e.g. escorted, whether the consumer should avoid driving or other restrictions)
  - Medication and supervision arrangements
  - Contact numbers for the consumer, carer and mental health unit
  - Identification of the services or persons responsible for managing risks during leave including any role for primary care services, community mental health services, or family members and / or carers
  - Guidance for the consumer and the family / carer concerning measures to manage risks during leave (e.g. self-harm / suicide; harm to others; domestic violence; the likelihood and consequences of substance abuse)
  - The provision of a crisis plan if difficulties arise during the leave period, and
  - Written advice and information provided to family / carer prior to the leave.

- Be approved in writing by the treating psychiatrist or his / her delegate, following consideration by the multidisciplinary team
  (Note that under the Mental Health Act 2007, the clinician approving leave for an involuntary patient must be an authorised medical officer).

- Be provided to the consumer, the carer/s (as appropriate) and relevant clinical staff.

Preparation for Leave

The consumer’s mental state and risk assessments should be reviewed immediately before planned leave, and if necessary leave arrangements may be altered or cancelled.

- Where appropriate, involve the acute community care team to ensure after hours support, flexible assertive community support and prompt intervention in crisis situations.
- Provide a comprehensive record of the short leave plan and any changes in the consumer’s health care record.
- Provide details of the support available to the consumer from family / friends.
Negotiate communication pathways with the consumer, the community team and any family member or friend who has accepted responsibility for the care of the person whilst on leave.

Develop a clear agreement with the consumer stating expected time of return, and process for notification if return is delayed. Staff must be alert to the reasons a consumer may provide for changing return timing or arrangements. Consider indications of deterioration of mental state.

Arrangements and responsibilities of leave are to be explained and agreed to by the consumer, and if relevant and appropriate, with family / carers. This will include information and instructions regarding the circumstances and contact details for the mental health unit should the staff need to be contacted.

Where the granting of leave relies on the expectation that the consumer will be supervised by a responsible adult at all times during leave, this should clearly be communicated to both the consumer and the carer/s. If the carer is unwilling or unable to take on this responsibility, decisions regarding leave should be reviewed, and documented.

Attention must be given to granting leave to involuntary patients who should be escorted by a staff member (or a family member / carer if appropriate). This will include information and instructions regarding risks and responsibilities of escorted leave; and the circumstances and contact details for the mental health unit should the staff need to be contacted.

Very short periods of unescorted leave for example, within the hospital grounds or to go to the local shop, are often a component of the consumer’s staged leave plan. This planning must also follow the standards identified above, and ensure that the risks, including the risk of absconding, have been considered by the multidisciplinary team and approved by the treating psychiatrist.

Before the consumer leaves, the clinical staff need to be assured that the person is able to understand the nature of the leave. The clinical staff also need to be satisfied that the person can do what is expected of them during leave, and be satisfied that the risks are known and can be contained within the limited nature of this leave occasion. Details of very short leave periods must be recorded in the consumer’s health care record.

Handover process on return

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

Inpatient staff must speak with the consumer and, where relevant and appropriate, with the family / carers after leave to find out about any concerns arising during leave. An assessment of the leave is to be documented in medical record and the impact of this information on management /ongoing care planning, needs to be considered.

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

In accordance with the requirements of the Mental Health Act 2007 and the LHD search protocols, the authorised medical officer should consider whether, for the safety of the person, other consumers, and staff, the consumer should be searched for potentially dangerous items on their return.

Short leave arrangements should be a consideration when developing the consumer’s leave plan and need to follow the principles outlined above.
2.5.2 Procedures for locating missing patients

LHD leave protocols must address the safety needs of both voluntary and involuntary consumers and:

- Clearly set out the procedures that mental health staff must follow if a consumer
  - Fails to return from leave as agreed, or
  - Is missing from the unit, and is considered to be at high risk of harm to self or others.

- Identify steps to be taken to locate and safely return the consumer to the inpatient unit including:
  - Notifying senior nursing and medical staff (treating psychiatrist or on call psychiatrist)
  - Contacting the family / carer
  - Noting that involuntary patients who have absconded are able to be apprehended and returned to the mental health facility in accordance with the Act
  - If the patient is a voluntary patient but there are concerns about the patient’s risk to themselves or others, consideration of initiating detention processes under procedures under s19 or s22 of the Mental Health Act 2007
  - If not seeking to detain the person, guidance around notifying the police to request a welfare check
  - Completion of relevant absconding incident reporting type in IIMS / Riskman
  - On the consumer’s return to the unit:
    - Re-assess his / her mental state and risk status
    - Review observation/supervision category
    - Interview the consumer to ascertain any factors that contributed to the absconding incident.

2.6 Consumers at risk of harm to self or others

2.6.1 Risk of harm to self

For mental health consumers, periods of inpatient leave, the time following return to the unit, and the first 28 days following transfer to the community are recognised as times of increased risk of possible self-harm or suicide. Ongoing care planning must take into account these risks to promote a safe transition.

Prior to transfer from an inpatient unit, the suicide risk status of a person must be reassessed to determine whether transfer to the community (including leave) can be approved at this time. The timing of this risk assessment may be up to 48 hours prior to the transfer, but the timeframe must relate to the consumer’s clinical situation. For example for overnight leave, for a person recently admitted, or one who has had a change of status, the risk assessment must be conducted within 24 hours of the transfer.

The risk assessment and the time it is conducted must be recorded in consumer’s notes. If the transfer continues, this information must be conveyed in writing to the receiving mental health service, private health providers and any agencies to which the consumer is being referred for support services.

A proportion of mental health consumers will be at chronic risk of suicide or self-harm and will need inpatient care when that risk is elevated. Once that level of risk has been reduced, further treatment in the inpatient environment may not be considered by the treating team to offer additional health or safety benefits. It is essential to ensure that the person has appropriate supports in place when they return to the community so that the risk is minimised. If the consumer is returning home or to supported accommodation, any current and ongoing risk of self-harm should be conveyed to the family and service provider who is providing ongoing care, along with recommendations of how to manage the risk and access help.

For consumers who have been hospitalised for lengthy periods, the impact of their return to the community, and their ability to cope, should be assessed sensitively. Associated risks should be identified and addressed.

Consult NSW Health’s Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units.

If the consumer is known to have access to a firearm, staff should consider the need to complete a Notification to NSW Police and Firearms Registry Form (refer to copy at Attachment 5).

2.6.2 Risk of harm to others

Prior to transfer (and leave), a further assessment of risk of harm to others, including any risk to children who are in contact with the consumer, must be conducted.

Based on this risk assessment and others conducted during the admission, a management plan must be documented in the Transfer of Care Plan and Transfer / Discharge MH-Clinical Documentation module. The consumer’s readiness to return to the community at this time should be reconsidered.

CMO service providers need to be provided with information about the client that is directly related to their service role, including the nature and level of any risks.

If the consumer is known to have access to a firearm, and there is an assessed level of risk to others, staff are required to complete a Notification to NSW Police and Firearms Registry Form (refer to copy at Attachment 5).

NSW Health staff who suspect, on reasonable grounds, that a child or young person is at ‘risk of significant harm’ from abuse or neglect must report these concerns to the Community Services’ Child Protection Helpline (13 36 27) as required under the Children and Young Persons (Care and Protection) Act 1998. Refer to the following Information Bulletin – KEEP THEM SAFE – Making a Child Protection Report (IB2010_005) for procedures on making a report.

The Child Protection Mandatory Reporter Guide (MRG) is a resource to help make a decision about whether to report. The guide is available online at http://sdm.community.nsw.gov.au/mrg/app/summary.page or in hard copy through LHD / Child Wellbeing Units. You may call the Child Protection Helpline to report directly, however the decision to report should always be informed by the Mandatory Reporting Guide which defines the reporting threshold for statutory child protection reports.

For additional guidance, call your local NSW Health Child Wellbeing Unit on 1300 480 420.
2.7 Transfer of care for specific circumstances

2.7.1 Voluntary admissions

Voluntary patients (as defined under the Mental Health Act 2007) can leave hospital at their own request at any time. LHDs should establish protocols for managing the transfer of care to the community outside of usual working hours, at weekends or during holiday periods.

There may be times when a voluntary inpatient seeks transfer of care out of hours, against medical advice, or chooses not to accept ambulatory or community follow-up for mental health treatment. In such situations, inpatient clinicians should maintain a collaborative approach in decision making, and

- Ascertain why the person wishes to leave prior to formal transfer of care.
- Request that the person discusses reasons and follow up management with the person’s consultant psychiatrist or the on-call psychiatrist.
- Inform relevant senior nursing and medical staff to ensure that a review is conducted as soon as possible.
- Involve the carers / family members who are relevant to the clinical decision in discussion about the situation.
- Assess mental status and any safety concerns. After assessing the person, the medical officer should discuss the review with the treating psychiatrist, or on-call psychiatrist. The person can be detained for up to two hours pending assessment by an authorised medical officer. If the voluntary patient needs to be detained in the mental health facility, the involuntary detention provisions of the MHA 2007 (s10) applies. The authorised medical officer must document the reasons for the change of legal status in the medical record. The person and the carers must be informed.
- Assess child protection issues and make appropriate notifications to Community Services in line with the Mandatory Reporter Guide.
- Liaise with the local community mental health service (Adult, CAMHS or SMHSOP as appropriate) to ensure assertive follow up arrangements at home within 24 hours of transfer of care.
- If the treating psychiatrist or on-call psychiatrist agrees to the unscheduled return to the community, document all action by the medical staff and clinical team in the medical record and in the MH-Clinical Documentation Transfer / Discharge Summary.

2.7.2 Involuntary admissions

The transfer of care process for involuntary patients will include consultation with the consumer, their carers, relevant agencies [Mental Health Act 2007 s78 & 79] and take into account the following procedural requirements:
**13. MENTAL HEALTH**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge by Authorised Medical Officer</td>
<td>Consumers must be discharged from involuntary treatment by an authorised medical officer (AMO) if the person is no longer mentally disordered or a mentally ill person, and the AMO is satisfied that care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person [Mental Health Act 2007 s12(2)].</td>
</tr>
<tr>
<td>Community Treatment Order (CTO)</td>
<td>Consumers may be placed on a CTO as part of the planning for safe transfer to the community. Sections 51-56 of the Mental Health Act 2007 (the Act) and clause 8 of the Regulations refer. The rationale for the CTO, and the consumer’s rights and responsibilities in relation to it, must be clearly explained so that can be understood by the consumer and carer. Best practice would indicate that the consumer be included in the development of the CTO care plan.</td>
</tr>
<tr>
<td>Tribunal Discharge</td>
<td>Under Act, a person held involuntarily may be discharged by the Mental Health Review Tribunal (the Tribunal).</td>
</tr>
<tr>
<td>Mentally Disordered Consumers</td>
<td>The discharge of a consumer meeting the criteria of ‘mentally disordered’ under the Act must comply with s 31. The Act also requires a daily re-assessment of any consumers detained as ‘mentally disordered’ are examined by an AMO at least once every 24 hours.</td>
</tr>
<tr>
<td>Guardianship</td>
<td>For the discharge of a consumer under the Guardianship Act 1987, notice must be given in advance to the consumer’s guardian.</td>
</tr>
</tbody>
</table>

### 2.7.3 Consumers on Community Treatment Orders

A Community Treatment Order (CTO), made under the Mental Health Act 2007 by the Mental Health Review Tribunal (the Tribunal), authorises compulsory treatment of a person in the community. A CTO can be an important component in the Transfer of Care Planning and is developed by the community mental health facility that will implement the treatment.

The following factors indicate an application for a CTO may be appropriate:

- Previous history of refusing to accept appropriate treatment leading to relapse into an active phase of mental illness
- Severity of the acute episode and associated recovery and adjustment issues
- Specific rehabilitation needs requiring community care coordination and support
- Past history of poor treatment response or co-morbidity
- Past history of poor adherence to the care plan necessitating a CTO, and
- Ongoing significant risk of harm to self or others.

Section 53 of the Mental Health Act 2007 outlines the issues which the Tribunal must consider in making a CTO. If a new CTO is to be implemented as part of the consumer’s successful transition to the community, it is implemented by the community mental health facility that has developed the CTO treatment plan. The community mental health facility that has developed the CTO treatment plan must allocate a case manager to the consumer. This should occur early in the admission so that the case manager can commence working collaboratively with the consumer and inpatient team prior to transfer of care. The case manager should be involved in the CTO application hearing and be in a position to provide a report as to whether the CTO is capable of implementation, how the consumer will benefit from the order and inform the Tribunal of the efficacy of any previous orders.
3. TRANSFER OF CARE FOR SPECIFIC POPULATION GROUPS

3.1 Children and adolescents

In addition to the general principles for the transfer of care, referred to at the beginning of this document, the following principles should be kept in mind when working with children, adolescents and their families.

- It is imperative that child protection requirements are considered at all stages.
- Children, adolescents and their parents / carers should have opportunities to participate in and contribute to decisions affecting their care.
- Involvement in care planning should take into account developmental stage, age, maturity and circumstances at the time including the nature and quality of parental capacity and involvement.

It is mandatory to involve the child or adolescent’s parents or guardians in planning for the transfer of care if they are under 16 years of age and recommended above that age. In circumstances where the Minister or Director - General of Community Services has parental or care responsibility, a Community Services caseworker must participate in the process.

3.1.1 Multisystem approach to Transfer of Care Planning

Preparing for transfer of care of children and adolescent requires a multisystem approach. The goal is to reintegrate the child or adolescent with family, education and community. In developing a structured Transfer of Care Plan, the following need to be taken into consideration:

- Safety and wellbeing
- Educational needs
- Skills for life
- Parenting issues
- Family and social connectedness.

School and Education

Successful re-integration to school or other learning institutions is an important component of transfer of care planning for children and adolescent. Clinicians should liaise with appropriate staff in the relevant educational institution and exchange appropriate information to guide comprehensive care and re-integration planning, in accordance with requirements of the Health Records and Information Privacy Act.

The Memorandum of Understanding between the NSW Department of Education and Training and NSW Health in relation to the School-Link Initiative supports the development and enhancement of shared care between the two agencies (PD2010_020).

3.1.2 Additional requirements when an adolescent is in an adult inpatient unit

CAMHS staff should facilitate care transitions to and from the adult inpatient unit and contribute to care planning. Adolescents admitted to an adult mental health inpatient unit will be prioritised for transfer to a local CAMHS service wherever possible. Adult units must have active liaison with a CAMHS team. Given the capacity issues within CAMHS, there will need to be agreed procedures set up at the local level for the management and transition of adolescents from adult units back to CAMHS developed by the LHDs.
3.2 Older people

The general principles and practices identified elsewhere in this document must be followed when planning for the transfer of care for older inpatients. In addition, for older people with mental illness or severe behavioural disturbance associated with dementia or other organic brain disorder, particular consideration should be given to:

- The complex interaction of physical health and mental health problems
- Level of physical impairment, particularly whether this presents a risk to the person’s safety or ability to remain in the current residence
- Risk of harm to self or others
- Risk of elder abuse
- Impact of severe behavioural or psychiatric disturbance because of dementia on, for example, the consumer’s accommodation arrangements or community participation
- Requirements for referrals to specialist care and support services such as nursing homes or Aged Care Assessment Teams
- Role of the Guardian (for older people under guardianship) in transfer of care planning.

It is essential to consider undertaking consultation with the LHD’s Specialist Mental Health Services for Older People (SMHSOP) during the consumer’s admission and in relation to transfer of care planning for expert advice on the ongoing care and treatment issues for this group of consumers.

In addition, if the carer of the older person is also aged, consideration should be given to the carer’s capacity to provide ongoing support.

3.3 Consumers caring for infants, children or adolescents

Prior to transfer of care, information regarding any child or children in the consumer’s care previously recorded in the Assessment or Care Plan must be reviewed and documented in the consumer’s medical record. Special attention must be made to risk factors that may impact on the consumer’s capability to care for their children such as:

- Changes in accommodation or level of support
- Changes in level of functioning, and
- The impact of medications or interventions on cognitive functions.

In planning for transfer of care to the community, consideration should be given to:

- Parenting support
- The needs of the child or children in the consumer’s care, and
- Assisting with referrals to early childhood services or child and family services or GP in consultation with the consumer, especially if there is an infant or toddler involved.

For further guidance consult the *NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010 – 2015* (PD2010_037).
If there are continuing concerns about the safety or wellbeing of the child or young person following the transfer of care:

- Other services or agencies may need to be involved; planning for this must occur prior to transfer of care and be included in follow-up arrangements noted in the Transfer of Care Plan
- A report to Community Services must be completed if there is a risk of significant harm (see section 2.4.2). It is recommended the consumer’s nominated clinician responsible for transfer of care refers to the Mandatory Reporter Guide.

### 3.4 Pregnant consumers

Planning for the transfer of care for consumers who are pregnant should include the following:

- Ensure the consumer is connected with a General Practitioner and with antenatal services. Assist with booking if required
- Due to the high risk of relapse, liaise with appropriate maternity services (e.g. Safe Start consultation liaison staff) in accordance with general privacy principles
- If there are concerns that may reasonably be expected to produce a substantial and demonstrably adverse impact on the child after the child’s birth, consideration should be given to making a prenatal report to Community Services Helpline (13 36 27). It is recommended the consumer’s nominated clinician responsible for transfer of care refers to the Mandatory Reporter Guide (p.7).

For further guidance, consult the SAFE START Strategic Policy (PD2010_016).

### 3.5 Aboriginal and Torres Strait Islander People

Clinicians should be sensitive to specific historical, cultural, spiritual and social factors of Aboriginal and Torres Strait Islander people when planning for transfer of care. Many Aboriginal people have had negative contact with government services which can cause suspicion and mistrust. This may be acutely important for Aboriginal people with mental health problems and disorders. The NSW Aboriginal Mental Health and Well Being Policy 2006-2010 (PD 2007_059) outlines the key principles for mental health service delivery to Aboriginal people.

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

Health staff should also:

- Identify community liaison contact(s) who can engage additional support for the consumer such as extended family, elders and community members
- Ensure actions are taken to resolve precipitating events and other life stressors
- Refer the consumer to Aboriginal health or medical services if the consumer so chooses
- Establish contact between consumer and Case Worker prior to transfer of care
- Obtain funds, where available, to assist with transport and accommodation of family at the time of transfer of care
- Ensure, where possible, that the family is present at the time of transfer of care to accompany the consumer home.
Risk of suicide is another significant factor. When transferring the care of an Aboriginal person who is at long-term risk of suicide, the clinician must take into account the consumer’s:

- Current mental state and wellbeing and
- The nature and impact of the home / community environment and availability of support.

The consumer may be at a significantly increased level of risk on return to a troubled home or community environment. For consumers who have been hospitalised for lengthy periods, the impact of their return to the community, and their ability to cope, should be assessed sensitively and risks identified and addressed.

3.6 Consumers from Culturally and Linguistically Diverse Backgrounds

The transfer of care for consumers from Culturally and Linguistically Diverse Backgrounds (CALD) requires a culturally sensitive approach. Health professionals should be aware of their own values, attitudes and beliefs. Staff should approach CALD consumers with sensitivity and respect for the social context of the consumer’s problems. It is important to understand the personal meaning of the illness for the consumer, their family and their community. CALD consumers may experience increased isolation. Therefore, where appropriate, promote or connect the consumer and their family with the multicultural agencies and support groups in the community (see PD2005_483 Non-English Speaking Backgrounds – Standard Procedures- Improved Access Area / Public Health Services).

Consider a referral to the Transcultural Mental Health Centre early in the admission, to support mental health literacy for carers and consumers in their own first language.

The Transfer of Care Plan should take into account the following factors:

- Comprehension and proficiency in English or literacy in another language
- Barriers to accessing health services due to language difficulties and cultural expectations
- Awareness of available community services
- Stressors experienced during the process of adapting to mainstream Australian culture
- Ensure care plans for transfer document the consumer’s first language and any requirement for a specific language interpreter
- Access to translated material at appropriate stages.

For further guidance, consult the Culturally & Linguistically Diverse (CALD) Carer Framework: Strategies to Meet the Needs of Carers (GL2009_018).

CALD consumers and their families should have access to interpreter services to facilitate the transfer of care process where appropriate. Consent is essential. When booking an interpreter, a consumer’s name and contact telephone number is required. Three-way telephones or conference phones should be available for use with telephone interpreters. Health staff should refer to Interpreters: Standard Procedures for working with Health Care Interpreters PD2006_053 for guidance on use of interpreters.

Where complex or unknown cultural dynamics are involved, for clarification of the diagnosis and assessment of cultural issues that should be considered in the provision of mental health care, cultural advice should be sought from the local multicultural staff within the LHD and / or NSW Transcultural Mental Health Centre.

Where the issues are related to torture and trauma it is advisable to consult with the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

Access to translated material should be available as required.
3.7 Consumers with intellectual disabilities

NSW Health and Ageing, Disability & Home Care (ADHC) have developed a Memorandum of Understanding (PD2011_001) to improve access and quality of service delivery for people with intellectual disability and mental illness. Guidelines to the MOU outline processes and procedures to support clinical practice and emphasise the collaborative approach that should be taken between the two agencies in the provision of services to consumers.

In addition to the standard procedures outlined in this document, planning for transfer of care for consumers with intellectual disability and mental illness are likely to require additional support from a range of services including mental health. It is important to:

- Include the key worker from accommodation services, disability service and / or the consumer’s guardian or advocate in the transfer of care planning process
- Transfer of care planning (including contingency and relapse response planning) needs to consider the specific needs of a consumer with intellectual disabilities, particularly in circumstances requiring readmission
- Identify relapse prevention needs to differentiate between behaviours related to the intellectual disability and the re-emergence of mental health symptoms
- Consider whether joint case management is necessary.

3.8 Consumers with accommodation needs

For mental health consumers, secure, stable, affordable housing with access to appropriate assistance, supports the person’s recovery and is essential in maintaining their mental and physical health. This policy requires the development of Transfer of Care Plans that address the housing and accommodation needs of the individual and ensure that connections to support services are provided, as required. During admission to the inpatient unit, information about the person’s current living arrangements, supports and risk of homelessness are to be identified.

Assessment of a consumer’s housing and accommodation support needs must be part of planning for the person’s return to the community. If required, referrals to a service that can assist with accommodation and accommodation support should be completed well in advance of the consumer leaving the inpatient unit.

Mental Health Services must maintain contact details, and be familiar with the referral procedures of local agencies such as Housing NSW, the Specialist Homeless Services program for people who are homeless or at risk of homelessness; and Housing and Accommodation Support Initiative (HASI) which provides accommodation support that is linked to clinical and psychosocial rehabilitation for people with a range of levels of psychiatric disability. These agencies should be engaged in the Transfer of Care Planning where relevant.

The development of local protocols will assist in meeting the transfer of care needs of patients who are homeless.

Mental Health facilities should also refer to the supplementary policy to PD2011_015 Care Coordination: From Admission to Transfer of Care in the Public Health System. The supplementary policy sets out issues for consideration in the management of transfer of care for homeless people in the public health system.
4. List of Attachments

1 Implementation checklist

<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>
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<tr>
<td>2. Review, LHD and unit mental health discharge/transfer of care and leave protocols to ensure they are consistent with the state-wide Policy’s requirements, principles and procedures</td>
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<tr>
<td>3. Ensure local protocols include guidance on managing a consumer’s transfer of care to the community outside of usual working hours, at weekends and during holiday periods.</td>
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<tr>
<td>4. Develop a ‘transfer of care’ checklist to ensure that all steps of the procedure are carried out.</td>
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<tr>
<td>5. Process for educating inpatient clinicians on the requirements of the Policy Directive and their responsibilities in relation to its local implementation</td>
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<tr>
<td>6. Educate clinical staff in the principles and practices for Transfer of Care Planning.</td>
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<tr>
<td>7. Develop and implement a process for monitoring compliance with the requirements and procedures for Transfer of Care Policy Directive that includes feedback to staff of compliance.</td>
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<tr>
<td>8. Establish a process for annual reporting through the Chief Executive on implementation of the Policy Directive’s requirements.</td>
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</tr>
</tbody>
</table>
2 Disclosure of information

Consumers should be consulted about who will be provided with their personal information and the reasons why, according to their age, maturity and safety needs. If the consumer has concerns about release of information, this should be discussed with them and their carers, and attempts made to resolve the concerns in the context of optimal ongoing care and the obligations under the Mental Health Act 2007 and NSW privacy legislation.

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

- **Health Providers**

  Under the Health Records and Information Privacy Act – 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. This expectation is best met by communicating with the patient about relevant treatment and service provision and ensuring patients receive a copy of the Privacy Leaflet for Patients or are directed to it.

- **Community Managed Organisations (CMOs)**

  While information exchange is important in the provision of a continuum of care, the disclosure of relevant information to recovery support, accommodation and other CMO service providers must be either for a directly related purpose (depending on the service provision) or occur where the patient consents to receiving the support service. Either way, the patient must have a reasonable expectation that their information will be used in such a manner or have consented to the service provision. This expectation is best met by discussing appropriate service provisions with the consumer and ensuring patients receive a copy of the Privacy Leaflet for Patients or are directed to it. In appropriate circumstances, where there may be safety concerns for the consumer and others, relevant risk assessment information may be provided if there is a serious and imminent of harm or the information is reasonably necessary in order to allow the CMO to provide the relevant service.

- **Families and Carers**

  While carers must be included in the transfer of care planning under the Mental Health Act 2007, with consent of the consumer, it may be good practice to involve other members of the family or carer network. A person under 18 may not exclude a parent from being given information about them [s72 (2 & 3)].

  In circumstances where a consumer is being discharged into the care of their family and/or carers, family and carers should be provided with relevant information to properly manage the consumer’s ongoing medical care where there is consent or a reasonable expectation on the consumer’s part that this will occur. This may include being given a written copy of the Transfer of Care Plan for transfer so that they can refer to information and care instructions at a later time. The copy of the plan will provide easy access to critical advice, such as information about the medication regimen and the management of suicide risk. In some circumstances, the provision of generic information about general matters relating to mental health care and treatment options to carers and family may be appropriate.

  Where the consumer has not consented, it is important that any disclosure to family or carers is directly related to the primary purpose for which the information was collected and the patient must have a reasonable expectation that their information will be used in such a manner. 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.
• **Role of Appointed Guardian**

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

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

• **State and Commonwealth Agencies**

Appropriate information must be provided to State and Commonwealth government agencies for mandatory statutory reporting purposes, such as the reporting of notifiable diseases; or where there are mandatory requirements to do so, including child protection concerns.

The law also allows for personal health information to be disclosed to other third parties 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.

Please refer to the NSW Privacy Manual for guidance on these requests.
3 Sample transfer of care checklist for return to the community

<table>
<thead>
<tr>
<th>TRANSFER / DISCHARGE CHECKLIST</th>
<th>Attach patient identification label or print using black pen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission date:</td>
<td>MRN:</td>
</tr>
<tr>
<td>Discharge date:</td>
<td>Time: Family Name</td>
</tr>
<tr>
<td>Primary nurse:</td>
<td>First Name:</td>
</tr>
<tr>
<td>Consultant on discharge:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Registrar</td>
<td>Sex: Male Female</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Date</th>
<th>Complete</th>
<th>Signature</th>
</tr>
</thead>
</table>

*Transfer / Discharge Summary*

*Transfer / Discharge Summary* faxed to GP &/or private psychiatrist prior to the consumer’s discharge

Phone call to community mental health centre to confirm transfer (write name of person contacted)

Relatives / carers informed of discharge by patient or staff

Relevant written information provided to private health professionals and NGO support agencies offering community care/support

K10/HONOS completed

Transfer of Care Plan documented in medical record

Medical entry in file including follow up plan

Ward clerk notified of discharge

Consumer’s name remove from white board

Discharge details recorded in Admission/Discharge Register

Treatment sheet placed in clinical file

Valuables returned to consumer

Medication supply for 5 days given on discharge

*Transfer / Discharge Summary* given to consumer/ carers

Copy of Transfer of Care Plan and associated information given to patient/carer on discharge

MH-CoPES survey questionnaire given to consumer

Transport arranged

*With credit to the former Sydney South West Area Mental Health Service*
### 4 Sample transfer of care checklist for transfer to other inpatient services (public mental health unit, private psychiatric hospital, general wards)

**TRANSFER / DISCHARGE CHECKLIST**

<table>
<thead>
<tr>
<th>Action</th>
<th>Date</th>
<th>Complete</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transfer / Discharge Summary</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Documentation provided to admitting service:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Full information on consumer’s history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Transfer/Discharge Summary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Relevant reports, case summaries and materials requested as per receiving unit’s admission policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recent investigations/tests and reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Updated risk assessment and management plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Updated care plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medication details</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phone call to other inpatient service to confirm transfer (write name of person contacted)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff have informed:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Carers/relatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- other agencies involved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>K10/HONOS completed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transfer of Care Plan documented in medical record</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical entry in file including follow up plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ward clerk notified of discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Consumer’s name removed from white board</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discharge details recorded in Admission/Discharge Register</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment sheet placed in clinical file</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Valuables transported with consumer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Copy of Transfer of Care Plan and associated information provided to admitting service on discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>YES survey questionnaire given to consumer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transport arranged</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5 Self-assessment tool for monitoring transfer of care

The following indicators are provided to assist services in quality monitoring of practices, and were adapted from the *Chief Psychiatrist’s Guideline: Discharge Planning for Adult Community Mental Health Services* (Victorian Government 2002).

<table>
<thead>
<tr>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
</tr>
<tr>
<td>The service has documented policies and procedures for transfer of care to guide staff in day to day practice.</td>
</tr>
<tr>
<td>The clinical record shows evidence that planning for transfer of care commenced on the person’s admission to the inpatient unit.</td>
</tr>
<tr>
<td>There is evidence that the Transfer of Care Plan was developed in collaboration with the consumer, and carers, external clinicians and support agencies.</td>
</tr>
<tr>
<td>There is evidence that the Transfer of Care Plan takes into account ongoing physical health needs.</td>
</tr>
<tr>
<td>There is evidence that the Transfer of Care Plan takes into account the need for support services (e.g. support with accommodation, daily living skills; parenting; education or employment; to reduce social isolation)</td>
</tr>
<tr>
<td>The clinical record reflects that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) was undertaken prior to transfer of care.</td>
</tr>
<tr>
<td>There is evidence that the decision to transfer care was reviewed by the consultant psychiatrist 24-48 hours prior to the physical movement of the consumer and that the decision was supported by a comprehensive risk assessment.</td>
</tr>
<tr>
<td>The service ensures that plans for transfer of care have been communicated to and agreed by the:</td>
</tr>
<tr>
<td>- Receiving service</td>
</tr>
<tr>
<td>- Consumer and</td>
</tr>
<tr>
<td>- Carers / guardian</td>
</tr>
<tr>
<td>in advance of the physical movement of the consumer.</td>
</tr>
<tr>
<td>Necessary follow up has been undertaken within a reasonable time for the consumer’s condition.</td>
</tr>
<tr>
<td>Mental Health Clinical Documentation <em>Transfer / Discharge Summary</em> was completed and placed on the file and copies forwarded to relevant parties within 12 hours.</td>
</tr>
<tr>
<td>The consumer, carers (unless otherwise indicated) and any relevant service provider was</td>
</tr>
<tr>
<td>- Advised on how to re-access the service if necessary in the future, and</td>
</tr>
<tr>
<td>- Provided with emergency contact numbers in writing and in an appropriate community language.</td>
</tr>
<tr>
<td>The inpatient unit provides written information to consumers, carers and relevant service providers involved in ongoing care, on</td>
</tr>
<tr>
<td>- Strategies to prevent relapse</td>
</tr>
<tr>
<td>- Identification and management of early warning signs and</td>
</tr>
<tr>
<td>- When and how to contact the mental health service.</td>
</tr>
<tr>
<td>A process exists to promote re-engagement with consumers who are unable to maintain follow-up arrangements.</td>
</tr>
</tbody>
</table>
6 Notification to NSW Police and Firearms Registry Form

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

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

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

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

Process for notifying NSW Police of risk concerns:
1. Ring Local Area Command Duty Officer to discuss the matter.
2. Fax this completed form to Local Area Command Duty Officer.
3. Fax this completed form to NSW Firearms Registry: 02 6670 8550
   Attention: Manager Review and Assessment NSW Firearms Registry.

<table>
<thead>
<tr>
<th>Patient's Family Name:</th>
<th>Given Name(s):</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residential Address
Telephone

**Where is the patient currently located (eg inpatient, emergency department, residential)?**

If an inpatient address to which the patient will be discharged?

<table>
<thead>
<tr>
<th>Anticipated date and time of discharge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(to ensure safety issues can be addressed at least 6hrs notice must be provided to police)</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

Description of circumstances which lead you to believe that the person may pose a threat if in possession of a firearm (include: relevant conversation, circumstances, observations, firearm type, effect of medical condition or treatment/medication on person’s capacity etc. Use over page if more space is needed)

Does the person have access to their own firearm? Yes: ☐ No: ☐ Not known: ☐

Does the person have access to other firearms? (eg spouse, other relatives, friends, neighbour)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

Name of person and location of firearm:

Details of person submitting this report: Medical Practitioner ☐ Registered/Enrolled Nurse ☐

Registered Psychologist ☐ Counsellor ☐ Social Worker ☐

Contact Telephone: ____________________________ Ext: ____________ Mobile: ____________

Contact Address: ________________________________________________________________

Name: ____________________________ Signature: ____________________________ Date: ____________________________

Note: Further details may be required by police to support legal process or legal action needed to protect persons.

The Information contained herein is confidential and any action by a practitioner does not give rise to any criminal or civil action of remedy (or breach privacy laws). If you have any enquiries, contact the NSW Firearms Register, Manager Review and Assessment on 1300 362 552, or the Duty Officer at your nearest Local Area Command.
7 Legal and legislative framework

ACTS
Mental Health Act 2007
Children and Young Persons (Care and Protection) Act 1998
Guardianship Act 1987
Disability Services Act 1993
Health Records and Information Privacy Act 2002

RELATED POLICIES and GUIDELINES
Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
Child Protection Mandatory Reporter Guide (MRG)
Clinical Handover–Standard Key Principles
Culturally & Linguistically Diverse (CALD) Carer Framework: Strategies to Meet the Needs of Carers
Child Wellbeing and Child Protection Policies and Procedures for NSW Health
Mental Health Clinical Documentation:
Mental Health Emergency Response 2007: Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSW Police Force
Non-English Speaking Backgrounds – Standard Procedures- Improved Access
NSW Aboriginal Mental Health and Well Being Policy 2006-2010
Privacy Manual for Health Information
Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines
Suicide Risk Assessment and Management Protocols for Mental Health Inpatient Units.
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.

MULTICULTURAL MENTAL HEALTH PLAN 2008-2012 (PD2008_067)

The NSW Multicultural Mental Health Plan 2008-2012 is the strategic state-wide policy and service delivery framework for improving the mental health of people in NSW from Culturally and Linguistically Diverse (CALD) communities.

This Plan was developed after extensive consultation, and reflects current and emerging trends across our communities. It aligns with relevant initiatives including:

- A New Direction for NSW: The State Plan;
- A New Direction for NSW: The State Health Plan;
- NSW: A new direction for Mental Health 2006; and

The Plan is a seminal document that synthesises epidemiological issues with the mental health challenges within CALD communities. This knowledge underpins a strong reform agenda for multicultural mental health at all levels of care, as well as ensuring responsive consultation with the CALD communities.

The Plan reflects and complements national and state policy directions and planning for multicultural mental health. It recognises that a comprehensive model of service delivery for multicultural mental health includes a range of services such as health promotion and prevention programs, early diagnosis, assessment and treatment services and care planning, to cultural consultancy and training and education.


PHYSICAL HEALTH CARE WITHIN MENTAL HEALTH SERVICES (PD2009_027)

1. **Introduction**

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. The seriously mentally ill also have high rates of mortality and reduced life expectancy as well as decreased access to healthcare.

Mental health services are uniquely placed to support an improvement in the physical health of those who use their service through the adoption of a holistic approach to the care and treatment of mental health consumers.

Appropriate support provided by well-trained mental health staff can assist consumers to identify and seek medical aid for physical illnesses or disease, reducing morbidity and mortality in those individuals. Working collaboratively with primary health providers, such as General Practitioners (GPs), mental health services also have a critical role to play in the initiation of preventative measures for consumers. Such measures will enhance both the physical and mental health of this group and ultimately improve their general wellbeing and quality of life.
2. **Policy Context**

This Policy Directive responds to concerns raised through various NSW Health review mechanisms regarding the physical health of consumers of mental health services. It is also in line with a recommendation from the Mental Health Sentinel Events Review Committee (SERC) Tracking Tragedy 2007 report.

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 Department of Health Policy Directives that should be considered when implementing this Policy Directive includes:

- Mental Health Act 2007
- National Standards for Mental Health Services (1996)
- NSW Carers Action Plan
- NSW Health Privacy Manual (Version 2, 27)
- PD2006_053 Standard Procedures for working with Health Care Interpreters
- PD2012_060 Transfer of Care from Mental Health Inpatient Services
- PD2010_018 Mental Health Clinical Documentation
- PD2011_029 Falls – Prevention of Falls and Harm from Falls among Older People: 2011_2015

3. **Aim and Objectives**

3.1 **AIM**

The aim of this Policy Directive is to provide direction to NSW mental health services regarding the provision of physical health care to consumers who use their service. It should be read in conjunction with the NSW Health *Physical Health Care of Mental Health Consumers – Guidelines (GL2009_007).* The Guidelines, which support this Policy Directive, provide comprehensive information and advice regarding how mental health services can improve the physical health of consumers. The Guidelines should be used to ensure the broad, overarching responsibilities of mental health services outlined within this Policy are met.

The minimum requirements noted within this Policy Directive provide clear direction to mental health services regarding a baseline for the provision of physical health care. All services are required to build on this base line utilising the Guidelines.

3.2 **OBJECTIVES**

The objectives of this Policy Directive are to:

3.2.1 Establish expected standards for the physical health care of consumers of mental health services (mental health consumers);

3.2.2 Clarify the role of mental health services, and appropriate linkages with other health care providers, in meeting the physical health care needs of mental health consumers;

3.2.3 Develop a consistent, co-ordinated, approach to the physical health care of mental health consumers; and

3.2.4 Improve the physical health care of mental health consumers.
4. **Principles**

Physical health care in all mental health settings must take into consideration the following principles:

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

4.2 Such care and treatment for mental health consumers:
- Is delivered in a respectful, non-judgemental and culturally sensitive way, with information about their illness, physical condition and treatment options provided to enable them to make informed choices;
- Recognises consumers as critical partners in the care team; and
- Involves their families and carers, with the consent, wherever possible, of consumers.

4.3 The physical health of mental health consumers is considered by mental health services in the planning and provision of any mental health interventions.

4.4 Working collaboratively with other health providers, particularly GPs, is key to providing quality physical health care for mental health consumers.

4.5 Physical health care includes access to health promotion, screening and preventative activities.

4.6 The provision of physical care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

5. **Responsibilities and Minimum Requirements for Mental Health Services**

5.1 **ALL SERVICES**

5.1.1 **Responsibilities**

*Mental health services in all settings have responsibility for ensuring that:*

5.1.1.1 The provision of 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 with which the consumer is involved.

5.1.1.2 Physical causes for a mental illness or disorder in consumers at risk, such as those with a first presentation of mental illness or those with major changes in their mental health presentation, are excluded.

5.1.1.3 The risk of adverse physical health outcomes due to the provision of mental health interventions is minimised.

5.1.1.4 A program to improve the standard of physical healthcare provided to consumers is developed and implemented that is consistent with the NSW Health Physical Health Care of Mental Health Consumers - Guidelines.

5.1.1.5 Staff are trained to conduct roles consistent with these Guidelines.

5.1.2 **Minimum Requirements**

*Mental health services in all settings must:*

5.1.2.1 Have clear criteria for when nursing or allied health staff should notify medical staff of concerns about the physical health of consumers.
5.1.2.2 Have clear protocols for identifying and responding to medical emergencies.

5.1.2.3 Include activities relevant to physical healthcare in rehabilitation and recovery programs.

5.1.2.4 Ensure care plans for all consumers address physical health needs, including alerts, special precautions, and plans to address acute and/or ongoing physical health issues.

5.1.2.5 Ensure all consumers have their weight and/or waist-hip ratio (WHR) measured every 6 months, or more frequently if the consumer is identified as over-weight, unless the consumer specifically declines.

5.1.2.6 Have two staff members present for physical examination that requires removal of clothing, or palpation of more than limbs, (such as initial examinations) unless a need for urgent care prevents this, or the consumer specifically requests this does not occur. In such situations the reason for not using a chaperone must be documented.

5.1.2.7 Ensure physical examinations carried out by mental health service staff are consistent with the core components listed within Appendix C.

5.1.2.8 Ensure that there are clear protocols for consumers receiving ongoing care (>3 months inpatient, >6 month community) to identify and develop consumer management plans that address consumers’ needs related to chronic health conditions and preventative health care. These must ensure that the issues in ‘List A’ in Appendix A have been discussed with the consumer, provided/conducted if appropriate, or reasons for not acting documented.

5.1.2.9 Develop and implement a strategy to improve partnership arrangements with local GPs.

5.1.2.10 Ensure all physical examinations are properly documented and recorded within the consumer’s clinical record. If such examinations have not been conducted by community mental health staff, there must be, at a minimum, documentation within the consumer’s community record of who conducted the examination, when it was conducted and any key findings.

5.2 MENTAL HEALTH INPATIENT CARE

5.2.1 Responsibilities

Within this setting mental health services have responsibility for ensuring that:

5.2.1.1 The acute physical health care needs of inpatients are identified, assessed and managed in a timely and effective manner, in line with the NSW Health Physical Health of Mental Health Consumers - Guidelines.

5.2.1.2 Access to medical or surgical support for inpatient mental health consumers is equivalent to such support available for non mental health inpatients.

5.2.1.3 Follow up mechanisms are identified and arranged for identified physical health care needs, and appropriate information is communicated at discharge to support this.

5.2.1.4 Access is available to appropriate mental health care for consumers with co-morbid physical health disability.

5.2.1.5 Local mental health service policy defines any limitations in the inpatient units’ ability to meet physical health care needs, and identifies mechanisms for access to physical health care for consumers with such needs.
5.2.1.6 Consumers in non-acute inpatient units have their ongoing physical health needs identified, assessed and managed. This includes appropriate access to health promotion, screening and preventative activities and incorporating physical health goals and activities in rehabilitation and recovery programs.

5.2.2 Minimum Requirements

Within this setting, mental health services must:

5.2.2.1 Have ready access to the equipment listed in Appendix B of this Policy Directive.

5.2.2.2 Ensure consumers receive a physical examination consistent with the core components of Appendix C within 24 hours of admission, unless an examination has already been conducted by the mental health service from which the consumer is being transferred and documentation of this is available within the consumer’s clinical record.

5.2.2.3 Re-examine consumers within 24 hours of admission from an Emergency Department, unless there is an agreement for satisfactory completion of the MH-OAT Physical Examination in the Emergency Department.

5.2.2.4 For consumers who have been admitted for longer than 3 months, discuss interventions and investigations relevant to ongoing health, and provide/conduct if appropriate, or document reasons for not acting.

5.2.2.5 Ensure consumers in non-acute care have a physical examination and focussed interview consistent with core components within Appendix C, plus examination for movement disorders, no less frequently than every 12 months.

5.3 COMMUNITY MENTAL HEALTH SETTINGS

5.3.1 Responsibilities

Within this setting mental health services have responsibility for ensuring that:

5.3.1.1 The physical health of a consumer is considered in the planning and provision of any mental health interventions.

5.3.1.2 A process occurs to exclude physical causes of mental illness in consumers at increased risk.

5.3.1.3 The risk of adverse physical health outcomes due to the provision of mental health interventions is minimised.

5.3.1.4 Improvement to partnership arrangements with providers of physical health care most relevant to the consumers who use their service is actively sought.

5.3.1.5 Consumers are assisted to access:
  - Physical health care equivalent to the general population
  - Appropriate inclusion in health promotion, screening and preventative activities
  - Physical health care to address needs arising from mental health interventions or mental illness

5.3.1.6 Advocacy is provided to improve such access, if required. Consumers who, due to the severity of their mental illness, have a persistent inability to access mainstream primary health services are identified, along with specific mechanisms to meet their physical health needs.
5.3.1.7 Physical health goals and activities are incorporated in rehabilitation and recovery programs.

5.3.2 Minimum Requirements

*Within this setting, mental health services must:*

5.3.2.1 Have a clear mechanism for accessing the equipment listed within Appendix B of this policy directive for consumers whose need for physical examination cannot be met through collaboration with GPs.

5.3.2.2 Ensure consumers receive physical examinations, conducted either by mental health service staff in any setting, the consumer’s GP or another health care provider. Such examinations must occur:

- Within 1 month of admission, unless:
  - an examination was conducted as part of inpatient care immediately preceding admission; or
  - an examination was conducted by the consumer’s GP or other health care provider within 1 month of referral, and documentation of this is available within the consumer’s clinical record;
- No less frequently than every 12 months; and
- More frequently than this, if clinically indicated.

5.3.2.3 Ensure consumers are supported to receive appropriate investigations as outlined within the *Physical Health Care of Mental Health Consumers - Guidelines*.

5.3.2.4 Ensure that an annual examination for movement disorders for all consumers taking antipsychotic medications, or who are otherwise identified as being at increased risk of movement disorder, is conducted.

5.3.2.5 Ensure ongoing monitoring for the emergence of physical health care needs of consumers through observation and direct enquiry, in collaboration with a consumer’s primary healthcare provider where possible, and document outcomes in the consumer’s medical record.

5.4 PSYCHIATRIC EMERGENCY CARE CENTRES (PECCs)

5.4.1 Responsibilities

*Models of care in this setting at the interface of Emergency Departments and acute mental health inpatient care are expected to continue to evolve. Within this setting mental health services have responsibility for:*

5.4.1.1 Actively seeking to improve partnership arrangements with Emergency Department staff to ensure mental health consumers access:

- Physical health care equivalent to the general population
- Physical health care appropriate for an acute mental health presentation that is consistent with the *Mental Health for Emergency Departments: A Reference Guide*

5.4.1.2 Ensuring consumers who remain in the unit for over 24hrs receive physical health care consistent with inpatient mental health guidelines.
6. Implementation

6.1 PROCESS

Implementation of this policy directive is required according to the process outlined in Appendix D and must be completed by 30 June 2010.

Verification that implementation has been effected within the Area Mental Health Service is required through completion and submission of the checklist provided at Appendix D. This form must be signed by the Area Mental Health Service Director and submitted to the Department of Health, Mental Health and Drug and Alcohol Office, as per the instructions provided on the form.

6.2 RESPONSIBILITIES

*The Chief Executive, Area Health Service has responsibility for ensuring that:*
6.2.1 Structures are established to appropriately implement this Policy Directive.

6.2.2 All line managers clearly understand they are accountable for effective implementation of the processes required to meet the outlined responsibilities of this Policy Directive.

*The Director, Area Mental Health Service has responsibility for ensuring that:*
6.2.3 This Policy Directive is successfully implemented within the Area Mental Health Service.

6.2.4 The Implementation Checklist (Appendix D) is completed and submitted to verify implementation by all mental health facilities/services within the Area Mental Health Service.

6.2.5 Local policies and procedures are developed to ensure the requirements of this Policy Directive are met.

6.2.6 Regular file audits are undertaken to monitor compliance with this Policy Directive.

6.2.7 Reporting occurs against the agreed measures, once they have been defined and communicated.

7. Monitoring and Reporting

Explicit measures are being developed to assess service quality and monitor progress against desired outcomes. Advice will be provided regarding these measures and the information to be collected to support the reporting process.

8. Appendices

The following appendices have been provided to support implementation of this policy directive:

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Relevant Health Interventions</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Equipment Checklist</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Physical Examination Core Components</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Implementation Plan &amp; Checklist</td>
</tr>
</tbody>
</table>
Appendix A - 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 WHR >1
- Regular exercise
- BP monitoring

**List B – potentially indirect interventions**
- Contraceptive advice (if of reproductive age) and sexual safety 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
### Appendix B - Equipment Checklist

<table>
<thead>
<tr>
<th>ITEM</th>
<th></th>
</tr>
</thead>
<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>
<td>✔</td>
</tr>
<tr>
<td>stethoscope</td>
<td>✔</td>
</tr>
<tr>
<td>sphygmomanometer</td>
<td>✔</td>
</tr>
<tr>
<td>thermometer</td>
<td>✔</td>
</tr>
<tr>
<td>tendon hammer</td>
<td>✔</td>
</tr>
<tr>
<td>non-stretchable measuring tape</td>
<td>✔</td>
</tr>
<tr>
<td>tuning fork (256 Hz)</td>
<td>✔</td>
</tr>
<tr>
<td>weighing scales</td>
<td>✔</td>
</tr>
<tr>
<td>urinalysis sticks</td>
<td>✔</td>
</tr>
<tr>
<td>Auriscope and ophthalmoscope</td>
<td>✔</td>
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<tr>
<td>Examination torch</td>
<td>✔</td>
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<tr>
<td>Snellen chart</td>
<td>✔</td>
</tr>
<tr>
<td>Height measure</td>
<td>✔</td>
</tr>
<tr>
<td>Disposable gloves</td>
<td>✔</td>
</tr>
<tr>
<td>Examination lubricant</td>
<td>✔</td>
</tr>
<tr>
<td>Neurological testing pins</td>
<td>✔</td>
</tr>
<tr>
<td>Peakflow monitor</td>
<td>✔</td>
</tr>
<tr>
<td>Glucometer</td>
<td>✔</td>
</tr>
<tr>
<td>Alcometer/breathalyser</td>
<td>✔</td>
</tr>
<tr>
<td>Oximeter</td>
<td>✔</td>
</tr>
<tr>
<td>X-ray box or electronic substitute</td>
<td>✔</td>
</tr>
<tr>
<td>Pathology venipuncture and associated collection equipment</td>
<td>✔</td>
</tr>
<tr>
<td>Pathology specimen containers</td>
<td>✔</td>
</tr>
</tbody>
</table>
Appendix C - Physical Examination Core Components

Core components of a physical examination of a consumer admitted to inpatient or community mental health care are:

- Observations - BP; pulse and respiratory rate; temperature
- Weight and waist-hip ratio or waist measurement
- 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:
  - equality of pupil size, or eye movement
  - facial symmetry
  - limb and hand power
  - gait
  - limb tone
  - orientation and alertness
  - involuntary movement or akathisia (the Abnormal Involuntary Movement Scale may be used to assist this if clinically appropriate)
### Appendix D - Implementation Plan & Checklist

**Area Mental Health Service:**

This document must be completed, signed and returned to the Mental Health and Drug and Alcohol Office (MHDAO) by the deadline noted below, to the attention of:

**Manager, Clinical Governance Team, MHDAO**

Locked Mail Bag 961, North Sydney  NSW  2059

**DEADLINE FOR RECEIPT OF COMPLETED FORM**

30 June 2010

<table>
<thead>
<tr>
<th>Action</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Nominate a health service staff member within each service to be responsible for implementing and monitoring adherence to the Physical Health Care for Mental Health Consumers (PHCMHC) Guidelines and Physical Health Care within Mental Health Services (PHCMHS) Policy Directive</td>
<td></td>
</tr>
<tr>
<td>▪ Undertake a review of current practices and identify and document any necessary practice improvements or changes to meet the requirements of the PHCMHC Guidelines and PHCMHS Policy Directive</td>
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<tr>
<td>▪ Develop and implement a strategy to establish or build on local partnerships with GPs</td>
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<tr>
<td>▪ Develop and implement a plan to support promotion of physical health care to stakeholders (consumers, carers, GPs, relevant NGOs)</td>
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<tr>
<td>▪ Organise required equipment, or develop and document a mechanism to support access to equipment</td>
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<tr>
<td>▪ Develop and implement a system to ensure audits are carried out to monitor compliance with the PHCMHC Policy Directive</td>
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</tr>
<tr>
<td>▪ Develop local policies and procedures to support services to meet the requirements of the PHMHC Guidelines and PHCMHS Policy Directive, including:</td>
<td></td>
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<tr>
<td>o individual roles and responsibilities</td>
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<tr>
<td>o necessary practice improvements</td>
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<tr>
<td>o implementation of GP strategy</td>
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<tr>
<td>o implementation of promotion strategy</td>
<td></td>
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<tr>
<td>o access to equipment</td>
<td></td>
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<tr>
<td>o reporting requirements</td>
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<tr>
<td>▪ Undertake a review of current staff skills, identify gaps in knowledge and organisational change management issues that may impact on implementation of the PHMHC Guidelines or PHCMHS Policy Directive and factor these into future training plans</td>
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</tbody>
</table>

Once signed, this form verifies that the above actions have been completed by all mental health services within the stated Area Mental Health Service.

Signed__________________________ Date__________/______/______

Name

Director, Area Mental Health Service

72(8/09)
PHYSICAL HEALTH CARE OF MENTAL HEALTH CONSUMERS (GL2009_007)

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

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

The Guidelines can be downloaded at:

SMOKE-FREE MENTAL HEALTH FACILITIES IN NSW – GUIDANCE FOR IMPLEMENTING (GL2009_014)

The Guideline provides practical guidance to Chief Executives and designated personnel in NSW Area Health Services who are planning to facilitate the implementation of the NSW Health Smokefree Workplace Policy in NSW public hospitals and residential mental health care facilities and drug and alcohol facilities (including step-down units) utilised by mental health consumers.

The Guidelines can be downloaded at

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 of 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.


82(04/03/10)
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.


13. MENTAL HEALTH

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.
13. MENTAL HEALTH

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), Gina Ka Lun (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.

120(10/03/11)
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.
13. MENTAL HEALTH

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 transfers 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:

- **Patient presents to Emergency Department and is assessed as meeting criteria for admission**
- **Treating Team contacts inpatient unit to establish bed availability and makes referral**
- **Referring consultant contacts consultant from receiving venue to support request**
- **Referring unit director contacts unit director of receiving venue to support request**
- **Referring site CAMHS Director to contact CAMHS Director of receiving site**
- **Send all relevant documentation to receiving venue and arrange appropriate transport and escort**
- **Site Service/Clinical Director to prepare brief of action so far for Director of Mental Health**

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.
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<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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</table>
| 0     | Proactive Routine Practice         | Facility Mental Health Beds Available | Site Senior Nursing Manager/Operations Manager and Site Service Directors | Transport and Escort Duties  
- 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.  
- Workforce Planning with Nursing Agencies to secure sufficient numbers of agency personnel with appropriate skills sets  
- Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport  
Community Team Presentations  
- 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.  
Demand Capacity  
- Predictive Bed Model and capacity planning with identified inpatient discharges, planned leave and contingency leave for each day  
- Identify OOA Clients and commence repatriation planning  
- Identify Private patients and commence private facility negotiations  
- Suitable ECT procedures to be mobilised to Day Only  
- Mobilise Non Acute Referrals/LLOS Meeting and Second Opinion Processes/Assertive Care Progression Model of Care  
Emergency Department  
- Key MH/ED CNC KPIs around completion of A1 with purposeful admission plan/projected LOS, bed finding negotiations  
- 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  
- 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 |
| 1     | Patients requiring Mental Health inpatient admission and no local mental health beds available | No Facility Mental Health Beds Available < 2 Facility Emergency Department Beds Available | 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 | Transport and Escort Duties  
- Circulate standardised briefings to SVH Transport, SESIAHS Community Transport Drivers and NSW Ambulance to increase staff awareness/preparedness and support for increased service demands.  
Community Team Presentations  
- 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  
Demand Capacity  
- 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.  
- Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport  
- Review Numbers of Leave Clients and redirect daily reviews to assertive Out Patient Review Clinics/Community Care  
- Review patients on leave for potential to remain on extended leave |
### 13. MENTAL HEALTH

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<th>Demand Threshold</th>
<th>Authority to Invoke Resource Mobilizing Capacity</th>
<th>Actions</th>
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|       | All local Network and SESIAHS Mental Health Beds full + > 8 hrs unplaced mental health patients in a SESIAHS Emergency Department. | 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 | - Contingency planning around escort resources to be negotiated with Facility Corporate Services Manager who has governance over site employed community transport service drivers.  
- Contingency planning around access to hospital vehicles for the purpose of non acute transport.  
- Contingency Planning with NSW Non Acute Transport Services around extended access to non acute transport services.  
- Circulate standardised briefings to NSW Police to increase staff awareness/preparedness and support for transport and potential service limitations.  
- Restrict CMT admissions to psychiatric emergencies only. Patients will need to meet the requirements for involuntary admission under the MHA.  
- CMT Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director  
- ECT and/or elective outpatient appointments restricted to Psychiatric Emergencies Only.  
- Investigate clinically appropriate alternative accommodation options/Hotels for all accommodation challenged patients who are occupying an acute MH bed inappropriately.  
- Situationetal 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 & definitive periods, resource dependant  
- Suspend all repatriation requests from other AHS to admit local client into an available bed within SESIMHS  
- Admissions restricted to psychiatric emergencies in all SESIMHS services  
- Patients will need to meet the requirements for involuntary admission under the MHA.  
- Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director  
- Redirect or defer elective admissions, consider non acute network partner Bloomfield accommodation ( i.e. Clozapine trials)  
- Suspend tertiary referral admissions to identified tertiary referral beds including NPI beds  
- 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 |
### Extraordinary Event

As identified by the DCO and Area Director Mental Health

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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 dependent:

- 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 MHRU Program and return MH RU patients to community
- Negotiate SESIMHS MHRU 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


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. 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
2. 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
3. where the current or proposed inpatient or community placement is deemed sub-optimal and problematic.

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.

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
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.
13. MENTAL HEALTH

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, etal)
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

13. MENTAL HEALTH

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. 4

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.
13. MENTAL HEALTH

- 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.
13. MENTAL HEALTH

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’.

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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.
13. MENTAL HEALTH

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 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.
13. MENTAL HEALTH

**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 corroboration 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.

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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>Category A = 3 – 9</td>
</tr>
<tr>
<td>B. Support System =</td>
<td>Category B = 10</td>
</tr>
<tr>
<td>C. Ability to Cope =</td>
<td>Category C = 11</td>
</tr>
<tr>
<td>Triage Rating (A+B+C) =</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 (Bengelsdorff 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.
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.
13. **MENTAL HEALTH**

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).


13. MENTAL HEALTH

12. APPENDICES
13. MENTAL HEALTH

12.1 NSW Health Mental Health Triage Module

<table>
<thead>
<tr>
<th>CONSUMER CONTACT NUMBERS:</th>
<th>ALERTS/RISKS?</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summary</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TRIAGE DETAILS</th>
<th>Date:</th>
<th>Time:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication issues</td>
<td>(e.g., language or cultural barriers, sensory impairment)</td>
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</table>

<table>
<thead>
<tr>
<th>Information taken by:</th>
<th>Face to face</th>
<th>Phone</th>
<th>Other</th>
</tr>
</thead>
</table>

| Purpose of contact | (pick appropriate option): | Seeking assistance/referral | Information |

<table>
<thead>
<tr>
<th>Is client/primary carer aware of referral?</th>
<th>Referred by:</th>
</tr>
</thead>
</table>

| Reason for referral | (please write out reason and give appropriate referral) |

| HISTORY | (e.g., past episodes, interferences, information at inquiry/admission) |

| MEDICAL ISSUES | (e.g., significant illnesses, allergies, adverse drug reactions, obesity, pregnancy) |

| CURRENT TREATMENTS | (e.g., medications, psychological interventions, complementary/alternative interventions, providers/services involved) |

| DRUG AND ALCOHOL USE | |

| CURRENT FUNCTIONING AND SUPPORTS | (e.g., concepts regarding language, peers, parents or other family responsibilities, name, age, current whereabouts and physical condition) |

<table>
<thead>
<tr>
<th>Staff Name:</th>
<th>Signature:</th>
<th>Designation:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Page 1 of 2

164(27/09/12)
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 ineffectual 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/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 'Assessment Plan' and 'Urgency of response' on page 2.

<table>
<thead>
<tr>
<th>URGENCY OF RESPONSE SCALE (CTRS: A+B+C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A</td>
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<tr>
<td>Category B</td>
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<tr>
<td>Category C</td>
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<tr>
<td>Category D</td>
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<tr>
<td>Category E</td>
</tr>
<tr>
<td>Category F</td>
</tr>
<tr>
<td>Category G</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:

| Grade of service: Average time to answer calls on average over a calendar month | 70% of Calls, answered within 30 seconds, when averaged over a calendar month. |
| Maximum Speed to Answer (MSA) | 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.) |
| 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. |
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>
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<td>Month XX</td>
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<td>TOTAL</td>
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</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.

   **Telephony Standards Summary**

<table>
<thead>
<tr>
<th>Month</th>
<th>% of calls answered in 30 seconds</th>
<th>% of calls waiting over 2 minutes</th>
<th>% of calls abandoned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
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<tr>
<td>Month 2</td>
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<td></td>
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<tr>
<td>Month 3</td>
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<td></td>
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<tr>
<td>TOTAL</td>
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</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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<tbody>
<tr>
<td></td>
<td>Client/Carer</td>
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<tr>
<td></td>
<td>GP</td>
</tr>
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<td></td>
<td>MH staff</td>
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<td>Other Health</td>
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<td></td>
<td>Emergency Services</td>
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<td></td>
<td>Other</td>
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<td>Month 1</td>
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<td>Month 3</td>
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<td>TOTAL</td>
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</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>
</tr>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>Month 1</td>
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<td>Month 2</td>
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<td>Month 3</td>
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<td>TOTAL</td>
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</table>
13. MENTAL HEALTH

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>
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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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<tbody>
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164(27/09/12)
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.

To download the rest of this Guideline please go to http://www.health.nsw.gov.au/policies/gl/2012/GL2012_008.html
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.
- 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 effective 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.
Appropriate mechanical restraints must:\(^5\):
- 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:\(^6\)
- 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.

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\(^5\) Protecting People and Property-NSW Health Policy and Standards for Security Risk Management in Health Agencies: Protecting People and Property Manual Chapter 14: Role of Security Personnel in NSW 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.
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

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle 1</td>
<td>Protection of fundamental human rights</td>
</tr>
<tr>
<td>Principle 2</td>
<td>Protection against inhumane or degrading treatment</td>
</tr>
<tr>
<td>Principle 3</td>
<td>Right to highest attainable standards of care</td>
</tr>
<tr>
<td>Principle 4</td>
<td>Right to medical examination</td>
</tr>
<tr>
<td>Principle 5</td>
<td>Documentation and notification</td>
</tr>
<tr>
<td>Principle 6</td>
<td>Right to appropriate review mechanism</td>
</tr>
<tr>
<td>Principle 7</td>
<td>Compliance with legislation and regulation</td>
</tr>
</tbody>
</table>

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.
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- 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:
• 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>
</table>
| PD2015_xxx | Minimising Restraint Use in Adults                                          | - Mechanical restraint  
|            |                                                                             | - Older adults in acute and subacute hospital setting including multipurpose services |
| PD2015_001 | Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach | Requirements for identifying, assessing and eliminating or controlling violence related risks, and for providing an appropriate response when violence occurs |
| PD2012_035 | Aggression, Seclusion & Restraint in Mental Health Facilities in NSW         | Mental health facilities                                                  |
| PD2012_008 | Violence Prevention & Management Training Framework for NSW Public Health System | Minimum standards for training |
### 13. MENTAL HEALTH

#### 13.177

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Focus Area</th>
</tr>
</thead>
</table>
| 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   | Mental health facilities – older people                                                                                                    |
| Policy Manual| Protecting People and Property - NSW Health Policy and Standards for Security | 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  
                  | Management in NSW Health Agencies                                           | 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></td>
<td>Toolkit-Minimising Restraint Use in Adults</td>
<td>Adults in acute and subacute hospital setting including multipurpose services</td>
</tr>
<tr>
<td></td>
<td>Physical Assessment for Mental Health Patients Form</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 / stimuli

### Strategy review
- Strategies reviewed (together with patient, family / carer and other health professionals) and adjusted as required

### Prevention

#### Management of escalation

**Assessment <> De-escalation <> Communication <> Review**

- 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

### Management of aggressive behaviour

**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 use as the last resort
- 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

### 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
### 13. MENTAL HEALTH

**13.179**

(b) Assessing and monitoring patients’ condition and risk while they are in restraint (adopted and modified from the dynamic risk assessment process)

<table>
<thead>
<tr>
<th>Category</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Airway?</strong></td>
<td>Can they get air in?</td>
</tr>
<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>
<tr>
<td><strong>Breathing?</strong></td>
<td>Are they able to breathe?</td>
</tr>
<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>
<tr>
<td><strong>Circulation?</strong></td>
<td>Can blood be circulated efficiently?</td>
</tr>
<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>
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<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>
<tr>
<td><strong>Level of consciousness?</strong></td>
<td>Are they alert?</td>
</tr>
<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>
<tr>
<td><strong>Deformity?</strong></td>
<td>Is there a risk of injuring any joints, limbs, or other skeletal/muscular structures?</td>
</tr>
<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>
<tr>
<td><strong>Existing medical condition or injury?</strong></td>
<td>Is there anything known about the patient’s medical history and/or complication that could influence the risk?</td>
</tr>
<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>

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 11,12 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

