To view any policy document as published on the Policy Distribution System click the link on the policy number in the table below.

CHAPTER 13 – MENTAL HEALTH

TABLE OF CONTENTS

CHAPTER 13 – MENTAL HEALTH	PD/IB/GL NUMBER
Seclusion and Restraint in NSW Health Settings	PD2020_004
Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People	GL2012_005
HEALTHPLAN – Mental Health Services Supporting Plan	GL2012_006
Clinical Care of people who may be suicidal	PD2022_043
Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services	PD2013_038
Sexual Safety of Mental Health Consumers Guidelines	GL2013_012
The NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025	IB2021_002
NSW Older People's Mental Health Services SERVICE PLAN 2017-2027	GL2017_022
Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care Guideline	GL2017_003
Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services	PD2019_045
Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines	GL2008_009
Mental Health Clinical Documentation Guidelines	GL2014_002
Physical Health Care within Mental Health Services	PD2017_033
Physical Health Care for People Living with Mental Health Issues	GL2021_006
SAFE START Strategic Policy	PD2010_016
SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants	GL2010_004
School-Link Initiative Memorandum of Understanding	PD2010_020
Electroconvulsive Therapy (ECT) ECT Minimum Standard of Practice in NSW	PD2011_003
Accessing inpatient mental health care for children and adolescents	IB2023_001
Chief Psychiatrist Panel Review of Complex Mental Health Treatment Plans	PD2011_055
Monitoring Clozapine-induced Myocarditis	GL2022_011
Forensic Mental Health Services	PD2012_050
Mental Health Triage Policy	PD2012_053
Call Handling Guidelines for Mental Health Telephone Triage Services	GL2012_008
Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments	GL2015_007
Psychiatric Emergency Care Centre Model of Care Guideline	GL2015_009
Older People's Mental Health (OPMH) Acute Inpatient Unit Model of Care	GL2022_003
Engagement and Observation in Mental Health Inpatient Units	PD2017_025
Adult Mental Health Intensive Care Networks	PD2019_024
Supporting Young People During Transition to Adult Mental Health Services	GL2018_022
Use of Audio-Visual Link for Mental Health Assessments under the Mental Health Act 2007	IB2022_007
Forensic Patient Electronic Monitoring	IB2022_008
Domestic Violence Routine Screening	PD2023_009

Last updated September 2023

SECLUSION AND RESTRAINT IN NSW HEALTH SETTINGS (PD2020_004)

PD2020_004 rescinds PD2012_035 and PD2015_004

POLICY STATEMENT

NSW Health's commitment to preventing seclusion and restraint aims to improve safety for people accessing public health services and staff.

This Policy Directive outlines the principles, values and procedures that underpin efforts to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint in NSW Health settings.

SUMMARY OF POLICY REQUIREMENTS

This Policy applies to all NSW Health staff working in all NSW public health settings.

Seclusion and restraint must only be used as a last resort, after less restrictive alternatives have been trialled or considered. The principle of least restrictive practice is common across all settings. It means NSW Health staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all.

The safety of staff must be maintained at all times, including during the planning, initiation, undertaking, monitoring and cessation of the seclusion and restraint of a person.

NSW Health services must have systems that:

- minimise and, where possible, eliminate the use of seclusion and restraint
- govern the use of seclusion and restraint in accordance with legislation
- report use of seclusion and restraint to the governing body.

All local health districts, specialty health networks and NSW Ambulance must have local procedures in place that are consistent with the principles and requirements identified in this policy by July 2020.

NSW Health districts and networks and NSW Ambulance must develop, implement and annually review a service level action plan to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint, in collaboration with staff, those accessing health services, carers and families.

Seclusion and Restraint in NSW Health Settings: Procedures.

1 BACKGROUND

1.1 About this document

NSW Health is committed to minimising and, where safe and possible, eliminating the use of seclusion and restraint.

The aim is to maintain and protect the safety of all people accessing services, staff and visitors.

It is not unusual for staff or others to raise concerns that safety will be compromised if seclusion and restraint are reduced. Current evidence indicates that reducing seclusion and restraint will minimise physical and psychological harm experienced by people accessing services and staff. This policy aligns with the National Safety and Quality Health Service Standards (2nd edition) requirements for minimising harm.

It articulates principles that apply to all NSW Health settings. It describes mandatory requirements and how these are tailored for specific healthcare contexts.

Section 3.9 outlines additional requirements for specific settings.

The principle of least restrictive practice is common across all settings. It means NSW Health staff will maximise a person's choices, rights and freedom as much as possible while balancing healthcare needs and safety for all. This requires leadership committed to:

- protection of human rights
- maintaining a safe workplace
- a just and learning culture
- a prevention approach to reducing seclusion and restraint
- respectful behaviours and interactions at all service levels
- recognising and addressing potentially traumatising or triggering environments and behaviour
- adequate staffing and resources, including training and supervision
- collaboration and co-design with those directly affected by the practices of seclusion and restraint.

1.2 Key definitions

NSW Health recognises that language has an impact on people and the use of inclusive and contemporary terms can minimise stigma.
This Policy is informed by current practice and consultation with people accessing NSW Health services and service providers. Key definitions for seclusion and restraint align with the National Safety and Quality Health Service Standards (2nd Edition).

Definitions may vary for legal purposes. Where there is variation, practice must be consistent with applicable legislative definitions and requirements. **In some cases, practices that do not meet the policy definition of restraint used in this document will still require appropriate consents.**

Given the scope of this Policy, the words 'person', 'people' or 'individuals' have been used to refer to anyone accessing NSW Health services

Word/Term	Definition	Additional notes
Acute Sedation	Acute sedation is the temporary use of medication to reduce agitation, irritability and ASBD for the purpose of assessment and treatment.	Acute sedation is not considered chemical restraint when it allows for assessment to be continued and treatment for the underlying condition to be commenced. NSW Health recognises that acute sedation may be experienced or perceived as coercive by people accessing services, carers, families and others. It is important that this practice is safely managed by expert clinical decision making around the level of sedation and by adherence to current clinical guidelines. The aim is to achieve an appropriate and safe level of sedation quickly with sufficient medication to manage ASBD and to facilitate an accurate assessment and appropriate management of the person's underlying condition. The level of sedation should ensure the person is drowsy but they must be rousable.
Acute Severe Behavioural Disturbance (ASBD)	Behaviour that puts the person or others at immediate risk of serious harm. This may include threatening or aggressive behaviour, extreme distress and self-harm.	Examples of indicators of ASBD may include: aggression, hostility, physical and verbal intimidation, hitting, spitting, cutting, kicking, throwing objects, damaging equipment, using weapons or objects as weapons, and highly disinhibited behaviours, including sexual disinhibition. While behavioural concerns associated with issues such as acquired brain injury, dementia or cognitive impairment may be longstanding, the use of the word 'acute' signals the need to address the behavioural concern now.
Carer	Carer is used to describe a person who provides ongoing unpaid support to a family member or friend who needs help because of disability, medical condition (terminal or chronic), mental illness or ageing. Carers may support their family member or friend when accessing NSW Health services.	Carer is defined under the NSW Carers (Recognition) Act 2010. Consent and information provision to a carer must be in line with the relevant legislation. Depending on legislation, such as Mental Health Act 2007, different terms include: Representative; primary care-giver; primary carer; person responsible; designated carer; principal care provider.
Chemical Restraint	The use of a medication or chemical substance for the primary purpose of restricting a person's movement.	The definition of chemical restraint is a challenging issue. This is partly due to the need to attribute a purpose to the use of the medication. Medication (including PRN) prescribed for the treatment of, or to enable treatment of, a diagnosed disorder, a physical illness or a physical condition in line with current clinical guidelines is not considered chemical restraint.

Least Restrictive Practices	Practices that maximise the autonomy, rights, freedom, wellbeing and safe care of the person as much as possible while balancing healthcare needs and safety for all.	Environments should be safe, supportive and least restrictive. Staff must not withhold access to spaces or items unnecessarily, unless there are safety reasons for people accessing services, staff and others.
Mechanical Restraint	The application of devices to a person's body to restrict their movement. This is to prevent the person from harming themselves or endangering others, or to ensure that essential medical treatment can be provided.	Mechanical Restraint devices must be authorised/approved by designated staff for use in each setting and for each occurrence of use and must be used only by authorised and trained staff. The use of furniture or other equipment solely for the purpose of restraining a person's freedom of movement is considered mechanical restraint. The application of limb restraints on both arms and legs at once is known as a four-limb restraint and requires a high level of observation. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury (for example, a splint to treat a fracture) is not considered mechanical restraint. In these instances, the appliances are the treatment. This is different from a device to restrain a person to ensure treatment is provided. Safety practices that are consistent with developmental norms, such as the use of cots, prams or high chairs for infants and toddlers, are not considered mechanical restraint. The use of wheelchairs or postural devices to assist mobility are not considered mechanical restraint. The use of bedrails as a safety mechanism to reduce the risk of a person accidentally falling out of bed is not considered mechanical restraint for the purpose of this policy, except in the circumstances associated with physical restraint as outlined in the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (see Section 3.8) and the Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019. An individual in a NSW Health aged care facility or hospital may specifically request to use a restrictive item to provide them with an enhanced feeling of safety or security. Where this is an informed decision, this individual's choice should be acknowledged, monitored and documented in their Health Care Record. An informed decision would require that other options have already been discussed with the person.
Physical Restraint	The application by staff of 'hands-on' immobilisation or the physical restriction of a person to prevent them from harming themselves or endangering others, or to	While restraint is often used when people exhibit ASBD, the definition also includes the use of physical restraint while administering medical procedures (e.g. blood tests) and to facilitate some treatments (e.g. inserting nasogastric tubes, anaesthetics, intubation).

	ensure that essential medical treatment can be provided.	Physically guiding or supporting a person, with their permission, to manage the same clinical procedures safely and effectively is distinguished from physical restraint by the degree of force applied and intention.
Restraint	The restriction of an individual's freedom of movement.	The scope of restraint in this policy is mechanical, physical and chemical restraint. These types of restraint are separately defined in this section for the purposes of this policy. Aged care legislation defines restraint as any practice, device or action that interferes with a person's ability to make a decision or restricts an individual's freedom of movement.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.	The intended purpose, duration and location are not relevant in determining what is or is not seclusion. Seclusion applies even if the person agrees or requests the confinement. However, if voluntary isolation is requested by a person and they are free to leave at any time then this does not meet the definition of seclusion. The person's awareness that they are confined alone and denied exit is not relevant to the definition of seclusion. The structure and dimensions of the area to which the person is confined are not relevant. For example, if a person is confined alone and prevented from leaving a courtyard, safe assessment room, their bedroom or other area, this meets the definition of seclusion. If a staff member (or other) is with the person, this does not meet the definition of seclusion. For residential aged care, seclusion is considered an 'extreme restraint' and must not be used.

1.3 Legal and legislative framework

There needs to be a lawful purpose to restrain any person or to use seclusion.
All staff must understand relevant consent processes and legislative requirements for the use of seclusion and restraint in their setting.

The lawful basis will depend on the circumstances. In some cases, there will be consent.

This will often occur where restraint is an incidental part of treatment and the person, or their substituted decision maker, has given consent to the treatment and there is express or implied consent to the restraint. There may be a legislative basis underpinning the restraint or seclusion, such as restraint used to provide involuntary treatment to people detained under the Mental Health Act 2007. Where a person lacks capacity and there is a need to use seclusion or restraint, the Civil and Administrative Tribunal of NSW has the power to authorise a guardian to approve the use of restrictive practices.

Seclusion or restraint may be used as an act of self-defence to defend oneself or another person during an assault which is likely to continue or to prevent a threatened and imminent assault. In such cases, the person carrying out the restraint or seclusion must believe that it is:

- necessary to defend him or herself or another person, or to protect property, and
- a reasonable response to the circumstances.

In these circumstances, restraint or seclusion must only be carried out as a last resort and occur only until the risk has passed.

In all cases, no more force is to be used than is reasonable and proportionate in the circumstances and necessary to deal with the risk of harm.

A public health facility owes a duty of care to any person they restrain or seclude and is to take all reasonable steps to minimise harm and provide and maintain a safe workplace. Staff must be trained in the use of seclusion and restraint and must be aware of the impacts of such practices.

Local health districts (LHDs), specialty health networks (SHNs) and NSW Ambulance must adhere to legal, privacy and consent requirements, particularly in relation to:

- Aged Care Act 1997 (Cth)
- Aged Care Legislation Amendment (Quality Indicator Program) Principles 2019
- Children and Young Persons (Care and Protection) Act 1998
- Carer Recognition Act 2010
- Drug and Alcohol Treatment Act 2007
- Guardianship Act 1987
- Health Records and Information Privacy Act 2002
- Mental Health Act 2007
- Mental Health (Forensic Provisions) Act 1990
- National Disability Insurance Scheme Act 2013 (Cth)
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth)
- Quality of Care Principles 2014 (applies to Aged Care)
- Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019
- Work Health and Safety Act 2011.

Staff are encouraged to read this policy in conjunction with other NSW Health and Commonwealth policies, guidelines and reports (see Attachment 2).

2 PRINCIPLES AND VALUES

NSW Health is committed to carrying out the principle of least restrictive practice in line with a human rights based approach and the PANEL principles of Participation, Accountability, Non-discrimination, Empowerment, Legality. The principles of prevention and trauma informed care also apply to this policy.

Application of these principles is supported by NSW Health's CORE values of Collaboration, Openness, Respect and Empowerment.

Principle	Applying the principle
Prevention	NSW Health services use a proactive and multicomponent approach and structured quality improvement to reduce seclusion and restraint. The Six Core Strategies to Reduce Seclusion and Restraint Use is an example of a multicomponent prevention approach. Services strengthen a culture of mutual respect, quality and safety and provide adequate resourcing to support the prevention of seclusion and restraint. Prevention occurs at both a system level (therapeutic programs, models of care, built environment) and an individual level (risk assessment, safety planning, positive behaviour support).
Least restrictive	NSW Health services maximise a person's choices, rights and freedom as much as possible while balancing safety (of people accessing services, staff and others) and healthcare needs. Environments should be safe, supportive and respect a person's dignity and privacy.
Participation	NSW Health services take a person-centred approach and collaborate with people accessing services and their carers and family regarding their care and treatment.
Accountability	NSW Health services have governance arrangements to authorise and review the use of seclusion and restraint.
Non-discrimination	NSW Health services respect the rights and dignity of all people. Services pay attention to the needs of particular groups that have faced barriers to realising their rights. This includes but is not limited to Aboriginal people, people with disabilities, children and young people, older people, refugees, lesbian, gay, bisexual, transgender, intersex (LGBTI) people, culturally and linguistically diverse (CALD) groups.
Empowerment	NSW Health services work in partnership with people and their carers and families. Collaboration and co-design happen at an individual and a service level. Services promote hope and build trust.
Legality	NSW Health services comply with relevant legislation, understand the human rights implications of restrictive practices and continually consider the principles of fairness, respect, equality, dignity and autonomy, as well the safety of people accessing services, staff and others.
Trauma informed	NSW Health services understand and respond to the prevalence and impacts of trauma, supporting care that does not traumatise or re-traumatise the person. Services provide care that is person-centred and recovery-oriented and upholds human rights. Services recognise that seclusion and restraint can be very traumatic for many people and may increase distress, re-traumatise and trigger memories from past trauma. Trauma informed care is applied in all health settings. Services recognise and address provocative and triggering practices and behaviour. NSW Health services also recognise and respond effectively to the risk of trauma for staff. NSW Health services recognise that many Aboriginal people have experienced and continue to experience significant intergenerational and other trauma. They take this into account when designing and providing care. Services consider cultural obligations (e.g. Aboriginal family and community roles) and personal backgrounds of staff when allocating roles during a seclusion or restraint episode.

3 KEY REQUIREMENTS

NSW Health organisations must recognise that while the use of seclusion and restraint as a last resort may be necessary to keep people safe, it can also be traumatic and harmful for staff, people accessing services, carers and families and must be minimised.

Particular attention must be given to:

- Aboriginal people and families
- people with disabilities
- people with mental health issues or substance misuse
- people with medical conditions (including pregnancy)
- people with identified trauma
- children and young people
- older people, especially those with cognitive impairment or behavioural and psychological symptoms of dementia (BPSD)
- refugees
- LGBTI people
- CALD groups
- people who are at risk of self-harm or suicide
- staff at risk of vicarious trauma.

3.1 Prevention

NSW Health organisations must develop and implement a service level action plan to reduce and where safe and possible prevent seclusion and restraint, in collaboration with staff, people accessing services, carers and families.

In addition, NSW Health organisations must have local protocols and procedures outlining prevention strategies to reduce, and where possible, eliminate the use of seclusion and restraint.

NSW Health organisations must ensure adequate staff numbers, peer support and appropriate skill mix to maintain a safe workplace for people accessing services, staff and others.

Proactive approaches that take steps to address the person's needs (e.g. communication strategies, sensory preferences, positive behaviour support plans) are encouraged.

NSW Health staff must collaborate with the person, their carers and families (as applicable), to understand potential triggers which may cause the person to become distressed and unsafe. Safety planning is intended to identify individual strengths, self-soothing techniques and helpful strategies for staff to use to attempt to de-escalate potential risk. Trauma informed care principles must guide the prevention of seclusion and restraint.

NSW Health organisations must ensure staff have appropriate access to mandatory training to prevent and respond to potential and actual aggression and violence in line with PD2017_043 Violence Prevention and Management Training Framework for NSW Health Organisations. This includes understanding the key causes and components of difficult, challenging or disturbed behaviour, prevention and de-escalation.

3.2 Use of seclusion and restraint

NSW Health organisations must develop local protocols to guide the use of seclusion and restraint.

3.2.1 Least restrictive

NSW Health staff must only use seclusion and restraint:

- where there is a legal basis to do so
- as a last resort to prevent serious harm, usually associated with ASBD
- to allow administration of lawful medical treatment
- after less restrictive alternatives, including prevention strategies, have been trialled or considered, where safe to do so
- proportionate to the risk of harm
- for the minimum duration necessary.

In considering alternatives, NSW Health staff are to assess and act on the need to withdraw to a safe place and call for assistance if faced with unsafe situations.

Health staff must not place themselves or others at unnecessary risk in carrying out their duties. In practice, there may be times when the duty of care to people accessing services may require intervention but at no time is the duty of care to override a staff member's right to safety.

3.2.2 Initiating seclusion or restraint

- The decision to use seclusion or restraint must be made using all available information. This includes assessing the known clinical history of allergies and adverse effects of medication(s) where acute sedation is used.
- The amount of force used during any restraint must always be the minimum amount necessary and proportionate to the risk.
- If seclusion and restraint is initiated, NSW Health staff must cease their use as soon as the reason for the intervention has ended and it is safe to do so.
- NSW Health staff must ensure that any interference with a person's privacy and dignity is kept to the minimum necessary to protect the safety of all, especially when restraint occurs in public areas and shared treatment areas or rooms.
- Placing people in the prone position entails a significantly increased risk of harm to the person. There have been instances of sudden death, often associated with the administration of parenteral medication while in prone restraint.
- NSW Health staff should avoid prone restraint. Safety Notice 003/16 must be followed if prone restraint is used.
- Staff are to avoid restraining in a way that interferes with the person's airways, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen or by obstructing the mouth or nose.
- Staff must avoid bending the person's head or trunk towards the knees if they are seated.
- The restraint of a patient or an individual in clinical care areas is the role of the clinical team, with supplementary support, if this is necessary, provided by security staff at the direction of clinical staff.
- Security staff may also be required to provide supplementary safety support during the seclusion of a person but must never be required to replace a clinical staff member where clinical observations are required.

3.2.3 Ratifying and subsequent clinical reviews of the use of seclusion and restraint

- Seclusion and restraint is often initiated at short notice, in response to an emergency situation.
- To ensure a robust clinical review, all use of seclusion and restraint must be ratified by a senior clinician as soon as possible, but not more than one hour after the practice was initiated. The outcome of the review will be to cease the practice or to ratify its continuation. The review must be documented in the Health Care Record.
- If seclusion or restraint has been ceased prior to ratification, the person is to be examined by a medical officer as soon as possible after the event.
- After the initial ratification, a senior clinician must review the person as frequently as possible but not less than every four hours, until the intervention is ceased.
- An additional review must take place at each shift handover.
- If seclusion or restraint continues for 24 hours or more, an additional review, which includes multidisciplinary involvement, must take place.
- The senior clinician ratifying or reviewing the practice must not have been involved in the decision to initiate seclusion and/or restraint. NSW Health requires ratification and reviews to be carried out by staff with seniority and skills in risk management, clinical safety and trauma informed care.
- The senior clinician may vary depending on time of day, context, local resources and available skill mix. Examples include a staff specialist, Visiting Medical Officer, nurse unit manager or paramedic in an ambulance. Reviews are to be carried out in-person or, where required, via phone or videoconference.
- NSW Health staff must make every effort to ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies, including bedding and clothing appropriate to the circumstances, food and drink and adequate hygiene and toilet arrangements.
- NSW Health must consider staffing and skill mix required to undertake increased observations and perform reviews. Senior medical staff must be considered alongside nursing and allied health provision to provide appropriate multidisciplinary skill mix.

3.3 Observations and engagement during seclusion and restraint

- NSW Health requires high levels of clinical care, monitoring and reporting when seclusion and restraint are used. Any deterioration in a person's physical condition, mental state or cognitive state must be managed promptly.
- For the safety of the person, NSW Health clinical staff must continuously observe, and where possible, engage with a person in seclusion or four-limb mechanical restraint for the duration of the practice.
- For other forms of restraint, NSW Health clinical staff must continuously observe and, where possible, engage with the person for the first hour. After the first hour, NSW Health staff must clinically observe a person in restraint at least every 15 minutes.
- For people at higher risk during the intervention, more frequent and additional monitoring may be indicated, for example where acute sedation has been used
- Clinical monitoring must include vital signs (respiratory rate, blood pressure, temperature and pulse rate). The frequency of monitoring vital signs must be determined by the Clinical Team, parameters set and reviewed when required.

- It may not be possible to monitor all of the vital signs if, by doing so, safety of the staff or person being secluded is compromised. However, in those circumstances, continuous visual observation is required to ensure safety. If vital signs cannot be taken, staff must ensure the reasons are documented in the Health Care Record.
- Observations must be conducted in person and must not be undertaken using closed circuit television (CCTV).

3.4 Governance of seclusion and restraint

- NSW Health staff must adhere to the legal framework authorising the use of seclusion and restraint.
- NSW Health organisations must ensure that there are clinical governance processes for review of all instances of seclusion and restraint within the healthcare setting to improve safety and quality.
- NSW Health staff must notify a senior manager (or on-call manager) if seclusion is used, as soon as practicable.
- The NSW Health Incident Management Policy (*PD2019_034*) requires NSW Health staff to notify all identified incidents, near misses and complaints in the incident management system (IIMS) or IMS+. Staff must include information about seclusion and restraint in these reports, where applicable.
- Where an adverse event occurs related to seclusion and restraint, NSW Health organisations must implement open disclosure, as required under the NSW Health Opend Disclosure Policy (PD2014_028).
- Where mechanical restraint devices are used, NSW Health organisations' governance committees must review and approve their use by the specific facility or unit. Specific policies, procedures and infection control advice must guide their use. These organisations must provide staff with specific training in the use of mechanical restraint devices.

3.5 Monitoring the use of seclusion and restraint

NSW Health staff must document all episodes of seclusion and restraint and debriefing sessions in the Health Care Record in proportionate detail to enable a review of practice.

Records should include:

• IIMS incident number (where seclusion or restraint is part of a reportable incident) • antecedents • adherence to prevention strategies • alternative least restrictive interventions trialled or considered • reason for seclusion or restraint • staff who initiated the use of seclusion or restraint • Aboriginal identification • authorisation • location of seclusion or restraint episode • medication offered or administered • reviews by senior staff	• frequency of observations • any physical injury • notification of family or carer • clinical examinations undertaken and outcomes • food and fluid intake • start and finish time of seclusion and/or restraint • active practices to reduce duration • debriefing, including service user and family/carer feedback • identification of future prevention and intervention strategies • multidisciplinary review • review of care plan. 327(06/03/2020)

NSW Health organisations must collect data and report on episodes of seclusion and restraint in accordance with this policy, legislative requirements and the National Safety and Quality Health Service Standards (2nd edition).

NSW Health organisations must make information and data about the use of seclusion and restraint available to staff, people accessing services and their carers and family to support quality improvement and aid preventive approaches.

3.6 Notification

Where legally permitted and after considering privacy requirements, NSW Health staff must make every effort to notify the following persons (as applicable to the person and legal status) about the use of seclusion and restraint and the reasons for using it as soon as practicable:

- a carer
- a guardian
- a parent if the person is under the age of 16 years
- other, as appropriate and identified by local protocols (e.g. senior executive).

This may not be feasible in specific situations, for example, care by NSW Ambulance.

3.7 Debriefing

NSW Health organisations must have protocols for debriefing after the use of seclusion or restraint, including safe and appropriate involvement of people who have been secluded or restrained, their carers and family (as applicable) and staff.

This may not be appropriate or feasible in all cases (e.g., care provided by NSW Ambulance).

Debriefing processes are intended to provide an opportunity to identify systemic practices and individual factors that provoke or trigger incidents. Debriefing should aim to maximise learning, minimise any potential traumatising effects and identify strategies to prevent future incidences.

3.8 Prohibited practice

NSW Health staff must not:

- use seclusion and restraint as a form of discipline, punishment or threat
- use seclusion or restraint as a means to reduce behaviours not associated with immediate risk of harm
- use seclusion for people who are actively self-harming or suicidal
- seclude a person who is also being mechanically restrained
- use metal handcuffs or hard manacles as a form of mechanical restraint (although a person may be in metal handcuffs when they have been transported by police or other custodial staff and remain under police or other custodial supervision while in the health facility)
- use vest restraints for older people.

4 ADDITIONAL REQUIREMENTS FOR SPECIFIC SETTINGS

4.1 Declared emergency departments and mental health units

As defined under the Mental Health Act 2007.

All mental health inpatient services must have 24-hour, everyday on-site supervision from accountable management representatives. This supervision must include in-person rounding on every shift.

In mental health units, each seclusion and restraint (currently physical and mechanical) episode must also be recorded in a dedicated Register to allow for reporting. This requirement also applies to seclusion and restraint of mental health consumers in declared emergency departments.

The Register must include:

- a separate entry for each episode of seclusion or restraint
- IIMS incident number (where seclusion or restraint is part of a reportable incident)
- details of the person being secluded or restrained, including identification of Aboriginal people
- date of seclusion and restraint episode
- type of seclusion and restraint episode
- time started
- time ended.

The register is to be kept in a secure location, noting adherence to privacy legislation and policy.

NSW Health organisations must submit seclusion and restraint data from all mental health units and declared emergency departments to the NSW Ministry of Health.

NSW Health organisations must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information and seclusion and restraint Registers.

There are no additional requirements for non-declared emergency departments. The general requirements outlined in this policy apply.

4.2 NSW Ambulance

A paramedic must be with the person being restrained at all times until handover is complete. Staff must record all physical/mechanical restraints in the person's Health Care Record and, for any person who meets the criteria for being mentally ill or mentally disturbed and being detained, staff must also complete a Mental Health Act 2007 Section 20 form (State Form SMR 025.205 NH606721) each time restraint is used.

4.3 Residential Aged Care

Includes State Government Residential Aged Care Facilities and Multipurpose Services

An approved health practitioner (i.e. a medical practitioner, nurse practitioner or registered nurse) who has day-to-day knowledge of the resident (for physical restraint), or a medical or nurse practitioner who has prescribed a medication (for chemical restraint) must:

- assess the resident as posing a risk of harm to themselves or any other person, and requires the restraint (physical or mechanical)
- document the assessment, unless the use of restraint is needed in an emergency then document the assessment as soon as possible after using the restraint
- document the alternatives that were considered and used, unless emergency restraint was necessary
- use the least restrictive form of restraint possible
- have informed consent of the person or their representative, unless restraint is needed in an emergency. If restraint is used without consent, inform the person's representative as soon as possible after the health practitioner starts to use the restraint

NSW Health staff must not use the following in residential aged care:

- seclusion
- posey crisscross vest
- leg or ankle restraint
- manacles/shackles (hard)
- soft wrist/hand restraints.

All residential aged care facilities funded by the Australian government must collect and provide quality indicator data to the Department of Health. This includes NSW State Government Residential Aged Care Facilities (SGRACFs). These services must measure, monitor and report on mandatory quality indicators including use of physical restraint. Official Community Visitors must have access to the seclusion and restraint Register and monthly summary of seclusion and restraint data from all visitable services.

4.4 Transportation and transfer of care

NSW Health staff must adhere to legal and policy requirements if using restraint during transportation. If a person is transferred while in restraint, the receiving medical practitioner, paramedic or senior registered nurse must use all available information to assess the need to continue or cease restraint. NSW Health staff should review the use of restraint as soon as possible, unless the person remains under the custody of an accompanying officer from NSW Police Force, Youth Justice NSW, Corrective Services NSW or Border Protection Services.

5. APPENDIX LIST

1. Implementation Checklist
2. NSW Health and Commonwealth policies, guidelines and reports

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:	**Date of Assessment:**		
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Develop local implementation plan in collaboration with staff, individuals who access health care services and carers/families.	❑	❑	❑
	Notes:		
2. Develop local policies, procedures and education programs to support implementation of the policy and incorporation of review feedback; includes any plans for specific areas (e.g. Emergency Department, Intensive Care Unit), staffing and physical environment.	❑	❑	❑
	Notes:		
3. Detail ways in which the principles and values of the policy will be implemented. Recognise the impact of seclusion and restraint as a physical and psychological safety issue for people accessing services and staff and take action to support a culture of quality improvement to reduce and where possible eliminate the practice	❑	❑	❑
	Notes:		
4. Promote the policy to all staff (paid and unpaid, contractors, etc.).	❑	❑	❑
	Notes:		
5. Establish monitoring and reporting processes, including implementation of risk assessments and prevention strategies.	❑	❑	❑
	Notes:		
6. Conduct annual (minimum) audits of compliance with policy.	❑	❑	❑
	Notes:		
7. Ensure that clinical governance processes include reviews of seclusion and restraint performance in all healthcare settings	❑	❑	❑
	Notes:		

Attachment 2: NSW Health and Commonwealth policies, guidelines and reports

NSW Health Policy documents

Policy Directives

- PD2012_042 - Aboriginal and Torres Strait Islander Origin - Recording Information of Patients and Clients
- PD2013_049 - Recognition and Management of Patients who are Clinically Deteriorating
- PD2014_028 - Open Disclosure Policy
- PD2015_001 - Preventing and Managing Violence in the NSW Health Workplace-A Zero Tolerance Approach
- PD2017_001 - Responding to Needs of People with Disability during Hospitalisation
- PD2019_049 - Compulsory Reporting for Residential Aged Care Services
- PD2017_025 - Engagement and Observation in Mental Health Inpatient Units
- PD2017_043 - Violence Prevention and Management Training Framework for NSW Health Organisations
- PD2018_002 - Service Specifications for Transport Providers, Patient Transport Service
- PD2018_027 - Identifying and Responding to Abuse of Older People
- PD2019_034 - Incident Management Policy

Guidelines

- GL2012_005 - Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused upon Older People
- GL2014_010 - NSW Acute to Aged Related Care Services Practice Guidelines
- GL2015_001 - Safe Use of Sensory Equipment and Sensory Rooms in NSW Mental Health Services
- GL2015_007 - Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments
- GL2016_016 - NSW SMHSOP Acute Inpatient Unit Model of Care Guideline
- GL2017_003 - Specialist Mental Health services for Older People (SMHSOP) Community Model of Care Guideline
- GL2017_022 - NSW Older People's Mental Health Services SERVICE PLAN 2017-2027
- GL2019_008 - Communicating Positively: A Guide to Appropriate Aboriginal Terminology

Other NSW Government documents that support good practice

- A Guide to Build Co-design Capability August 2019
- Advance care planning in New South Wales
- Building collaborative cultures of care within NSW mental health services
- Carers (Recognition) Act 2010 No 20
- Charter for Mental Health Care in NSW
- Disability Inclusion Act 2014 No 41
- Lived Experience Framework for NSW
- Making an Advance Care Directive

- Mental Health for Emergency Departments: A Reference Guide (NSW Health, 2015) (commonly referred to as 'the Red Book')
- NSW Health - NSW Police Force Memorandum of Understanding 2018: Incorporating provisions of the Mental Health Act 2007 (NSW) No 8 and the Mental Health (Forensic Provisions) Act 1990 (NSW)
- Protecting People and Property-NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies - in particular:

  Chapter 14 Role of Security Staff in NSW Health

  Chapter 29 Code Black Arrangements
- Safe Assessment Room Guidelines[1]
- Safety Notice 003/16 Use of Prone Restraint and Parenteral Medication in Healthcare Settings

Commonwealth guidelines/documents that support good practice

- Aged Care Quality and Safety Commission (2018). Guidance and Resources for Providers to support the Aged Care Quality Standards
- Australian Commission on Safety and Quality in Health Care: Open Disclosure
- Australian Commission on Safety and Quality in Health Care's Recognising Signs of Deterioration in a Person's Mental State
- Australian Commission on Safety and Quality in Health Care's Delirium Clinical Care Standard
- Australasian Health Facility Guidelines seclusion room
- Australian Human Rights Commission-Human Rights Explained fact sheets
- Charter of Aged Care Rights
- Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care
- Guidance and Resources for providers to Support Aged Care Quality Standards
- Mental Health Statement of Rights and Responsibilities 2012
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018
- National Mental Health Commission Seclusion and Restraint Project
- National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services
- National Safety and Quality Health Service (NSQHS) Standards User Guide for Aboriginal and Torres Strait Islander Health
- National Safety and Quality Health Service (NSQHS) Standards Guide for Multi-Purpose Services and Small Hospitals
- National Safety and Quality Health Service (NSQHS) Standards User Guide for Health Services Providing Care for People with Mental Health Issues
- Royal Commission into Aged Care Quality and Safety: Restrictive Practices in Residential Aged Care in Australia
- Safe in Care, Safe at Work ACHMN 2019
- Safe Work Australia Review of the model WHS laws: Final report 2018
- Safe Work Australia Work related psychological health and safety: A systematic approach to meeting your duties

1 Not yet published

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

The key principles outlined in the Australian National Seclusion and Restraint Project (2009) *National Suite of Documentation* guide this document. These principles are summarised below and detailed in PD2012_035 Appendix 3.

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

USE OF THE GUIDELINE

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

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

For the complete Guideline please go to
http://www.health.nsw.gov.au/policies/gl/2012/GL2012_005.html

157(28/06/12)

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.

To download the Guideline go to http://www.health.nsw.gov.au/policies/gl/2012/GL2012_006.html

CLINICAL CARE OF PEOPLE WHO MAY BE SUICIDAL (PD2022_043)

(PD2022_043 replaces PD2016_007)

POLICY STATEMENT

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

The requirements of this Policy Directive apply specifically to the specialist mental health workforce providing clinical care across community, inpatient and emergency settings and in collaboration with other health professionals and the individual's support network.

SUMMARY OF POLICY REQUIREMENTS

NSW Mental Health Services are to implement processes consistent with the requirements of this Policy Directive to ensure the provision of timely evidence-based clinical care of people at risk of suicide in NSW Health services.

All NSW Health staff have a role in identifying and responding to people who may be suicidal.

Local Health District and Specialty Health Network Chief Executives and Health Service Executives need to assign responsibility, personnel and resources to implement and 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 and ensure that all mental health service staff are aware of the requirements.

NSW mental health services and clinicians are to meet minimum standards for the clinical care of people who may be suicidal which includes the key components of:

- Identification: the early identification of suicide risk, including subsequent triage and interim observational management followed by timely and appropriate referral for further assessment.
- Assessment: the comprehensive mental health assessment of people presenting with, or identified as possibly having, suicidal thoughts or behaviour. Assessment includes but is not limited to appropriate supervisory consultation and documentation of mental state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and any other actions and precautions taken as an outcome of those assessments.
- Formulation: synthesising and documenting information collected during the assessment to develop an understanding of the person and their circumstances to inform care planning such as appropriate interventions and treatment.
- Brief intervention: activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk.
- Treatment: refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan, in consultation with the person and their support system.
- Transition and discharge: Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality as these stages represent times of potential increase in suicide risk.

Processes and protocols for the clinical care of people who may be suicidal are to align with requirements for incident management, open disclosure and mental health clinical documentation where applicable.

Local Health District and Specialty Health Network policies, procedures and standards need to be developed in consultation with the Mental Health Branch, NSW Ministry of Health to ensure they are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document.

Health services are to ensure that all staff undertake appropriate education and training.

1. BACKGROUND

Suicide prevention is everyone's business, and all NSW Health staff have a role to play. It is important that all health staff can identify people at risk of suicide, take action that may prevent suicide deaths and implement management strategies, including referral to relevant services for further assessment and expert supports.

This Policy has been specifically developed for the specialist mental health workforce providing care across community, inpatient and emergency settings, in collaboration with other health professionals and the individual's support network.

Mental health clinicians may work in emergency departments, mental health telephone triage services, community mental health services, mental health inpatient facilities and general health facilities. When care is provided by community teams this will extend to other settings such as the home, school, aged care facilities and other community settings.

Mental health services and clinicians have a particular responsibility and skills in assessing, advising and implementing effective strategies that aim to prevent suicide, including facilitating access to appropriate care.

Non-clinical mental health staff and supports also have a vital role to play in comprehensive and effective suicide prevention in the health system.

In 2020 NSW Health instituted the Zero Suicides in Care Initiative, informed by the Zero Suicide Healthcare Framework which identified that evidence-based practices can be applied across the elements of suicide care, supported by leadership, training and ongoing improvement. The Zero Suicide Healthcare Framework includes an aspirational goal of eliminating suicide deaths, implemented within a safety culture that supports consumers, family, carers and staff to heal following critical incidents.

Consistent with Zero Suicides in Care, NSW mental health services[1]:

- Lead system-wide culture change committed to reducing suicides:

  Supporting the development of organisations that demonstrate leadership, providing tangible supports to staff, promoting a culture of restorative justice and learning, and ensuring people with lived experience co-design the development and evaluation of the program.

- Train a competent, confident, and caring workforce:

  Commitment to the ongoing development of all mental health staff utilising local and state-wide resources and ensuring that all staff, both clinical and non-clinical, are able to engage with people who may be suicidal.

- Care for all people presenting to mental health services:

  Responding to the needs of people at risk of suicide in a manner that is caring, compassionate, trauma-informed, culturally responsive, respectful, and non- judgmental.

- Improve policies and procedures through continuous quality improvement:

  Organisations collect data and evaluate clinical outcomes and the effect of training and clinical model change through continuous quality improvement in a safety oriented and supportive culture.

1.1 Principles of care

Building positive therapeutic engagement with a person who is experiencing suicidal ideation is essential for compassionate clinical care for people who may be suicidal at all stages of suicide care. Research shows a strong link between the quality of the therapeutic relationship and therapeutic outcomes[2].

An empathetic and compassionate approach by the clinician will build important trust and rapport. A good therapeutic relationship includes trust, care and respect, agreement on the goals of care, and collaboration on the care plan and tasks to be undertaken.

Compassionate care of people who may be suicidal is also culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed (including recognising the potential of mental health service environments and interventions to cause or compound trauma), and evidence-based.

1.2 About this document

This Policy Directive establishes minimum standards that NSW mental health services and mental health clinicians are required to meet; in the identification of people who may be suicidal, and the assessment and treatment of people with suicidal thoughts and behaviour within NSW Health care settings.

This Policy reinforces the emphasis on comprehensive assessment and broadens the focus on provision of brief interventions to all people presenting to health services who may be suicidal and, where appropriate, providing advice about or referral to appropriate clinical and non-clinical services within or outside of NSW Health.

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 roles and responsibilities of mental health services and clinicians to inform local policies and procedures
- Support a consistent and coordinated evidence-informed approach to the application of clinical guidelines and training.

1.3 Key definitions

Carer	An individual who provides care and support to a family memberor friend who lives with a disability, mental illness, alcohol or drug dependency, chronic condition, terminal illness or who is frail due to age.
Culturally responsive	Culturally responsive services and staff are self-aware, respectful of all cultures, and actively respond to the cultural needs and strengths of all people, paying particular attention to social and cultural factors in managing therapeutic encounters and providing culturally safe care environments.
Cultural safety	Cultural safety requires healthcare professionals and their healthcare organisations examine the potential impact of their own culture on service delivery. Healthcare professionals and organisations are required to acknowledge and address their biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care. Cultural safety encompasses a critical consciousness with ongoing self-reflection, self-awareness and accountability for providing culturally responsive care, as defined by consumers and their communities, and as measured through progress towards achieving health equity. Cultural safety has universal application but is most important in the Australian context for

	Aboriginal and Torres Strait Islander people.
Evidence-based care	Healthcare practice that involves integrating the best available research evidence with clinical knowledge and expertise, whileconsidering consumers unique needs and preferences.
Family	'Family' has different meanings for different people, and customs for parenting, marriage and kinship vary across cultures and societies. Family usually means two or more people with shared ancestry or enduring legal or cultural ties to each other and may encompass any significant person includingpartners, parents, children, grandparents, siblings, extended family and others significant to the person.
Mental Health Clinician	A person who provides evidence-based, clinical care for mental health, including medical practitioners, nurses and allied health clinicians.
Mental health service	Any specialised mental health service within NSW Health or funded by NSW Health, including clinical and non-clinical care services and settings.
Mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception, or memory.
Mental State Examination	An examination used to gain an understanding of a persons psychological functioning at a particular point in time including but not limited to consideration of appearance and behaviour, speech, mood, affect, thought, perception, cognition, insight and judgement.
Non-clinical care services and settings	Mental health services that predominantly or exclusively provide non-clinical care and support, such as Safe Havens.
Peer worker	A staff member who has personal, lived experience of mental illness or suicide, and recovery, or of supporting family or friends with mental illness or suicidality. This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.
Person-centered care	Care that is respectful of, and responsive to, the preferences,needs and values of the individual patient.
Priority populations	Population subgroups identified as having a risk of suicide or self-harm that is higher than that of other populations, the impacton the community is different or they have specific requirements for culturally appropriate suicide prevention or postvention services.
Psychosocial history	An evaluation of the patient that includes a history of psychiatric illness, developmental history, educational history, marital and family life, and employment history.
Recovery	From the perspective of the individual, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.
Recovery-oriented care	The application of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.
Restorative justice	A process to involve, to the extent possible, those who have a stake in a serious adverse incident and collectively identify and address harms, needs and obligations in order to heal and put things as right as possible.
Restorative, just and learning culture	A culture within a mental health setting of restorative justice and forward-thinking accountability that is non-blaming, supports healing for consumers, families and staff, and ensures learnings are translated into actions to improve systems of care.
Risk stratification	A systematic process to classify patients who are at risk of suicide, and inform interventions offered. This is not the current best practice approach; mental health services and clinicians are to offer treatment

	for the individual based on comprehensive individual assessment.
Safety planningintervention	A collaborative process with the person, clinician and family and carers that leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis.
Self-harm	Any behaviour that involves the deliberate causing of pain or injury to oneself.
Suicide	An act of intentionally terminating one's life.
Suicide attempt	Self-initiated, potentially injurious behaviour with the intent to die, but does not result in a fatal outcome.
Suicide prevention	An approach that aims to decrease the number of people who die by suicide or attempt suicide, focusing on reducing risk factors in individuals for suicide and enhancing available resources that prevent suicide and suicidal behaviour.
Suicide risk factors	Biological, psychological and social factors that are associated with an increased risk of suicide, including modifiable and non-modifiable risk factors.
Suspected suicide	The term used until the Coroner has made the determination the death was suicide.
Trauma-informed care	An approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.

1.4 Implementation

Local Health District and Specialty Health Network Chief Executives and 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 that all mental health service staff are aware of the requirements of this Policy
- Ensure mental health clinicians undertake training in assessment and management of suicidality
- Work together with the Mental Health Branch, NSW Ministry of Health to ensure Local Health District and Specialty Health Network policies, procedures and standards are consistent with all relevant state-wide policies, procedures and guidelines referenced in this document
- Comply with this Policy including role modelling behaviours consistent with a restorative just culture.

Implementation of this policy is to be supported by:

- Integration of peer workers across clinical settings, as well as establishing care pathways and collaborative approaches between clinical and non-clinical services
- Consultation and partnerships with Aboriginal mental health workers and community
- Co-design approaches, where appropriate.

1.5 Legal and legislative framework

The NSW Health Legal Compendium contains the full list of NSW Health legislation, policy directives and guidelines and are to be referred to for a complete list of relevant Policy Directives and Guidelines and the most up to date version of all documents.

1.5.1 NSW Legislation

- *Children and Young Persons (Care and Protection) Act 1998* (NSW)
- *Disability Inclusion Act 2014* (NSW)
- *Guardianship Act 1987* (NSW)
- *Health Administration Act 1982* (NSW)
- *Health Administration Regulation 2020* (NSW)
- *Health Care Complaints Act 1993* (NSW)
- *Health Records and Information Privacy Act 2002* (NSW)
- *Health Records and Information Privacy Regulation 2022* (NSW)
- *Health Services Act 1997* (NSW)
- *Mental Health Act 2007* (NSW)
- *Privacy and Personal Information Protection Act 1998* (NSW)

1.5.2 Key policy directives and guidelines

- NSW Health Policy Directive *Mental Health Triage Policy* (PD2012_053)
- NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025)
- NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).
- NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045)
- NSW Health Policy Directive *Seclusion and Restraint in NSW Health Settings* (PD2020_004)
- NSW Health Policy Directive *Incident Management* (PD2020_047)
- NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039)

Refer to the NSW Health Legal Compendium, Mental Health for additional relevant Policy Directives and Guidelines.

2. WORKING WITH DIVERSE PEOPLE AND SPECIFIC NEEDS

Clinical care of people who may be suicidal needs to be respectful of, and responsive to, the preferences, needs and values of the individual person. This includes consideration of the whole person, including factors such as their culture, language, age, gender identity, sexual orientation, physical and mental health and abilities, occupation, socioeconomic status, and geographic location, and modifying approaches where appropriate.

All NSW Health mental health services are to ensure:

- Locally developed protocols are in place that respect diversity and guide the delivery of care that is person-centered, respectful, trauma-informed, culturally responsive and appropriate to the local population and context
- All mental health service staff complete appropriate training for working with culturally, socially and linguistically diverse people and priority populations
- All mental health services are delivered in culturally safe service environments with access to Indigenous and/or culturally responsive non-Indigenous staff

- All consumers, families and carers who do not speak English as a first language, or who are deaf have access to professional healthcare interpreters in accordance with the NSW Health Policy Directive *Interpreters - Standard Procedures for Working with Health Care Interpreters* (PD2017_044).

All mental health clinicians have the responsibility to ensure a person's social and cultural context and identity is considered and respected when developing care plans, providing interventions, engaging with families, carers and support networks, and when connecting a person with healthcare supports including peer workers and Aboriginal health workers.

Different characteristics of the individual's need are to be considered together, as many people may belong to more than one diverse or cultural group and this intersectionality can lead to different needs and experiences within healthcare[3].

3. IDENTIFICATION

All NSW Health staff have a role to play in the early identification of suicide risk, which can occur:

- In any part of the health system, including where health services are provided in the home or community
- As part of structured screening in health services which may include use of screening tools to increase early identification of suicidal risk beyond self-disclosure or clinical judgement (noting that screening tools alone must not be used to assess risk or determine treatment) [3, 4].
- At any stage of an individual's interaction with health and mental health services.

All mental health services are to:

- Ensure locally developed protocols are in place that support:
  - Appropriate and timely triage of persons experiencing suicidality and interim observational management pending referral to mental health services
  - Staff to ask people directly about their suicidal ideation, as many people do not talk about suicidal thoughts and plans unless asked directly[5]
  - Establishment of referral pathways to assist in early identification and access to care for people with suicidal behaviour or ideation.
- Provide guidance to staff regarding expected processes for identifying emergent suicidal ideation during care.

The NSW Health Policy Directive *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 express self-harm ideation.

4. ASSESSMENT

All mental health clinicians undertaking assessment are to:

- Provide clinical management and care in accordance with the *Mental Health Act 2007* (NSW)
- Undertake a comprehensive mental health assessment with people presenting with, or identified as possibly having, suicidal thoughts or behaviour, and seek supervision and support in this responsibility where appropriate
- Ensure clinical records document ongoing mental health state, assessment and risk formulation, safety planning, treatment, suicide care planning, review, transition and handover, and actions and precautions taken as an outcome of those assessments
- Include consultation with supervisors and the person's key carer network where management plans change to support ongoing communication across the care and social support systems

- Complete a [NSW Police Force Firearms Registry Disclosure of Information by Health Professionals Form] if the person is known to have access to a firearm, and there is an assessed level of risk of harm to self or others.

A comprehensive mental health assessment:

- Is an opportunity to build therapeutic engagement and show compassion and understanding
- Is based on a comprehensive clinical interview conducted by the mental health clinician/s in collaboration with the person at risk of suicide and their family and carers. Corroborative history is to be obtained whenever possible
- Includes assessing suicidal thoughts and behaviour, medical and psychiatric history, psychosocial history, life stressors, drug and alcohol history including current use and withdrawal status, presence of risk factors for suicide including current access to lethal means, a person's strengths and protective factors, and available supports and ability to recover in the community
- Includes review of current care levels, engagement and observation or status in the community
- Includes a Mental State Examination (MSE)
- Is to be sensitive to the distress of the person and the fact that assessment involves significant disclosure. This must be carried out in a manner that is culturally safe, recovery-oriented and trauma-informed
- Focuses on treatment planning and risk minimisation, not prediction or risk stratification
- Provides an understanding of the person at a point in time. This understanding will evolve and be reviewed over time.

A further comprehensive mental health assessment may be required to reassess a person's suicide risk and planned care, particularly in response to any changes in personal circumstances or care needs.

5. FORMULATION

Formulation is the process of synthesising information collected during an assessment to develop an understanding of a person and their circumstances and informs care planning.

When a person is identified as having suicidal ideation, mental health clinicians must undertake suicide prevention formulation. Suicide prevention formulation is relevant to a person's suicide risk. It aims to capture how a person's history and context interact to produce and mitigate suicide risk.

A person-centered suicide prevention formulation provides the best way to ensure that the most effective care can be tailored to a person's needs and the process includes:

- Considering the suicide risk factors a person presents, as identified in the comprehensive assessment
- Identifying which risk factors are modifiable and can be addressed
- Determining the nature of an individual's internal coping resources and how they can be strengthened
- Detailing the external resources available to help a person navigate distress such as family, social network, professional supports or wider community
- Considering the changeability of the current situation including factors internal to the person, potential changes in important relationships and external factors that could rapidly escalate risk
- Consulting and collaborating with colleagues, including advice sought from senior colleagues, particularly where the decision is made not to admit someone to a mental health inpatient unit where ongoing suicidality is identified.

The suicide prevention formulation provides the basis for the safety plan and, where appropriate, a comprehensive care plan. Suicide risk formulations are reviewed regularly and updated with any significant changes in presentation, context or availability of support.

Suicide prevention formulation is documented in the electronic medical record system (eMR). Most people requiring ongoing mental health care will require a comprehensive mental health formulation in addition to a suicide risk formulation.

6. BRIEF INTERVENTION

Brief interventions refer to activities that can be enacted immediately to help to ensure a person is safe and better able to manage suicide risk. Brief interventions can be used early in the therapeutic engagement process – as early as first contact. This enables timely support to be provided and immediate needs to be addressed, while also promoting ongoing engagement with care.

Brief intervention is to be outlined in a safety plan that incorporates the following activities routinely used when a person is identified with suicidal risk:

- Address access to lethal means
- Provide education and information to the person, and their family and carers
- Identify contingency plans in the event of acute deterioration using an agreed escalation process
- Where appropriate, identify non-clinical services within and outside of NSW Health where the person may be able to access support in future crisis or receive short term support to address interpersonal or social factors contributing to the suicidal crisis.

A safety planning intervention is a collaborative process with the person and clinician and family and carers wherever possible. The intervention leads to the development of a tailored, prioritised list of strategies and sources of support a person can use when they experience a suicidal crisis. The safety planning intervention is to include identification of warning signs, internal coping strategies, identification of social contact that may distract from suicidal thoughts, access to social supports to help resolve the crisis, professional supports and counselling on access to lethal means. Clear actions and roles and responsibilities for addressing access to lethal means are also be agreed upon in this process.

The safety plan is to be put in place as early as possible and reviewed regularly as circumstances change, including after a crisis or suicide attempt.
In addition to the person having a copy of the safety plan, a copy must be documented in the electronic medical record (eMR) system in accordance with the requirements for clinical documents.

7. TREATMENT

All people who are identified as requiring ongoing clinical care in NSW specialist mental health services are to address the risk of suicide, require a comprehensive care or treatment plan. The plan is to be developed in collaboration with the person, their family, carers and key supports. Treatment refers to the care, therapies and resources that support a person to address their suicidality directly and is documented in a comprehensive care plan that:

- Addresses modifiable risk factors
- Mitigates the impact of long-standing risk factors
- Consolidates and builds on a person's strengths and available resources.

Modifiable risk factors include mental illness (mood disorders, psychosis, anxiety disorders,bipolar disorder, eating disorders), impact of past trauma, substance misuse, pain, physical illness, isolation, unemployment and factors related to social and cultural networks.

Suicidal thoughts can be treated directly using evidence-based treatment models known to specifically reduce suicidality.

Ongoing management of a person's mental health and/or suicidal risk requires mental health clinicians regardless of their setting to:

- Prioritise the safety and wellbeing of the person at risk of suicide and NSW Health staff
- Consider decisions about care and treatment in accordance with the *Mental Health Act 2007* (NSW), including that:
  - People receive care and treatment in the least restrictive environment possibleenabling the care and treatment to be effectively given
  - Every effort that is reasonably practicable is made to obtain the person's consent and to involve them in treatment and recovery planning, considering their capabilities, preferences, views and expressed wishes
  - The views of a parent, designated carer, guardian or principal care provider are sought and considered by clinicians when making decisions about the person
- Ensure care in a public health facility includes a safe physical environment
- Routinely consider a person's cultural context and identity, and how this may influence suicidality and pathways to recovery
- Regularly reassess the person noting that suicidal risk can fluctuate with both deterioration and improvement in overall mental state
- Review the treatment plan regularly along the care pathway, including transition points or when the context or other factors change.

8. TRANSITION OF CARE AND DISCHARGE

Transitions of care and discharge represent times of potential increase in suicide risk[6].

Follow-up at transition and post-discharge is to be incorporated into the care plan, including timing, frequency and modality. Follow-up arrangements must consider factors such as the person's age, cultural identity, geographic location, diagnosed mental illness, access to communication technology, domestic situation and support networks[3].

All mental health clinicians regardless of their setting are to:

- Ensure the requirements outlined in the NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045) are followed for the care of people with suicide risk
- Review and update assessments and care plans at points of significant transitions in care
- Conduct warm handover to other service providers that combines written referrals with a person-to-person discussion using a consistent format such as ISBAR (Introduction, Situation, Background, Assessment, Recommendation)
- Follow up within 24-48 hours of transition of care where possible or as agreed in the care plan based on clinical need and the person's individual circumstances, and document accordingly
- 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 and ideally within 72 hours, or within a maximum of 7 days.
- At each transition point, ensure accurate and up to date contact details for the person, their next of kin or carer, and their general practitioner are recorded in the person's electronic medical record (eMR).

8.1 Discharge

Discharge planning is a collaborative process involving the person and their family or carers. Discharge planning commences on entry to the service.
Safe discharge from an acute inpatient care unit requires mental health clinicians to deliver assertive and coordinated follow-up through direct contact as soon as possible following discharge. 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.
Ongoing care options include:

- Community mental health services
- The person's general practitioner
- Inpatient and community private sector care
- Non-clinical services such as The Way Back Support Service
- Drug and Alcohol Services.

Discharge from the mental health service must be accompanied by:

- Written details of discharge plans including referrals to other treatment teams, such as general practitioners or non-clinical assertive follow-up supports provided to the person
- Information about how the person or their family/carers can escalate concerns about deterioration including access to the 24/7 Mental Health Line 1800 011 511.

8.2 Responding to people with ongoing suicidality

Mental health services are required to develop 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 are to involve all relevant parties, integrating clinical and non-clinical care and supports (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 suicidal ideation and assess the risk at each presentation
- Where available, refer to brief intervention models such as Project Air for more comprehensive care planning
- 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 and linkage to programs that promote emotional self-mastery and problem-solving skills.

9. MANAGEMENT FOLLOWING A SUSPECTED DEATH BY SUICIDE

The NSW Health Policy Directive *Incident Management* (PD2020_047) outlines how services identify all people affected by suspected death by suicide including; consumers, carers and staff, the needs of those people, and who is responsible for addressing their needs.

A serious adverse event review (SAER) is required for suspected death by suicide of a person:

- Within an acute psychiatric unit or acute psychiatric ward

- Who has received care or treatment for a mental illness from the relevant health services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation
- Who is a NSW Health staff member.

All NSW Mental Health Services are to ensure:

- Effective local incident management systems are consistent with the NSW Health Policy Directive *Incident Management* (PD2020_047)
- Effective local open disclosure processes are consistent with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028), including the provision of ongoing support for families, carers and staff which is responsive to their needs and expectations, for as long as is required
- There are active measures to support their workforce and any staff member affected by a suicide death or suicide attempt is offered support from their team manager, clinical supervisor and the Employment Assistance Program (EAP).

All mental health clinicians regardless of their setting need to:

- Demonstrate compassion, openness, respect and empathy to the family and carers of a person who has died
- Be aware of and observe a standardised approach in communicating with families and other support people after an incident in care that is consistent with the NSW Health Policy Directive *Open Disclosure Policy* (PD2014_028)
- Advise any clinician (including private psychiatrists and general practitioners) or non-clinical psychosocial support service who has been managing care of the deceased in the community of the death as soon as possible.

10. CLINICAL SUPERVISON AND SUPPORT

All NSW Mental Health Services are to:

- Ensure clear local protocols are in place to support less experienced clinicians to seek advice from more senior clinicians regarding the clinical assessment or care of people who may be suicidal
- Ensure that mental health clinicians have access to appropriate clinical supervision, consultation or advice from a senior clinician at all times
- Recognise the ongoing impacts on clinicians and aim to mitigate times of high distress including anniversaries.

11. CLINICAL DOCUMENTATION

All NSW public mental health services are required to use available electronic medical record (eMR) systems for the documentation of clinical practice and care.

All NSW Mental Health Services need to ensure mental health clinicians complete training in mental health clinical documentation, and related eMR systems and processes.

All mental health clinicians regardless of their setting have a professional and legal responsibility to maintain clear, accurate and timely records and to document clinical practice and care as mandated in the NSW Health Policy Directive *Mental Health Clinical Documentation* (PD2021_039).

12. ENVIRONMENTAL HAZARDS

Mental health inpatient facilities are to remove or reduce environmental hazards for patients with suicidal behaviour and ideation.

All NSW Mental Health Services are to:

- Ensure respectful and trauma-informed development and implementation of standardised practices intended to improve patient safety, eliminate hazards and reduce the likelihood of adverse incidents occurring, including:
    - Ensuring each shift changeover incorporates assessment of environmental risks
    - Undertaking monthly 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
    - Ensuring strategies to monitor and prevent potentially dangerous items being brought into the inpatient unit by patients, family, carers or friends
    - 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
    - Designating a staff member responsible for undertaking the environmental audit which is to be dated, signed and retained as a formal record.

The *Access to Means of Suicide and Deliberate Self-Harm Facility Checklist* (appendix 16.1) has been developed to specifically address safety issues in mental health inpatient facilities.

Mental health inpatient units are also to ensure minimum standards of observation and engagement to manage the risk or concern of harm to a consumer or others, consistent with the NSW Health Policy Directive *Engagement and Observation in Mental Health Inpatient Units* (PD2017_025).

13. EDUCATION AND TRAINING

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

All NSW Mental Health Services are to ensure that:

- All mental health clinicians, regardless of setting, undertake training in identification and assessment of the person at risk of suicide, suicide risk formulation, safety planning, treatment and management
- All mental health service staff undertake appropriate training in culturally responsive practice and trauma-informed care.

All mental health clinicians, regardless of their setting, need appropriate education and training to:

- Understand current clinical and legal responsibilities in the delivery of mental healthcare
- Integrate the key principles of good clinical care in the delivery of clinical management and care of people with suicidal behaviour and ideation, including:
    - Empathetic and compassionate approaches
    - Building positive therapeutic engagement
    - Providing care that is culturally responsive, inclusive, non-judgmental, person-centered, recovery-oriented, trauma-informed and evidence-based.

- Deliver evidence-based clinical practice in the assessment and management of people with suicidal behaviour and ideation
- 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
- Maintain competency in undertaking detailed evaluations of suicidal behaviour and ideation.

14. REFERENCES

[1] "Zero Suicide Framework," Education Development Center, [Online]. Available: https://zerosuicide.edc.org/about/framework. [Accessed 23 June 2022].

[2] T. DeAngelis, "Better relationships with patients lead to better outcomes.," *Monitor onPsychology,* vol. 50, no. 10, 2019, November.

[3] Taylor Fry, commissioned by the Mental Health Branch, NSW Ministry of Health, "Care ofpeople who may be suicidal – rapid review," Agency for Clinical Innovation, Sydney, 2022.

[4] Matheson, SL; Shepherd, AM; Carr, VJ. Commissioned by the Mental Health Drug andAlcohol Office (MHDAO) NSW Ministry of Health and brokered by the Sax Institute, "Management of suicidal behaviour - a review for models of care: an Evidence Check rapid review," Sax Institute, Sydney, 2014.

[5] J. Schreiber and L. Culpepper, "Suicidal ideation and behavior in adults," UpToDate,Waltham, MA, 2022.

[6] H. Bickley, H. IM, K. Windfuhr, J. Shaw, L. Appleby and K. N, "Suicide within two weeksof discharge from psychiatric inpatient care: A case-control study," *Psychiatric Services,*vol. 64, no. 7, p. 653–659, 2013.

APPENDIX – ACCESS TO MEANS OF SUICIDE AND DELIBERATE SELF HARM CHECKLIST

This checklist may be used or adapted to assist with review of the physical structure of the mental health inpatient unit to identify:

- Any obstructions to the observation of high-risk patients
- Structures that could be used in suicide by hanging.

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

Safety risks are to be determined with reference to the workplace health and safety matrix as outlined in NSW Health Policy Directive *Enterprise-Wide Risk Management* (PD2022_023).

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Hanging points				
Non-collapsible curtain rails				
Non-collapsible bed frames				
Non-collapsible shower frames				
Internal piping				
Shower or bath fittings and curtains				
Exhaust fan				
Wardrobes and cupboards, including clothes rod				
Light fittings, ceiling fans and ceiling panels				
Bedroom and bathroom doors, hinges,door handles and knobs				
Windows, blinds and curtains				
Fire/duress alarms and signage				
Blind spots				
Corners				
Alcoves				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Under stairways				
Power-board rooms				
Other				
Access to facility and exit points				
Door security including use by non-regular staff				
Gate security including use by non-regular staff				
Garden fences and walls, including movable garden furniture/objects				
Air conditioning vents				
Other				
Hazards at exit points				
Consider potential access to busy roads, railway lines, rivers, oceans,cliffs and other hazards				
Poisonous substances kept in locked cupboard or storeroom				
Medication				
Reagents				
Cleaning fluids				
Any other hazardous material				
Windows – structure and design				
Are windows made of full glass, meshed glass or small panes				
Safety policy and procedures				

Risk Vulnerability Points	Reviewed	Current Safety Risk (Nil, Low, Med, High)	Required Action	Target Safety Risk
Search of patient on admission				
Leave plans include search on return relevant to risk assessment				
Further search of patient (where permissible) when there are groundsfor suspicion				
Monitoring of items conveyed from friends and family to patients and information provided on the safety of items bought in to the unit				
Access to areas of particular risk: bathrooms, kitchens, toilets				
Removal of linen from patient's bedroom where there are concerns around self-harm				
Careful observation of: - cutlery, including plastic cutlery - tools - power cords, phone chargers - plastic bags - any other potentially dangerous objects				
Incident reporting, investigating and reviewing				

Actions required to reduce risk:

Implementation procedure:

Completed by:	Name:	
	Signature:	
Next review date and time:		

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

PURPOSE

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

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

MANDATORY REQUIREMENTS

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

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

IMPLEMENTATION

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

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

BY JUNE 2014

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

BY JUNE 2015

- This Policy Directive is successfully implemented within the LHD, as *p*er 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) a person is forced, coerced or tricked into sexual acts against their will or without their consent, or b) a child or young person under 16 years of age is exposed to sexual activities, or c) a young person over 16 and under 18 years of age is exposed to sexual activities by a person with whom they have a relationship of 'special care' e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.
Sexually disinhibited behaviour	Poorly controlled behaviour of a sexual nature, where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations; at the wrong time; or with the wrong person.
Sexual harassment	Unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Can involve physical, visual, verbal or non-verbal conduct.
Sexual health	A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons. (World Health Organisation)
Sexual safety	The recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.
Sexual safety 'champions'	Individuals who work in mental health who have an interest in or responsibility for sexual safety, or sexual assault prevention and response, as it relates to mental health consumers, and are willing to act as advocates for the implementation of the NSW Ministry of Health *Sexual Safety of Mental Health Consumers Guidelines* and this policy directive.
Sexual safety incident	The term used to refer to an incident that breaches or compromises the sexual safety of a consumer, and which is recognised as either sexual assault or harassment, consensual sexual activity in an inappropriate setting or sexually disinhibited behaviour.
Trauma informed care	Mental health treatment that is directed by: • a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual; and • an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. (Jennings, 2004)[2]

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.

[2] Jennings, A. (2004). *The damaging consequences of violence and trauma: facts, discussion points, and recommendations for the behavioural health system.* Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

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-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.

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

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

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

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

5.1.1.9 Recognise gender differences within their care provision.

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

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

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

5.1.2 Minimum Requirements

Mental health services in all settings must:

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

5.1.2.2 Develop sexual safety standards that define appropriate behaviour for the service setting in consultation with all members of the service, including consumers and their families and carers – see Appendix A in the *Sexual Safety of Mental Health Consumers Guidelines* for example standards.

5.1.2.3 Provide clear information and advice to consumers that takes account their cultural background, gender, age, sexual orientation, and personal experiences regarding:
- their rights and responsibilities in relation to sexual safety
- the sexual safety standards that exist in the service setting
- the process for addressing a sexual safety incident
- the support services available should they experience sexual assault or harassment
- how to manage sexual health issues, such as contraception, sexually transmitted diseases (STDs) and pregnancy.

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

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

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

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

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

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

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

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

5.2 Acute Inpatient Mental Health Setting

5.2.1 Responsibilities

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

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

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

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

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

5.2.2 Minimum Requirements

Within this setting, mental health services must also:

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

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

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

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

5.3 Non-acute and residential mental health settings

5.3.1 Responsibilities

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

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

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

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

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

5.3.2 Minimum Requirements

Within this setting, mental health services must also:

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

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

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

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

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

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

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

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

5.4 Community mental health setting

5.4.1 Responsibilities

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

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

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

5.4.2 Minimum Requirements

Within this setting, mental health services must also:

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

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

192(14/11/13)

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

Step	Action	Information
1	**Acknowledge and affirm the disclosure**	Be non-judgemental, compassionate and understanding when a consumer discloses their experience of sexual assault or harassment and respond promptly, in accordance with the *Sexual Safety of Mental Health Consumers Guidelines*, whether the assault occurred prior to or after the consumer's admission.
2	**Explore the disclosure**	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.
3	**Establish and maintain safety**	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.
4	**Secure any evidence**	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.
5	**Offer support and options**	Provide the consumer with advice and information regarding their options (Appendix D of the *Sexual Safety of Mental Health Consumers Guidelines*) 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).
6	**Organise medical care**	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.
7	**Assess capacity to make informed decisions**	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.

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 relationships 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

Local Health District (LHD)	Individual service
To be completed by June 2014	
▪ Nominate a lead staff member to be responsible for driving implementation of the Guidelines and Policy Directive at LHD level ▪ 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	▪ Nominate a staff member to be responsible for implementing and monitoring adherence to the Guidelines and Policy Directive at a local level
▪ Promote the availability of the Guidelines and Policy Directive and encourage services to order adequate hard copies	▪ Order adequate hard copies of Guidelines to support ready access by staff, consumers and carers
▪ Provide clear advice to services and key staff regarding the changes required in order to meet the *Sexual Safety of Mental Health Consumers Guidelines* and Policy Directive	▪ Introduce the Guidelines and Policy Directive to staff, consumers and carers involved with the service and communicate about implementation process ▪ Develop and implement a consultation strategy involving consumers, carers and staff to define and promote the sexual safety standards for the service ▪ Develop and implement a strategy to establish or build on local partnerships with key stakeholders, such as the local Sexual Assault Service and other sexual assault agencies, GPs, NSW Police Force, relevant Community Managed Organisations etc
▪ Consult with services regarding training requirements and feed outcomes up to MHDAO ▪ Provide feedback to MHDAO on any draft training framework or materials developed	▪ Consult with staff, consumers and carers regarding training/education needs and feed information up to identified lead staff and champions ▪ Develop plan that identifies individual staff members to participate in training and consumers interested in education
▪ 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

<table>
<tr><th>Local Health District (LHD)</th><th>Individual service</th></tr>
<tr><td colspan="2">To be completed by June 2015</td></tr>
<tr><td>Develop local policies and procedures to support services to meet the requirements of the Sexual Safety of Mental Health Consumers Guidelines and Policy Directive
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</td><td>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</td></tr>
<tr><td>Promote the availability of the training once it is released by MHDAO and advise of the need for staff to participate</td><td>Implement training/education plan for staff and consumers
Ensure future training plans factor in the need for refresher training</td></tr>
<tr><td>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</td><td>Complete Individual Service Implementation Monitoring Form</td></tr>
</table>

APPENDIX IV - Mental Health Service Implementation Monitoring Form

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

Mental Health Service Name		**Date**	/ /
Authorised by Service Manager	**Name**		
	Signature		

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

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?	❑	❑	❑

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

APPENDIX V - Local Health District Implementation Verification Form

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

LOCAL HEALTH DISTRICT		**Date**	/ /
Verified by Mental Health Director	**Name**		
	Signature		

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

IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Lead staff member and champions nominated to drive implementation of the Guidelines and Policy Directive at LHD level	❑	❑	❑
	Notes:		
2. Availability of the Guidelines and Policy Directive promoted and services encouraged to order adequate hard copies of Guidelines	❑	❑	❑
	Notes:		
3. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
4. Review undertaken by services regarding the changes required to service delivery and practices to meet the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
5. Plans developed and implemented by services to support compliance with the Guidelines and Policy Directive	❑	❑	❑
	Notes:		
6. Services consulted regarding training requirements and outcomes communicated to MHDAO	❑	❑	❑
	Notes:		
7. Available training and requirement to attend promoted to services	❑	❑	❑
	Notes:		

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

SEXUAL SAFETY OF MENTAL HEALTH CONSUMERS GUIDELINES

(GL2013_012)

GL2013_012 rescinds GL2005_049.

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.

To download the Guidelines please go to
http://www.health.nsw.gov.au/policies/gl/2013/GL2013_012.html

192(14/11/13)

THE NSW ABORIGINAL MENTAL HEALTH AND WELLBEING STRATEGY 2020-2025 (IB2021_002)

IB2021_002 rescinds PD2007_059

PURPOSE

This Information Bulletin is to advise that the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025 has been released. The Strategy is available from the NSW Health website - Mental Health – Resources.

KEY INFORMATION

The Strategy supports and assists NSW Health services in delivering respectful and appropriate mental health services in partnership with Aboriginal services, people and communities.

The Strategy is the foundation for change that will support a future way of working under the national Agreement for Closing the Gap in Aboriginal Health outcomes. The Strategy is supported by three goals:
Goal 1: Holistic, person and family-centred care and healing
Goal 2: Culturally safe, trauma-informed, quality care
Goal 3: Connected care

Each goal is underpinned by several strategic directions. These provide clear guidance for NSW Health services on what actions are required to achieve each goal.

Co-design of local implementation plans
All Districts and Networks are to co-design local implementation plans with Aboriginal stakeholders (including consumers, carers, those with lived experience and families). Implementation Plans are to be co-signed by the Director/Manager of Aboriginal Health and the Director of Mental Health, approved by Chief Executives and submitted to the Mental Health Branch by 30 September 2021 at MOHMentalHealthBranch@health.nsw.gov.au.

The co-design processes are to be based on the five principles identified in the Agency for Clinical Innovation's *A Guide to Build Co-design Capability*.

Local implementation plans are to provide specific, operational guidance to enable the implementation of the Strategy within the local context.

In developing implementation plans, Districts and Networks will need to consider:
- how key deliverables and actions may be embedded in individual or local performance planning
- how the plans complement existing commitments or activities on Aboriginal engagement and co-design
- how public and community accountability can be best achieved and supported, including through local consultation and reporting
- how a co-design and genuine partnership approach can lead to improved planning, delivery, evaluation and coordination of services.

Monitoring and reporting framework
The Ministry will develop and implement a monitoring and reporting framework with a co-design approach to help Districts and Networks measure progress.

The monitoring and reporting framework will help Districts and Networks to provide data on a regular basis. This will help inform future decisions and drive better outcomes.

Where possible, the Ministry will develop performance indicators with Districts and Networks to assess performance against the strategic actions in addition to measures already identified in Service Agreements.

Further information
For further information, contact the Mental Health Branch at MOH-MentalHealthBranch@health.nsw.gov.au.

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

GL2017_022 rescinds GL2006_013

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

This document can be accessed at the following link:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_022

314(13/12/17)

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

PURPOSE

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

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

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

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

KEY PRINCIPLES

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

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

USE OF THE GUIDELINE

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

This document can be accessed at the following link:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2017_003

314(18/10/17)

DISCHARGE PLANNING AND TRANSFER OF CARE FOR CONSUMERS OF NSW HEALTH MENTAL HEALTH SERVICES (PD2019_045)

PD2019_045 rescinds PD2016_056

PURPOSE

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

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

Key Performance Indicators
This Policy Directive aims to address three key performance indicators to improvemental health outcomes:
- reduce re-admissions within 28 days to any acute mental health unit
- increase community follow-up within 7 days post discharge from an acute mental health unit
- reduce the number of involuntary patients who abscond (Types 1 and 2) frominpatient mental health units.

This Policy Directive supersedes PD2016_056 *Transfer of care from mental healthinpatient services*.

MANDATORY REQUIREMENTS

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

IMPLEMENTATION

Roles and Responsibilities

The Ministry

- provides mandatory requirements for mental health discharge planning andtransfer of care
- reviews and takes appropriate follow up action on the implementation reportssubmitted by Local Health Districts and Specialty Health Networks.

Chief Executives

Ensure that:

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

Mental Health Staff

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

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

1 BACKGROUND

1.1 About this document

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

1.2 Scope of policy

This Policy Directive applies to **NSW Health mental health staff involved in the assessment, care, discharge planning and/or transfer of care of a mental health consumer**. It sets out the principles and essential requirements for effective and safe discharge planning and transfer of care for consumers of all ages (younger people, adults and older persons) **to services including but not limited to**:

- public mental health inpatient units
- community mental health services
- medical wards
- Local Health Districts (LHDs) and Specialty Health Networks (SHNs)
- private psychiatric hospitals
- general practitioners
- private psychiatrists, psychologists and other health professionals
- community managed organisations (CMOs)
- drug and alcohol inpatient units
- community drug and alcohol services
- government agencies and service providers (for example, Community Living Supports, Housing and Accommodation Support Initiatives, National Disability Insurance Agency/National Disability Insurance Schemes, Police and Correctional facilities)
- aboriginal community controlled health services (ACCHS)
- residential aged care facilities

1.3 Key definitions

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

1.4 Legal and legislative framework

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

This Policy Directive has also been informed by:

- *National Mental Health Service Standards* (2010)
- *National practice standards for the mental health workforce* (2013)
- *National Safety and Quality Health Service Standards* (second edition-2017)
- recommendations from *New South Wales Auditor-General's Report (Performance Audit), Mental Health Post Discharge Care* (2015)

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

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

Other relevant legislation, related policies and guidelines are listed at Appendix E.

2. KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

3 DISCHARGE PLANNING AND TRANSFER OF CARE

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

3.1 Discharge Planning: Working with consumers, families and carers

Mental health services must:

- **Identify a key contact/coordinator from the multidisciplinary treating team**, who is responsible for ensuring that each step of the discharge planning process is completed.
- **Estimate the date of discharge (EDD) in collaboration with the consumer and their family/carer**, based on mental state and other assessments. Regular review of this date must consider current events and clinical advice. The EDD supports timely transfer of care planning and is helpful for the consumer and carer.
- **Carry out regular mental state examinations and assessments of the consumer's personal strengths and vulnerabilities, social supports, safety and practical needs**. These assessments should consider factors such as:
  - harm to self or harm to others (including children in contact with the consumer)
  - risk from others
  - parenting and family responsibilities
  - housing, homelessness or risk of homelessness
  - medication history (including non-adherence with psychiatric medication)
  - history of trauma
  - history of substance use or misuse
  - co-existing physical health and other disabilities
  - history of domestic violence as a victim or perpetrator
  - vulnerability to elder abuse
  - access to firearms or weapons
  - existing and planned support services and their location.
- **Develop and document management strategies for identified risks** in the consumer's *Mental Health Care Plan* in their medical record and consider the need for documenting any appropriate 'Alerts' and 'Problems'.
- Services should **facilitate the use of risk assessment processes and management strategies** that respond to violence, abuse and neglect and prioritise the safety and wellbeing of consumers, regardless of whether the consumer is identified as the victim or the perpetrator.
- **Consider the need for a Community Treatment Order** (Part 3 *Involuntary treatment in the community* of the Act), where appropriate.
- **Consider child protection and wellbeing issues** and respond accordingly (refer to the *Child Wellbeing and Child Protection policies and procedures for NSW Health*).
- **For consumers with long inpatient stays** who are being discharged under the *Pathways to Community Living* initiative, refer to local *Pathways to Community Living* procedures and processes.
- **Support the consumer to update or develop their Wellness Plan**, which will include contingency plans for changes in circumstances including:
  - deteriorating mental or physical health and
  - emergency contacts.
- Ensure all relevant information for safe discharge are discussed with the consumer and family as well as **provided in writing.**

3.2 Discharge Planning: Working with other services

Mental health services must:

- **Engage the receiving service,** for example the community mental health team, other health provider or support service, in discharge planning.
- **Establish mechanisms to enhance the transition experience and reduce the risk of the consumer being lost to care**, for example:
    - Facilitate the consumer's engagement with the receiving community mental health team, other health provider and support service. This could be an introduction by phone, videoconference/telehealth or face-to-face prior to discharge.
    - Use mental health peer workers, if the consumer requests this, to support the consumer transitioning from inpatient to community based services.
    - Offer input from Aboriginal Health Workers or culturally diverse workers in discharge planning.
    - Offer the consumer and their family/carer access to translating and interpreting services where appropriate.
- **For consumers who live in social or community housing**, make early contact with Family and Community Services (FACS) or the relevant community housing provider to ensure that rental obligations are considered and occupancy is maintained.
- Services involved in current and ongoing treatment must **establish a follow-up procedure** for consumers who do not keep or are reluctant to engage with the planned follow-up arrangements as part of discharge planning.

3.3 Transfer of care

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

3.3.1 Planning for transfer of care

- Transfer of care discussions are to include the consumer's goals and practical considerations such as:
    - estimated time and date of discharge (EDD)
    - transportation needs
    - access to suitable services
    - supports post-discharge
    - other responsibilities such as parenting and family issues
    - safety planning where the consumer is a victim of domestic and/or family violence or other abuse. Safety planning should be undertaken by, or with a psychosocially trained health worker in consultation with the consumer
    - appropriate referrals for ongoing care and supports.
- Ensure that the local *Transfer of Care Checklist* in the electronic medical record or its equivalent is completed for all consumers.
- Discuss the *Your Experience of Service* (*YES*) with the consumer and give them supporting documentation (e.g. brochure) and a paper copy or the online link with the service code identifier, to complete.
- Discuss the *Carers Experience Survey (CES)* with the carer and give them supporting documentation and a paper copy or the online link with service code identifier, to complete.

3.3.2 Transferring care

From a community mental health service:

- When a **community mental health service is transferring a consumer's care to an external service provider**, including a general practitioner, private psychiatrist or psychologist, they must include the *Discharge/Transfer Summary* from any recent inpatient admission. This summary document offers important information about recent treatment and care of a psychiatric or medical condition, including changes in medication.
- When transitioning **from a community mental health service**, the multidisciplinary team should review all prior discharges/transfers. This review should **confirm in writing** that discharge/transfer is indicated and that the care plan is comprehensive.

From an inpatient service:

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

To a medical or other ward:

- When transferring **to a medical or other ward**, discuss the transfer with the consumer and carer/s. Ensure that risk assessments and tailored management strategies are conducted.
- Ensure all relevant information for safe transfer of care are included in the **verbal clinical handover** to the ward's treating team as well as **provided in writing.**

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

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

3.3.3 At the time of discharge/transfer:

With consumers and families/carers:

- The *Discharge/Transfer Summary* document or (if unavailable at discharge) the *Information Handout* is a crucial document for consumers and their families providing information on care and safety of consumers.
- **It is imperative that the *Discharge/Transfer Summary* or *Information Handout* is given to the consumer and their family/carer at the time of discharge and a copy kept in their medical record**.
- The nominated mental health key contact/coordinator must take time to go through the *Discharge/Transfer Summary* with the consumer and their family/carer, and ensure they understand it and answer any questions.
- Section 3.5 Documentation provides detailed guidance on information to be included in the *Discharge/Transfer Summary.*
- The consumer must also receive a copy of their *Wellness Plan*.

With receiving service provider/s:

- The *Discharge/Transfer Summary* document must be forwarded to the receiving service provider and other support services within 12 hours of discharge/transfer, or earlier as clinically indicated.
- The discharging (referring) service must phone the receiving service provider and other support services to advise that the consumer has been discharged, where the consumer's follow up appointment is within 24 hours of discharge.

3.4 Follow-up in the community

- Timing of follow up contact should be based on clinical need/priority and discussed at the time of discharge with the consumer/family as part of the discharge planning process.
- **The receiving community mental health service** must contact the consumer within seven (7) days of discharge from an acute inpatient mental health unit including a Psychiatric Emergency Care Centre. This contact must include clear plans for next actions/follow-up. Identification of clinical deterioration should be escalated and managed as appropriate.
- Where the team is unable to contact the consumer, (or the consumer is a young person), they must contact the consumer's family/carer to gain their perspective on how well the consumer is settling in the community and to identify any concerns that need to be addressed, or to identify additional referrals that could assist this process.

3.5 Documentation

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

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

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

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

4 THE ROLE OF LEAVE TO SUPPORT DISCHARGE PLANNING AND RECOVERY

Many of the requirements for assessment, communication, documentation and transfer of care as set out in this document also support the planning and management of approved leave.

Graduated leave provides the consumer and the treating team with the opportunity to assess readiness for discharge to the community. Leave periods may present increased risk for the consumer and for others, however leave should be designed to provide opportunities for a strengths-based approach geared towards a consumer's identified goals for discharge.

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

4.1 Leave Procedures

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

4.1.1 The leave plan: Development and communication essentials

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

Local leave procedures must ensure that leave plans:

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

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

4.1.2 Approval of the written leave plan

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

4.1.3 Provision of written leave information

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

- purpose of leave
- departure and return times
- medication and supervision requirements
- guidance on measures to manage risks during leave
- contact details for the inpatient unit
- arrangements for crisis support
- any restrictions on the consumer's activities and agreed responsibilities.

4.1.4 Post leave follow up requirements include:

- discussion with the consumer, family / carer / community mental health service about the success of leave
- mechanisms for post leave reports to inform clinical reviews
- local safety and security practices to ensure that the consumer has not brought materials to the unit following leave that could pose a threat to themselves or others.

4.1.5 Failure to return from leave or absent from the unit

Steps to follow if a consumer;

  - does not return from leave as arranged
  - is missing
  - has absconded from the unit (i.e. involuntary patients under the Act).

- If there are concerns about a voluntary patient's vulnerability or risk of harm to themselves or others, consider initiating detention processes under Section 19 of the Act **or** provide guidance about notifying the police to request a welfare check.
- If an involuntary inpatient has not returned from approved leave (or has absconded from the unit), procedures must take into account requirements under the Act including notifying the police (also refer to section 3.4.7 of the *NSW Health-NSW Police Memorandum of Understanding 2018*).
- Services must complete incident reporting requirements in line with NSW Health PD2014_004 *Incident Management Policy* and local procedures.

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

5 PRIVACY AND INFORMATION SHARING

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

The collection, use or disclosure of a consumer's personal or personal health information must comply with the following legislation:

- The *Privacy and Personal Information Protection Act 1998* (NSW)
- The *Health Records and Information Privacy Act 2002 (NSW)*

In essence, the disclosure of the consumer's information must be:

- directly related to the purpose for which the information was collected
- relevant to the treatment, care or support provided by the third party
- for statutory provisions for mandatory notification purposes (see Appendix A)

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

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

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

6 MONITORING AND REPORTING

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

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

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

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

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

7 APPENDICES

Appendix A: Privacy and Information Sharing

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

- **Health Providers**

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

- **Community Managed Organisations (CMOs)**

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

- **Family and Carer**

Carers identified under the Mental Health Act 2007 must be included in transfer of care planning. However, with consent of the consumer, it may be good practice to involve other members of the family or carer network. A person who is over the age of 14 and under 18 years may not exclude a parent from being given information about them (Section 72(3) of the Act).

Where a consumer is being discharged into the care of their family and/or carers, and with the consumer's consent, they should have sufficient information to properly support the consumer's ongoing health care needs. This may include providing a written copy of transfer of care documents that provide easy access to critical information such as advice about the medication regimen and the management of suicide risk. The consumer must also have a reasonable expectation that their information will meet this requirement. This expectation is best met by communicating with the consumer about relevant discharge planning and ensuring consumers receive a copy of the Privacy Leaflet for Patients

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

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

- **Role of Appointed Guardian**

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

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

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

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

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

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

Please refer to the *Privacy Manual for Health Information* for guidance on these requests (see Appendix E).

APPENDIX B: Sample Information Handout for consumers returning to the community

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

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

The content of this handout will vary according to the consumer's clinical needs, the setting and other local factors, but should include:

- the consumer's name and current contact details
- date of discharge from service/facility
- carer's name and contact details
- current medication/s, regimen, advice about possible side effects and safety measures
- current medical concerns/treatment/follow-up
- follow up health care arrangements or details of support services, such as:
    - community mental health service: name, address, telephone contact details, name of contact person and appointment details
    - GP phone number and appointment details
- early warning signs of relapse, identification of risks and strategies to reduce eachrisk identified
- contingency plans and relapse prevention strategies
- emergency telephone contacts for access/re-entry to the mental health service
- information or standard handouts about educational or community support services
- information on family and carer support services.

Appendix C: LHD/SHN 6-month implementation reporting form

Mental Health Discharge Planning and Transfer of Care 6-month Implementation Verification Form

LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH NETWORK		Date	/ /
Verified by Mental Health Director	Name		
	Signature		
First 6 month progress report ❑			

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

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

Appendix D: LHD/SHN 12-month implementation reporting form

Mental Health Discharge Planning and Transfer of Care LHD/SHN 12-month Implementation Verification Form

LOCAL HEALTH DISTRICT/ SPECIALTY HEALTH		**Date**	/ /
Verified by Mental Health Director	**Name**		
	Signature		
Second 12 month progress report ❑			

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

SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO:

MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)

Appendix E: Legislative framework, policy and guidelines
Legislation

1. *Mental Health Act 2007*
https://www.legislation.nsw.gov.au/#/view/act/2007/8
2. *Guardianship Act 1987*
https://www.legislation.nsw.gov.au/#/view/act/1987/257
3. *Health Records and Information Privacy Act 2002*
https://www.legislation.nsw.gov.au/#/view/act/2002/71
4. *Privacy and Personal Information Protection Act 1998*
https://www.legislation.nsw.gov.au/#/view/act/1998/133
5. *Children and Young Persons (Care and Protection) Act 1998*
https://www.legislation.nsw.gov.au/#/view/act/1998/157
6. *Crimes (Domestic and Personal Violence) Act 2007*
https://www.legislation.nsw.gov.au/#/view/act/2007/80/full

Related polices, guidelines, manuals, and other related documents

7. Childstory. (n.d.). *Child Protection Mandatory Reporter Guide (MRG)*. Retrieved from https://reporter.childstory.nsw.gov.au/s/
8. Ministry of Health. (2016). Information Bulletin IB2016_028. *Your Experience of Service (YES) Questionnaire Translations*. NSW. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2016_028.pdf
9. NSW Ministry of Health. (2009). Policy Directive PD2009_060. *Clinical Handover –Standard Key Principles Policy*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2009_060.pdf
10. NSW Ministry of Health. (2010). Policy Directive PD2010_018 *Mental Health Clinical Documentation Guidelines.* Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_018.pdf
11. NSW Ministry of Health. (2010). Policy Directive PD2010_037. *Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_037.pdf
12. NSW Ministry of Health. (2010). Policy Directive PD2013_007. *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf
13. NSW Ministry of Health. (2011). *Care Co-ordination: from Admission to Transfer of Care in NSW Public Hospitals – Reference Manual*. Retrieved from http://www.health.nsw.gov.au/pfs/Publications/care-coordination-ref.pdf
14. NSW Ministry of Health. (2011). Policy Directive PD2011_015. *Care Coordination:Planning from Admission to Transfer of Care in NSW Public Hospitals*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_015.pdf
15. NSW Ministry of Health. (2012). Policy Directive PD2012_20. *NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012 – 2016.*
16. NSW Ministry of Health. (2014). Guidelines GL2014_002. *Mental Health Clinical Documentation* Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2014_002.pdf
17. NSW Ministry of Health. (2014). Policy Directive PD2014_004. *Incident Management Policy*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_004.pdf
18. NSW Ministry of Health. (2014). Policy Directive PD2014_025. *Departure of Emergency Department Patients*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_025.pdf
19. NSW Ministry of Health. (2015). *Privacy Manual for Health Information*. Retrieved from http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manualfor- health-information.pdf
20. NSW Ministry of Health. (2015). *Mental Health for Emergency Departments – A Reference Guide*. Retrieved from https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mental-health-edguide.aspx

21. NSW Ministry of Health. (2017). Guidelines GL2017_003. *Specialist Mental Health Services for Older People(SMHSOP) Community Services Model of Care Guideline*. Retrieved from http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_003.pdf
22. NSW Ministry of Health. (2018). *NSW Health – NSW Police Force Memorandum of Understanding 2018*. Retrieved from https://www.health.nsw.gov.au/mentalhealth/resources/Pages/mou-health-police-2018.aspx
23. NSW Ministry of Health. (2018). Guidelines GL2018_022. *Supporting Young People During Transition to Adult Mental Health Services*. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2018_022.pdf
24. Stavropoulos, P., & Kezelman, C. (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.* Adults Surviving Child Abuse (ASCA). Retrieved from https://www.blueknot.org.au/resources/Publications/Practice-Guidelines
25. Molyneaux E, Turner A, Candy B, Landau S, Johnson S, Lloyd-Evans B., *Crisisplanning interventions for people with psychotic illness or bipolar disorder:Systematic review an meta-analyses*. BJPsych Open (2019) 5, e53, 1–9. doi:10.1192/bjo.2019.28

References

1. Agency for Clinical Innovation. (2015). *Guidelines for the use of Telehealth forClinical and Non Clinical Settings in NSW*. Retrieved from https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0010/258706/ACItelehealth-guidelines.pdf
2. Audit Office of New South Wales. (2015, December). *New South Wales Auditor-General's Report: Performance Audit: Mental health post-discharge care*. NSW: Australia. Retrieved from https://www.audit.nsw.gov.au/sites/default/files/pdfdownloads/2015_Dec_Report_Mental_health_post-discharge_care.pdf
3. Australian Commission on Safety and Quality in Health Care. (2017, November). *National Safety and Quality Health Service Standards: second edition*. Retrieved from https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf
4. Commonwealth of Australia. (2010). *National standards for mental health services 2010*, pp42-44. Canberra, ACT, Australia. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf
5. Department of Health & Human Services. (2014, February). *Transfer of care from acute inpatient services*. Retrieved from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/
6. Mental Health Carers NSW (MHCN). (2019). *Carer Experience of Service Survey (CES).* Retrieved from Mental Health Carers NSW: https://www.mentalhealthcarersnsw.org/wp-content/uploads/2018/08/The-Service-Guide-to-the-CES_v1-1.pdf
7. Mental Health Coordinating Council. (n.d.). *Recovery Oriented Language Guide,Second*. Retrieved from http://www.mhcc.org.au/wpcontent/uploads/2018/05/Recovery-Oriented-Language-Guide_2018ed_v3_201800418-FINAL.pdf
8. Ministry of Health. (2016). Information Bulletin IB2016_028. *Your Experience of Service (YES) Questionnaire Translations*. NSW. Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2016_028.pdf
9. Ministry of Health, NSW. (2019). *Privacy leaflet for patients*. Retrieved from https://www.health.nsw.gov.au/patients/privacy/Pages/privacy-leaflet-forpatients.aspx
10. National Institute for Health and Care Excellence (NICE). (2016, August). *Transition between inpatient mental health settings and community or care home settings - NICE guideline [NG53]*. Retrieved from http://www.nice.org.uk/guidance/ng53
11. Victorian Government Department of Health. (2013, November). *National practice standards for the mental health workforce (2013)*. Melbourne, VIC, Australia. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/content/5D7909E82304E6D2CA257C430004E877/$File/wkstd13.pdf

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.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2008/GL2008_009.html

MENTAL HEALTH CLINICAL DOCUMENTATION GUIDELINES (GL2014_002)

GL2014_002 rescinds GL2008_016.

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.

The Guidelines can be accessed at http://www.health.nsw.gov.au/policies/gl/2014/GL2014_002.html

PHYSICAL HEALTH CARE WITHIN MENTAL HEALTH SERVICES (PD2017_033)

PD2017_033 rescinds PD2009_027

PURPOSE

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

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

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

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

MANDATORY REQUIREMENTS

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

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

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

IMPLEMENTATION

Chief Executives are required to ensure:

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

Managers must:

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

Clinicians are required to:

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

NSW Ministry of Health will:

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

BACKGROUND

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

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

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

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

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

KEY PRINCIPLES

1. Mental health consumers are entitled to quality, evidence based education, care, and treatment for all aspects of health, including physical health.
2. Physical health for mental health consumers is considered by mental health services in planning, education, access, health promotion, screening and preventative activities.
3. Physical health care for mental health consumers must:
   a) recognise consumers as critical partners in the care team
   b) appropriately involve consumers, their families and carers
   c) discuss with the consumer and be delivered in a respectful, non-judgemental and culturally sensitive way
   d) support the consumer to make informed choices.
4. Mental health services work collaboratively with other key health providers in providing quality physical health care for mental health consumers. GPs, Primary Health Networks and non-government organisations have a pivotal role in the provision of care.
5. Physical health care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

PHYSICAL ASSESSMENT CORE COMPONENTS

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

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

- current prescribed, over the counter or alternative medications
- drug and alcohol use assessment, including smoking

- the presence of any new physical problems or symptoms that are concerning the consumer, their carer or family
- known presence of
    - diabetes
    - high blood pressure
    - high cholesterol
    - asthma or other respiratory illness
    - ‘other’ illness
- relevant family history

If the assessment is being conducted as part of a review it should also include information about;

- diet
- physical activity
- the consumer’s wish to discuss any relevant health issues
- the consumer’s participation in relevant preventative health care

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

The core components of a physical examination are:

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

RELEVANT HEALTH INTERVENTIONS

Health interventions particularly relevant to the long term health status of mental health consumers are listed below. ‘List A’ includes those that are particularly relevant to cardiovascular health and ‘List B’ are other potentially indirect interventions.

List A – Cardiovascular Health

- Smoking cessation (if relevant)
- Weight control interventions, including dietary and life-style advice, if BMI > 25 or abdominal obesity
- Regular exercise
- BP monitoring

List B – Potentially Indicated Interventions

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

MONITORING AND REPORTING

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

APPENDIX

Attachment 1: Equipment checklist

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

Attachment 2: Implementation checklist

<table>
<tr><td>LHD/Facility:</td><td colspan="3"></td></tr>
<tr><td>Assessed by:</td><td colspan="3">Date of Assessment:</td></tr>
<tr><td>IMPLEMENTATION REQUIREMENTS</td><td>Not commenced</td><td>Partial compliance</td><td>Full compliance</td></tr>
<tr><td rowspan="2">4. Assign responsibility, personnel and resources to implement the principles and procedures in mental health service settings.</td><td>❑</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="3">Notes:</td></tr>
<tr><td rowspan="2">5. Local policies and procedures developed and disseminated to support services to understand and meet the requirements of the Guidelines and Policy.</td><td>❑</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="3">Notes:</td></tr>
<tr><td rowspan="2">6. Develop and implement a strategy to establish or build on local partnerships with GPs, Primary Health Networks, Community Managed Organisations and other health providers</td><td>❑</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="3">Notes:</td></tr>
<tr><td rowspan="2">7. Undertake a review of current staff skills, identify gaps in knowledge and factor these into future training plans.</td><td>❑</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="3">Notes:</td></tr>
<tr><td rowspan="2">8. Identify, develop and implement strategies to address at risk populations.</td><td>❑</td><td>❑</td><td>❑</td></tr>
<tr><td colspan="3">Notes:</td></tr>
</table>

PHYSICAL HEALTH CARE FOR PEOPLE LIVING WITH MENTAL HEALTH ISSUES
(GL2021_006)

GL2021_006 rescinded GL2017_019

GUIDELINE SUMMARY

NSW Health is committed to improving the physical health outcomes and reducing early mortality of people with a lived experience of mental health issues. Local Health Districts (Districts) and Specialty Health Networks (Networks) have a responsibility to provide equitable access to high quality, holistic, person-centred physical health care.

This Guideline builds upon the Fifth National Mental Health and Suicide Prevention Plan and the Equally Well Consensus Statement. It reinforces the expectations of NSW Health and the measures required to deliver a whole of health approach to reduce the physical health inequalities experienced by people with lived experience of mental health issues.

KEY PRINCIPLES

Improving and sustaining the physical health care of people with lived experience is the responsibility of all NSW Health mental health and non-mental health services.

All Services are to review their current policies, procedures and practices against the expectations stated in this Guideline. Local policies and protocols are to be developed to address any identified gaps.

The core expectations of this Guideline are;

- All services in contact with people with lived experience of mental health issues are to offer and support interventions to prevent physical illness and promote and sustain health.
- Mental health services are to complete routine physical health screening as an essential component of care.
- Mental health services are to deliver equitable and timely access to physical health assessment, intervention and review.
- Mental health services are to provide access to equitable, evidence-based interventions that target cardiometabolic and behavioural risk factors.
- Clinicians are to complete routine comprehensive assessment as part of an integrated physical and mental health care plan.
- Clinicians are to support, coordinate and document any additional assessments and/or investigations required.
- Clinicians are to offer routine medication assessment and optimisation to minimise risk and negative medication effects.
- Mental health services are to develop partnerships and pathways with key stakeholders to address identified physical health needs as part of an integrated care plan.
- Clinicians are to use a coordinated team approach to deliver high-quality holistic care.
- District and Networks are to deliver safe and effective physical health assessments, interventions and treatment. These are to support sustained health outcomes and health care experiences that matter to the people who receive them.

To view the Physical Health Care for People Living with Mental Health Issues: Guideline go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_006

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.

- GL2010_004 - SAFE START Guidelines: Improving mental health outcomes for parents and infants available at: http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html
- PD2010_017 - Maternal and Child Health Primary Health Care Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

The SAFE START Strategic Policy can be downloaded from http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html

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.

- PD2010_016 - SAFE START Strategic Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_016.html
- PD2010_017 - Maternal and Child Health Primary Health Care Policy available at: http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

The SAFE START Guidelines can be downloaded from http://www.health.nsw.gov.au/policies/gl/2010/GL2010_004.html

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.

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 School-Link Initiative Memorandum of Understanding between NSW Health and the Department of Education and Training (DET). *Available from the School-Link webpage:* http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_020.pdf

84(25/03/10)

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.

ACCESSING INPATIENT MENTAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS (IB2023_001)

IB2023_001 rescinded PD2011_016

PURPOSE

This Information Bulletin advises NSW Health of the release of the framework Accessing Inpatient Mental Health Care for Children and Adolescents and the guide Guide to Understanding Inpatient Mental Health Admissions for Children and Adolescents that replaces the NSW Health Policy Directive Children and Adolescents with Mental Health Problems Requiring Inpatient Care (PD2011_016).

KEY INFORMATION

The decision to admit a child or adolescent into inpatient care is challenging due to the limited research evidence, and the diversity of children and adolescents and their ill-health. Internationally, it has been recognised that inpatient care can be a traumatic experience for children and adolescents (and their families, carers, or close social supports).

In response to new evidence and approaches, as well as a shift in consumer's expectations of appropriate mental health support to children and adolescents, Perinatal Child and Youth, Mental Health Branch, NSW Ministry of Health have developed two new documents to support clinical decision-making and empower decision makers.

Accessing Inpatient Mental Health Care for Children and Adolescents is a framework for clinicians and health care providers who are involved in decision-making surrounding whether, and under which model of care, to admit children and adolescents into inpatient mental health care.

Guide to Understanding Inpatient Mental Health Admissions for Children and Adolescents is a resource document for people who are currently involved in or may become involved in caring for a child or adolescent experiencing mental-ill health. This could include families and carers, social workers, Peer Workers, education professionals, adult mental health, and nonmental health clinicians such as paediatricians and emergency department consultants, general practitioners, communities and justice professionals and children and adolescents themselves.

The framework and the guide builds on the key principles outlined in the NSW Health Policy Directive Children and Adolescents with Mental Health Problems Requiring Inpatient Care (PD2011_016) and provides for determining the most appropriate treatment facility for those children and adolescents with mental health problems who require inpatient treatment. This includes admission into specialist child and adolescent mental health service (CAMHS) units, paediatric hospitals and paediatric wards in general hospitals, and Psychiatric Emergency Care Centres (PECCs).

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.

MONITORING CLOZAPINE INDUCED MYOCARDITIS (GL2022_011)

GL2022_011 replaced PD2012_005)

GUIDELINE SUMMARY

This Guideline provides guidance for NSW Health staff in the monitoring, detection and management of clozapine-induced myocarditis. It includes a threshold and guidance for cessation where clinically indicated.

KEY PRINCIPLES

Clozapine is an effective antipsychotic medication for the management of treatment-resistant schizophrenia. It is associated with various cardiac disorders including myocarditis, cardiomyopathy and death.

Myocarditis is most commonly observed early in treatment. Consumers receiving clozapine must be monitored carefully throughout treatment to minimise the risk of adverse cardiac events.

There is to be a collaborative care approach to monitoring and management of clozapineinduced myocarditis. Treatment must be person-centred and consumers and family/carers are to be actively involved in the provision of care. Consumers must be informed of the benefits of treatment with clozapine as well as the associated risks.

Sound clinical judgement and knowledge are essential in the implementation of this Guideline to ensure safe monitoring and use of clozapine in consumers.

Local Health Districts and Specialty Health Networks must have local procedures in place to establish roles and responsibilities in relation to clozapine monitoring, including pathways for medical escalation, onward referral and transfer of care.

Given the potential success of clozapine, every opportunity for continuation of clozapine is to be taken provided it can occur safely.

To view the Monitoring Clozapine induced myocarditis Guideline, go to https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_011

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.[3]

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
http://www.health.nsw.gov.au/policies/pd/2012/PD2012_050.html

[3] Australian Health Ministers' Advisory Council, Mental Health Standing Committee (2006) *National Statement of Principles for Forensic Mental Health*.

MENTAL HEALTH TRIAGE POLICY (PD2012_053)

PURPOSE

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

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

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

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

MANDATORY REQUIREMENTS

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

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

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

IMPLEMENTATION

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

- Providing the corporate governance structure for the SMHTAL Program.
- Establishing and funding the 1800 number.
- Marketing and communication of the SMHTAL Program.
- Funding Local Health Districts/Health Networks to improve their mental health telephone triage services so that they are able to meet the Standards and to support the ongoing operation of the service.
- Developing state-wide policies, protocols and operating guidelines relating to mental health telephone triage.

- Funding the development and delivery of standardised mental health telephone triage training to mental health clinicians who undertake the mental health telephone triage function.
- Monitoring the performance of mental health telephone triage services to ensure they conform to the Standards.
- Monitoring and quality improving the operation of the SMHTAL Improvement Project.

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

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

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

1. BACKGROUND

1.1 About this document

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

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

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

NSW Health recognises that an efficient triage framework is required to provide timely and equitable access to appropriate mental health services in a consistent manner across the State.

1.2 Key definitions (for the purpose of this policy)

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

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

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

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

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

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

1.3 Aim of this document

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

1.4 Key principles

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

2. ROLES AND RESPONSIBILITIES

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

2.1 NSW Ministry of Health

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

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

2.2 Local Health Districts/Health Networks

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

- Implementing the State Mental Health Triage Policy.
- Developing and implementing uniform operating procedures in line with State call handling guidelines (refer Guideline 'Call Handling Guidelines for Mental Health Telephone Triage Services' 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, capital works activity and other costs associated with the delivery of triage services.
- Implementing routine evaluation and clinical practice improvement processes, including complaint/incident management.
- Communicating with stakeholders within the Local Health District/Health Network about the operation of its mental health telephone triage services

2.3 Mental Health Telephone Triage Service Clinicians

The primary role of a mental health clinician undertaking the telephone triage function is to offer assistance to all callers at the first point of contact.

Mental health clinicians undertaking the telephone triage function will be experienced mental health clinicians with current registration or professional affiliation in the disciplines of nursing, social work, psychology, occupational therapy. While there is no explicit definition of "experienced mental health clinicians", for the purposes of the SMHTAL Program "experienced" means having at least three years' experience working in acute mental health settings conducting initial mental health assessments.

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

The triage module must also be completed when referring to another service such as:

- Health service (not mental health)
- General Practitioner
- Another Local Health District/Health Network
- Non-Government Organisation
- Specialist mental health services
- Information for possible future referral i.e. client may be escalating.

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

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

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

2.4 Mental Health Clinician/Team Receiving Triage

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

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

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

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

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

3. THE TRIAGE PROCESS

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

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

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

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

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

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

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

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

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

4. RISK ASSESSMENT

4.1 Clinical Risk Assessment

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

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

Possible risk factors include:

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

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

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

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

4.2 Occupational Health and Safety Risk Assessment

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

Alerts include:

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

5. COMPLETING THE TRIAGE DOCUMENT

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

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

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

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

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

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

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

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

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

'Communication issues' includes issues such as preferred language required or cultural and gender considerations or any sensory impairment. If an interpreter is required, then the preferred language should be noted, for example, 'Arabic interpreter is required'. Where cultural issues are present, a brief summary should be noted, for example: 'Cultural issues may be present, Aboriginal Liaison Officer may be required'.

Reason for referral (include whether client is opposed to referral):
Summarise reason for service being sought by self or other, including a brief outline of what is happening in their current situation that has caused them to call.

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

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

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

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

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

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

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

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

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

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

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

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

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.

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.

Crisis triage rating scale		CTRS: A + B + C	
		Scores are:	
A. Dangerousness =	____________	Category A =	3 – 9
B. Support System =	____________	Category B =	10
		Category C =	11
C. Ability to Cope =	____________	Category D =	12 – 13
		Category E =	14 – 15
Triage Rating (A+B+C) =	____________	Category F =	NA
		Category G =	NA

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

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

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

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.

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

2003: NSW Police Force Disclosure of Information by Health Professionals version 1.2 March 2003.
2005: NSW Health Suicidal Behaviour – Management of Patient with Possible Suicidal Behaviour PD2005_121.
2013: NSW Health Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013_007.
2013: NSW Health Management of NSW Police Force Officers' Firearms in Public Health Facility and Vehicles GL2013_002.
2006: NSW Health Interpreters - Standard Procedures for Working with Health Care Interpreters PD2006_053.
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*.
2007: NSW Health Aboriginal Mental Health and Well Being Policy 2006-2010 PD2007_059.
2014: NSW Health Mental Health Clinical Documentation Guidelines GL2014_002.
2008: NSW Multicultural Mental Health Plan 2008-2012 PD2008_067.
2010: NSW Health Mental Health Clinical Documentation PD2010_018.
2011: NSW Health Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines PD2011_001.

11. REFERENCES

Auditor General's NSW (2005) Auditor General's NSW Report Performance Audit Emergency Mental Health Services NSW Department of Health [The Audit Office of New South Wales].

Broadbent, M., Jarman, H., & Berk, M., (2002). Improving competence in emergency mental health triage, *Accident and Emergency Nursing*, 10, 155 – 162.

Erdman, C. 2001. The Medicolegal Dangers of telephone Triage in Mental Health Care. *The Journal of Legal Medicine*, 22:553-579.

Happell, B., Summers, M., & Pinikahana, J. (2002). The triage of psychiatric patients in the hospital emergency department: a comparison between emergency department nurses and psychiatric nurse consultants. *Accident and Emergency Nursing*, 10, 65 – 71.

Happell, B., Summers, M., & Pinikahana, J., (2003). Measuring the effectiveness of the national Mental Health Triage Scale in an emergency department. *International Journal of Mental Health Nursing* 12, 288-292.

Kevin, J., (2002) An examination of telephone triage in a mental health context. *Issues in Mental Health Nursing*, 23:757-769.

Lee, S. (2006) The characteristics of police presentations to an emergency department in a community hospital. *Australasian Emergency Nursing Journal* 9, 65—72.

National Institute of Clinical Studies (2006) Victorian Emergency Department Mental Health Triage Project August 2005 – March 2006, National Institute of Clinical Studies (NICS) & Victorian Department of Human Services.

National Standards for Mental Health Services (2010).

NSW Health (2004) Your guide to MH-OAT Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools, NSW Health North Sydney.

NSW Health (2005) Clinical Services Redesign Program (CSRP) Emergency Mental Health Project (CSRP-DOH-05-003) Statewide Mental Health Project Final Report [Accenture & NSW Health].

NSW Health (2006) GL2006_013 Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015 NSW Health North Sydney.

Sands, N. (2004) Mental health triage nursing: an Australian perspective. *Journal of Psychiatric and Mental Health Nursing* 11, 150–155.

Sands, N., (2007) Mental health triage: towards a model for nursing practice, *Journal of Psychiatric and Mental Health Nursing* 14, 243–249.

12. APPENDICES

12.1 NSW Health Mental Health Triage Module

NSW HEALTH

Mental Health

Site

TRIAGE

SURNAME

MRN

OTHER NAMES

☐ MALE ☐ FEMALE

D.O.B. ______/______/______

M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONSUMER CONTACT NUMBERS:

ALERTS/RISKS? ☐ No ☐ Yes Summary *(summarise after triage completed)*

TRIAGE DETAILS

Date: Time: Location:

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

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

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

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

Reason for referral *(Include whether client is opposed to referral)*

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

MEDICAL ISSUES *(e.g. significant illnesses, allergies, adverse drug reactions, delirium risk, pregnancy)*

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

DRUG AND ALCOHOL USE

CURRENT FUNCTIONING AND SUPPORTS *(e.g. concerns regarding living situation, parental or other carer responsibilities, note name, age, current whereabouts of dependent/s)*

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

TRIAGE

SMR025.000

PH 607 - 08/2008

Page 1 of 2

MH_OAT Triage.indd 1 21/08/2008 11:13:31 AM

MANDATORY

First Name: ______ Surname: ______ DOB: ______ MRN: ______

LEGAL STATUS/FORENSIC ISSUES *(e.g. Mental Health Act involuntary patient orders, Guardianship)*

MENTAL STATE IMPRESSIONS *(consider information provided by client and other sources)*

POSSIBLE RISKS *Y=Yes, N=No, UK=Unknown*

	Suicide Y	Suicide N	Suicide UK	Violence Y	Violence N	Violence UK
Significant past history of risk	☐	☐	☐	☐	☐	☐
Recent thoughts, plans, symptoms indicating risk	☐	☐	☐	☐	☐	☐
Recent behaviour suggesting risk	☐	☐	☐	☐	☐	☐
Concern from others about risk *(assessment should include corroboration where possible)*	☐	☐	☐	☐	☐	☐

	Y	N	UK
Current problems with alcohol or substance misuse	☐	☐	☐
Major mental illness or disorder	☐	☐	☐
At risk mental state *(e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)*	☐	☐	☐
Person's level of risk appears to be highly changeable	☐	☐	☐
Significant uncertainty in the assessment of the level of risk	☐	☐	

Overall Risk *(current/immediate)*

	High	Med	Low
Suicide	☐	☐	☐
Violence	☐	☐	☐
Other* *(specify)* ______	☐	☐	☐
Other* *(specify)* ______	☐	☐	☐

*Consider other risks e.g. self-harm, child safety, absconding, exploitation, domestic violence, abuse, neglect, environment risks

SUMMARY *(overall clinical impression, including possible risks; please also document any 'Alerts/Risks' on Page 1)*

ACTION PLAN

Urgency of response *(see CTRS Guideline)*

☐ **A** Immediate	☐ **D** Within 48 hours	☐ **F** Requires further triage contact/follow up
☐ **B** Within 2 hours	☐ **E** Within 2 weeks	☐ **G** No further action required
☐ **C** Within 12 hours		

- ☐ Department of Community Services notified
- ☐ Police notified
- ☐ Ambulance notified
- ☐ Referred to Inpatient Mental Health service
- ☐ Referred to Community Mental Health service
- ☐ Referred to Emergency Department
- ☐ Referred to Community Health
- ☐ Intepreter booked
- ☐ Aboriginal Liaison Officer notified
- ☐ Other: ______

Details of Action Plan: ______

CONTACTS

Communication undertaken with	Name	Contact details	Comments/issues
Yes ☐ Primary carer/family			
Yes ☐ General practitioner			
Yes ☐ Referrer			
Yes ☐ Other *(specify)*			

Staff Name: Signature: Designation: Date:

SMR025.000 Page 2 of 2

BINDING MARGIN - NO WRITING

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 clearly 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.
3	Passively accepts intervention strategies.
4	Wants help but is ambivalent or motivation is not strong.
5	Actively seeks treatment, willing and able to cooperate.

Ascertainment guidelines: The clinician may make the rating following a brief assessment over the telephone. It is recommended that if the score is equal to or less than 9, the response to the consumer should be one of extreme urgency, with appropriate documentation in the *Triage's* 'Action Plan' and 'Urgency of response' on page 2.

URGENCY OF RESPONSE SCALE (CTRS: A+B+C)

Category A 3 — 9	Extreme Urgency	Immediate response requiring Police/Ambulance or Other Service (e.g. overdose, siege, imminent violence)
Category B 10	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 11	Medium Urgency	See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour)
Category D 12 — 13	Low Urgency	See within 48 hours (e.g. moderate distress, has some supports in place but situation becoming more tenuous)
Category E 14 — 15	Non Urgent	See within 2 weeks
Category F		Requires further triage contact/follow up
Category G		No further action required

MENTAL HEALTH — CRISIS TRIAGE RATING SCALE

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.

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:

Period	Due Date
1 January – 31 March	14 April
1 April – 30 June	14 July
1 July – 30 September	14 October
1 October – 31 December	14 January

....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

Month	In-bound call volume	In-bound calls handled	Bus Hours	Outside Bus Hours	Average duration of calls handled
Month XX					
Month XX					
Month XX					
TOTAL					

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

Month	% of calls answered in 30 seconds	% of calls waiting over 2 minutes	% of calls abandoned
Month 1			
Month 2			
Month 3			
TOTAL			

Comments

(b) Non –telephony standards

Comment on the performance of the non-telephony Standards.

	Standard	Comments on adherence to Standard
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.	• 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) 7(b)	Each MHTTS is able to provide advice and information relating to the availability of public or private MH services. 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

Month	Source of Complaint					
	Client/Carer	GP	MH staff	Other Health	Emergency Services	Other
Month 1						
Month 2						
Month 3						
TOTAL						

Briefly describe the more serious or common complaints received and how they were resolved

Nature of the Complaint	Resolution

(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

Month	Severity rating (SAC)			
	1	2	3	4
Month 1				
Month 2				
Month 3				
TOTAL				

Briefly describe the more serious incidents or common incidents and how they were resolved

Nature of the Incident	Resolution

(c) Quality Monitoring and Improvement Activities

Describe other quality monitoring or improvement activities conducted, e.g. file audits, staff supervision.

Other quality monitoring or improvement activity	Description	Date

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

PSYCHIATRIC EMERGENCEY CARE CENTRE MODEL OF CARE GUIDELINE (GL2015_009)

PURPOSE

Psychiatric Emergency Care Centres (PECCs) were introduced in NSW from 2005 as one component of a series of strategies designed to enhance Mental Health (MH) Emergency Care services alongside community mental health teams, Emergency Department mental health clinicians, consultation liaison psychiatry services, psychiatry registrars and consultant psychiatrists.

The earlier version of the PECC Operational Model of Care Guideline attempted to articulate a consensus regarding detailed aspects of PECC operations. The facilities in which PECCs operate differ from each other including with regards to governance, overall mental health resources and how these resources are configured and managed and the physical location and design of the PECC and it has become apparent that it is neither desirable nor possible to standardise resourcing or service delivery arrangements for managing the care of people with mental health problems including those presenting to Emergency Departments (ED).

This updated PECC Model of Care Guideline provides high level guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services' model of care.

KEY PRINCIPLES

MH care in the ED is a collaborative process, with shared responsibility between Emergency Department and MH clinicians and managers and other specialities (e.g. Toxicology, Drug and Alcohol), where relevant. The relative portion of this shared responsibility varies according to individual patient needs and local service arrangements.

PECCs are integrated with a range of community-based and inpatient care options and represent the least restrictive hospital-based inpatient care option. It is intended to be utilised by consumers with low to medium acuity mental health problems for whom less restrictive care (e.g. community based care), is considered inappropriate and unsafe and who are likely to require only a brief (up to 48 hours) period of time in hospital.

The guiding principles for PECCs are:

1. Collaborative decision-making
2. Least restrictive, short-term inpatient care
3. Outcome based monitoring.

USE OF THE GUIDELINE

It is the intention of this guideline that individual PECCs represent a locally determined service collaboration and configuration, based on the guided principles contained within this document. Services should monitor, evaluate and if necessary re-design these agreements by way of carefully chosen outcome and process data reflective of important aspects of mental health emergency care.

This document will assist in the process of establishing, monitoring or reviewing PECC services, their role in the emergency space and in relation to the remainder of community - inpatient MH services.

Download the Guidelines at: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2015_009

OLDER PEOPLE'S MENTAL HEALTH (OPMH) ACUTE INPATIENT UNIT MODEL OF CARE (GL2022_003)

GL2022_003 rescinds GL2016_016

GUIDELINE SUMMARY

This Guideline promotes evidence-based good practice in older people's mental health (OPMH) acute inpatient units across NSW, supporting consistent, high quality and safe care. It includes guidance around relationships and processes, clinical interventions, facility design, staffing and performance.

KEY PRINCIPLES

This Guideline reflects current best practice for older people's mental health acute inpatients units and findings from consumer and carer consultation, including a strong preference for direct admission pathways.

It provides recommendations with supporting evidence to guide implementation of a good practice model of care in older people's mental health acute inpatient units. It includes service development guidance to support implementation of core elements of good practice in all units, while informing the development of advanced practice where appropriate.

Emphasises recovery-focused, person-centred, biopsychosocial and trauma-informed care. It promotes timely triage, intake and admission, comprehensive assessment, collaborative care planning with the older person and their carers, and clinical review and transfer of care that maximises consumer engagement, choice and control.

It promotes access to a range of clinical interventions to achieve the older person's treatment goals and support their recover.

It highlights the importance of appropriate care for specific population groups, integrated care (including mental health and physical health care), multidisciplinary staffing and care, minimising seclusion and restraint, and appropriate physical environments.

It promotes alignment of older people's mental health acute inpatient unit practice with national and state practice and performance standards.

This Guideline aligns with NSW Health Guideline NSW Older People's Mental Health Services Service Plan 2017-2027 (GL2017_022) and reflects findings from the NSW OPMH Recovery-Oriented Practice Improvement Project (2017).

USE OF THE GUIDELINE

This Guideline is intended to support ongoing quality improvement and service development in existing older people's mental health acute inpatient units and to inform planning of new units.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_003

ENGAGEMENT & OBSERVATION IN MENTAL HEALTH INPATIENT UNITS (PD2017_025)

PURPOSE

The purpose of the policy is to identify the minimum requirements for mental health inpatient units relating to levels of observation. The policy will guide and direct clinicians in relation to their responsibilities pertaining to observation.

The aims of these requirements are to ensure that observation levels and engagement are adequate to assess and address the risk of harm to patients or others.

MANDATORY REQUIREMENTS

The policy mandates the practice of assessments by Medical Officers to provide direction to nursing staff regarding the level and purpose of observation required for individual patients.

Nursing staff actively contribute to this assessment, and may increase the level of observation for a patient if required.

If a patient's observation level is increased by nursing staff due to clinical deterioration or concern, this must be escalated and result in a medical review as soon as possible.

The policy requires ongoing multidisciplinary reviews of observation and engagement levels for individual patients to ensure they are responsive to the needs of the consumer.

The outcomes of patient observation and engagements must be contemporaneously documented to inform the continuing and regular review of the observation level.

Observation levels must take into account other risk mitigation factors of the mental health inpatient unit such as ward programs, allied health programs and the clinical environment.

Local procedures must include an evaluation process that mandates audits of observation and engagement practice. These audits will include random inpatient unit visits.

Reports on the outcomes of these audits should be reported to the mental health director.

IMPLEMENTATION

Chief Executives ensure that mental health directors are aware of the policy directive and have a timeframe for full implementation.

Mental health directors review local procedures and practices to determine alignment with this policy and if differences are found, local procedures are updated or developed that clearly outline mandated responsibilities for medical and nursing staff in accordance with this statewide policy.

Mental health directors ensure that an evaluation process is adhered to to ensure compliance to this policy.

Mental health directors ensure that all staff are aware of this policy and procedures which must include random inpatient unit visits and documentation audits.

BACKGROUND

About this document

This policy identifies the minimum standards of observation and engagement to consumers within mental health inpatient units.

This policy replaces previous guidance on mental health nursing observations within the Suicide Risk Assessment and Management Protocols – Mental Health Inpatient Unit (NSW Department of Health, 2004).

The policy ensures that engagement and observation levels continue to assess and manage the risk or concern of harm to a consumer or others.

The policy enables a shared definition and understanding across NSW to improve consumer safety and focus upon consumer centred care.

Local procedures should be developed that align with the procedures, definitions and documentation requirements outlined within this policy.

The policy is relevant to all mental health clinicians involved in the engagement, observation, assessment and review of consumer's within NSW mental health inpatient units.

Key definitions

Observation
Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making. It is the formal and objective assessment of a person's condition – physical, mental, social. Observation is not passive nor does it predominantly include watching consumers from a distance. Undertaking observations requires nurses to be person centred and engage therapeutically with inpatients.

Observations through engagement are for safety, protection from harm and maintenance of wellbeing. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery.

The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and to ensure safety of the environment in which the care is being provided.

Observation is indelibly linked with clinical assessment. Observation informs ongoing decisions about care and must be a continuous feature of the care of people in mental health inpatient units.

The principles of observation in mental health inpatient care include engaging with people during purposeful observation which actively contributes to comprehensive care. There are several principles that underlie the practice of observation:

- Observation is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the person
- Appreciation of how inpatient environments influence behaviour
- Observations are communicated between colleagues
- There is a clear process of documentation that is timely and descriptive.

Ongoing engagement with the consumer, family and carers support shared decision making around continued observation and care planning

> *Nursing Observation through engagement in psychiatric inpatient care, Victoria Department of Health, 2013*.

The following definitions of observation levels are designed to provide a common language and state wide understanding of the differing levels and requirements for the management of each observation level.

Level 1: Constant Observation
Arm's length: The most restrictive form of observation to mitigate the highest risk or concern for a consumer. At all times a nurse must be within one metre of the consumer; or
Visual: A highly restrictive form of observation to mitigate a consumer assessed at high risk of harm. At all times, the consumer must remain under the visual observation of a nurse.

Level 2: Observation every 15 minutes – this level of observation is significantly restrictive to mitigate risks for consumers who are assessed as being at a high level of concern. Nurses must regularly engage and randomly observe consumer's on this level at least every 15 minutes (at a minimum).

Level 3: Observation every 30 minutes
This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 30 minutes (at a minimum).

Level 4: Observation every hour
This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 60 minutes (at a minimum).

Level 5: Observation every two hours
This level of observation should include random and regular checks of the location and activity of the consumer every two hours (at a minimum).

Policy context

This policy aligns with Standard 2 of the *National Standards for Mental Health Services, 2010*.
This policy supports the implementation of Standard 2: Safety which promotes the optimal safety and wellbeing of consumers in all mental health settings.

This Policy identifies the requirements of staff to regularly review the level of risk or concern related to a consumer and their level of observation. This policy does not relate to the Physical health care of consumers and/or physical observations required. Directives and Guidance for the Physical Health care of mental health consumers may be found in the Physical Healthcare within Mental Health Services Policy (PD2009_027).

This policy is supported by the Transfer of Care from Mental Health Inpatients Policy (PD2016_056); Aggression, Seclusion and Restraint in Mental Health Facilities Policy (PD2012_035) and Clinical Care of People who may be Suicidal Policy (PD2016_007).

Responsibilities and minimum requirements relating to observation of consumers during episodes of restraint and seclusion are attended to within the Policy Directive Aggression Seclusion and Restraint in Mental Health Facilities in NSW (PD2012_035).

OBSERVATION AND ENGAGEMENT

2.1 Observation includes engagement with the consumer as well as visual observation.

> **2.1.1** Consumer observation must be purposeful and include person centred engagement.
>
> **2.1.2** Levels of observation must be allocated according to an individual's assessments and needs and not at set levels for a whole unit or a point of care (e.g. at admission).
>
> **2.1.3** Staff allocating and maintaining observations should explain to the consumer their level of observation and the requirements relating to this level of observation to ensure engagement and participation of the consumer in their health care.

2.2 A consumer's assessment, management and care plan need to reflect the multidisciplinary teams planning and inform the level of observation and engagement required for individual consumers.

Nurses must record the observation and engagement in the medical record. This documentation must include:

- the level of observation
- the observation and engagement undertaken
- assessment of the consumer's mental state

Consumer's identified as being at higher levels of concern or changeability require more frequent observation, engagement and assessment.

2.3 Clinical handovers between multidisciplinary teams must include assessments of observation and engagement levels.

2.4 Nursing clinical handover for each consumer must include the level of observation and the engagement and assessments undertaken to ensure a safe transfer of care and clear understanding of the plan for the receiving nurses.

2.5 The Nursing Unit Manager (or delegate), along with the medical director (or delegate) are responsible for determining if the levels of observation set for all consumer's in that unit are appropriate, and are reviewed.

2.6 Where there are insufficient nursing resources to undertake observation and engagement, the Nursing Unit Manager (or delegate) will escalate to the responsible Nurse Manager. Where avenues for staffing are exhausted a collaborative decision by the Nursing Unit Manager (or delegate) and local nursing administration will direct distribution of current resources while other arrangements are made.

NURSING SPECIFIC RESPONSIBILITIES

3.1 The Nursing Unit Manager or delegate is responsible for ensuring that all nursing staff are aware and able to fulfil their responsibilities for completing the agreed observation of all inpatients within the unit. This includes the prioritisation of observations within the unit and ensuring nurses are allocated and where required (e.g. Observation level 1, fatigue management, etc.) share the observation responsibilities.

3.2 The Nursing Unit Manager or delegate must randomly review throughout a shift that observation levels are being undertaken and documented as prescribed.

3.3 Nurses may at any time increase the level of observation for an individual consumer based on assessment or concern.

3.4 This increase must be escalated to the responsible medical officer and/or through nursing management and result in a medical review as soon as practicable in line with local clinical deterioration procedures.

3.5 Documentation of observations are to be recorded on locally developed forms that align with the requirements of this policy. Each Level of Observation (i.e. 1, 2, 3, 4 and 5) will require a separate form. These forms must form part of the consumer's medical record when completed.

3.6 Engagement and assessment must be recorded contemporaneously in the medical record in line with the documentation requirements listed within this policy.
3.7 Tick box observation forms must not be used because they do not adequately document the consumer's level of risk or record the observation.

3.8 The Observation form must allow the nurse to document the actual time the observation took place and clearly identify the nurse completing the observation.

3.9 Minimum observations documented on the observation form must include the consumer's location and activity at the time of being seen.

3.10 The medical record will reflect the engagement with the consumer and the resulting assessment.

3.11 The documentation of each engagement and assessment must be inclusive of the consumers' mental state, current risks and concerns (both subjective and objective), interactions with staff and other persons, and be reflective of the targeted rationale for observation.

3.12 Observations must be conducted regularly according to the assessment of the level of risk or concern. It is recommended that staff occasionally undertake additional rounds between the prescribed times so that consumers cannot discern a pattern/set routine. The risk of set routines in observation is that a consumer may harm themselves, or others, between regular and predictable observation times.

3.13 Where an observation has been missed, the reason must be documented on the consumers observation form by the responsible nurse.

3.14 The observation level, engagement and resulting assessments of each consumer must form part of each clinical handover.

MEDICAL OFFICER RESPONSIBILITIES
4.1 Assessments must be conducted and documented by medical officers to determine the level of observation required for individual consumers. Decisions should be made with the multidisciplinary team, consumer and where possible the family and or carers to ensure collective input and decision making.

4.2 Active feedback to the consumer, family and carers regarding observation levels and assessment ensures ongoing and collective engagement of all parties within care planning.

4.3 The level of observation, its rationale and reviews of the level of observation must be clearly documented by the responsible medical officer within the medical record so clinicians may easily identify the level of observation and the ongoing targeted nursing assessments required as part of this observation level.

4.4 Only medical officers may reduce an observation level, this should occur in consultation with the multidisciplinary team.

5 LEVELS OF OBSERVATION

Level	Description of level of supervision	Documentation requirements	Review
Level 1 - Constant Observations (Arms Length)	At all times a nurse must be within one metre of the consumer. Assessment of the safety of the consumer and nursing staff must be taken into account when allocating this level of observation. The observation of a consumer on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. A consumer on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the consumer's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 1 - Constant Observations (Visual)	At all times the consumer must be within the line of sight of the nurse responsible for undertaking the observation. This level of observation requires a skilled and knowledgeable nurse as the indication and outcome of this level of observation is constant assessment. The observation of consumers on this level should where possible be inclusive of gender and culturally appropriate allocation of nursing staff. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.

Level 2 - 15 Minute Observations	This level of observation should only be used infrequently due to: • the challenge it poses to regular engagement. • the pattern of this observation becoming easily identifiable by consumer's who may use the time between observation opportunistically and impulsively. Therefore, this level may be used as a step down from Level 1 observations or a step up from Level 3. Should escalation from Level 3 to Level 2 be instigated by nursing staff, discussion with the Nursing Unit Manager (or delegate) and medical officer should occur immediately to assess whether an observation Level 1 is required to mitigate the identified risk or concerns. This level of observation should include random and regular checks of a consumer's location and activity within the unit at least every 15 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Consumers on this level of observation should not be allocated leave from the unit unless the purpose of leaving the unit is to attend to medical care/treatment. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through four contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least daily by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.

Level 3 - 30 Minute Observations	This level of observation should include random and regular checks by nursing staff of a consumer's location and activity within the unit at least every 30 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive. Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through two contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 4 - Hourly Observations	This level of observation should include random and regular checks by nursing staff of a consumer's location and action within the unit at least every 60 minutes. The nursing staff should check the location and action of the person preceding and following the point of nursing handover. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive Consumers on this level of observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians.	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	At least weekly, led by the responsible medical officer in collaboration with the Nursing Unit Manager or delegate.
Level 5 - Two Hourly Observations	Consumers on this level of observation are considered by the treating team to be at minimal risk. Consumers on this level of	Contemporaneous documentation must be undertaken by nursing staff within the medical record. This level of observation is supported through a	At least weekly, led by the responsible medical officer in collaboration with

	observation should be actively engaged in the unit program and as a result, regularly seen and engaged with throughout each shift by multiple clinicians. The nursing staff should check the location and action of the person preceding and following the point of nursing handover and at least every two hours. Periods of inpatient leave are to be inline and compliant to directives within the appropriate NSW Policy Directive)	contemporaneous documented assessment per shift through the outcome of active engagement by nursing staff. The assessment must be targeted to reflect the management/care plan directed and documented by the medical officer/ multidisciplinary team with a purpose to inform ongoing review of the observation level. During all periods where a consumer is asleep, the nursing staff must be able to view the patient's respiratory rate, activity during sleep/night hours (e.g. awake, asleep, laying on side, snoring etc.) and this be contemporaneously documented within the medical record.	the Nursing Unit Manager or delegate.

SERVICE / DISTRICT LEVEL POLICES AND REVIEWS OF EFFECTIVENESS

6.1 Local procedures are to be developed which include the directions within this policy.

6.2 The local procedure should clearly outline the importance and purpose of overnight nursing observations and balance the consumer's need for sleep hygiene with safety.

6.3 The local procedure must outline the minimum standard of documentation relating to night time observations in relation to description and respiration as identified within this policy.

6.4 Services must ensure that observations are undertaken effectively.

6.5 Random inpatient unit visits and documentation audits should be conducted to ensure that observations and regular engagement are being undertaken effectively. The results of these audits will form an ongoing component to the monitoring and evaluation of this Policy Directive. Services must build the capacity of their workforce to ensure that observations are:

a. Grounded in therapeutic engagement that is facilitated through empathy and understanding of a persons lived experience

b. Conducted in a way that fosters a therapeutic relationship between nurses and the people for whom they provide care.

LIST OF ATTACHMENTS

Attachment 1: Implementation Plan – Engagement and Observation within Mental Health Inpatient Units

ADULT MENTAL HEALTH INTENSIVE CARE NETWORKS (PD2019_024)

PURPOSE

This Policy Directive sets out the NSW Mental Health Intensive Care Unit (MHICU) Referral Networks. It defines the referral pathway for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to access more intensive care for patients experiencing high acuity mental illness and complex needs, within an integrated model of care.

MHICUs are centres of specialist expertise in the management of people presenting with highly acute and complex mental illness. MHICUs operate as supra LHD services, and are state-wide referral facilities. Referral to a MHICU occurs from an inpatient mental health facility as the least restrictive option when the patient can no longer be safely cared for due to the risk that their behaviour poses to themselves or others

Each MHICU is a part of a local clinical referral Network and the state wide integrated Network of clinical services that provide timely access to appropriate care.

This Policy Directive also sets out the principles and procedures each LHD should develop and monitor for the care of consumers requiring mental health intensive care.

MANDATORY REQUIREMENTS

- All options for consumer placement to other mental health facilities should be explored before seeking a referral to a MHICU.
- LHDs to admit consumers with the highest acuity or most complex clinical needs from their designated zone into the MHICU
- MHICUs only provide care to those consumers with the highest acuity or most complex clinical needs.
- Referral and transfer to a MHICU is a time-limited episode of care. On stabilisation of symptoms and/or reduction in the level of clinical risk, consumers will be repatriated to the referring LHD.
- The referring LHD will facilitate the transfer to the MHICU.
- The MHICU will facilitate return transfer back to the referring LHD.
- LHDs must inform relevant clinical staff of this policy directive.

IMPLEMENTATION

- This Policy Directive applies to all adult mental health inpatient facilities.
- LHDs/SHNs must have local policies and procedures in place that are consistent with the principles and procedures identified in this policy by August 2019

Local Health District/Network Chief Executives are responsible for:

- Ensuring implementation of the Policy Directive, with the Chief Executive as the final point of arbitration and escalation.
- Documenting and implementing local governance and escalation plans to ensure the appropriate accommodation of patients who need to access a MHICU bed. This must include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review. Escalation plans must include procedures for clinicians to follow in instances where an appropriate bed is not available within the zone or difficulties are experienced with patient acceptance and placement.
- Meeting the MHICU needs of their LHD and linked LHDs including the provision of clinical advice and ensuring access to appropriate treatment.

Local Health District/Network Mental Health Directors are responsible for:

- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe.
- Ensuring that all options for placement of the referring LHD's patient within the originating LHD have been explored, and that transfer to a MHICU is clinically appropriate.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring timely repatriation. On stabilisation of symptoms and/or reduction in the level of clinical risk, MHICU patients must be repatriated to the referring LHD. Repatriation is the responsibility of the referring LHD.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Mental Health Intensive Care Units are responsible for:

- Ensuring information in the Patient Flow Portal and/or Emergency Access View is current and correct at each shift handover

Patient Flow Units/Bed/ After Hours Managers are responsible for:

- Facilitating referrals for Statewide MHICU transfers in consultation with the local MHICU

Adult Mental Health Intensive Care Networks Procedures

1 BACKGROUND

1.1 About this document

This Policy Directive provides guidance to ensure that patients with high acuity mental illness and complex clinical needs receive timely treatment in the most appropriate setting.
Mental Health Intensive Care Units (MHICUs) are units with a small number of beds and high staff to patient ratios that provide a highly specialist and intensive multidisciplinary mental health care to patients who present with clinical complexity and risks that cannot be safely and effectively managed in an acute mental health inpatient unit.
In NSW there are six MHICUs that currently provide tertiary level intensive mental health care and operate as part of a state wide Network.
This procedure describes key processes of MHICUs as follows

- Inclusion and exclusion criteria for referral
- Referral processes
- Transfer of patients between MHICUs and LHD inpatient mental health units
- Roles and responsibilities of MHICUs and referring inpatient mental health units in relation to the transfer and return transfer of patients
- Roles and responsibilities of referring inpatient mental health units during a patient's admission to a MHICU

1.2 Key definitions

Complex clinical needs: Complex clinical needs refers to the care that a patient requires to manage their acute presentation. Complex needs require significant intervention and ongoing support in a range of biomedical, psychological, social and occupational domains.
High acuity: a high acuity patient is a patient that is acutely unstable in their clinical presentation and require increased multidisciplinary review, intervention and care.

MHA: *Mental Health Act 2007*
Patient: It is noted that the preferred terminology for people with a lived experience of mental distress and/or mental illness is "consumer", however for the purposes of this document "patient" has been used to refer to this population. This term is used to identify that the patient is an admitted inpatient and is accessing mental health intensive care services.

Referring inpatient mental health unit: A LHD/SHN based public inpatient mental health unit that has referred a patient to a MHICU for intensive management or stabilisation.

1.3 Legal and legislative framework

This Policy Directive refers to the care of people who are subject to the restrictions and directions of the *NSW Mental Health Act, 2007*. In cases where this policy and the MHA are in conflict, the directions of the MHA are to be followed in the first instance. Transfer procedures, detainment of patients and communication with designated carers are all included in the MHA.

1.4 Relevant Information

This Policy Directive has been informed by, and is designed to be read in conjunction with the following NSW Health Policy Directives and frameworks:

- Australian Health Ministers' Advisory Council (2003). *A National Framework for Recovery-Oriented Mental Health Services*. Author, Canberra
- Blue Knot Foundation (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.* Author, Sydney
- Mental Health Commission of NSW (2014). *Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report.* Author, Sydney
- NSW Health. *NSW Ministry of Health Demand Escalation Framework.*
- NSW Health (2006). *Aboriginal Mental Health and Wellbeing Policy 2006- 2010.* Author, Sydney
- NSW Health PD2018_011: *NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*
- NSW Health PD2017_025: *Engagement and Observation in Mental Health Inpatient Units*
- NSW Health PD2016_056: *Transfer of Care from Mental Health Inpatient Services*
- NSW Health PD2016_007: *Clinical Care of People Who May Be Suicidal*
- NSW Health PD2012_035: *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW.*
- NSW Health PD2011_015: *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*
- NSW Health PD2009_060: *Clinical Handover- Standard Key Principles*
- NSW Health PD2014_025 - Departure of Emergency Department Patients

2 ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

The Adult Mental Health Intensive Care Network defines the links between LHDs/ SHNs and MHICUs. The Networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries.

There are six (6) local mental health intensive care Networks (Networks), each served by one MHICU. In addition, the Forensic Hospital acts as a second tier referral facility where the patient demonstrates a very high risk of harm to themselves or others, or if a patient requires admission to a MHICU and no other beds are available.

Table 1: State Wide Adult Mental Health Intensive Care Network

MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent's Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs

3 OVERARCHING PRINICPLES OF CARE

3.1 Guiding principles for the Adult MHICU Network

The operation of the Adult MHICU Network, and arrangements for patient referral and transfer between referring inpatient mental health units and MHICUs is to be guided by the following principles:

1. The care of the patient is to be collaborative, recovery oriented, trauma informed and person centred, respecting the patient's human rights and dignity whilst being provided in the least restrictive environment alongside input from the patient's family and support people.
2. Referral and transfer to a MHICU is a time-limited episode of care for the intensive management of high acuity and complex symptoms. On the stabilisation of symptoms and/or reduction in the level of clinical risk, the patient is repatriated to the referring inpatient mental health unit as soon as practicable.
3. Admissions are determined with consideration to the existing patient mix in each Network Zone, and then within the broader Adult MHICU Network.
4. In cases of significant distance between the referring inpatient mental health unit and the MHICU, the benefits of admission to the MHICU must outweigh the risks associated with transferring the patient and their separation from family, carers and identified support people.
5. Determination and coordination of safe and timely patient transfer relies on current and accurate clinical handover between senior clinicians at each site. Relevant service executives and patient flow units should be included in all communication.
6. All processes must comply with the Adult Mental Health Intensive Care Network Policy (PD 2019_024).

3.2 Defining the MHICU patient

A MHICU patient is an existing patient of an acute mental health unit, who requires a high level of multidisciplinary care, observation and review to remain safe in the acute inpatient environment. A patient appropriate for a MHICU may demonstrate the following risks or behaviours

- Significant risk or continued attempts to harm themselves, with the intent of self-harm and/or suicide.
- Significant risk or actions of violence, physical, sexual or verbal abuse and/or harassment towards other patients, visitors or staff.
- Deterioration of mental health, or increasing symptoms of mental illness including disinhibition, disorganisation, disruption of others and/or significant distressing symptoms of psychosis leading to increased vulnerability
- Repeated attempts to leave the unit without authorisation, if detained under the MHA.

Patients admitted to MHICU are generally categorised as the “most unwell”. That is, these patients demonstrate the highest level of risk, are at the most risk and/or whose symptoms are not resolving to a lower level of acuity in acute inpatient wards. These are patients for whom accessing a higher level of care will provide the resources, observation and structure to contain their experience of distress.

4 REFERRAL TO MHICUS

4.1 Referral to a MHICU

4.1.1 Referral Documentation

The referring inpatient unit will provide a comprehensive clinical handover and package of clinical documentation to the MHICU at the time of referral and transfer.
Referral documentation will include:

- Referral form
- Current assessment by treating psychiatrist
- A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
- MHA documentation, including designated carer form
- Contact details of family/ carers and support people
- Medication charts
- Risk Assessment
- 7 days of progress notes
- Details of management and medication strategies trialled and outcomes of these

4.1.2 Assessment

Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of the highest acuity patients. Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the Network or difficulties are experienced with patient acceptance and placement.
It is the responsibility of the receiving MHICU to assess whether a referral is appropriate or not, considering the inclusion and exclusion criteria and the current patient population. The receiving MHICU will confirm receipt of referral documentation to the referring inpatient unit, and will assess referrals and respond to referrals within six hours of referral, or next day in business hours if the referral is received after 11am.
If a referral is not accepted for admission, the MHICU will provide a rationale for this. The MHICU clinical team will also be available to provide clinical consultancy to the referring inpatient unit as required to enable safe care and management of the patient.

4.1.3 Inclusion Criteria

Patients admitted to MHICU are:

- Aged 18 or over
- Detained under the NSW Mental Health Act 2007
- Requiring an intensive level of observation and care to manage deterioration of mental health, increased acuity of mental health symptoms and significant risk of violence, suicide or vulnerability
- Presenting with behaviour that severely compromises the patient's or another person's physical or psychological wellbeing and safety
- Medically stable

4.1.4 Exclusion Criteria

Patients not appropriate for admission have:

- A diagnosis of dementia, intellectual disability, substance misuse or intoxication in the absence of a primary diagnosis of a mental illness
- Physical frailty that affects the patient's care in an intensive care environment
- Medical conditions, including intoxication or detoxification from alcohol or other substances that cannot be safely managed in a MHICU

4.1.5 High Risk Presentations from Emergency Departments or Community

A MHICU admission from an Emergency Department or a community mental health tea, may occur after a psychiatrist's assessment in the following exceptional circumstances:

- To avoid further deterioration and in cases of significant and ongoing risk of violence and aggression, patients should not progress through the usual admission pathway of trialling acute unit care.

Where a patient is referred to a MHICU from an Emergency Department the mental health service has a responsibility to assist the Emergency Department in the proactive management of the patient until the patient is able to be transferred.

4.1.6 Local referral

Referrals from inpatient units will be made to the MHICU in their Local Network in the first instance (Table 1). If a referral is considered appropriate, every effort is to be made by the receiving MHICU to facilitate timely access. This may require a patient with less intensive health care needs in the MHICU to be repatriated to the patient's referring inpatient unit, or another bed in the referring LHD.

4.1.7 State Wide referral

State Wide referrals will only occur when a local MHICU bed is unavailable, and following an assessment of MHICU and referring LHD resources to ensure that only patients meeting the inclusion criteria at the time of assessment are receiving MHICU care. In this case, all patients currently being treated in the Local MHICU will have higher health care needs than the patient being referred. Following consultation with the referring LHD, the Local MHICU is responsible for finding a State Wide MHICU bed for the referred patient. The Local MHICU liaises with the relevant hospital patient flow processes and State Wide MHICU to identify a bed, and forwards the referral to the State Wide MHICU. The Local MHICU will inform the referring inpatient unit of the State Wide referral, and will provide the contact details of the State Wide MHICU.

Once a bed is identified in the state wide Network, the referring inpatient unit will contact the State Wide MHICU and liaise for the transfer of clinical care. The referring inpatient unit remains responsible for the transfer of the patient to a MHICU.

4.1.8 Clinical Handover

The referring inpatient unit will provide a comprehensive clinical handover and package of care documentation to the MHICU at time of transfer. The package of documents will include

- Original MHA documentation, including a signed Section 78
- Medication Charts (including current PRN medication)
- Contact details of family and carers

If no access to the referred patient's electronic medical records are available by the MHICU, the package of documents will also include:

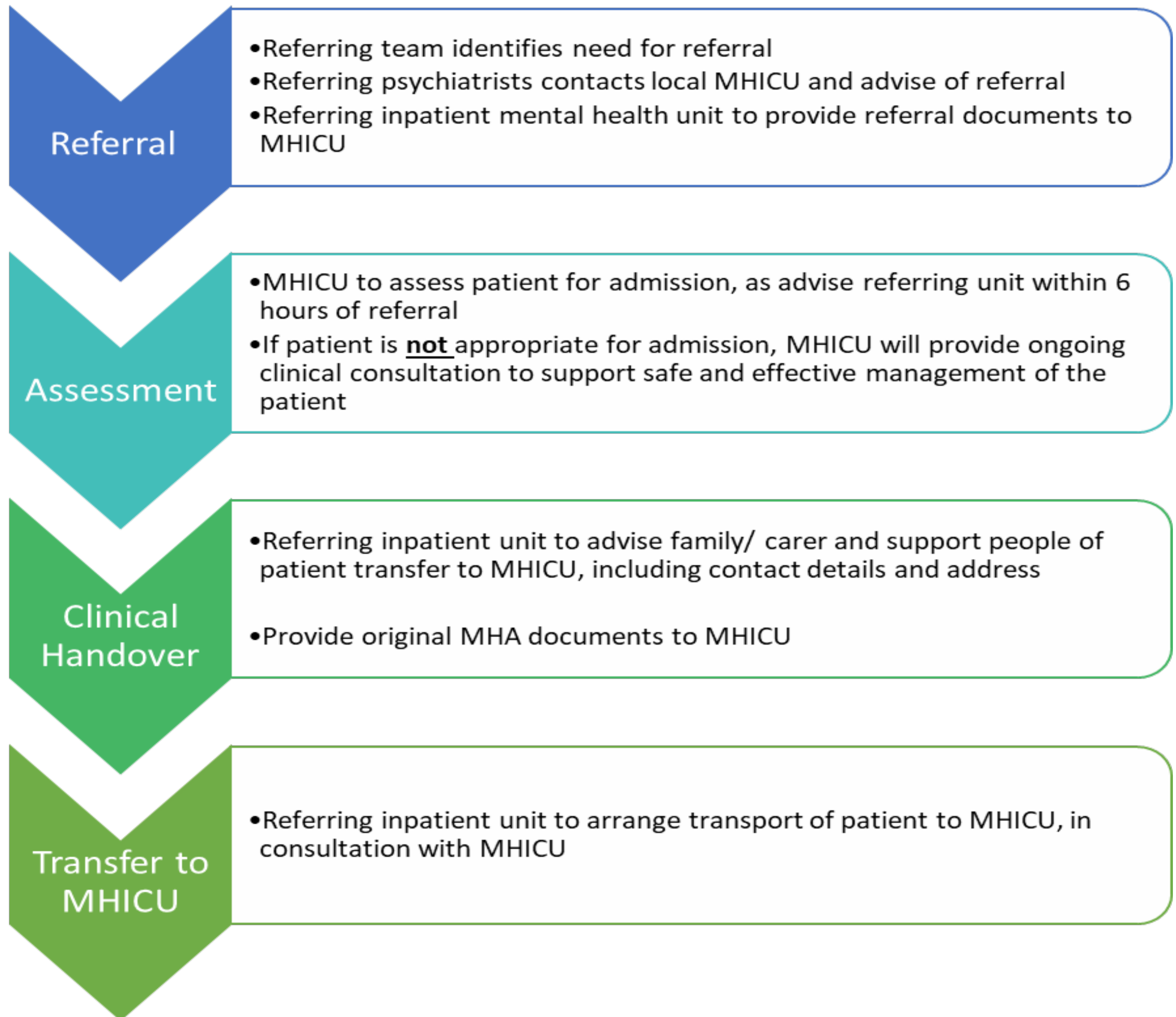
- Current assessment by treating psychiatrist
- Patient History
- A care plan, including the expected goals and length of MHICU admission and a plan for return transfer to the referring inpatient unit
- Risk Assessment
- 7 days of progress notes
- Details of management strategies trialled and outcomes of these
- Any available allied health assessments and reports

4.2 Transfer to a Mental Health Intensive Care Unit

It is the responsibility of the referring inpatient unit in consultation with MHICU to arrange for the timely and safe transfer of a patient. Transport arrangements should be in accordance with local policy and resources, and may require coordination with hospital security services, the NSW Ambulance Service and NSW Police consistent with the NSW Health- NSW Police Memorandum of Understanding 2018.

Family, carers and designated support people should be involved in any care planning and informed of any referral. *PD 2016_056 Transfer of Care from Mental Health Inpatient Services* details the principles and requirements for the safe transfer of a patient's care across settings. The referring inpatient unit must ensure the continued involvement of family and carers by providing information about options for contact and visits.

Figure 1: MHICU Referral Flowchart



Inclusion Criteria	**Exclusion Criteria**
Aged 18 or over	A diagnosis of dementia, intellectual disability, substance misuse or intoxication without a primary diagnosis of a mental illness
Detained under the *NSW Mental Health Act 2007*	Physical frailty that affects the patient's care in an intensive care environment
Requires an intensive level of observation and care to manage deterioration in mental health AND significant risk of violence, suicide, absconding or vulnerability	Medical conditions that cannot be safely managed in a MHICU

4.3 MHICU processes

4.3.1 Daily Multi-disciplinary Team (MDT) Handover

Clinical Handover refers to the safe transfer of professional responsibility and accountability for some or all aspects of a patient's care to another person or professional group
Consistent with intensive care practices, MHICU teams are to undertake a daily MDT handover, which provides the opportunity to discuss and review the presentation of each patient.
Handover meetings will review the EDD, care strategies, clinical incidents and care plans for each patient. Handover meetings must include prioritisation of patients for transfer or return transfer in the case of a higher acuity referral and identification of patients ready for return transfer to referring inpatient units. Following the daily handover meeting, MHICU updates Emergency Access View to accurately reflect bed status and vacancies.
Regular (at least weekly) communication must occur between the MHICU clinical team and the referring inpatient unit clinical team of admitted inpatients. Best practice is to invite a member of the referring inpatient unit team to the MDT clinical review, in person or using videoconference or teleconference facilities. This includes where referrals have been referred from a lower acuity ward in the same facility. If this is not feasible, an identified MHICU clinical team member is to liaise with the referring inpatient team regarding treatment progress, achievement of care plan goals, changes to the EDD and plans for the return transfer of the patient to the referring inpatient unit.

4.3.2 Identification of patients for transfer

Each LHD that hosts a MHICU is responsible for meeting the mental health intensive care needs of that LHD and linked LHDs within their local Network.
It is the responsibility of the MHICU to identify appropriate patients for transfer to LHD inpatient units in order to create capacity for acceptance of higher acuity referrals. Ideally, the identified patient will be transferred to their referring inpatient unit in this instance. If a bed is not available and cannot be made available by the referring inpatient unit, then the patient may be transferred to an available bed within the patient's host LHD with return transfer to the referring LHD to be expedited
Patients identified for transfer will be those who:

- Have demonstrated a reduction in the level of clinical risk to themselves and others as assessed by MDT in consultation with the patient
- No longer require intensive supervision and observation

4.4 Return transfer of patients

4.4.1 Roles and responsibilities of MHICU and inpatient units

It is the responsibility of the MHICU senior clinicians, following discussion with the referring LHD senior clinicians, to return transfer a patient when the clinical risk has reduced and/ or the exacerbation of mental health symptoms has stabilised. The MHICU is responsible for arranging the timely and safe return transfer of a patient as it is clinically indicated.

The referring inpatient unit will initiate appropriate local patient flow processes to ensure a bed is available to facilitate the return transfer of a patient from a MHICU. The referring inpatient unit will advise MHICU of the appropriate timing of return transfer (of no more than 24 hours from the time of request). MHICU will arrange transport of the patient and advise the inpatient unit of these arrangements, including the anticipated time of arrival.

If no bed is available for return transfer, the MHICU will contact the LHD mental health patient flow manager and identify an alternative bed for transfer within the patient's host LHD. Once the patient has reached an acute inpatient unit, the process for return transfer and/or discharge of the patient to the referring inpatient unit and/or community mental health team will progress consistent with existing local policies and procedures.

4.4.2 MHICU Clinical Handover

MHICU will provide a comprehensive clinical handover to the inpatient unit, including the following:

- Successful management strategies
- Outcomes of agreed care goals
- Medication changes
- Therapeutic interventions
- Recommendations for ongoing management

MHICU will provide a package of documents to the inpatient unit, including:

- Original MHA documentation
- Medication Charts
- Contact details of family and carers

If no access to the referred patient's electronic medical records created by MHICU are available by the inpatient unit, the package of documents will also include:

- Current assessment by treating psychiatrist
- Patient History
- Risk Assessment
- 7 days of progress notes

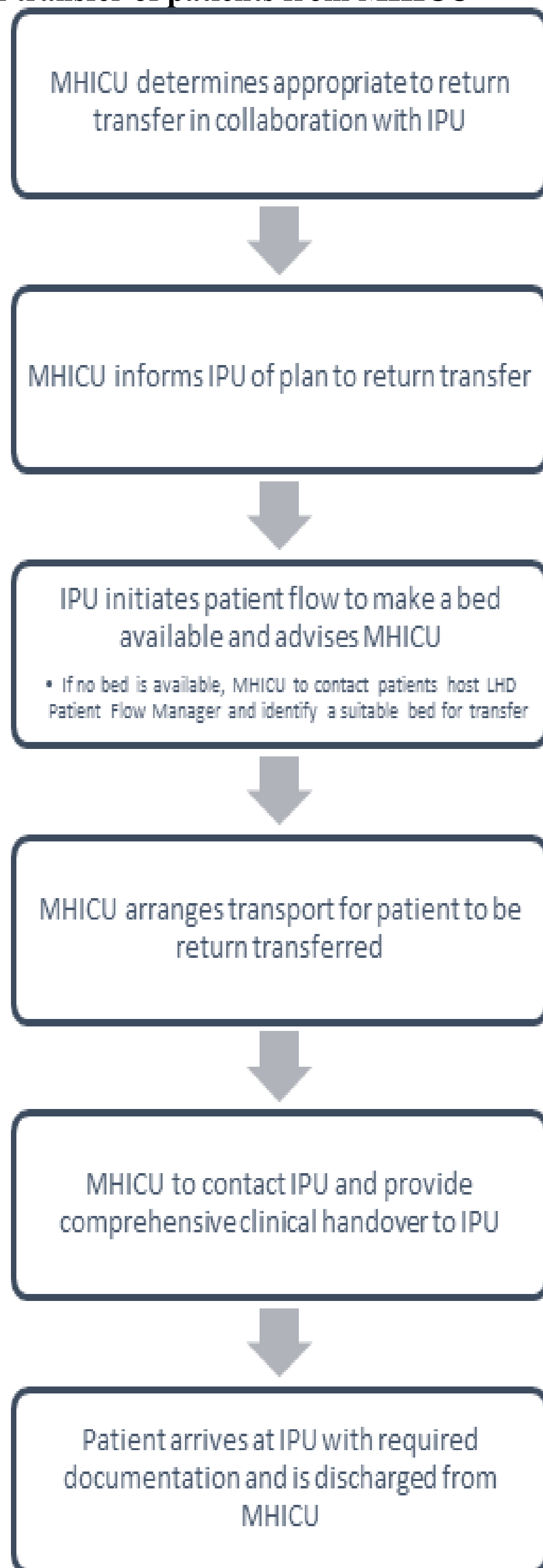
For further information regarding clinical handover, please refer to NSW Health PD2009_060: *Clinical Handover- Standard Key Principles.* \

4.4.3 Discharge from MHICU to a community setting

MHICUs do not have usually have access to the full range of service resources for each LHD/region to enact and monitor appropriate community referrals in order to facilitate an effective and sustainable discharge to the community.

It is not usually appropriate for a patient to be discharged from a MHICU to the community. However, in rare situations where patients are discharged from a MHICU to a community setting, it will be with the clear collaboration and consent of the relevant accepting community mental health team.

Figure 2: Return transfer of patients from MHICU



5 PATIENT FLOW THROUGH THE ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

5.1 Use of the Patient Flow Portal and Emergency Access View applications

Patient Flow Portal (PFP) and Electronic Patient Journey Boards (EPJB)

The PFP and EPJB are electronic patient flow tools that supports teams to manage their units demand and capacity planning by providing a highly visual tool to facilitate multidisciplinary care, standardising inter-facility transfer processes and supporting the implementation of demand escalation.

It is expected that the EPJB is used by all acute mental health inpatient services, including MHICUs.

At a minimum, each MHICU is required to update the EPJB every four hours, including the Estimated Date of Discharge (EDD) and Waiting for Waiting for What (W4W) functions. Patients identified as ready for return transfer to their referring inpatient unit will be highlighted using the Inter Ward Transfer (IWT) or Inter Hospital Transfer (IHT) functions.

The MHICU EPJB includes the “MHICU Bed Status tool”, which is used to provide detail of MHICU bed status (staffed and available beds), the on-call details of the MHICU consultant, and patient acuity to assist in the location and access of beds for patients in the greatest need of higher level care.

A daily “MHICU Bed Status” report can be automatically generated and emailed to LHD mental health executive, patient flow managers and clinical directors.

Emergency Access View

The Emergency Access View (EAV) is a real time dashboard displaying the live position against a number of patient demand and patient flow measures. The EAV includes a MHICU Dashboard, and is linked to the PFP to draw information from a single source.

The MHICU Dashboard will support MHICU demand through improved visibility of Network beds, highlighting available beds and the contact details to access these beds. The MHICU Dashboard also provides increased visibility of people in “depart ready” beds, and issues of exit block and delays in transfers.

The MHICU Dashboard will be accessible by LHD executive, Patient Flow Managers and MHICU staff to facilitate the timely access to beds.

5.2 Access to MHICU Beds

MHICUs are tertiary, specialised facilities. MHICUs should not be used to assist in the management of patient flow or clinical capacity for patients who do not meet the criteria for a MHICU admission.
The highest acuity patients in the Network will have access to a MHICU, with lower acuity patients to be transferred from MHICUs to referring inpatient units to facilitate the care of people who have greater clinical needs. To do this, inpatient units will access the MHICU Bed Status link on the EPJB, to identify the appropriate contact for referral.
Where the local MHICU is full and unable to identify a lower acuity patient to transfer from the MHICU, that MHICU will use EAV to identify an available MHICU bed outside of the local Network, and then link the referring inpatient unit with the receiving MHICU to facilitate the transfer and care of patients.

5.3 Patient Flow Process

Usual MHICU patient flow processes are outlined in Section 4: Common MHICU Processes. Consistent with the NSW Ministry of Health Demand Escalation Framework, MHICUs will have a demand escalation framework and pathways in place to manage peak variation and changes in patient flow.

As part of a demand escalation framework, MHICUs will require the following plans to be in place to support effective patient flow:

- Short Term Escalation Plan (STEP)
- Facility Demand Escalation Matrix
- Capacity Escalation Plan

These plans will need to interact with facility and LHD demand escalation plans, as well as with regular review by the Zone.

5.3.1 Estimated Date of Discharge

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from MHICU to the referring inpatient unit. It provides everyone involved with the patients care, including the patient and their family with a projected date to coordinate the patient's care needs. While for some patients the EDD may change due to clinical issues; review of best practice confirms that an accurate EDD can be set for most patients.
The use of an EDD will assist patient flow managers and referring inpatient units to plan the return transfer of patients into appropriate wards, prevent MHICU delays in returning patients to appropriate wards and reduce patients receiving care outside their home mental health service.

5.4 "Depart Ready" and "Good to Go" Identification

5.4.1 Depart Ready

Patients identified as "Depart Ready" will be patients that have been identified for return transfer, have been accepted by the appropriate inpatient unit and have patient transport booked to return the patient to the referring inpatient unit.
Exit block will occur when G2G patients have not been transferred within 24 hours of identification.

5.4.2 Good to Go

Patients identified through the EPJB as "Good to Go" (G2G) are those that have been identified as appropriate for transfer to a lower acuity inpatient unit. These patients should be identified using the G2G cell on the EPJB, and should be flagged with the referring inpatient unit to begin preparing for return transfer, this may include creating appropriate capacity.

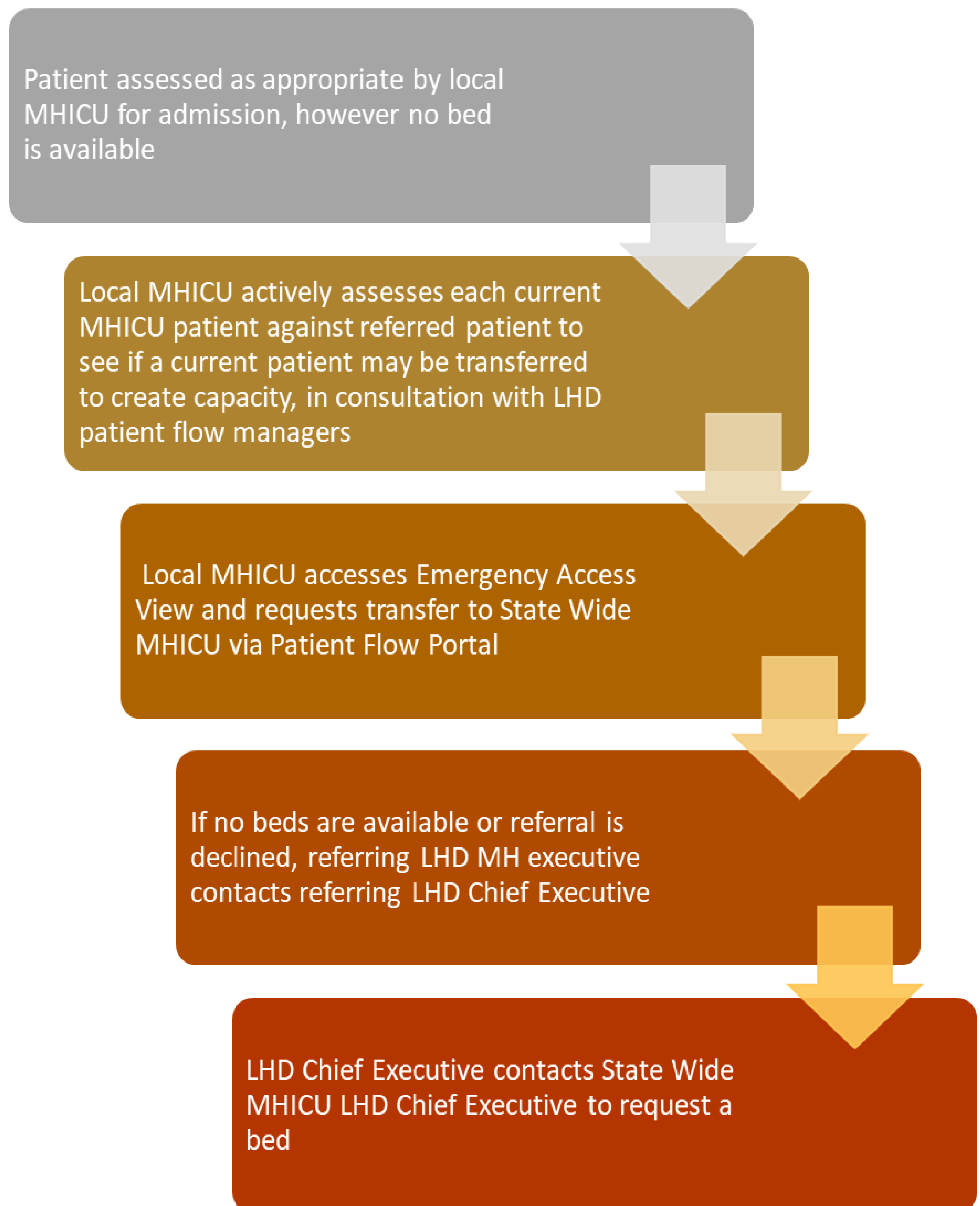
5.5 Network Coordination, Escalation and Management of Delays

LHDs and SHNs will develop formal specialist clinical referral Network procedures to guide clinicians and facilitate patient flow, ensuring appropriate, safe and timely patient referrals, return transfers and clinical consultancy to the Network. LHDs and SHNs will establish processes, led by the Clinical Director for the following purposes:

- Patient referral and priority of referrals in relation to the existing Network and MHICU patient mix
- Patient assessment by MHICU
- To support the LHD with clinical consultancy and management strategies in circumstances where there is a delay in transfer, where it is unsafe to transport the patient or when no MHICU bed is available
- To ensure the referring inpatient unit maintains active engagement in the care of the patient following referral and transfer, including clinical review and case conferences
- To arrange return transfer and support patient transfers
- For the operational review of processes to improve collaboration between services and the operation of both the local and statewide Network

Should issues arise in coordinating the care and treatment of a patient within the Network, issues should be escalated to the LHD executive and Chief Executive, following local guidelines. Resolution of issues will occur at this level.

Figure 1: Escalation Pathway



6 LIST OF ATTACHMENTS

1. Implementation Checklist
2. Adult Mental Health Intensive Care Network Flowchart

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Development and documentation of LHD clinical governance and escalation pathways and demand escalation frameworks to ensure patient flow	❑	❑	❑
	Notes:		
2. Development of pathways and communication processes between zoned LHDs and MHICUs to ensure streamlined referral and tranfer of MHICU patients	❑	❑	❑
	Notes:		
3. Development of local procedures for MHICU referral, care and transfer that are consistent with this policy directive	❑	❑	❑
	Notes:		
4. Appropriate identfiication and training of clincial and administrative staff in Patient Flow Portal and Emergency Access View applications	❑	❑	❑
	Notes:		
5. Identfication of the LHD Chief Executive as the final point of arbitration and decision making	❑	❑	❑
	Notes:		
6. Audits to review compliance with this document are conducted annually (minimum)	❑	❑	❑

Attachment 2: Adult Mental Health Intensive Care Network Flowchart

MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent's Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs

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 under16 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 [4,5] 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

[4] Geoffrey K. Isbister, Leonie A. Calvera, Colin B. Page, Barrie Stokes, Jenni L. Bryant, Michael A. Downes, (2010), Randomized Controlled Trial of Intramuscular Droperidol Versus Midazolam for Violence and Acute Behavioral Disturbance: The DORM Study, *Ann Emerg Med* 2010; 56(4): 392-401 (available)
[5] Leonie Calver, Colin B. Page, Michael A. Downes, Betty Chan, Frances Kinnear, Luke Wheatley, David Spain, Geoffrey Kennedy Isbister. The Safety and Effectiveness of Droperidol for Sedation of Acute Behavioral Disturbance in the Emergency Department. Annals of Emergency Medicine, 2015; DOI: 10.1016/j.annemergmed.2015.03.016

SUPPORTING YOUNG PEOPLE DURING TRANSITION TO ADULT MENTAL HEALTH SERVICES (GL2018_022)

PURPOSE

Continuity of care is the cornerstone of good clinical practice. Transitional care is recognised as potential risk factors for anyone receiving health care. In the case of young person with mental health issues or challenges, suboptimal transition can lead to disruption of critical developmental milestones and have adverse impacts on their health, social and educational/vocational outcomes.

This Guideline supports local health districts and specialty networks in developing local policies and protocols that support the optimal transition of young people. In particular, from community-based or inpatient specialist Child and Adolescent Mental Health Service (CAMHS) care or Youth Mental Health Service (YMHS) care to Adult Mental Health Service (AMHS) care.

This Guideline focuses on the ongoing health care needs of young people in the context of their evolving and changing developmental needs and pathways to recovery. It outlines responsibilities of NSW specialist mental health services to ensure continuity of care and safety are maintained during the period of service transition.

KEY PRINCIPLES

The following principles are adapted from NICE guidance on transition for young people1 and the NSW Agency for Clinical Innovation/Trapeze key principles2.

- Young people and their families and/or carers are listened to, are engaged in and guide the transition process.
- Service delivery, culture and practice incorporate a recovery focus with an emphasis on hope.
- Young people who are likely to require transition should be identified as early as possible in their contact with CAMHS or YMHS and preparation for transition should be included in early care planning.
- Services work closely together to recognise the developmental stage of the young person and to facilitate a transition process between the services that takes account of the pace that the young person is comfortable with and the need they have for the continued age-appropriate involvement of their family/carers.
- Transition planning and support should be developmentally appropriate and flexible, recognising that the young person’s circumstances and autonomy are continuing to evolve.
- Transition planning and support should be strengths-based, using a language of hope, empowering, engaging and enabling young people and their families and/or carers while working towards meaningful goals throughout the transition process.
- Transition planning and support should use person-centred approaches with an individualised transition plan for each young person that includes support provided by their family and/or carers, general practitioner, education and other government agencies, Primary Health Networks and other non-government organisations and services providers that are culturally relevant and safe.
- Local CAMHS/YMHS and AMHS should partner in the development and review of transition protocols, communication processes and tools and the identification of transition coordinators/facilitators.
- Young people and their families and/or carers should be involved in service design, delivery and evaluation related to transition and in planning and coproducing transition policies, supporting materials and tools.

USE OF THE GUIDELINE

This Guideline outlines the principles and actions that aim to optimise the outcomes and experiences of young people and their families and carers during periods of service transition. Services are encouraged to develop their own local policies and protocols for the period of service transition for young people.

This Guideline provides a framework and, where available, evidence based guidance to assist NSW Health mental health services to:

- support a safe and effective transition for young people (Section 2)
- manage essential components and phases of transition (Section 3)
- select from a range of evidence informed approaches and implementation resources that support transition (Section 4 and 5)

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_002

325(12/10/18)

USE OF AUDIO-VISUAL LINK FOR MENTAL HEALTH ASSESSMENTS UNDER THE MENTAL HEALTH ACT 2007 (GL2022_007)

GUIDELINE SUMMARY

This Guideline provides guidance on the use of audio-visual link to conduct mental health assessments under section 19A and section 27A of the *Mental Health Act 2007* (NSW). This Guideline provides information on clinical considerations when using audio-visual links.

KEY PRINCIPLES

The *Mental Health Act 2007* (NSW) allows for mental health assessments under section 19A and section 27A to be conducted via audio-visual link when it is not reasonably practicable for the examination to occur in-person as per the requirements under section 19 and section 27.

This Guideline provides information about factors clinicians can consider when deciding whether it is not reasonably practicable for the examination to be conducted in-person including clinician availability, the impact of a delayed assessment and risk assessment principles.

It provides information about the key principles that clinicians are to consider when conducting an assessment via audio-visual link which includes:

- The principles of care and treatment under the *Mental Health Act 2007* (NSW).
- Maintaining the dignity and privacy of the person undergoing the assessment.
- Maintaining the safety of staff and the person undergoing assessment.
- Seeking consent from persons undergoing assessment where possible.
- Carers are to be consulted where reasonably practicable.
- Mental health services are to offer and support interventions to promote and sustain a person's physical health.
- Provision of culturally appropriate and safe care to Aboriginal people.
- Audio-visual link must be carried out using secure channels approved by NSW Health.

Local Health Districts and Specialty Health Networks are responsible for ensuring staff are trained to conduct assessments via audio-visual link.

Monitoring data and information is to be recorded and stored in the person's medical record. Monitoring and data collection directives must be adhered to.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_007

342(12/07/22)

FORENSIC PATIENT ELECTRONIC MONITORING (GL2022_008)

GUIDELINE SUMMARY

This Guideline is for treating teams applying for and managing forensic patients with an order for electronic monitoring. It has been issued based on sections 85(1) and 94(4) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

KEY PRINCIPLES

Electronic monitoring is defined as the use of an electronic device to monitor or track the location of a person at any given time, including by Global Positioning System.
The purpose of electronic monitoring is to focus on improving community safety and improving outcomes for forensic patients.

The *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW) expressly allows the Mental Health Review Tribunal to order electronic monitoring as a condition of a forensic patient's leave or conditional release.

When considering making an application to the Mental Health Review Tribunal for electronic monitoring, the treating team are to adhere to the following key principles:

- Be the least restrictive practice in the patient's circumstances.
- Not become routine practice.
- Facilitate leave or release opportunities.
- Facilitate consent-based approaches by all parties.
- Be one of a suite of options available to monitor the patient.
- Have a clear planned approach and a clear purpose.
- Be determined by a risk assessment.
- Incorporate an agreed evaluation process for monitoring and reporting.

Monitoring data and information is to be recorded and stored in the patient's health record.

Use of the Guideline

This Guideline is a resource to support treating teams when considering and/or implementing electronic monitoring for forensic patients on leave or release across Local Health Districts and Specialty Health Networks.

This Guideline details each of these principles in more depth, guiding Local Health Districts and Specialty Health Networks to better align their services with the principles to deliver safe care for forensic patients and the community when undertaking electronic monitoring.

The guideline can be downloaded at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2022_008

DOMESTIC VIOLENCE ROUTINE SCREENING (PD2023_009)

POLICY STATEMENT

NSW Health is committed to early identification of domestic violence and promoting awareness of the health impacts of violence. Domestic violence routine screening is mandatory for all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health and alcohol and other drug services.

Other appropriate NSW Health services, following NSW Ministry of Health approval, can implement domestic violence routine screening with all women 16 years and over in line with this Policy Directive.

SUMMARY OF POLICY REQUIREMENTS

Domestic violence routine screening is conducted through five phases: delivering the domestic violence routine screening preamble; asking the screening questions; taking appropriate actions in response to the woman's answers; explaining and offering the domestic violence Z-card; and documenting screening and outcomes in medical records.

Health workers are to take account of clients' broader social context and be responsive to clients' needs, including by addressing additional barriers that women from priority populations may face.

All clinical staff and Aboriginal Health Workers who conduct screening must complete the four-hour mandatory face-to-face Domestic Violence Routine Screening Training. In participating health services, staff must complete the training before conducting screening.

Screening must occur with all eligible women, except in the following circumstances: others are present; the woman is not well enough to answer the screening questions; or the woman has made a recent disclosure of domestic violence.

Where domestic violence is identified prior to screening health workers are to respond in line with the requirements of this Policy and related NSW Health policies.

Domestic violence routine screening must be conducted at face-to-face appointments in a safe and private space, not via telehealth. Where privacy cannot be assured, domestic violence routine screening is not to proceed. Where health services are delivering services through a mix of face-to-face and telehealth, health services must prioritise domestic violence routine screening at face-to-face appointments.

If domestic violence routine screening cannot be conducted when initially scheduled, attempts must be made at subsequent appointments or on subsequent occasions of service until the domestic violence routine screening is completed.

Health workers must read out the preamble on the Domestic Violence Routine Screening form before asking the screening questions and then ask the screening questions, in full and as instructed, on the Domestic Violence Routine Screening form.

Responses to disclosures of domestic violence must include risk assessment and safety planning.

All women who disclose domestic violence are to be offered a referral to a counsellor, social worker, or other appropriate trained psychosocial worker within NSW Health or relevant specialist services.

Health workers must also address the safety, health, and wellbeing needs of children and young people. Workers are to respond to suspected risk of significant harm and take action that promotes the safety of both adult and child victims of domestic violence. This includes identifying responses to assist women to continue to care for their children in a safer environment where possible.

Where a woman or where children are identified as being at serious threat, workers must prioritise action to reduce the threat.

All women must be offered a Z-card, and have its contents explained, regardless of the outcome of the domestic violence routine screening.

Where a woman discloses other forms of violence and abuse, including family violence, health workers will respond in line with this Policy's procedures and other relevant NSW Health policies.

Responses to screening questions and subsequent actions must be documented in the woman's medical record, including if they do not disclose violence. This includes completing the Domestic Violence Routine Screening form. Domestic Violence Routine Screening forms must be completed in the electronic medical record where available.

Local Health Districts and Specialty Health Networks are to support health workers to deliver domestic violence routine screening by:

- Ensuring that Domestic Violence Routine Screening Training is provided to clinical staff and Aboriginal Health Workers whose role involves delivery of domestic violence routine screening.
- Identifying appropriate staff to complete the Domestic Violence Routine Screening Facilitator Training so that they can deliver the Domestic Violence Routine Screening Training within their Local Health District or Specialty Health Network.
- Ensuring workers who conduct screening and respond to disclosures have access to support. This includes promoting awareness of and access to domestic and family violence leave provisions, and other supports for workers who may themselves be experiencing domestic and family violence.
- Promoting screening practices that are accessible, safe and respectful to all women, including women from priority populations.
- Establishing and maintaining consultation and referral pathways from screening services to specialist violence, abuse and neglect practitioners and services both within and beyond NSW Health.
- Monitoring and reporting on the implementation of domestic violence routine screening and training as required.

The full Domestic Violence Routine Screening policy is available at:
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=pd2023_009