

Children and Adolescents with Mental Health Problems Requiring Inpatient Care

Summary This policy defines the key principles and provides a framework for determining the most appropriate treatment facility for those children and adolescents with mental health problems who require inpatient treatment. This includes admission into the following inpatient units: Specialist Child and Adolescent Mental Health units; Paediatric hospitals and paediatric wards in general hospitals; Adult Acute Mental Health wards; and PECCs (Psychiatric Emergency Care Centre).

Document type Policy Directive

Document number PD2011_016

Publication date 08 March 2011

Author branch Mental Health

Branch contact 9816 0383

Review date 01 December 2021

Policy manual Patient Matters

File number

Previous reference N/A

Status Review

Functional group Clinical/Patient Services - Mental Health, Baby and Child

Applies to Specialty Network Governed Statutory Health Corporations, Local Health Networks, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Public Hospitals

Distributed to Public Health System, Ministry of Health

Audience Mental Health clinical;emergency depts;paediatric depts

ACCESS FRAMEWORK FOR CHILDREN AND ADOLESCENTS WITH MENTAL HEALTH PROBLEMS REQUIRING INPATIENT CARE

PURPOSE

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

MANDATORY REQUIREMENTS

Health Service Implementation

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

Mental Health Service Evaluation

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

IMPLEMENTATION

Roles and responsibilities of the NSW Department of Health:

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

Roles and responsibilities of Chief Executives:

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

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

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

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

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

Roles and responsibilities of all clinicians:

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

REVISION HISTORY

Version	Approved by	Amendment notes
March 2011 (PD2011_016)	Director-General	Revised policy for managing placement of children and adolescents into inpatient units. Replaces GL2005_006
September 1990 (GL2005_006)	Director-General	<i>Mentally Ill Young People – Severely Disturbed – Interim Guidelines for Acute Care</i> Originally issued as Circular 90/95. Made obsolete 9/3/2010 by IB2010_017

ATTACHMENTS

1. **Access Framework for Children and Adolescents with Mental Health Problems Requiring Inpatient Care**

**Access Framework for Children and Adolescents with
Mental Health Problems Requiring Inpatient Care**



Issue date: March 2011

PD2011_016

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1 BACKGROUND

1.1 About this document

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

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

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

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

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

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

1.2 Legal and legislative framework

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

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

The *Children and Young Persons (Care and Protection) Act 1998* was amended in 2010. The Information Bulletin - *KEEP THEM SAFE - Making a Child Protection Report (IB2010_005)* must be followed.

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

1.3 Policy context

In 2009 *Caring Together: The Health Action Plan* for NSW was released in response to the recommendations made by Commissioner Garling following his inquiry into acute care services in NSW Public Hospitals. Recommendation 9b relates to the provision of hospital care for children and adolescents, recommending where possible to provide care in facilities designated and set aside for children and young people.

While there has been an expansion of specialist CAMHS beds recently, the Mental Health – Clinical Care and Prevention (MH-CCP) model predicts that NSW will require more specialist CAMHS beds than are currently available. There are currently plans for three new specialist CAMHS declared units in NSW at Orange, Shellharbour and Hornsby with an upgrade of the service at Sydney Childrens' Hospital.

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

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

2 ACCESS TO MENTAL HEALTH INPATIENT SERVICES FOR CHILDREN AND ADOLESCENTS

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

2.1 Key Principles

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

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

Inpatient services for children and adolescents, if required, should be selected based on the following overarching key principles. Inpatient care must be the:

- least restrictive alternative, and must consider their safety and that of others;
- closest available to home and usual supports wherever possible, especially for younger children and Aboriginal families;
- most developmentally and clinically appropriate care given available resources.

2.2 Spectrum of Care

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

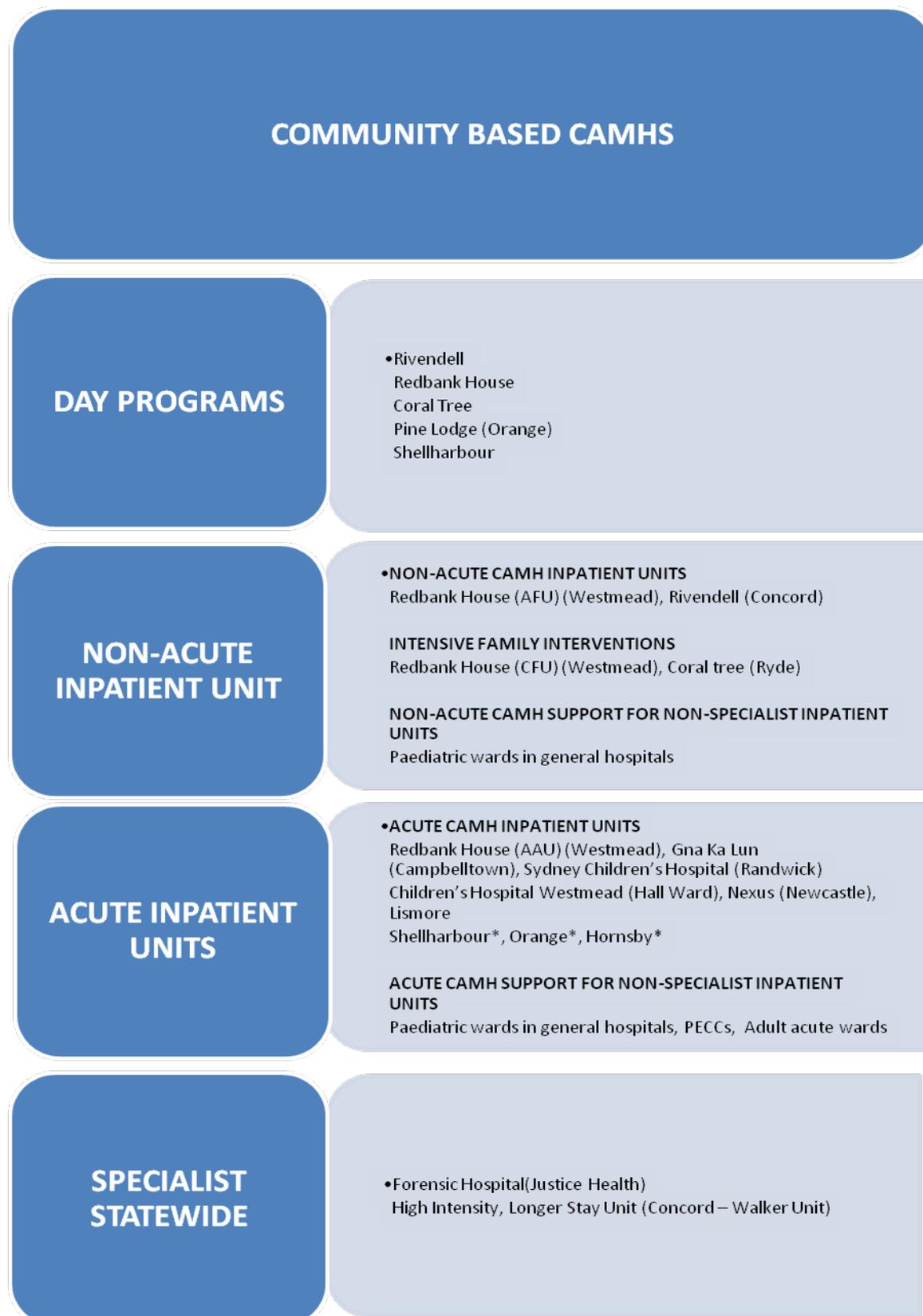
In comprehensive services, these service settings are not discrete and care transitions are characterised by continuity in care planning and delivery, which improves service delivery and risk management. CAMHS positions, such as the consultation liaison nurse

positions, bridge inpatient and community-based services and improve coordination and continuity of care.

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

- Community care teams should be engaged prior to or at the time of an acute admission
- Admissions to inpatient units should be carefully negotiated and planned with clear goals
- Community care teams should remain involved throughout the episode of inpatient care to facilitate timely discharge.

Figure 1. The spectrum of mental health care for 0-17 year olds and their families in NSW is shown in the following diagram.

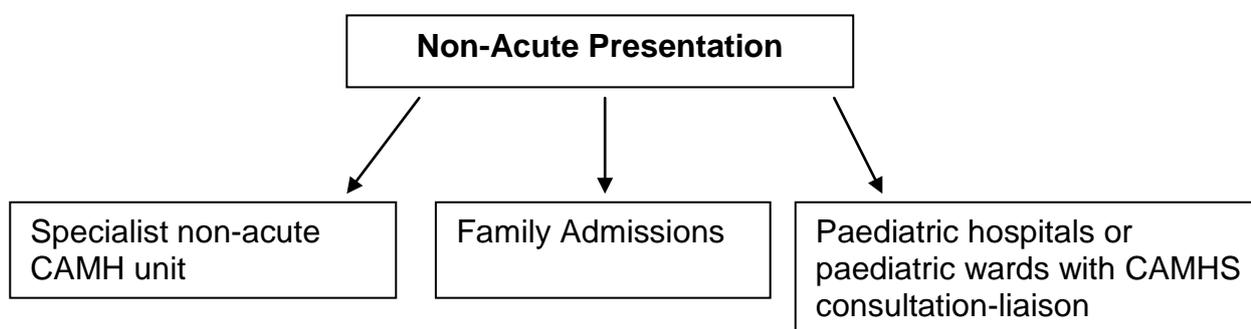


* Planned units

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

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

2.2.1 Non- Acute admissions



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

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

Family admissions (up to 12 year olds)

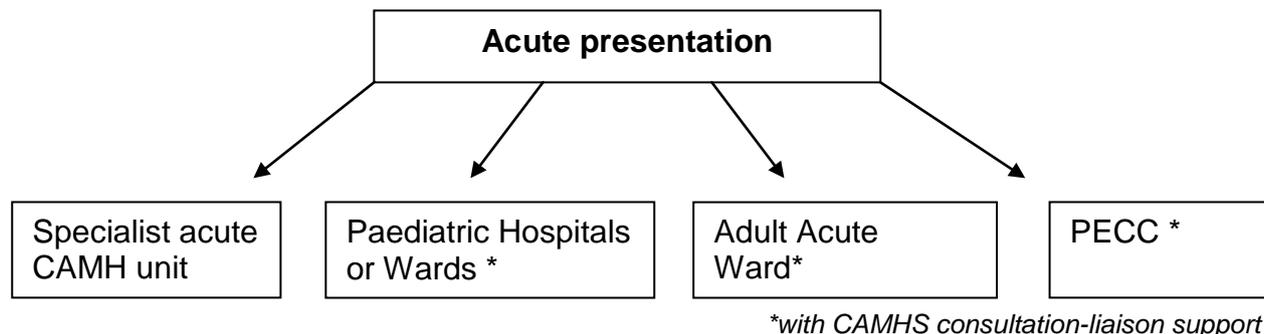
Both Redbank House and Coral Tree Family Service provide “family admissions”. This type of program provides more intensive family-oriented assessment and treatment, particularly where there are associated mental health and parenting problems.

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

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

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

2.2.2 Acute admissions



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

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

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

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

The current units are:

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

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

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

Non CAMHS acute care

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

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

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

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

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

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

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

2.2.3 Admission to the highly specialised statewide units

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

Walker Unit (12-17 year olds)

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

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

Bronte Unit (14-21 year olds)

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

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

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

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

2.3 Key decision making factors

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

Prioritisation must be made on the basis of clinical need and a commitment to a safe environment. Each patient should be individually evaluated and placed to optimise clinical outcomes. The ward milieu and patient mix is important for all inpatient units but is even more critical for children and adolescents.

The aims of hospitalisation should be clearly defined when admission is being considered. Hospital admission should not be a strategy solely for providing supervised care placements for children and adolescents. Children and adolescents in the predicaments of homelessness or breakdown in care should only be admitted if there are specialist mental health assessment requirements or therapeutic goals that are best achieved by inpatient care.

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

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

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

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

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

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

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

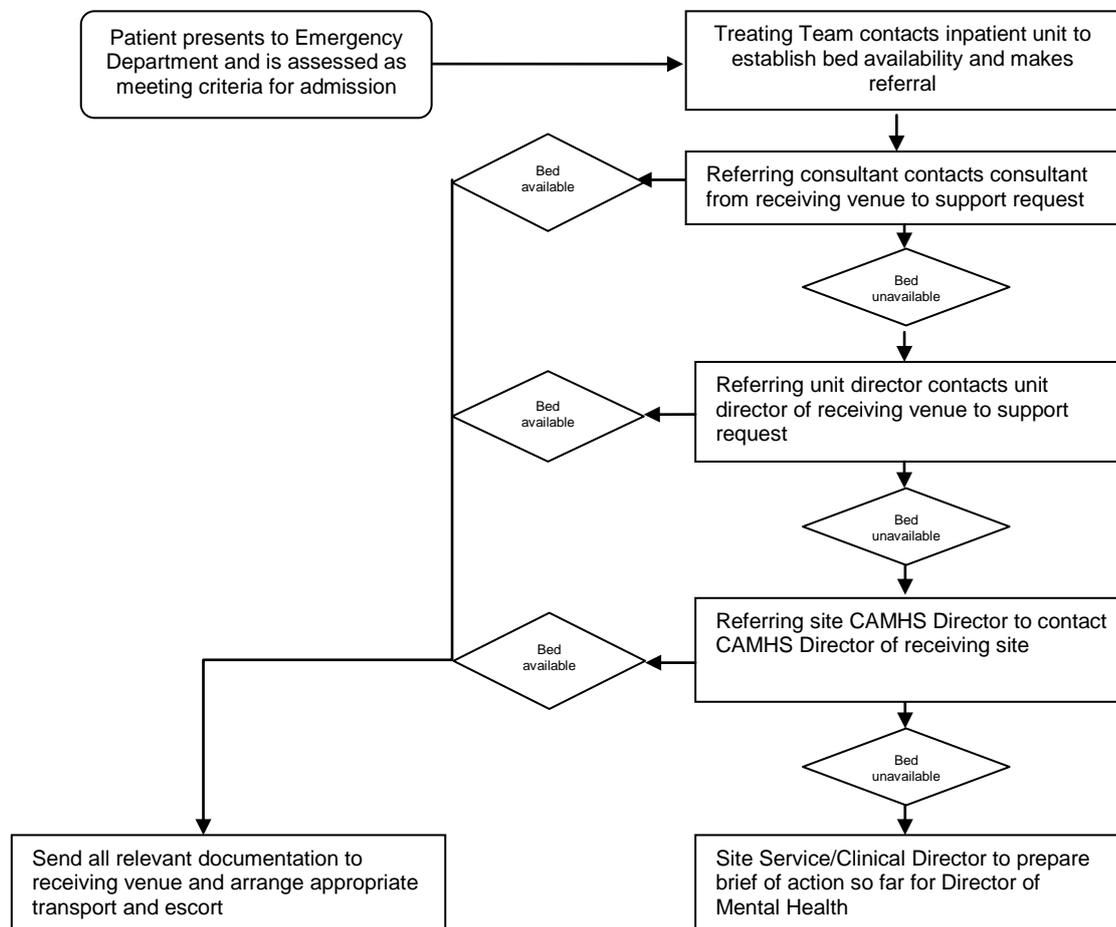
Although it rarely occurs in children, chronic suicidal and/or self-harming behaviour can become a more frequent presentation for adolescents. Specialist CAMHS assessment and involvement in treatment planning is essential. Repeated or extended inpatient admission can be counter-therapeutic for some adolescents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

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

2.4 Escalation process

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

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



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

At a state level the Operational Management Working Group of the Complex Needs Patients Subcommittee is responsible for accepting referrals from local Mental Health Programs regarding patients assessed as being at persistent high risk of harm to self or others, and where current/proposed accommodation or inpatient placement is deemed unsuitable or problematic. Referral to this committee is made by the Directors of Mental Health. See Attachment 2 for Terms of Reference.

The Operational Management Working Group of the Subcommittee will review and will provide recommendations to the Director of the Mental Health and Alcohol Office on the care and management of individual patients with complex needs referred by representatives of the mental health service responsible for the patient's current and/or ongoing care. MH-Kids is involved when children and adolescents are referred.

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

3 LIST OF ATTACHMENTS

1. SESIMHS Extraordinary Event Management and Demand Plan for Acute Inpatient Beds –2009-2010
2. Operational Management Working Group (Complex Needs Patient Subcommittee) Terms of Reference

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

Level	Threshold	Demand Indicator	Authority to Invoke Resource Mobilizing Capacity	Actions
0	Proactive Routine Practice	<p>Facility Mental Health Beds Available</p> <p>Facility Emergency Department Beds Available.</p> <p>Mental Health Inpatient Bed Access = Nil</p> <p>Predicted Discharges match predicted Emergency & Planned admissions</p>	<p>Site Senior Nursing Manager/ Operations Manager and Site Service Directors</p>	<p>Transport and Escort Duties</p> <ul style="list-style-type: none"> Resource list of medical, nursing and support staff available for <u>overtime</u> and/or <u>transport/escort</u> duties. Resource bases to include community MH, MH Consultation Liaison, Nursing Allocations Office and other SESIMHS Network Hospital's workforce. Workforce Planning with Nursing Agencies to secure sufficient numbers of agency personnel with appropriate skills sets Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport <p>Community Team Presentations</p> <ul style="list-style-type: none"> Standardise a Triage Assessment Process where all Community Referrals to the SESIMHS MHS are triaged via the CMT Leader and individually discussed with the Patient Flow Coordinator in consultation with the Duty Consultant. <p>Demand Capacity</p> <ul style="list-style-type: none"> Predictive Bed Model and capacity planning with identified inpatient discharges, planned leave and contingency leave for each day Identify OOA Clients and commence repatriation planning Identify Private patients and commence private facility negotiations Suitable ECT procedures to be mobilised to Day Only Mobilise Non Acute Referrals/LLOS Meeting and Second Opinion Processes/Assertive Care Progression Model of Care <p>Emergency Department</p> <ul style="list-style-type: none"> Key MH/ED CNC KPIs around completion of A1 with purposeful admission plan/projected LOS, bed finding negotiations Assertive planning around comprehensive ED discharge planning including standard community information packs/ AODS/Sexual Assault/support agency information/ pre packs of medications/pharmacy dispensing medications after hour's information/NGO support services Emergency Department escalation plan for managing multiple presentations, co morbid AODS/Clinical Pharmacology/ Sexual Assault cases/Non English Speaking presentations or surges in MH emergency assessments to be formalised and circulated to all operational teams

Access Framework for Children and Adolescents with Mental Health Problems Requiring Inpatient Care

1	Patients requiring Mental Health inpatient admission and no local mental health beds available	<p>No Facility Mental Health Beds Available</p> <p>< 2 Facility Emergency Department Beds Available.</p> <p>Predicted Discharges less than predicted Emergency & Planned admissions</p>	<p>Site Senior Nursing Manager/ Operations Manager and Site Service Directors in Consultation with Area Mental Health Access Team and Local Patient Flow Coordinator, Staff Specialist or Registrar</p>	<p>Transport and Escort Duties</p> <ul style="list-style-type: none"> Circulate standardised briefings to SVH Transport, SESIAHS Community Transport Drivers and NSW Ambulance to increase staff awareness/preparedness and support for increased service demands. <p>Community Team Presentations</p> <ul style="list-style-type: none"> Standardise a Triage Assessment Process where all Community Referrals to the Network MHS are triaged directly by Network/Facility CMT Leader and individually discussed with the Nursing Manager/Operations Manager <p>Demand Capacity</p> <ul style="list-style-type: none"> Brief local Private Mental Health Facility Operations Mx to increase staff awareness/preparedness and support for increased service demands. Mobilize suitable current inpatients that have private MH insurance. Identified sub acute patients suitable for transfer to adjacent network services using non police/ambulance transport Review Numbers of Leave Clients and redirect daily reviews to assertive Out Patient Review Clinics/Community Care Review patients on leave for potential to remain on extended leave <p>Emergency Department</p> <ul style="list-style-type: none"> Negotiate redeployment of additional MH assessment resources from C/L Team/Rehabilitation/Outpatients to attend ED to manage increased load of presentations requiring assessment and management.
Level	Threshold	Demand Indicator	Authority to Invoke Resource Mobilizing Capacity	Actions
2	All local Network and SESIAHS Mental Health Beds full + > 8 hrs unplaced mental health patients in a SESIAHS Emergency Department.	<p>Facility ED full and unable to off load ambulances</p> <p>> 5 MH patients waiting to be seen or waiting for MH review</p> <p>> 3 admitted MH patients awaiting transfer to MH Bed</p> <p>or Delay in</p>	<p>Site Senior Nursing Manager/ Operations Manager and Site Service Directors in Consultation with Area Mental Health Access Team and Local Patient Flow Coordinator, Staff Specialist or Registrar, Area Director Mental Health</p>	<p>Transport and Escort Duties</p> <ul style="list-style-type: none"> Contingency planning around escort resources to be negotiated with Facility Corporate Services Manager who has governance over site employed community transport service drivers. Contingency planning around access to hospital vehicles for the purpose of non acute transport. Contingency Planning with NSW Non Acute Transport Services around extended access to non acute transport services. Circulate standardised briefings to NSW Police to increase staff awareness/preparedness and support for transport and potential service limitations. <p>Community Team Presentations</p> <ul style="list-style-type: none"> Restrict CMT admissions to psychiatric emergencies only. Patients will need to meet the requirements for involuntary admission under the MHA. CMT Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director <p>Demand Capacity</p> <ul style="list-style-type: none"> ECT and/or elective outpatient appointments restricted to Psychiatric Emergencies Only Investigate clinically appropriate alternative accommodation options/Hotels for all accommodation challenged patients who are occupying an acute MH bed inappropriately Situational escalation that may include deployment of MH skilled observation staff, patient transfer, occupation of

Access Framework for Children and Adolescents with Mental Health Problems Requiring Inpatient Care

		discharges from Ward > 4 hours		<p>regional or rural beds within NSW, occupation of local MH over census beds for limited & definitive periods, resource dependant</p> <ul style="list-style-type: none"> ▪ Suspend all repatriation requests from other AHS to admit local client into an available bed within SESIMHS ▪ Admissions restricted to psychiatric emergencies in all SESIMHS services ▪ Patients will need to meet the requirements for involuntary admission under the MHA. ▪ Admissions not meeting the above criteria should be negotiated directly with the Clinical Director/Service Director ▪ Redirect or defer elective admissions, consider non acute network partner Bloomfield accommodation (i.e. Clozapine trials) ▪ Suspend tertiary referral admissions to identified tertiary referral beds including NPI beds <p>Emergency Department</p> <ul style="list-style-type: none"> • Invoke Emergency Department escalation plan for managing multiple presentations, co morbid AODS/Clinical Pharmacology/Sexual Assault cases/Non English Speaking presentations or surges in MH emergency assessments including redeployment of C/L, Rehabilitation, Community medical resources and support teams
3	Extraordinary Event As identified by the DCO and Area Director Mental Health	Extraordinary Event	DCO and Area Director Mental Health	<p>As above. Situational escalation process inclusive of Area Mental Health Service Director & Director of Clinical Operations. The repertoire of options may include specific risk mitigation strategies that may include the following actions for limited & definitive periods, resource dependant</p> <ul style="list-style-type: none"> • Suspend all non SESIMHS admissions into available beds within SESIMHS + NSW Health • Circulate standardised briefings to Other Area Health Facility to increase awareness/preparedness and support for increased service demands. • Suspend SESIMHS MHRU Program and return MHRU patients to community • Negotiate SESIMHS MHRU Program pts as Non Acute Admission with Network Partner/Bloomfield • Co manage Older Adult MH Pts on General Hospital Aged Care Units/Behaviour Disturbed Units • Co Manage Older Adult MH Pts in MAU/War Memorial Hospital/Garrawarra Hospital respite beds • Suspend all Justice Health Presentations/Schedule to SESIMHS. • NSW Health to Circulate standardised briefings to Long Bay Gaol to increase awareness/preparedness and support for transfer of pts to adjacent area

Reference: Lessons Learned from a Nightclub Fire: Institutional Disaster Preparedness. *Journal of Trauma-Injury Infection & Critical Care*. 58(3):487-491, March 2005. Mahoney, Eric J. MD; Harrington, David T. MD; Biffi, Walter L. MD; Metzger, Jane RN, DNSc; Oka, Tomomi MD; Cioffi, William G. MD

Mass Causality Management of a Large Scale Bioterrorist Event An Epidemiological Approach. *Emergency Medicine Clinics of North America* 2002 May;20(2):409-36

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

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

Terms of Reference

The Operational Management Working Group of the Subcommittee will:

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

Target Group

A sub group of the Operational Management Working Group will consider and provide advice on individual patients meeting the following criteria:

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

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

Membership

- Chair of the Complex Needs Patients Subcommittee or delegate
- Director/Clinical Director (or delegate), Mental Health, Greater Southern AHS
- Director/Clinical Director (or delegate), Mental Health, Greater Western AHS

- Director/Clinical Director (or delegate), Mental Health, Hunter New England AHS
- Director/Clinical Director (or delegate), Mental Health, Justice Health
- Director/Clinical Director (or delegate), Mental Health, North Coast AHS
- Director/Clinical Director (or delegate), Mental Health, Northern Sydney Central Coast AHS
- Director/Clinical Director (or delegate), Mental Health, South Eastern Sydney Illawarra AHS
- Director/Clinical Director (or delegate), Mental Health, Sydney West Area Health Service
- Director/Clinical Director (or delegate), Mental Health, Sydney South West AHS

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

Secretariat

Clinical Governance Team, Mental Health and Drug and Alcohol Office

Frequency of meetings

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

Quorum

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

Timeframe for Review

Reviewed annually