

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

Summary This Policy Directive establishes minimum standards to support effective and safe discharge planning and transfer of care for consumers of 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.

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Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Public Hospitals

Distributed to Ministry of Health, Public Health System

Audience Mental Health Directors and staff; Medical Officers; Mental Health Clinicians including Consultant Psychiatrists; psychiatrists; All Mental Health Staff

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

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 improve mental health outcomes:

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

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

MANDATORY REQUIREMENTS

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

- mental health staff are aware of the requirements of this Policy Directive
- mental health staff are trained and supported to implement the requirements of this Policy Directive
- local relevant policies and procedures align to the key principles and procedures in this Policy Directive

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

IMPLEMENTATION

Roles and Responsibilities

The Ministry

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

Chief Executives

Ensure that:

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

Mental Health Staff

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

REVISION HISTORY

Version	Approved by	Amendment notes
September-2019 (PD2019_045)	Deputy Secretary, Health System Strategy and Planning	Replaces the PD2016_056 to include recommendations from: <ul style="list-style-type: none"> New South Wales Auditor-General's Report (Performance Audit), Mental Health Post Discharge Care (2015); and coronial inquests and learnings from Root Cause Analysis investigations.
December 2016 PD2016_056	Deputy Secretary, Strategy and Resources	Amendments to PD2012_060 to include new requirements for the approval of inpatient leave and to update references to the Mental Health Act 2007 that has been revised since PD2012_060 was published.
November 2012 PD2012_060	DD-G System Purchasing and Performance-	Replaced PD2008_005 – Scope of policy extended to children and adolescents, and older people in inpatient mental health services.
January 2008 PD2008_005	Director-General, NSW Health	New Policy -Discharge Planning for Mental Health Inpatients

ATTACHMENT

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

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



Issue date: September-2019

PD2019_045

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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 the 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	<p>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.</p> <p>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.</p>
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 policy context

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/quality-improvement/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/carers 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 each risk identified
- contingency plans and relapse prevention strategies
- emergency telephone contacts for access/re-entry to the mental health service
- information or standard handouts about educational or community support services
- information on family and carer support services.

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 <input type="checkbox"/>				
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance	
1. Nomination of a staff member responsible for implementing the policy within the organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Access to the Policy Statement and Procedures is promoted throughout the organisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
3. Review undertaken by services regarding the changes required to service delivery and practices to meet the Policy Statement and Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
4. Local protocols developed and disseminated to support services to understand and meet the requirements of the Policy Statement and Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
5. Implementation plans, including education strategy developed by the service to support compliance with Policy Statement and Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
<p>SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO: MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)</p>				

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 NETWORK		Date	/	/
Verified by Mental Health Director	Name			
	Signature			
Second 12 month progress report <input type="checkbox"/>				
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance	
Review process has been established to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
a) Measure the percentage of discharged consumers and their family/carer who were included in the discharge planning and transfer of care process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
b) Measure the percentage of discharged consumers and their family/carer who received the relevant discharge information at discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
d) Documentation that referral / discharge information has been received by the receiving health and/support service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<u>Notes:</u>			
<p>SUBMIT COMPLETED FORM TO MENTAL HEALTH BRANCH BY EMAIL TO: MOH-MentalHealthBranch@health.nsw.gov.au (attention Clinical Services team)</p>				

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 policies, 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
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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
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19. NSW Ministry of Health. (2015). *Privacy Manual for Health Information*. Retrieved from <http://www.health.nsw.gov.au/policies/manuals/Documents/privacy-manual-for-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-ed-guide.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
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