Health
Justice Health and
Forensic Mental Health Network

PRINT WARNING
Printed copies of this document or part thereof
must not be relied on as a current reference document.
Always refer to the electronic copy for the latest version.

Custodial Mental Health Operations Manual

October 2022

TRIM Ref: DG79726/25

Version History

Version	Date	Reason
1.0	23 March 2018	Final version for publication.
1.1	26 October 2018	1. Objectives of mental health services. 2. Additions to obtaining patient history. 3. Managing patients with co-morbid conditions added. 4. Role of the Aboriginal Mental Health Clinician added. 5. National Disability Insurance Scheme 6. Minor edits.
2.0	1 July 2020	1. Updates needed to specify service delivery as per recommendation from the Cluster of Homicides Review 2019 2. Inclusion of addendum documents to outline sub-specialty areas of service delivery by Custodial Mental Health 3. Inclusion of new/updated procedures relating to the care of patients at risk to self and others.
2.1	28 May 2021	1. Inclusion of discharge criteria 2. Inclusion of outlining when to use the Mental Health Assessment and Triage forms
2.2	August 2021	1. Updates required relation to Transfer of Patients under RIT management plan between the Mental Health Screening Unit (MHSU) PODs 19/20/21 and Darcy POD/O Block 2. Update guidance relating to the new Mental Health and Cognitive Impairment Forensic Provisions Act 2020
2.3	March 2022	1. Updates related to of the MRRC Outreach Team – inclusive of Darcy POD staff. 2. Inclusion of the use of the MRRC Outreach Patient Tracker 3. Removal of Risk Intervention Team responsibilities – the management of RIT at Darcy and Silverwater Women's Correctional Centre transferred from CMH to Operations and Nursing. 4. Updates to sample daily duties for Hamden and Outreach team nurse. 5. Update of Bed Demand Meeting information – now referred to Patient Flow Committee 6. Removal of overview of Aboriginal Mental Health Clinician role. This position is currently not funded.

2.4	October 2022	1. Update related to defining language to be used on the HPNF when a patient is required to remain at MRRC on a medical hold. 2. Changes to types of patients to be assessed by CMH 3. Removal of Key Personnel section – can become outdated quickly, this information can be found on the CMH intranet page.

Contents

Introduction **7**
Related Policies and Procedures 7
Services Provided by Custodial Mental Health 8
Target Population 9
Objectives of Mental Health Services 9
Service Areas **12**
Silverwater Correctional Complex 12
Ambulatory Mental Health Sites 13
Partner Services **14**
Long Bay Hospital 14
The Forensic Hospital 14
State-wide Community and Court Liaison Service 14
Community Forensic Mental Health Service 15
Mental Health Review Tribunal 15
CMH Access and Service Areas **16**
Mental Health Helpline 16
On-call Services: ROAMS 16
Outreach MRRC 17
Mental Health Screening Unit – MRRC 26
High Support Accommodation Areas – Hamden 40
Outpatient Psychiatry and Nurse Practitioner Clinics 47
Procedure for Booking Telehealth Clinics 47
Custodial Mental Health Outreach Telehealth Service 51
Primary Care Consultation-Liaison Psychiatry 52
Perinatal Infant Mental Health Services 52
Specialist Mental Health Services for Older People 55
Women's Mental Health Services 57
Care of Forensic Patients in the Custodial Setting 61
Ambulatory Mental Health Nurse 62
Correctional Patients: process for Involuntary Treatment 63
Custodial Diversion Program 64
Section 35 Procedures **65**
Section 58 Procedures **66**
Forensic Community Treatment Orders **68**

National Disability Insurance Scheme 69

Appendix 1 71

Medical Officers Clinic Session Guidelines 71

Appendix 2 73

Sample Daily Duties 73

Abbreviations

AMHW	Aboriginal Mental Health Worker
AMHN	Ambulatory Mental Health Nurse
AO	Administration Officer
CDCMH	Clinical Director Custodial Mental Health
CFMHS	Community Forensic Mental Health Service
CH	Custodial Health
CHIME	Community Health Information Management Enterprise (Electronic Health Record)
CMH	Custodial Mental Health
CMHT	Community Mental Health Team (Local Health District)
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
CNE	Clinical Nurse Educator
CSNSW	Corrective Services NSW
CSO	Clinical Support Officer
CTO	Community Treatment Order
D&A	Drug and Alcohol
DCDCMH	Deputy Clinical Director Custodial Mental Health
EDRMS	Electronic Document and Records Management System, CSNSW
FCTO	Forensic Community Treatment Order
FH	Forensic Hospital
FMHLO	Forensic Mental Health Liaison Officer
FP	Forensic Patient
GP	General Practitioner
HPNF	Health Problem Notification Form
HRIS	Health Records and Information Service
JHeHS	Justice Health electronic Health Record System
LBH	Long Bay Hospital
LHD	Local Health District
MCMH	Manager Crisis, Mental Health, CSNSW
MDT	Multidisciplinary Team
MHA	Mental Health Act 2007
MHCC	Mental Health Clinical Coordinator
MHFPA	Mental Health (Forensic Provisions) Act 1990
MHCIFPA	Mental Health and Cognitive Impairment Forensic Provisions Act 2020
MHN	Mental Health Nurse
MHRT	Mental Health Review Tribunal

MHSU	Mental Health Screening Unit
MHU	Mental Health Unit, Long Bay Hospital
Ministry	NSW Ministry of Health
MRRC	Metropolitan Remand and Reception
Centre NDIS	National Disability Insurance Scheme
NM	Nurse Manager
NP	Nurse Practitioner
NUM	Nursing Unit Manager
OIMS	Offender Integrated Management System, CSNSW
OS&P	Offender Services and Programs CSNSW
O&N	Operations and Nursing
PAS	Network Patient Administration System
PBDS	Personality and Behavioural Disorders Services, CSNSW
PC	Primary Care
PCN	Network Primary Care Nurse, Operations and Nursing,
PIMHS	Perinatal and Infant Mental Health Service
POD	Place of Detention – also known as a wing
PopH	Population Health
RIT	Risk Intervention Team
SAPO	Services and Programs Officer, CSNSW
SCCLS	State-wide Community and Court Liaison Service
SMHSOP	Network Specialist Mental Health Services for Older People, CMH,
SNSDS	Specific Needs and State-wide Disability Services, CSNSW
Corrective Services NSW	
S&P	Network Services and Programs stream
SWCC	Silverwater Women's Correctional Centre

Introduction

1. Scope

This manual sets out the operational framework and procedures for Custodial Mental Health (CMH). CMH is a specialist mental health service within Justice Health and Forensic Mental Health Network (the Network) that provides a range of mental health services to adults in NSW correctional centres.

The manual is a resource for Network staff working within correctional centres and must be read in conjunction with relevant policies that are set out below. The manual contains procedural flowcharts and references to relevant policies of the Network and Corrective Services NSW (CSNSW). The need for a manual has been identified to clarify procedures for those working within CMH and our partner services with the aim of improving patient outcomes.

2. Related Policies and Procedures

Policies

This Custodial Mental Health Operational Procedure Manual is the companion manual to the following Network policies:

- 1.443 *Custodial Mental Health – Referral and Case Management Policy*
- 1.192 *Primary Agency for Forensic Patients in Custody (Adults)*
- 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells*
- 1.231 *Health Problem Notification Form (Adults)*
- 1.300 *Remote Off-site and After Hours Clinical Services Policy*
- 1.340 *Accommodation – Clinical Recommendations (Adults)*
- 1.360 *Segregated Custody and Mandated Protection*
- *1.380 Implementation Guide: Clinical Care of People who may be Suicidal*
- 1.442 *Mental Health Helpline*.

Procedures

There are also a number of procedures that relate to sub-speciality areas of CMH. These include:

- FCTO Procedure Guidelines
- PIMH Service Procedure Manual
- Procedure Manual Case Management of Forensic Patients in Correctional Centres
- SMHSOP Procedure Manual and Model of Care
- Telehealth Procedure Manual
- Custodial Diversion Program Procedure Manual
- 1800 Mental Health Helpline Procedure Manual

Procedures are available at Network Intranet>Policies and Procedures>Procedures and Manuals>*Mental Health Procedures*). This *CMH Operational Procedure Manual* replaces the previous Version 1 of the document and the *MHSU Operational Manual*, which hasbeen incorporated into this manual.

3. Services Provided by Custodial Mental Health

CMH is a specialist mental health team, which has mental health nurses (MHNs), nurse practitioners (NPs), an Aboriginal Mental Health Clinician, psychiatrists, career medical officers (CMOs), and psychiatry registrars who are supported by administrative and managerial staff. CMH clinicians work alongside staff from other Network clinical streams and CSNSW staff, including Psychology, Offender Services and Programs, and Custodial Operations staff in the provision of mental health services. Mental health services begin at the point of reception and continue through to release from custody or transfer to another correctional centre.

At July 2020, there were 39 correctional centres – including three privately operated centres - in New South Wales, with close to 13,000 inmates. Prior to the COVID-19 pandemic, the prison inmate population was at approximately 14,000.

For an up to date list of correctional centres in NSW see the NSW Department of Justice website:

http://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/table-of-correctional-centres/correctional-centres.aspx

The Network provides clinical services to inmates in all correctional centres, but the level of service provision varies from centre to centre depending on various factors including, the level of clinical need, security classification, whether the centre houses remand or sentenced inmates, size of the centre and location.

The mental health services provided by CMH generally conform to a hub and spoke model, with the mental health hubs located in the metropolitan areas.

At present, the CMH services include:

- the Mental Health Screening Unit (MHSU) for males in the Metropolitan Remand and Reception Centre (MRRC) which contains approximately 43 beds
- the MHSU for females in Silverwater Women's Correctional Centre (SWCC), containing approximately 10 beds
- Hamden Places of Detention (POD)15 in the MRRC, housing approximately 64 inmates each
- intake and assessment in the MRRC
- outreach mental health services to other areas of the MRRC and SWCC
- the Custodial Mental Health Telehealth Service, which services all correctional centres that do not have onsite mental health clinicians
- The Network 1800 Mental Health Helpline, which is a service access line for individuals who come into contact with the NSW criminal justice system. It can be accessed free of charge on 1800 222 472 by staff, external providers and all persons in adult or juvenile custody, as well as by their relatives, carers and friends. The Helpline is a 7 day a week, 24 hour service. (Refer to Network policy 1.442 *Mental Health Helpline* for more details)
- Psychiatry and nurse practitioner out-patient clinics both in person and by telehealth in selected correctional centres in NSW. (The list of current locations of CMH out-patient clinics is in the CMH Psychiatry Roster which is published on the Network intranet at: Rosters)
- Targeted case management of patients with severe and enduring mental illness and other complex mental health needs

- case management of forensic patients with mental illness
- case management of patients on Forensic Community Treatment Orders
- Perinatal and Infant Mental Health Service, and
- Specialist Mental Health Services for Older People.
- Custodial Diversion Services

4. Target Population

The target population for CMH is inmates entering NSW correctional centres with severe and enduring mental illness who require intervention from specialist mental health services.

The inmate population within the NSW correctional system is characterised by adults aged over 18 years of age who present with a high prevalence of physical and psychological morbidity. The 2003 survey *Mental Illness Among New South Wales Prisoners* (Allnutt and Butler, 2003) identified that the custodial population had substantially greater levels of acuity and morbidity than the greater community (12 month prevalence of any psychiatric disorder in the NSW inmate population is substantially higher than in the general community, 74 per cent vs. 22 per cent). Mental health morbidity is higher within the remand population with almost half of the receptions (46 per cent) and over one third of the sentenced population having suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.

It is well recognised that remand populations have increased acuity and psychiatric morbidity and therefore require increased mental health supports (Frotter et al., 2002; Nicholls et al., 2004; Ogloff, 2002; Olley et al., 2009). Similarly, there is also a greater risk of suicide among remand populations; although there may also be elevated risks among inmates with lengthy sentences.

5. Objectives of Network Mental Health Services

The general objectives of Network mental health services are to:

- Promote mental health and wellbeing and, where possible, prevent the progression of mental illness and risk to self and others; and
- When mental health problems and illness do arise, reduce the impact of mental illness, promote recovery and physical health, and encourage meaningful participation in society, by providing services that:
  - are safe and responsive to consumer and carer goals,
  - facilitate the early detection of mental illness and appropriate intervention,
  - coordinated and provide continuity of care,
  - are timely, and readily available to those who need them, and
  - are efficient and sustainable.[1]

[1] Adapted from Australian Government Productivity Commission (2018), *Report on Government Services 2018* Part E, Chapter 13 accessed 12 July 2018 at <https://www.pc.gov.au/research/ongoi ng/report-on-government-services/2018/health/mental -health-management>

Service Areas

Silverwater Correctional Complex

Specialist mental health services provided by CMH are located around the state but they are concentrated at the Silverwater Correctional Complex, where MRRC and SWCC are co-located.

Metropolitan Remand and Reception Centre

MRRC is a maximum security correctional facility for male offenders with approximately 1100 beds as at July 2020. The MRRC is one of three correctional facilities within the Silverwater Correctional Complex located 21km west of Sydney's central business district.

Patients who arrive at the MRRC:

- come directly from court or Police cells on remand, or are transferred from other correctional facilities throughout NSW to stay at the MRRC while they attend court in the Sydney metropolitan area, or
- are housed as sentenced patients at the MRRC following completion of their court matters while they wait for a vacant bed at their correctional centre of classification, or
- May be transferred from other correctional facilities due to requiring intensive mental health care at the MHSU.

Most patients at the MRRC leave the centre within the first few months of their arrival. They may be granted bail, be released or classified and transferred to their centre of classification. The MRRC accommodates remanded and sentenced patients. It is a centre of high patient turnover with a throughput of approximately 2000 patients a month.

MRRC is divided into different areas known as wings or, more commonly, PODs (Places of Detention).

Hamden POD 15 is an accommodation area for persons with severe and enduring mental illness and vulnerable patients. Forensic patients, those being people who are subject to a special verdict of act proven but not criminally responsible (APNCR) or unfit to be tried, may be held in Hamden pending transfer to the Forensic Hospital or other placements as recommended by the MHRT.

Protection patients, those being patients at risk of violence from others, because of the nature of their crime or other reasons, are housed in Hamden PODs 15/16.

There is also an outpatient type health centre operated by Operations and Nursing (O&N) at MRRC known as J Block with satellite health centres operating from the Goldsmith and Hamden PODs.

The MHSU in MRRC is a 43 bed unit which houses patients from correctional centres around the state who require further screening, assessment, and management of major mental illness whilst in custody. In many ways the MHSU functions as a high dependency psychiatric unit, although patients cannot be involuntarily treated here.

Silverwater Women's Correctional Centre (SWCC)

SWCC is a maximum security facility for women and the major reception centre for women in NSW. It is also located within the Silverwater Correctional Complex along with MRRC.

SWCC houses remanded and sentenced women from all over NSW. It contains the MHSU for women, a mental health step down unit, an Intensive Management and Programs Unit (IMPU) and an accommodation area (Mum Shirl Unit) for highly vulnerable women.

Ambulatory Mental Health Sites

Custodial Mental Health Services also provide onsite mental health care at spoke sites across the state, including at other metropolitan and regional correctional centres.

Onsite mental health care is provided at the following custodial settings:

- Bathurst Correctional Centre
- Cessnock Correctional Complex (Cessnock Main, Shortland ¾)
- Dawn De Loas Correctional Centre, which is collated on the Silverwater Complex site
- Dillwynia Correctional Centre Areas 1 and 2
- Goulburn Correctional Complex including High Risk Management Unit
- John Moroney Correctional Centre
- Lithgow Correctional Centre
- Long Bay Correctional Complex, including the Metropolitan Special Programs Centre
- Mid North Coast Correctional Complex
- Outer Metropolitan Multi-Purpose Correctional Centre (OMMPC)
- South Coast Correctional Complex
- Wellington Correctional Centre

The role of clinicians at the Ambulatory sites are details at page 58.

Where onsite mental health services are not available, the CMH telehealth team provide mental health support via centre based clinics.

While onsite mental health services are necessary, particularly at busy reception centres, the level of resources available at these spoke sites are not equivalent to that offered at the Silverwater Complex. As such, patients' placements and transfers need to be considered by CMH to ensure that the services accessible to patients are commensurate to their clinical presentation, needs and level of risk.

Further detail regarding outpatient clinics are provided at page 42.

Partner Services

Cooperative interagency working between the Network, CSNSW, and LHD community mental health services is essential to achieve continuity of care and the best possible outcomes for patients.

CMH has strong links with various other services and agencies, including:

- other mental health services in the Network, for example, Long Bay Hospital (LBH) Mental Health Unit (MHU), State-wide Community and Court Liaison Service (SCCLS), Community Forensic Mental Health Service (CFMHS), and the Forensic Hospital (FH),
- other Network clinical streams such as O&N, Primary Care (PC), Population Health (PopH), and Drug and Alcohol (D&A), and
- Specific Needs and State-wide Disability Services (SNSDS), CSNSW. Some of these agencies and services are described below.

Long BayHospital

LBH is an 85 bed facility located on the Long Bay Correctional Complex that provides medical and mental health care to inmates of the NSW correctional system. It is a both a health facility and a correctional centre managed under the *Crimes (Administration of Sentences) Act 1999*.

The MHU within LBH consists of three wards; E, F, and G, with a total of 40 beds. The MHU provides treatment to patients who require involuntary treatment under the Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (MHCIFPA).

While the MHU comprises only 40 of the beds in the facility, the whole of LBH is a declared mental health facility under section 109 of the *Mental Health Act 2007* (MHA).

For more information, see Policy 1.030 *Referrals for Admission – LBH Mental Health Unit (Adults).*

The Forensic Hospital

The FH is a high secure declared mental health facility providing inpatient treatment and rehabilitation to forensic patients, correctional patients and a limited number of high risk civil patients from LHD mental health facilities who cannot be safely treated in lower security settings. The FH works in close collaboration with the LHD medium secure units within the Network to provide a range of care options for forensic and correctional patients. While the FH is a high secure facility, it is not a correctional centre.

For more information, see Policies 1.325 *Referral, Admission and Transfer of Care (Adults) FH* and 1.327 for adolescents.

State-wide Community and Court Liaison Service

SCCLS assists the Local Courts with the diversion of people with mental illness so that they can remain out of custody by linking them to appropriate mental health services in the community. It aims to ensure that consumers with a mental illness who are appearing in the Local Court have access to appropriate mental health treatment.

An important interface between CMH and SCCLS is the Custodial Diversion Program, which targets individuals in MRRC and SWCC at the Silverwater Correctional Complex who are appearing in court via audio-visual link (AVL). The Custodial Diversion Clinical Nurse Consultant (CNC) works closely with the clinicians in CMH to provide integrated care for people with mental disorders in custody.

Community Forensic Mental Health Service

CFMHS is a consultation-liaison forensic psychiatry service that provides specialist forensic assessments and advice to LHD clinicians on the treatment and management of forensic and high-risk civil patients in the community. The target population includes, forensic patients with mental illness who are conditionally released or pending conditional release to the community, and mentally ill civil patients who are at high risk of serious offending and who are either in the community or returning to the community from secure settings including custody.

CFMHS provides expert advice to staff in the custodial setting on risk management processes or on particularly violent or challenging patients. The CFMHS can offer support to patients who are assessed as high-risk upon their release to the community and are referred to a community mental health service.

The CFMHS may also offer in-reach support and brief community reintegration support to patients exiting custody once a LHD community mental health service has been identified.

CFMHS is also a training resource and an important link to community partnerships where forensic and high-risk civil patients are concerned.

For more information see Network Policy 1.439 *Community Forensic Mental Health Services Remit of Services*.

Mental Health Review Tribunal

The NSW Mental Health Review Tribunal (MHRT) is a specialist quasi-judicial body constituted under the MHA. It has a wide range of powers to conduct mental health inquiries, make and review orders, and hear some appeals about the treatment and care of people with a mental illness.

The MHRT has a president, several deputy presidents, a registrar and approximately one hundred part time members.

For forensic matters, a MHRT panel consists of three members: a lawyer who chairs the hearing, a psychiatrist, and another suitably qualified member. The MHRT reviews the cases of all forensic and correctional patients:

- who are subject to a special verdict of act proven but not criminally responsible;
- who have been found unfit to be tried; or
- who have been or are waiting for longer than 14 days to be transferred from prison to a mental health facility because of a mental illness.

The MHRT also reviews and makes orders in relation to patients who have been made subject to forensic community treatment orders (FCTOs).

The role of the MHRT is to ensure that the patients' rights are respected and that they receive treatment in keeping with best practice, in the least restrictive environment. The MHRT has powers regarding making orders for detention, transfer, or conditional or unconditional release under the MHCIFPA. The MHRT decisions can involve the consideration of complex issues and can impact directly on people's lives, health and liberty. In making its decisions, the MHRT seeks to balance several sets of often competing rights - the individual's right to liberty and safety and freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to remain safe and protected. Given the importance of these decisions, it is essential that the MHRT receives the very best evidence available when hearing applications and making its decisions.

CMH Access and Specialist Service Areas

Mental Health Helpline

The Network Mental Health Helpline (hereafter, the Helpline) is a free service access line operated by CMH, which provides advice to patients in correctional centres, their relatives and carers, as well as staff of Network, CSNSW, and LHDs. The Helpline is also a point of referral to services.

Network staff and staff from other LHDs can call the Helpline for advice and referral of patients, including administrative advice about the mechanisms for referral, assessment, and admission to the MHSUs.

- During office hours, the Helpline is staffed by mental health clinicians, generally MHNs, from CMH.
- From 1530 to 1900 weekdays and 0700 and 1900 hours on weekends and public holidays, the telephone is transferred to an on-call senior clinician from CHM.
- From 1900 overnight to 0700 hours the next day, the telephone is transferred to the Afterhours Nurse Manager (AHNM) based in the Forensic Hospital.

For more detailed information and procedures refer to: Policy 1.442 *Mental Health Helpline*.

On-call Services: ROAMS

There is a 24 hour on-call mental health service available for Network clinical staff in the custodial setting provided by the Network psychiatry registrars, with the support of a 24 hour on-call Network consultant psychiatrist.

The on-call psychiatry service can be contacted outside normal working hours and in urgent situations where there is no immediate possibility of face-to-face review and where the patient's usual treating psychiatrist or psychiatry registrar is not available on the telephone.

The on-call psychiatry registrar is based afterhours in the Forensic Hospital. The contact details for the on-call psychiatry registrar are:

[redacted]

Refer to Policy 1.300 *Remote Off-site and After Hours Clinical Services Policy* for more details.

A roster of ROAMS psychiatry registrars and consultants is maintained 24 hours a day for patient care matters related to psychiatric problems for adults. The roster is posted in advance on the Network Intranet at *Rosters*.

The ROAMS Psychiatry Registrar can provide:

- clinical advice
- telephone orders for psychotropic medications, where indicated and in accord with the Mental Health Model of Care.

Administrative advice about the mechanisms for referral, assessment and admission to the MHSUs is best sought from the Mental Health Helpline.

CMH provides an on-call Consultant Psychiatrist to support the on-call Psychiatry Registrars.

The on-call registrars should consult the *Forensic Psychiatry Registrars Supplement* of the *Justice Health and Forensic Mental Health Network Orientation Handbook* for detailed information regarding procedures and clinical guidelines for the on-call service.

Outreach MRRC

Patients received into a NSW correctional centre are assessed by Primary Care Nurses (PCNs) from O&N at the point of entry. The assessment includes the use of a screening tool, the *Reception Screening Assessment* (RSA), to assist in identifying people with a health problem, including mental illness that requires ongoing assessment and management.

For more information refer to Policy 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells.*

Referral to Custodial Mental Health

Where a patient is identified as experiencing a mental illness and meets the criteria for referral to CMH, a PCN should refer the person to CMH.

The criteria for referral to CMH are set out in Policy 1.443 *Custodial Mental Health Referral and Case Management Policy* at section 3.1.1:

CMH should assess patients presenting with severe and enduring mental disorders with a high degree of clinical complexity, which could include:

- patients with functional psychoses
- patients with severe affective disorders
- forensic patients
- patients who required the services of an LHD mental health service
- patients subject to a community treatment order or FCTO
- patients facing terrorism charges
- patients with severe personality disorder presenting an increased risk to self-and/or others.

Referrals to CMH from Network staff must be made using the waitlist function in the *Patient Administration System* (PAS).

All patients referred to CMH will generally be assessed by a MHN in the first instance or, where indicated, a psychiatry registrar, psychiatrist, or NP.

Network medical practitioners can obtain consultation and advice regarding the management and referral of patients with mental disorders from the CMH on-call consultant psychiatrist service during business hours, if required. The roster of on-call CMH consultants is provided by email to the Clinical Directors Primary Care and Drug and Alcohol.

Prioritisation of Patients with Suspected Mental Disorders

During an episode of care of a patient, priorities can change rapidly and clinical staff need to be able to constantly re-assess situations and respond appropriately. Guidelines help with the allocation of triage categories and assist in the interpretation of the definitions of each category.

As there is increased risk of negative patient outcomes for those patients with high acuity who are not seen in a timely manner, one of the ways to establish priority is to ask what will be the consequence if a particular course of action is not taken immediately, in the next hour, within the shift, or in the next week.

Patients can experience deterioration in their mental state in all healthcare settings. An acute deterioration in a person's mental state is an adverse outcome and can be associated with an acute exacerbation of illness,

increased risk of harm to self and/or others, risk of harm from others, and the use of restrictive practices. Responding to deterioration in a person's mental state requires the completion of a comprehensive assessment of possible triggers and employing strategies to mitigate the risk of further deterioration, in a manner that is person-centred, culturally appropriate and recovery-oriented.

Patients should be triaged according to their clinical presentation and an appropriate triage category allocated. Subsequently, a wait list entry in PAS is created. PAS is an integrated system for managing patient care. For all triage categories, the person making the wait list entry must record a clear, concise, descriptive statement of the clinical problem of the patient that provides a summary of the clinical assessment and entry as recorded in JHeHS

PAS Mental Health Triage Categories

Clinical judgement is always required. Nevertheless, the following are examples of health related conditions that should be treated immediately or where the patient should be transferred to a hospital:

- possible delirium
- acutely mentally unwell and due for release, requiring assessment to consider the need for transfer to a civil mental health facility on an involuntary basis (under a Schedule of the MHA) and release plan
- patients expressing suicidal ideation and intent, actively suicidal
- patients being treated with clozapine during the first 18 weeks (pathology/observations), or
- acute behavioural disturbance suggestive of underlying mental illness.

Note that CMH uses CHIME as the primary interface with the patient administration system. CHIME does not have the functionality for 'walk-in appointments.' Accordingly, the following arrangements apply in CMH for dealing with patients who need to be seen immediately.

Clinicians in CMH must enter the patient's name on a wait list for a MH clinic and then immediately book an appointment from that wait list. This will activate the patient's appointment in CHIME and, subsequently, staff can arrive and depart the appointment in CHIME.

The PAS Mental Health Triage Categories are set out in the PAS Waiting List Priority Level Protocol and are:

1. **Urgent**: to be seen within one (1) to three (3) days. Examples of clinical presentation/problems include:
    a. patients displaying acute behavioural disturbance suggestive of underlying, untreated or undiagnosed mental illness
    b. patients currently under treatment of specialist mental health services who present with symptoms suggestive of deteriorating mental health - for examples acute or active symptoms of psychosis
    c. patient who have entered custody on clozapine, but not yet recommenced medication
2. **Semi Urgent**: to be seen within three (3) to 14 days. Examples of clinical presentation/problem include:
    a. patients new to custody requiring medication should have an interim phone order for one week while awaiting a more comprehensive assessment
    b. patients who are on the wait list for MHSU and Hamden or Step down units
    c. Patients who are on a FTCO who are non-adherent with their medication, are in breach of their order or due for release
    d. patients who are non-compliant with medication
    e. patients who require a mandatory review within seven (7) days of discharge from a mental health

inpatient unit. The review date must be entered into PAS.

f. patients on clozapine treatment for less than 18 weeks for ongoing care and management in accord with the clozapine guidelines.

3. **Non Urgent**: to be seen within 14 to 90 days. Examples of clinical presentation/problem include:

   a. those being treated under the MHCIFPA , including forensic patients, , or subject to a FCTO as a component of case management.
   b. patients on clozapine treatment for more than 18 weeks for ongoing care and management in accord with the clozapine guidelines.
   c. patients who present with or report new symptoms that are suggestive of an emerging mental health problem that requires further investigation, but who is not yet presenting with acute symptoms.

4. **Routine**: to be seen within a 12 month period. Examples of clinical presentation/problem include:

   a. patients with severe and enduring mental illness who have been responsive to treatment and are stable on their current treatment regime. The recommended review date must be stipulated in the notes and PAS.

5. **Follow up**:
   a. Patients who have been treated by specialist mental health services and require follow up. The review date and reason for clinical review must be stipulated in the PAS comment section and e-progress notes in JHeHS.

Obtaining Corroborative History

Where a patient is referred to CMH, the MHN should make all reasonable efforts to obtain any available corroborative history about the patient, including:

- SCCLS mental health reports
- Network psychiatric court reports
- CFMHS reports
- discharge summaries from inpatient admissions or community mental health services, and
- reports/ summaries from community service providers, such as general practitioners.

Network psychiatric court reports and SCCLS mental health reports are stored in the Clinical Correspondence section in JHeHS.

If in doubt, CMH staff can check whether a SCCLS report exists by telephoning the SCCLS Administration Officer (AO) on [redacted]

Where a report by the CFMHS exists, a hardcopy of the report is always placed in the patient's health record. Soft copies are stored in HPRM and in JHeHS in Clinical correspondence.

CMH staff can check whether a CFMHS report exists by telephoning the CFMHS AO on [redacted] who can check their database and provide a soft copy, if required. The CMH AOs can also contact CFMHS if required.

Obtaining Information from Community Health Service Providers

Health Information and Records Service (HIRS), have procedures for obtaining the health records of patients from community health services for example, GPs, CMHT, at the time of patients' reception into custody.

Patients are asked to sign a *Release of Information* (ROI) form on reception, which is then sent by fax or

email to HIRS. HIRS has a system for tracking these requests and alerting clinicians when the information has been returned. Further, it may be necessary to complete a ROI during the initial or subsequent assessment by CMH and this is processed by way of established HIRS processes.

It is the responsibility of CMH MHNs to review the received information from community providers for patients of CMH and act on that information, as appropriate, when it is returned.

The information received via a ROI request must be considered as one part of a complete patient assessment or review. Such information on its own may not be sufficient or definitive for establishing a patient's history. Patient assessment, history, and information gathering are essential to inform clinical decision making.

Assessment Process and Referral

MH clinicians should assess patients referred to them in accord with the clinical standards applicable to their discipline, that is, medical, nursing, or allied health.

The MHN will determine whether a Mental Health Assessment or Triage form is required to be completed for each patient referred to CMH. A Mental Health Assessment must be comprehensively completed for each referred patient who present with the following severe and enduring mental disorders/conditions and with a high degree of clinical complexity:

- patients with functional psychoses
- patients with severe affective disorders
- forensic patients
- patients who required the services of an LHD mental health service
- patients subject to a community treatment order or FCTO
- patients facing terrorism charges
- patients with severe personality disorder presenting an increased risk to self-and/or others.

A Mental Health Triage form must be completed for patients who have been referred but do not meet the criteria above, once completed it must be uploaded to JHeHS. For patient's requiring follow up MHN review or referral to the psychiatrist/NP, the MHN must complete the appropriate waitlist in PAS.

There are a number of transfer of care pathways or discharge criteria that must be considered by CMH clinicians when discharging a patient from CMH treatment and management. These are:

Mental Health Consultation-Liaison Nurse (MHCLN)/General Practitioner (GP)

A CMH clinician may refer and transfer care for a patient who are presenting with non-complex mental health concerns to the GP once they have completed an assessment of the patients treatment and management needs. This type of patient is known as a 'Level A' patient as per Policy 1.443 *Custodial Mental Health Referral and Case Management* and. The definition of a 'Level A' patient is: A patient with stable or non-acute deterioration in their mental health status requiring either:

- continuation of their current psychotropic medications, or
- possible adjustment or initiation of non-complex psychotropic medications.

A referral to the GP can be made via the relevant PAS Waitlist. The patient must have a documented mental health triage or assessment in the patient's JHeHS.

Corrective Services NSW Psychology/Services and Programs Officers/Chaplaincy Services

A CMH clinician may refer and transfer care for a patient who are presenting non-complex mental health concerns to

the Psychology/Services and Programs Officers/Chaplaincy Services. This could include, counselling, referral to a specialist program, management strategies for situational risk factors, bereavement etc

A referral to the local CSNSW services can be done via direct email or by using the *Referral Between CSNSW and Justice Health* Form (JUS210.005).

Discharge

A CMH clinician may discharge a patient from the treatment and management of CMH post assessment where:

- There is no evidence of a mental illness, determined by both the clinical assessment and available collateral information;
- The patient is not prescribed medication for a mental illness/disorder;
- The patient has been assessed as stable, with no imminent risks, and has been referred to primary care and/or CSNSW services (as above).
- Care of the patent is assumed by the Primary care mental health Consultation and Liaison Nurses and GP

The reason for discharging a patient from the treatment and management of CMH must be clearly documented in JHeHS. All patients discharged from the care of CMH must have the occasion of service closed in CHIME.

Cell PlacementRecommendations

Network Policy 1.340 *Accommodation – Clinical Recommendations (Adults)* contains policy and guidance on the making of recommendations to CSNSW on the cell placement of patients for health reasons.

In summary, the policy requires Network staff to make clinically based recommendations for patient accommodation to CSNSW where the health needs of patients require special consideration. Any such recommendations must be based on a thorough assessment of the patient's physical and mental health needs and the risk of harm to self or others. It is ultimately the responsibility of CSNSW staff to consider the clinical recommendations regarding cell placement made by Network staff and make a determination on this and the security and safety requirements of the inmate in accord with section 232 of the *Crimes (Administration of Sentences) Act 1999*.

Clinicians must take into consideration any issue that is directly related to a patient's physical health, mental health or substance use history, which may have an impact on the type of cell placement that would be suitable for them. Clinical staff making a recommendation must provide CSNSW with a clear and concise description of the reasons for the special cell placement recommendation so that CSNSW can monitor the individual patient's welfare.

Network staff must not recommend that a patient is housed naked.

Staff must not recommend a cell placement for punitive reasons or to obtain a urine sample for CSNSW drug screening.

Network staff must use the Health Problem Notification Form (HPNF) to inform CSNSW staff of cell placement recommendations. Refer to Network policy 1.231 *Health Problem Notification Form (Adults)*.

Placement Options

Cell placement options include:

- Normal Cell Placement
- Ground Floor Placement (bottom bunk)
- Shared or Group Cell Placement
- One-out Cell Placement

- Assessment cell/camera cell
- medical observation cell
- Detoxification Placement, and
- Placement as recommended by the Risk Intervention Team (RIT)

For detailed guidance on cell placements, see Network policy 1.340 *Accommodation – Clinical Recommendations (Adults)*.

Health Problem Notification Form (HPNF)

The HPNF is used to communicate Network advice and recommendations regarding a patient's clinical status to CSNSW. Health staff have a duty of care to advise custodial staff of actual or potential health problems. The use of HPNFs is mandated by Network Policy 1.231 *Health Problem Notification Form (Adult)*, which provides guidelines on the appropriate use of a HPNF to improve communication between CSNSW and the Network regarding the safe care, clinical needs, and risks of patients.

The information in a HPNF may concern placement or possible signs of conditions and illness – for example, substance use withdrawal or depression.

The HPNF is completed in PAS and printed in triplicate. The documents are signed by the health care professional and the receiving CSNSW officer. One copy is always placed in the patient's medical record. CSNSW places one copy in the patient's case management file and one in the accommodation unit where the patient is housed.

Formal advice must occur at reception and whenever a patient's clinical situation changes. Relevant symptoms or signs should be written in lay language. To ensure that CSNSW has the most current information, it is essential that a new form is completed each time there is a change in clinical presentation and/or care needs. If there is no change in clinical needs when a patient is reviewed, it is not necessary to complete a new HPNF.

For longer-term patients, the minimum requirement is completion of a new HPNF annually. The HPNF can be used to advise CSNSW of the need to transfer to another facility for medical reasons.

When a patient located at the MRRC/ SWCC and is referred to either the MHSU or Hamden Accommodation Area/ MSU or MPU and is waiting for placement, a Network Medical Hold is completed. This ensures that the patient is not moved from the MRRC/SWCC centre while awaiting a bed, a medical hold must also be completed for patients are housed at non MRRC/ SWCC locations and have been referred to specialist mental health beds to ensure the patient remains at the location providing mental health services until transfer can be facilitated. The clinician applying for medical hold must update PAS non-clinical-movement alert to reflect that medical hold is active. See Network Policy 1.263 *Medical Holds*.

Where a medical hold is required for a patient to remain at MRRC due to mental health reasons, this must be clearly documented on the HPNF by stating 'Seen by mental health – medical hold required'. Where a patient has been assessment and does not require to remain at MRRC to receive mental health care the HPNF must state 'Seen by mental health - no medical hold required'.

MRRC Outreach Team Handover and Psychiatrist Daily Clinic Tracker Sheet

The MRRC outreach Team is staffed seven days a week 07.00-15.30hrs by nursing staff. Additionally, a psychiatrist works four days a week. The focus of care is on triage, assessment, initiation of appropriate treatment, referral, and short term management of patients housed within the MRRC.

The Nursing Unit Manager (NUM) Outreach Team is responsible Monday to Friday and nurse-in-charge (NiC) Saturday and Sunday for triaging the PAS Referral Waiting list. This includes prioritising the patients on the waitlist for the MHN, psychiatrist or nurse practitioner (NP). The prioritisation of

patients should be based on clinical urgency and acuity, and also take into consideration which patients have waited the longest.

At the beginning of the shift, the Outreach Team handover occurs at 07.30hrs with the NUM1/NiC and CMH nursing and medical staff present. The Outreach Team's NUM /NiC must facilitate a discussion in relation to patients of concern and patients for assessment/triage. A list of patients needing to be seen by the MHN is emailed by the Outreach team's NUM /NiC the day prior to the staff rostered to this shift. Patients of concern identified out of hours will be added to the list on the morning of the clinic. The psychiatrist are emailed a list of patients to be seen at the commencement of the psychiatry clinic by the NUM Outreach Team. The NUM1 liaises and assists the Psychiatrists with any requirements throughout the clinic.

On completion of a patient review, the Psychiatrist must complete the Daily Clinic Tracker Sheet. The Daily Clinic Tracker Sheet outlines the follow up requirements (if any), follow up timeframes, cell placements, handover notes and comments required for PAS. It also requires the psychiatrist to highlight requirements where the patient is to be referred to a CMH Hub area, is cleared to return to the main prison population or requires specialist placement.

At the end of the shift an Outreach Team handover occurs at 15.00hrs – this involves both MHN's and psychiatrists. This is an opportunity to handover patients of concern, highlight and allocate any tasks for follow up and discuss any operational or clinical issues.

At the end of the clinic, the psychiatrist must email the Daily Clinic Tracker Sheet to the Outreach Team nursing members ([redacted]), Primary Health NUM, CMH Administration Team and the Outreach Team NUM1. The Outreach Team NUM 1 will coordinate any tasks requiring follow up and the CMH Admin team will enter all relevant appointment information to PAS and save the document to Content Manager.

Release to a civil mental health facility under the Mental Health Act (MHA)

Where a patient who is mentally ill is to be released from a correctional centre and the patient's condition is such that he or she will need inpatient mental health treatment, a medical practitioner or an accredited person can write a certificate, known as a Schedule 1 (Sch 1), under the MHA, which authorises the transfer of patient to a declared mental health facility on an involuntary basis.

Generally, CMH staff will organise the Sch 1 prior to 15:30 hours (after which mental health coverage at MRRC is reduced). However, if the court result comes in after 15:30 hours, then the MHN must handover to Cumberland bed manager via number below and provide the requested documentation, this must then be handed over to the MHSU nurse after hours nurse or the PH afterhours NUM.

The handover document (copies of the medication chart, recent progress notes, A1 assessment, psychiatric reports and the original Sch 1, is organised by the NUM1 Hamden/Outreach during the day and is given to the ambulance transferring the patient.

The telephone numbers in the following procedures are specific to the transfer of a patient to Cumberland Hospital, but the general principles apply to any transfer under a Sch 1:

1. Contact Ambulance/transport services on 131 233 and inform them that the patient is being transferred to Cumberland Hospital under a Sch 1.
2. Contact Auburn Police on 9646 8699 and inform them that the patient is being transferred to Cumberland Hospital under a Sch 1 and NSW Ambulance have already been contacted. They may ask for a copy of the Sch 1 paperwork and this can be found at the front of the health record and can be faxed to them on 9646 8622.
3. Contact Cumberland Bed Demand Manager on [redacted] to advise that the patient is

being transferred to Cumberland under a Sch 1.

4. When the ambulance arrives, give them the handover document prepared by the MHN. This document consists of copies of the medication chart, recent progress notes, A1 assessment, psychiatric reports, and the original Sch 1 order.
5. Document in the health record that the patient has been transferred.

Mental Health Screening Unit – MRRC

Introduction

The MHSU at the MRRC is a purpose built 43-bed unit for the assessment and treatment of people with mental health problems in custody. It is comprised of a 13 bed High Dependency Unit and two 15 bed Sub-acute Units. The MHSU operates with a multidisciplinary model of care to ensure the comprehensive assessment, treatment and transfer of patients with mental health problems. A focus of the MHSU is to achieve better outcomes through the joint management patients with mental health problems within the correctional system through effective assessment and appropriate referral.

The development of the MHSU was a collaborative project between CSNSW and the Network. The MHSU was developed to enhance the delivery of mental health services across the state to incarcerated people and forms part of a suite of services provided by CMH at the Silverwater and Long Bay Correctional Complex which include:

- Mental Health Intake and Triage
- Hamden Block Mental Health Step Down POD 15
- MSPC2, 3 Wing Mental Health Step Down area
- LBH2, 13 Wing Mental Health Step Down area
- Outreach Mental Health Nursing Services to all other areas of MRRC.

The MHSU is a quasi-inpatient unit where people are assessed, individualised case plans are devised and treatment is commenced. Referral pathways are identified and facilitated according to the individual needs of the patient.

The MHSU assists the criminal justice system and other community services by providing relevant information to facilitate diversion from custody. It is paramount for strong links to be maintained between CSNSW, the Network, LHD community mental health services and Community Offender Services to promote the best outcomes for patients.

Aims of the MHSU

The aims of the MHSU are to:

- facilitate the timely and comprehensive assessment and treatment of people in custody who have or are suspected of having a mental illness,
- promote collaboration with the other Network specialist mental health services and CSNSW to deliver optimal care and treatment,
- divert mentally ill people away from the correctional system to appropriate mental health services in the community,
- promote improved and appropriate linkages with community mental health teams, hospitals and CSNSW programs to ensure transfer care following discharge from the unit.

- adopt a multidisciplinary approach to assessment and management of people with mental health problems in custody, and
- provide a safe, secure, and therapeutic environment for mentally ill people for the purpose of assessment and treatment by the multidisciplinary team.

Unit Description

The MHSU has 43 beds divided into three distinct Places of Detention (PODs). POD 21, the High Dependency unit, consists of 13 beds including 1 disability cell and 5 assessment cells. PODs 19 and 20 are the Sub- acute units and consist of 15 beds each.

High Dependency Unit (POD21)

This unit is for patients who are acutely mentally unwell and require a significantly increased level of care, in a low stimulation environment. It has a shared activity room, one common yard, and one smaller exercise area to provide flexibility as required dependent on patients' level of risk. The unit has five assessment cells, which are under constant camera observation. There is one disability cell. The unit also provides adaptable accommodation options, with access to three single cells that can be converted to share accommodation.

Staffing levels include an increased ratio of custodial staff per patient, Services and Programs staff (SAPO), parole officers and CMH staff. Services unique to this unit are the *Risk Intervention Team* (RIT) and the formulation of specific management plans by the multidisciplinary team (MDT) to review patients at high risk of harm to self/others and from others.

Sub-acute Units (PODs 19 and 20)

These units are for people who are mentally unwell and require an increased level of care. Each POD accommodates 15 people with a shared group activity room and a common courtyard. PODs 19 and 20 have flexible accommodation options with the use of single cells that can be converted into shared accommodation. Staffing levels include an increased ratio of custodial staff per individual, SAPO, parole officers and of CMH staff.

Unit Management Principles

The MHSU is jointly managed by the Nursing Unit Manager 1 (NUM1) and the Nursing Unit Manager 3 (NUM3) CMH, CSNSW Manager of Crisis Mental Health, CSNSW SAPO, and the Functional Manager (FM) CSNSW. Communication and consultation between CSNSW, the Network, and all relevant stakeholders is an expectation of all staff working within the MHSU.

Legislative Framework

The MHSU is managed under the provisions of the *Crimes (Administration of Sentences) Act 1999* and the *Crimes (Administration of Sentences) Regulations 2014*.

The MHSU is not a declared mental health facility but it may accommodate patients who have been scheduled under the MHCIFPA while awaiting transfer to a declared mental health facility, such as the MHU at LBH.

Safe practice and environment

The MHSU is integrated with the existing MRRC security infrastructure. The requirements of security do not vary from those of the current systems that are already in place at the MRRC.

Information Management

The MHSU has the required information technology systems and infrastructure appropriate to the systems currently operating at MRRC.

Video conferencing (tele-psychiatry) equipment is provided at MRRC. This is used within the MHSU for clinical consultations and efficient communication with internal and external agencies.

Admission criteria and referral procedures

The target population for the MHSU is patients:

- requiring a period of assessment for diagnostic clarification,
- requiring assessment and commencement of treatment for major mental illness, or
- patients with acute mental illness and waiting for a bed in a declared mental health facility.

Patients with acute mental illness are eligible for placement irrespective of protection status and/or level of risk to self or others.

Patients with behavioural issues, not due to mental illness or substance withdrawal disorders, are not suitable for admission to the MHSU.

Emergency access for admission or transfer outside the MHSU core business hours of 0700 to 1530, Monday to Friday can be arranged through consultation between the MHSU Nurse in Charge (NIC) and CSNSW Assistant Superintendent.

Referrals for the purpose of standard comprehensive medico-legal reports to the courts are not accepted into the unit. Such reports are coordinated through the Court Report Coordination Unit.

Referral to MHSU

Patients may be referred to the MHSU by Network clinicians using the pathways outlined in this manual. Consideration will be given to urgent referrals in consultation with the management team of MHSU.

Patients requiring admission to the MHSU should be assessed by a MHN and/or psychiatrist/ NPMH if available.

In emergency situations where onsite mental health staff are not available, local centres may liaise with the CMH Outreach telehealth service to determine if there is capacity for the patient to be assessed. When CMH Outreach telehealth are unable to assess the patient in a timely manner, the local centre should make arrangements for the patient to be transferred to a location with onsite mental health services for further assessment and advice.

Where necessary, a RN or CSNSW psychologist may refer to the MHSU in consultation with the local NUM).

A completed Network Custodial Mental Health Referral form (JUS200.072), along with a completed *A1 – Assessment of Current Presentation* form, should be sent to the MHSU by email at: [redacted] or facsimile on: [redacted]

All movements into, out of, and within the MHSU must be accompanied by a current HPNF.

MHSU Wait List

On receipt of the referral form and the A1 – Assessment of Current Presentation form, the NUM 1 and/or NUM3 will place the individual on the PAS waiting list for admission to the MHSU.

The decision to admit and discharge patients from the unit is a decision made by the multidisciplinary team (MDT) based on clinical priority.

When a bed is available in the MHSU and has been approved by the MDT, an acceptance form will be forwarded to the referring centre, CSNSW Inmate Transfers and the MRRC movement coordinator. The referring centre must ensure an appropriate HPNF is completed including reference to acceptance at the MHSU and any specific accommodation requirements.

The NUM 1 MHSU or NUM3 CMH must liaise with the MRRC movement coordinator and enter an OIMS placement alert.

Custodial Mental Health Patient Flow

Effective and efficient patient flow and demand processes contributes to ensuring the delivery of high quality, safe and timely care to patients. Patient flow processes aim to ensure the right patient is receiving care in the right type of bed placement at the right time. These processes involve both Network and Corrective Service NSW (CSNSW) staff working collaboratively to ensure better patient management and thus improving patient flow.

A weekly Patient Flow Committee meeting is held order to assess clinical priority and suitability of all referrals. Acceptance is based on a number of factors including the patient's current clinical presentation and management issues. Patient flow processes are outlined in the Custodial Mental Health Patient Flow Procedure

Admission Procedure

When the patient is admitted into the MHSU, routine admission and continuing care procedures must be completed. Each discipline has set responsibilities to undertake for all people within the MHSU. A joint risk assessment is conducted by the team on patients considered to be at risk to self, to others, or from others.

On admission, Network staff provide the following:

- comprehensive mental health nursing assessment including a Mental State Examination
- risk assessment, including risk to others
- physical health assessment
- medication reconciliation
- identification of and subsequent contact with carers/family, if possible
- relevant admission documentation including admission checklist and action referrals where required
- assessment of special needs including cultural and spiritual needs
- completion of a HPNF that reflects risk assessment findings and recommendations for accommodation and interaction with others
- allocation of a treating psychiatrist and a comprehensive psychiatric review including implementation of a treatment plan
- liaison with SAPO, CSNSW and external community providers to obtain relevant corroborative information,

The CSNSW psychologist provides the following:

- comprehensive psychological assessment of all patients in the MHSU
- treatment to address individual psychological needs on a priority referral system
- a psychological history of the patient to assist the through care process

- contribution to the care and treatment of patients by providing expert psychological advice to the multidisciplinary team
- consultation with the treating psychiatrist where diagnostic clarification is required
- P1 psychology referrals where indicated, and
- liaison with Network, CSNSW and external community providers to obtain relevant corroborative information.

Involuntary Treatment

The MHSU is not a declared mental health facility. Patients may only be treated involuntarily within a declared mental health facility under the MHA. Long Bay Hospital and the Forensic Hospital are declared mental health facilities.

Multidisciplinary Team Approach and Case Management

The multidisciplinary team consists of Network nursing staff, Psychiatrist, OS&P staff, Custodial, and Probation and Parole staff. The team adopts a collaborative approach to the assessment and care of people including discharge planning.

Multidisciplinary Case Conferences

Multidisciplinary case conferences are held from time to time on complex or challenging cases and all relevant staff are expected to attend.

Transfer of Care Procedures

A comprehensive discharge plan is formulated by the treating team for each individual once the decision for the individual to be discharged is made by the treating psychiatrist. The decision to discharge an individual is discussed with the team where the final decision is the responsibility of the treating psychiatrist.

The discharge plan provides information regarding the initial reason for admission, assessment findings, diagnostic clarification and ongoing care and treatment. Management strategies to address challenging behaviours are also included where indicated. Consumer participation is included in the formulation of this plan and is recorded by signature prior to discharge from the MHSU.

An individual discharge plan must include the following:

- Summary of the episode of illness, interventions and continuing care and treatment plan
- Management strategies for challenging behaviours where indicated
- Individual early warning signs indicating potential for relapse and strategies to address same
- Recommendation for placement
- Referral pathways as identified
- The discharge plan must be stored in the patient's e-health, and
- A wait list entry placed in PAS high-lighting the need for clinical review within 7 days of discharge from the unit.

Transfer of care to the Forensic Hospital

Patients can only be transferred to the Forensic Hospital when an order is made by the MHRT or on an order under section 86 of the MHCIFPA

Transfer of care to Long Bay Hospital

LBH is a declared mental health facility under the MHA and provides services for patients who require involuntary treatment. Referrals for admission to LBH the MHU must be made in accordance with Network Policy 1.030 *Referrals for Admission Long Bay Hospital Mental Health Unit (Adults)*.

Before a patient can be considered for admission to E, F or G Wards at LBH, the patient must have been assessed as being a mentally ill person under the MHCIFPA with two Schedule 1 certificates completed by a psychiatrist and a medical practitioner and a section 86 order obtained. Once a section 86 order has been made, the patient is placed on the LBH wait list on PAS and discussed at the weekly LBH Bed Demand meeting.

Acceptance of patients is generally based on clinical need and bed availability.

When a patient is accepted to LBH, the acceptance form is faxed to the NUM which, together with an Unplanned Transfer form is then given to the Deposition Clerk MRRC. The transfer is facilitated by CSNSW. The MHN in the MHSU also raises a new HPNF to guide CSNSW to facilitate the accepted placement.

Transfer of care to Hamden Mental Health Area

A patient may be transferred from the MHSU to Hamden Mental Health POD as a step-down from intensive mental health care. This placement must be documented in the MHSU discharge plan and be accompanied by a current HPNF.

The MCMH will liaise with the movement coordinator to facilitate the transfer.

Consideration should be given to seeking a FCTO for those patients who require ongoing treatment and who have a history of readmission to hospital due to non-compliance with treatment in the community. For more information see the *Forensic Community Treatment Orders Procedures*.

Transfer of care to normal discipline within CSNSW

Patients discharged from the MHSU, without requiring step-down placement in Hamden, still require appropriate care planning. This involves a joint management plan from the treating team which outlines the recommended placement and required referrals. Where mental health follow-up is required, the care plan must reflect placement with access to appropriate mental health services.

Transfer of Patients under RIT management plan between the Mental Health Screening Unit (MHSU) PODs 19/20/21 and Darcy POD/O Block

Patients housed in MHSU PODs 19, 20 and 21 who deteriorate and present at an increased risk of suicide or self-harm may be placed on a 'Mandatory Notification' in accord with CSNSW Policy 3.7 *Management of Inmates at Risk of Self-Harm or Suicide* and Network Policy 1.380 *Clinical Care of People who may be Suicidal.*

There are five Assessment Cells in the MHSU POD 21. If a patient in MHSU PODs 19, 20, 21 is placed on a 'Mandatory Notification' (referred herein as "RIT"), the patient must be transferred to one of these Assessment Cells if available. Where an Assessment Cell in the MHSU POD 21 is not available, the patient must be transferred to an Assessment Cell in Darcy POD or O Block. Any patient that is transferred to Darcy POD/O Block on a RIT will be managed by the Darcy/O Block RIT, CMH will provide handover and mental health consultation whilst the patient remains on RIT.

Procedure

1. Where Network or CSNSW staff consider that a patient in MHSU PODs 19/20/21 to be at an increased

risk of suicide or self-harm, the guidance set out in Policy 1.380 *Clinical Care of People who may be Suicidal* and Policy 3.7 *Management of Inmates at Risk of Self-Harm or Suicide* should be followed.

2. Where a CMH or Primary Health clinician decides to place a patient on a RIT, they must manage the patient, in conjunction with CSNSW, which is inclusive of developing an Immediate Support Plan.

3. Where a CMH or Primary Health clinician decides that the patient requires placement in an Assessment Cell, the patient must be transferred to an available Assessment Cell in the relevant RIT area outlined above.

4. As soon as practicable, the CMH or Primary Health clinician must provide a clinical handover to the relevant RIT team outlining the patients diagnosis, mental health history, current and historical risks and any known protective factors. This can be via email, telephone or face to face. This handover must be documented in the patients' health record.

5. The CMH or Primary Health clinician must complete a clinical handover to their local Primary Health and CMH team. This information must be included in all verbal and written clinical handover processes. They must also must notify the Primary Health NUM, CMH NUM1, CMH NUM3 and Manager Crisis Mental Health of the commencement of RIT.

6. Where a patient has been placed on a RIT by CSNSW the NUM 1 (or delegate) must review the CSNSW Bed State Book daily to identify any patients that may have been transferred temporarily to an Assessment Cell after hours.

7. The CSNSW Manager Crisis Mental Health (or delegate) will place a hold on the patient's mental health bed whilst the patient is transferred to an Assessment Cell.

8. While the patient is housed in a RIT area, Primary Health are responsible for coordinating the patient's care. The relevant CMH NUM1 will liaise with the local RIT team daily to receive a handover and provide mental health consultation as required.

9. A Psychiatry review should be completed for patients transferred from a mental health area and placed on RIT within 72 hours.

10. On cessation of a RIT (or an Assessment Cell becomes available at the MHSU) the RIT Primary Health Nurse must provide the local CMH team with a clinical handover, outlining the discharge plan. This handover can be via email, telephone or face to face. This handover must be documented in the patients' health record.

11. Once discharged from RIT management, the RIT Team conducting the RIT will arrange transfer of the patient to their bed held in the local mental health area. The patient's Health Problem Notification Form (HPNF) must also be updated and provided to CSNSW.

12. In the event of a prolonged delay in transfer of the patient from an Assessment Cell, a case conference should be conducted. This case conference should involve members of the CMH team, RIT Team and CSNSW Functional Manager to confirm the patient's ongoing management plan and placement.

Release to the community

The MHA may be used to facilitate the discharge of a patient who requires continued involuntary inpatient care after their release from custody. The medical officer/psychiatrist /accredited person should complete a MHA Schedule 1, if required, and the MHN must notify the receiving hospital and forward all of the relevant paperwork. Transport of the patient to hospital is the responsibility of NSW Ambulance Services and is coordinated by the MHSU nursing staff.

Prior to the release of a patient from the MHSU to the community, appropriate referrals must be made to relevant services, which may include a LHD community mental health service, GP and/or Community Corrections.

Consideration should be given to seeking a Community Treatment Order, or a variation of an existing

FCTO, for those patients who require ongoing treatment in the community and who have a history of readmission to hospital due to non-compliance with treatment in the community.

Network Staff Roles

Network staff are responsible for the clinical assessment, ongoing care and treatment of all patients within the MHSU. CMH clinicians are responsible for:

- participation in case management reviews
- liaison with internal and external health providers
- disclosure of relevant clinical information with the courts to facilitate diversion from court, where appropriate
- initiation of appropriate emergency treatment and referral, when necessary
- discharge planning with patient participation in preparation for release from custody and/or on transfer to other correctional settings
- providing family and carers with appropriate information where indicated and possible.

Multidisciplinary case management is facilitated by the following means:

- daily clinical handover
- weekly case reviews
- joint bed demand meetings
- joint discharge planning, and
- joint assessment and management of people at high risk of harm to self, harm to and from others.

The roles of the various team members are set out below.

Medical Staff

Medical staff within CMH include the Clinical Director (CDCMH) and Deputy Clinical Director (DCDCMH), staff specialists, visiting medical officers, psychiatry registrars and career medical officers.

The consultant psychiatrist for each patient is responsible for leading the clinical care of patients in the MHSU.

Details of the role and responsibilities of psychiatrists (visiting medical officers, VMOs, and staff specialists) in CMH are contained in their respective position descriptions. A summary of the expectations and responsibilities of psychiatrists working in the MHSU is to:

- provide expertise in assessment and management of patients in custody with mental health needs
- refer patients to appropriate services within the custodial setting
- prescribe and monitor psychotropic medications to patients, where indicated
- participate in risk assessment and management of patients and make appropriate recommendations regarding placement and management
- liaise with the MHRT, prepare reports as requested, and attend hearings, when necessary, for forensic patients, correctional patients, or patient subject to FCTOs or CTOs
- support other Network clinicians and provide advice regarding mental health issues affecting patients

- refer to and liaise with other health agencies in situations where patients are released from the custodial setting to the wider community
- participate in research, quality improvement and teaching activities related to mental health within the custodial setting
- provide supervision and mentoring to staff, where appropriate.

Psychiatry Registrar – under the supervision of a Consultant Psychiatrist

- Carries out individual initial physical assessments and ongoing reviews of all patients in the unit
- Provides treatment and care planning
- Participates in multidisciplinary case management reviews
- Implements discharge planning.

General Practitioner (GP)/ Nurse Practitioner Primary Care/ Drug and Alcohol/ Population health

- A GP/NP from PC visits the MHSU on a weekly basis and completes the physical assessment, and develops care plans for patients in the MHSU.
- For new admissions, a physical assessment should be completed within seven days.
- Provides primary health care to patients in the MHSU as required
- Liaises with mental health staff to ensure the transfer of important clinical information.
- Where the GP forms an impression about a patient's health needs, this should be clearly documented and communicated to the MHN and, where possible, directly to the assigned psychiatrist.
- Nurse Practitioners from specialist D&A or Population health are provided as required and by arrangement.

Mental Health Nurses

A Primary Nurse model of care is in place in the MHSU with the Primary MHN for each patient being responsible for:

- the completion of nursing admission procedures
- daily coordination and provision of day to day mental health care and general health needs
- completion of CHIME Standard Measures
- ensuring appropriate patient alerts are placed in PAS
- metabolic monitoring
- discharge and release planning.
- Provides mental health care and treatment
- Implements and facilitates treatment recommendations
- Participates in multidisciplinary Risk Assessment and Intervention Team (RAIT)
- Performs ongoing observation, assessment, and review
- Completes CHIME Standard Measures
- Carries out medication administration and delivery of care to patients

- Attends to individual discharge and transfer of care needs.

Endorsed Nurse (EN) and Endorsed Enrolled Nurse (EEN)

- Provides mental health care under direction of the RN and within scope of practice
- Implements and facilitates treatment recommendations
- Performs ongoing observation, assessment and review
- Completes collection of MHOAT Standard Measures
- Carries out medication management
- Attends to individual discharge and transfer of care.

Nursing Unit Manager 1 (NUM1)

- Principally responsible for the management of the unit
- Plays a consultation-liaison role for mental health nursing staff as required
- Supports the administrative operations of the MHSU including oversight and coordination of admission and discharges
- Provides direct clinical care to patients
- Assists with applications for FCTOs
- Develops and provides clinical education
- Participates in clinical research when required
- Develops, implements and reviews clinical unit processes
- Supports court diversions, discharge planning, and transfers of care
- Liaises with the NUM3
- Collects statistical data and completes audits as directed by NUM3
- Provides clinical leadership, mentorship and preceptorship to staff, students and transitional nurses.

Clinical Nurse Educator Mental Health (CNE)

- Functions as a specialist nurse
- Provides direct clinical care for patients
- Provides education to the multidisciplinary team
- Provides clinical leadership, mentorship and preceptorship to staff, students and transitional nurses
- Facilitates practice improvement projects and research
- Liaises with the NUM
- Provides local orientation to new staff
- Provides and monitors completion of mandatory staff training and education.

Nursing Unit Manager 3 (NUM3)

- Functions as the operational manager of mental health services at the MRRC and SWCC
- Supports the NUM1 in bed management and movement coordination of patients to and from the MHSU
- Maintains ongoing communication with CSNSW management to meet operational needs

- Participates as a member of the joint management team of MHSU
- Consults and liaises regarding mental health services at the MRRC and SWCC.

CMH Administrative Staff

Administration Officer Level 6

The Administration Officer (AO6) position acts as the main liaison person on all matters related to the Custodial Mental Health Service with discretion and confidentiality. The Administration Officer (AO6) is responsible for providing high-level administrative support to the CD and NM CMH and NUM of the MHSU. This position supervises and oversees the Clinical Support Officer and Administration Officer Level 3 to the MHSU.

Administration Officer Level 3

The Administration Officer Level 3 (AO3) is responsible for providing a wide range of clerical, administrative, keyboard and data entry support for CMH. This includes completing occasions of service in PAS and CHIME, ordering of stores, typing court reports, telephone duties, mail coordination and meeting venue coordination.

Clinical Support Officer

The Clinical Support Officer (CSO) role supports the activities of nurses and medical staff. The CSO provides timely and accurate administrative/transactional services for members of the health care team under the direction of the NUM2 MHSU. The role complements existing roles, systems and processes in each mental health location of the MRRC including but not limited to completing and creating PAS waitlists and CHIME, telephone duties and assisting with audits, ProAct and leave applications.

PA to Clinical Director and Deputy Clinical Director CMH (AO3)

The Personal Assistant is responsible for providing administrative support to the CDCMH and DCDCMH and providing support to staff specialists and other medical staff, processing of TESL and leave applications, and the typing of court reports.

CSNSW Staff

Manager Crisis Mental Health MHSU (MCMH)

- Participates as a member of the joint management team of MHSU
- Manages all OS&P staff working in the MHSU and on the *Risk Assessment Intervention Team*
- Manages all offender services and programs offered within the MHSU
- Participates in bed management and assists in the movement and coordination of people to and from the MHSU
- Coordinates professional development for OS&P staff
- Collects statistical data and completes audits as directed by Manager of Services and Programs, CSNSW
- Refers to internal and external agencies
- Consults and liaises with mental health services to provide information to internal and external agencies
- Participates in multidisciplinary team meetings including ward rounds and daily handover.

Services and Programs Officer (SAPO)

- Establishes and maintains ongoing communication between the individual and the community including family, carers and agencies
- Reviews current and recent assessments including the Intake Screening Questionnaire and medical / mental health information as it relates to welfare needs

- Participates in multidisciplinary RAIT/RIT
- Participates in multidisciplinary reviews
- Provides corroborated social history to the multidisciplinary team
- Maintains ongoing case management
- Provides information relating to court dates and outcomes to the multidisciplinary team
- Maintains statistical data specific to MHSU
- Participates in multidisciplinary team meetings including ward rounds and daily handover.

Psychologist

- Participates in multidisciplinary RAIT/RIT
- Participates in multidisciplinary joint management plan reviews
- Reviews current and recent assessments, including Intake Screening Questionnaire and medical/mental health information, as it relates to the psychological needs of the individual
- Assesses people in the MHSU to identify psychological needs
- Maintains statistical data specific to MHSU
- Provides ongoing case management
- Participates in multidisciplinary team meetings including ward rounds and daily handover.

Community Corrections Division

- Provides expert advice to sentencing authorities through the preparation of detailed assessments and reports
- Advises and recommends appropriate sentencing options to the court and other judicial bodies
- Administers risk assessment instruments
- Compiles detailed and comprehensive offender assessments
- Participates in multidisciplinary team meetings to provide advice and information on community options and strategies for transition from custody to a community environment.

Assistant Superintendent CSNSW (AS)

- Supervises all custodial staff in the MHSU to ensure the provision of appropriate dynamic and static security
- Completes the Security Compliance Journal daily and ensures a copy is sent to the Manager of Security
- Checks the daily state board to establish states, vacancies and cleared patients requiring movement in and out of the unit
- Participates in case management and case planning in consultation with the multidisciplinary team
- Participates in the Weekly Bed Demand meetings
- Participates in RAIT and joint management plan reviews
- Supervises custodial staff and ensures that all duties are completed in accord with policies and written procedures
- Participates in daily multidisciplinary handover
- Ensures that daily observation sheets are completed accurately.

Senior Correctional Officer (SCO) CSNSW

- Supervises the daily activities of Correctional Officers and First Class Correctional Officers to ensure the provision of dynamic and static security
- Contributes to the safety, security, welfare and management of patients, the safety and security of staff and the general public
- Complies with CSNSW policies and procedures as well as those within the unit
- Participates in joint management plan reviews when required
- Participates in daily multidisciplinary handover
- Supervises the accuracy of daily observation sheets.

Correctional Officer (CO) CSNSW

- Reports directly to Senior Correctional Officer
- Provides a high standard of continuous security in the containment and oversight of patient activities
- Contributes to the safety, security, welfare and management of patients and the safety and security of staff and the general public
- Complies with CSNSW policies and procedures as well as those within the unit
- Participates in daily multidisciplinary handover
- Maintains daily observations of the patients.

Official Visitors

Official Visitors are appointed by the Attorney General and Minister for Justice and are independent of CSNSW. Official Visitors visit correctional facilities regularly, listen to patients' enquiries and complaints and try to resolve them locally by speaking with centre managers. If Official Visitors are unable to resolve matters locally they will bring them to the attention of the Commissioner or Minister.

High Support Accommodation Areas – Hamden

Hamden Mental Health Accommodation Area

Service Description

Hamden Mental Health Accommodation Area (MHAA) is a section of the MRRC which can house people with severe mental illness and complex needs while they remain in custody.

It consists of 65 beds, known as Hamden 15.

CMH provides intensive outpatient treatment in Hamden POD 15in MRRC for patients with complex mental health needs who would be vulnerable in the mainstream correctional environment. Patients needing complex planning for imminent release or transfer, including forensic patients are also housed in Hamden. The Hamden MHAA provides a short to medium term placement for patients with the view to stabilising presenting symptoms and as a pathway to other correctional accommodation or release to the community.

The mental health team consists of MHNs, Clinical Nurse Consultant, and Consultant Psychiatrist. The team works in cooperation with CSNSW clinical staff such as Psychology, SAPO, Drug and Alcohol and Probation and Parole. The mental health team is supported by an O&N PCN, D&A services and PC provides a GP.

The population housed in Hamden consists of forensic patients, patients on clozapine, patients who are treatment-resistant and patients who are vulnerable due to their mental illness. The majority of the population are remanded. However, there is scope to house sentenced patients who require mental health management in a more supportive environment, but who are not acutely ill such that they require hospital admission. Patients housed in Hamden 15 are of varied protection status. While they remain in the Hamden MHAA, they are signed off protection and mix with others. When they leave the MHAA their protection status is reactivated. This includes patients attending visits or who are transferred to other areas in the MRRC.

The demand for beds within Hamden MHAA is high and the intention is for short stay placements. However, there is capacity to extend the length of stay in extenuating circumstances. This may include:

- forensic patients with legal orders to remain in Hamden
- patients with complex mental health needs who are unable to function in the mainstream correctional community, and
- patients requiring complex release planning.

The Hamden MHAA is within a maximum security correctional centre, which results in the following restrictions:

- patients are locked in cells from 1430 to 0730 hours.
- no work or rehabilitation programs.

These conditions should be considered when deciding whether to hold a person in Hamden MHAA.

Admission Criteria

1. Primary DSM-V Axis I diagnosis of:
   a. psychotic disorder
   b. bipolar affective disorder

   or

   c. Axis I diagnosis of substance abuse/dependence comorbid with either of the above and not the primary diagnosis, and one of the following:
2. The patient requires further assessment, initiation of, or titration of treatment, and further management in an area with more mental health support, or
3. The patient is a forensic patient (received a special verdict of APNCR or found unfit to be tried) and has a MHRT order to remain at Hamden,
4. The patient is recommended for commencement of clozapine,
5. The patient is compliant with prescribed medications.

Generally, patients would not be suitable for Hamden where:

1. The primary clinical problem is related to Axis II psychopathology, that is, personality disorder, or
2. It is the first presentation of a mental illness that requires extensive investigation and observation (as these patients would be better managed within the MHSU).

Criteria for Discharge from Hamden

Before a patient can be discharged from Hamden, the clinical team must consider the continuing condition of the patient and how they will be managed in the mainstream population. Very few patients may require a longer stay in Hamden. When deciding whether a patient can be discharged from Hamden POD, the clinical team should consider whether:

- there has been a significant improvement in the patient's mental state and level of functioning
- the patient is adherent with treatment, and
- any risks to self or others, or risk of treatment non-compliance can be adequately managed in the alternate placement.

Discharge Process

The Hamden MHT will ensure that a patient's individual needs regarding placement are communicated with CSNSW Classification Department and that recommendations are made for locations with sufficient mental health resources to meet the needs of each patient. For example, writing '*Clear for gaol of classificatio*n' is insufficient. Patients housed in Hamden must be reviewed by a Consultant Psychiatrist or CMH Medical Staff member prior to the commencement of the discharge process. Once reviewed, the Hamden MHT can commence and co-ordinate the discharge process/management plan for the patient.

A comprehensive discharge management plan must be completed that includes a rationale for discharge and an updated HPNF specifying location(s) that would be suitable to the patient's needs.

A copy of each of these documents must be placed on the patient's hard copy health record, e-progress notes and case management file.

The patient must be placed on the appropriate waitlist in PAS for follow-up by a MHN and psychiatrist.

The Hamden NUM for the patient or delegate must provide a handover to the mental health team in the

receiving correctional centre if the receiving location is known.

Release Planning

The responsibilities of nursing staff in release planning can be summarised into the following key areas:

- engage in collaborative release planning with the patient
- identify a release address in advance of the release date (where possible) to enable referral to an appropriate LHD community mental health services. The referral should be facilitated by contacting the State-wide Mental Health Telephone Access Line (MHTAL) at telephone 1800 011 511
- provide a written and oral handover to the local community mental health team upon referral, including alerting the receiving team of any risk and safety concerns
- attend to appropriate CSNSW referrals such as Welfare, Probation and Parole, Drug and Alcohol and other relevant external service providers
- organise a one week supply of medication for the patient to take upon release
- complete the discharge summary on the JHeHS Discharge/Transfer Continuity of Care form
- document all actions taken by staff in the e-progress notes.

Staff Roles

Nursing Unit Manager (NUM) Level 1

The NUM is responsible for leading and coordinating care in the Hamden Mental Health area. The NUM also participates in problem solving associated with the functioning of the unit/ward. Additionally, the NUM1 is responsible for:

- facilitating collaborative patient care
- establishing and maintaining processes to facilitate performance improvement
- using patient and carer feedback to inform service delivery
- enabling a culture of enquiry about nursing practices and monitoring and maintaining a safe environment for patients, staff and visitors, in collaboration with the relevant stakeholders
- ensuring the safe handling of drugs in accordance with the *Poisons and Therapeutic Goods Act 1966*
- liaising with other sectors across mental health services and ensuring efficient referral pathways and good professional networks
- coordinating mental health care in PODs 15 and 16.

Clinical Nurse Consultant Forensic Patients

The CNC Forensic Mental Health (FMH) works Monday to Friday 0700 to 1530 hours. The primary focus of this role are forensic patients, rather than mainstream mental health patients.

The role of the CNC Forensic Patients is comprehensively outlined in *Procedure Manual Case Management of Forensic Patients in Correctional Centres*.

Psychiatrists

The psychiatrist(s) assigned to Hamden are broadly responsible for:

- assessment of patients including, taking a medical/mental health history, noting previous treatment, referring to collateral information, establishing presenting symptoms, mental state examination, diagnosis and initiating treatment as appropriate

- referring patients for additional medical interventions and assessments dependent on patients' presentation
- reviewing patients in a timely manner
- recommending when the patient is fit to re-enter mainstream correctional services
- preparing reports for the MHRT and participating in hearings

Mental Health Nurses

Two MHN positions are deployed to the Hamden area seven days a week from 0700 to 1530 hours.

One MHN is deployed seven days a week from 1330 to 2200 hours.

The MHN is responsible for the provision of mental health nursing care in accord with the responsibilities of a registered or enrolled nurse, which include:

- ensuring medication adherence and noting any present or emergent side-effects
- conducting comprehensive mental health assessments and risk assessments on admission
- obtaining corroborative histories, where appropriate
- regular reviews of patients' mental state
- coordinating services with general practitioners, psychiatrists and other health professionals
- release planning, which may include liaison with family members, community mental health services and other external services regarding treatment and support to facilitate continuity of care for patients leaving custody
- communicating with SCCLS to assist in the diversion of patients with a mental illness
- advocating for patients with mental health issues
- discharge planning, including recommendations to classification locations that would be suitable for the health needs of the patient
- completing CHIME standard measures and CHIME activity data
- recording information and booking appointments, or making wait list entries in PAS or JHeHS

Note: Administration of opiate substitution medications is by members of the O&N nursing team.

Outpatient Psychiatry and Nurse Practitioner Clinics

Outpatient CMH Psychiatry and Nurse Practitioner Mental Health (NP) clinics are conducted both on-site and, at particular centres, by telehealth where there is no onsite mental health cover.

For the location and dates of CMH Psychiatry and NP outpatient clinics see the *Rosters* on the Network intranet.

Procedure for Booking Telehealth Clinics

This procedure is for the booking of telehealth rooms and equipment by staff of CMH.

There are eLearning modules and tips sheets on the use of telehealth equipment and bookings here on the Network intranet.

Justice Health Administration Centre, Malabar

- A clinician who intends to conduct telehealth clinics must contact the Project Officer Forensic Mental Health (POFMH) on [redacted] to make advance bookings for the telehealth equipment and rooms at the

Justice Health Administration Centre (JHAC), Malabar. Where possible, notice of at least six months should be given. If a roster of future clinic dates is available, this should be emailed to the POFMH.

- The POFMH will book the room and equipment via the Network Outlook booking system and notify the clinician by email with the confirmed dates and send a copy to the Administration Officer and PA to the CDCMH.
- If a telehealth room is unavailable on a requested date, the POFMH will notify the clinician as soon as practicable and advise of alternative locations.
- Every effort will be made to reorganise pre-booked meeting rooms where required but this cannot be done on the day of a telehealth clinic or with less than one week notice.
- Once dates have been confirmed, the clinician must contact the POFMH to advise of known future cancellations, for example, TESL or annual leave. The POFMH will cancel the room and equipment for those dates and notify the clinician.

Justice Health Olympic Park (JHOP), Sydney Olympic Park

All bookings by CMH clinicians (who are not a member of the CMH Outreach telehealth Service) for telehealth facilities and rooms at the JHOP should be made through the CMH Administration Officer at the Mental Health Screening Unit by telephoning [redacted].
The CMH Outreach telehealth service book clinics at JHOP via the Outlook diary.

Metropolitan Remand and Reception Centre, Silverwater

All bookings by CMH clinicians for telehealth facilities and rooms at the MRRC should be made through the Administration Officer at the MHSU by telephoning [redacted].

Other Correctional Centres

To use the facilities and rooms at other correctional centres, please contact the relevant health centre directly.

Clinic Guidelines - Outpatient Clinic Procedure

- Ideally, on attending the assigned health centre, the Psychiatrist/NPMH should liaise with the Ambulatory Mental Health Nurse (AMHN) at the centre to review the PAS list and triage patients appropriately. If the MHN is not available or has not completed an appointment list, the visiting psychiatrist or NPMH will liaise with the centre NUM
- The Psychiatrist/NPMH is expected to review the referred patient by interview and review of the available health records and other relevant documents, including any collateral information that has been obtained at the time of reception or subsequently.
- Notes are made in the Network e-progress notes documenting the relevant clinical information, clinical impression and management plan.
- If medication or a change in medication is indicated, this must be written on a Network long stay medication chart or on an auxiliary medication chart if the clinic is being conducted via telehealth.
- The results of the clinical assessment and management plan are discussed with the AMHN during the clinic. If no AMHN is available, the clinical handover should be provided to the centre NUM or Nurse in Charge(NIC)
- Where recommendations regarding placement of the patient within the custodial setting, or where there are risks identified which require assertive management/follow-up, or where there are specific cell placement recommendations, the Psychiatrist/NPMH, in collaboration with the AMHN, NUM, or NIC, is responsible for communicating this information to CSNSW through use of a HPNF. Refer to Network Policy 1.231 *Health Problem Notification Form (Adults)*.
- In situations where further advice is required by the Psychiatrist/NPMH, for example, complex clinical, operational or ethical situations, the psychiatrist/NPMH should contact the CDCMH or DCDCMH in the first instance.
- In urgent situations where the CDCMH or DCDCMH is not available, the Service Director Custodial Mental Health may be contacted.
- For outpatient clinics at MRRC and SWCC, at the conclusion of each clinic, the psychiatrist must ensure their PAS appointment lists are completed and faxed to the Administration Officers on [redacted] for completion of PAS and CHIME entries.

Role of the Nurse Practitioner Mental Health (NPMH)

This position works closely with MHNs, MH CNCs, CNSs, GPs and psychiatrists in the completion of comprehensive mental health assessments, making referrals as indicated, initiating treatment and management plans, ordering and interpreting relevant investigations and ensuring patients are wait listed for follow up as required in keeping with their individual ScOP.

The NPMH also acts as a resource for the MH CNC and CMHNs, GPs and primary health teams. There is an expectation of the PAS, JHeHS and CHIME requirements being completed for clinics; with the NPMH completing their own PAS, JHeHS and CHIME entries. The endorsed NPMH acts as a nursing clinical supervisor for the T/NP during the period of transition.

Psychiatrist/NPMH Responsibilities

The Psychiatrist/NPMH attending a particular assigned clinic is expected to be able to be contacted in normal working hours on days when attending the clinic to give advice in urgent situations, as a first port of call, for the Health Centre nursing and medical staff.

When a Psychiatrist/NP is not contactable, for example, when on leave, undertaking work in another service, engaged in private practice, travelling, or the call is outside the psychiatrist/NP's normal working Hours, the health centre nursing or medical staff should contact the on-call psychiatry registrar on [redacted]

All medical practitioners and nursing staff in CMH are required to be competent in the use of PAS and JHeHS.

The Network is cognisant of the need to reduce the undue administrative impost on MOs and maximise clinical time spent with patients. At a minimum, medical practitioners in CMH must:

- review patient history and alerts on PAS (F8 function)
- apply appropriate clinical alerts on PAS if alert not already flagged
- Use PAS to refer patients to the Network Outpatients Department, Network Inpatient Facilities and to external health entities, where required
- Create discharge summaries (MHSUs only).

Managing Patients with Co-morbid Conditions

Where a psychiatrist or NPMH is managing a patient with comorbid conditions, the practitioner should, as a matter of course, liaise with any other practitioners who are treating the patient.

Any clinical issues must be documented in the progress notes in accord with the appropriate professional standards.

Where a patient has an emergent health issue and the patient is not already under the care of a general practitioner or a relevant specialist, the patient should be referred to the appropriate health practitioner by placing the patient's name on the relevant waitlist in PAS.

Where a clinical issue is non-urgent and the name of the other clinician is known, the practitioner may contact the other treating clinicians by telephone or email.

Where a clinical issue requires urgent attention, the practitioner should contact the relevant specialty by telephone via ROAMS at:

[redacted] and selecting one of the following options:

1. After Hours Nurse Manager
2. Primary Health
3. Drug and Alcohol.

For Oral Health or Population Health (BBVs, infectious diseases) matters, the clinician should contact the applicable clinical director for that service.

Support for Psychiatrists in Health Centres

The NUM or NIC of a Health Centre is expected to ensure an appropriate level of support is available for a CMH Psychiatrist or NPMH during a clinic.

The Psychiatrist/NP should conduct a handover post consultation to ensure the support person enters the correct information in PAS. It is recommended that the appointment list printed from PAS or the 'today's clinic list in JHeHS is used to assist with this process. All clinical decisions must be documented in the patient's health record in accord with usual documentation requirements.

Prior to the commencement of a Psychiatrist/NPMH session:

- The AMHN or NUM of the centre should triage and prioritise Psychiatrist/NP waiting list and make appointments for the prioritised patients
- Clinical Support Officer (CSO) or Health Centre Clerk (HCC) should print the Psychiatrist/NP appointment waiting list from JHeHS and give a copy to the NUM/NIC or delegate clinician
- HCC/CSO must retrieve the health record and treatment charts of all patients on the appointments list
- CSO/HCC should provide both the appointments list and wait list to the Psychiatrist/NP for further triaging and amendments if required.
- The final list is given to the clinic officer.

During the Psychiatrist/NPMH clinic:

- CSO or another staff delegated by the NUM/NIC should 'arrive' and 'depart' patients in CHIME in real time as patients attend the Psychiatrist/NP Clinic or as soon as possible afterwards.
- AMHN must place patients on the appropriate waiting list for follow up appointments as recommended by the Psychiatrist/NPMH
- The psychiatrist/NP will make comment on the appointment list or handover diary for transcribing into PAS wait list entries. Examples of such comments are a diagnosis or clinical impression, whether the patient is stable or unstable, and the recommended time frame for review. Sample comment: *Schizophrenia, stable on depot, review in 2/12*.
- NUM, AMHN or delegate clinician must complete HPNFs as instructed by the Psychiatrist/NPMH.

Clinic Cancellations

Where a psychiatrist is unable to conduct a clinic for a reason that is known in advance, , the psychiatrist must, at a minimum, inform the NUM of the health centre and the AO3 CMH, noting that approval for any leave must have been sought in advance from the CDCMH.

Where a psychiatrist is unable to attend a clinic for an unplanned reason, for example, sickness, the psychiatrist must, at a minimum, inform the NUM or CSO of the health centre. Health Centre staff should inform the AO3 CMH of the absence.

Custodial Mental Health Outreach Telehealth Service

The Custodial Mental Health (CMH) Outreach Telehealth Service provides a mental health service to those patients identified as being Clinical Level B per Mental Health Model of Care (see Important Notice dated 12/9/16 TRIM DG64800/16, Prison Mental Health MOC Review TRIM DG54278/16) who are stable on their current treatment regime.

Other patients who are appropriate for referral to the CMH telehealth Service are those patients requiring assessment for the purpose of the Mental Health Act i.e. Section 35 requests when no other appropriate resource is available.

The CMH telehealth service does not routinely provide services for those patients identified as:

- Level A- these patients are serviced by the GPs with support of the Mental Health Consultation Liaison Service phone [redacted]
- New Receptions for initial assessment- these patient should be seen by on site mental health staff or transferred to a location with onsite mental health services.
- Patients identified as being at high risk of suicide / on mandatory notifications. These should be managed by way of the Mandatory Notification Protocol and Policy Number 1.380 Clinical Care of People who may be Suicidal
- Patients presenting with acute exacerbation of illness- these patients would be better managed by being transferred to locations with onsite mental health services.
- Patients presenting with acute or chronic behavioural disturbances
- Patients on Forensic Community Treatment Orders (FCTO)
- Forensic Patients (i.e. unfit, NGMI, limiting term)
- Signing off pathology results for patients not under the care of the CMH Outreach Service.

Services Provided by CMH Outreach telehealth Services

The CMH telehealth service focuses upon the management of stable Level B patients. This includes, clinical review by MHN/NP and psychiatrist, recharting medications, reviewing pathology results for metabolic monitoring and release planning.

Centres Serviced by CMH Telehealth Service

The CMH telehealth Service has targeted the following locations to provide and outreach service:

- Broken Hill, Cooma, Hunter, Shortland 5/6, Kirkconnell, Macquarie , Mannus, Mary Wade, Oberon, Shortland 5/6, St Heliers, Tamworth and Glen Inness by arrangement

Please see Telehealth Procedure Manual for further information.

Primary Care Consultation-Liaison Psychiatry

The MHCLN provides evidence-based, best practice; care, assessment and follow up to patients in custody, who have been placed on the GP waitlist and are presenting with non-complex mental health concerns, according to priority with time sensitivity.

The MHCLN enhances the effectiveness and utilisation of GP resources with the aim of improving access to healthcare for patients who have mental health issues by providing an expert patient-centred nursing assessment and care coordination of patients throughout the state.

The MHCLN participates in patient care provision to patients and liaises with clinicians from all streams throughout the Network. For more information, please see Primary Care Guidelines for the management of Clinical Level A Patients with Mental Disorders.

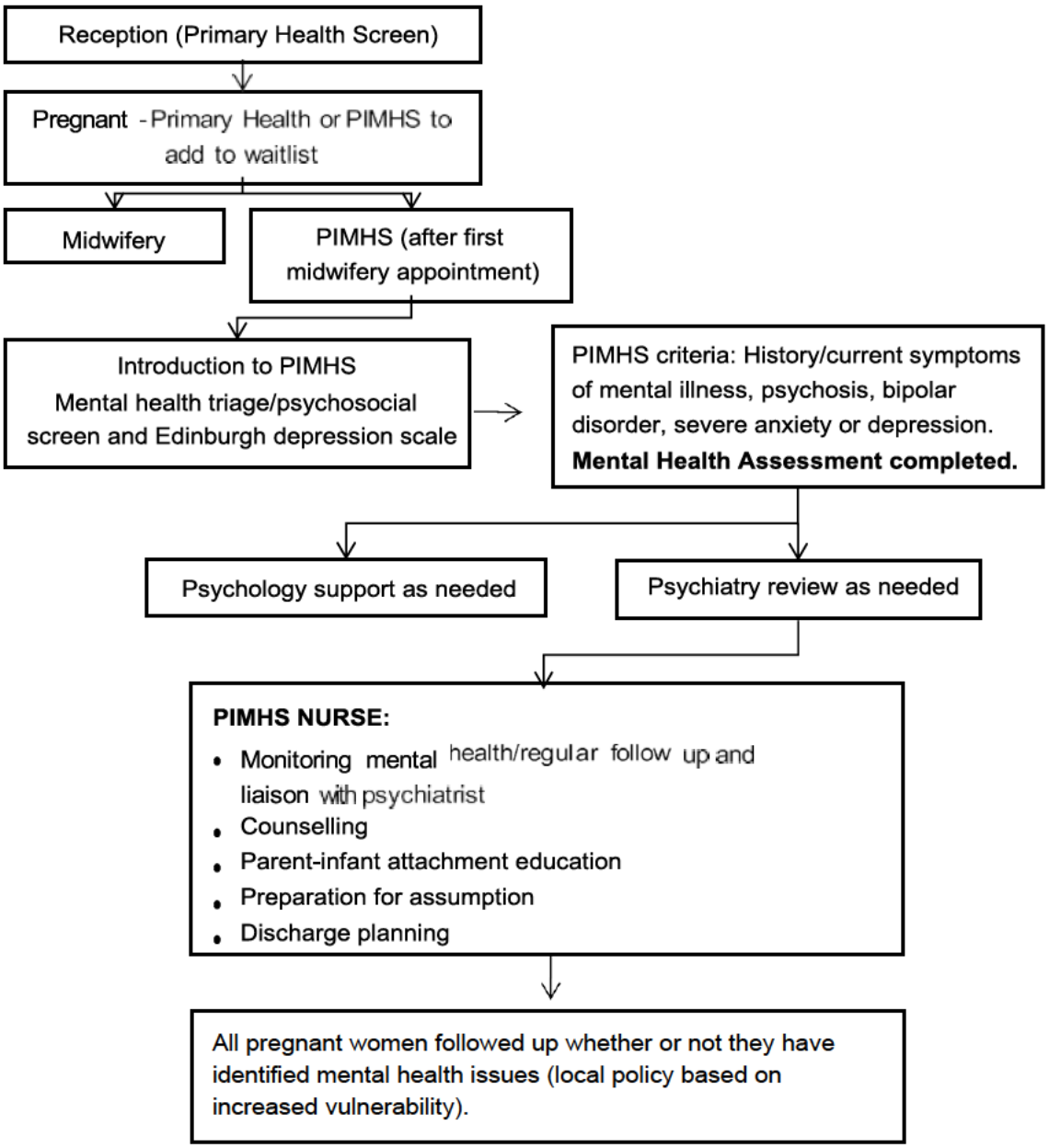
Perinatal Infant Mental Health Services

PIMHS is a subspecialist service within CMH that co-ordinates the mental health care of pregnant women in custody with a particular emphasis on the parent-infant relationship. All pregnant women are seen and assessed by the service for psychosocial and mental health vulnerabilities in accord with the Safe Start guidelines, PD2010_016 *SAFE START Strategic Policy* and GL2010_004 *SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants*

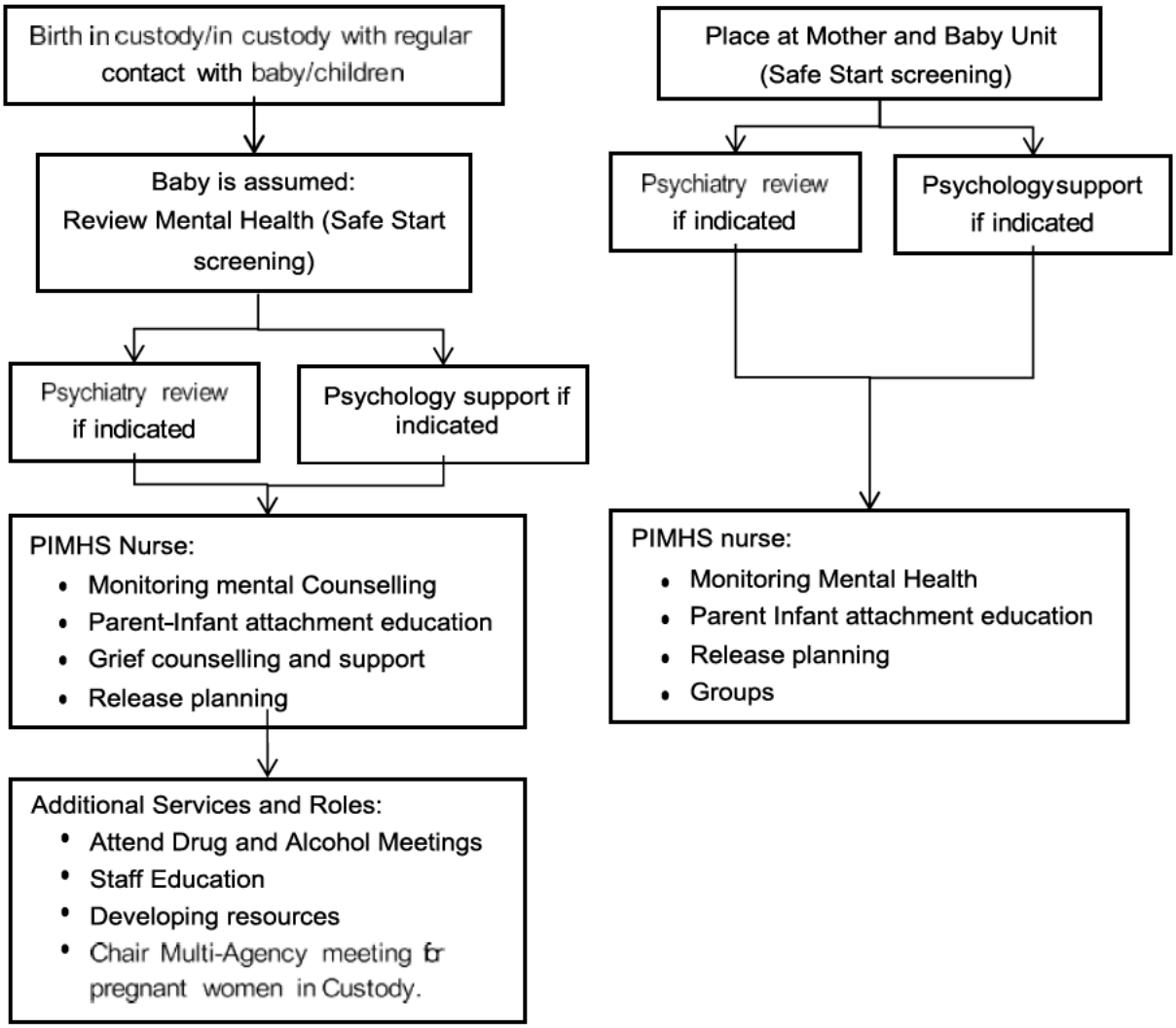
PIMHS follows up all pregnant women throughout their pregnancy and provides continuity of care, support, counselling, therapeutic interventions and referral to psychiatry services as required. The PIMH service works closely with Midwifery, Drug and Alcohol, and other CMH services within the Network and with LHD social work services and Family and Community Services (FaCS) in the community.

For further information please refer to the *PIMH Service Procedure Manual.*

Antenatal PIMHS Pathway for Pregnant Women in Custody



Postnatal PIMHS pathway for Pregnant Women in Custody



Specialist Mental Health Services for Older People

The Specialist Mental Health Service for Older People (SMHSOP) is a specialised mental health service within CMH, the primary function of which is to provide specialist care to older people presenting with moderate to severe mental health disorders and/or mental health problems in the context of dementia or behavioural and psychological symptoms of dementia (BPSD) in the custodial setting.

The pathway to referral is:

- identification of patient
- completion of organic screen if not completed within the last six weeks (in accord with the SMHSOP referral form)
- recent review by a General Practitioner or Psychiatrist
- completion of the SMHSOP referral form (*JUS200.078*) and referral e-mailed to the SMHSOP email address: [redacted]
- Presentation of patient referral at Aged Care Bed Demand meeting held second and fourth Thursday of the month.

If the patient requires both older person's mental health assessment and functional assessment, telephone or e-mail contact can be made with SMHSOP CNC at any time during the referral process.

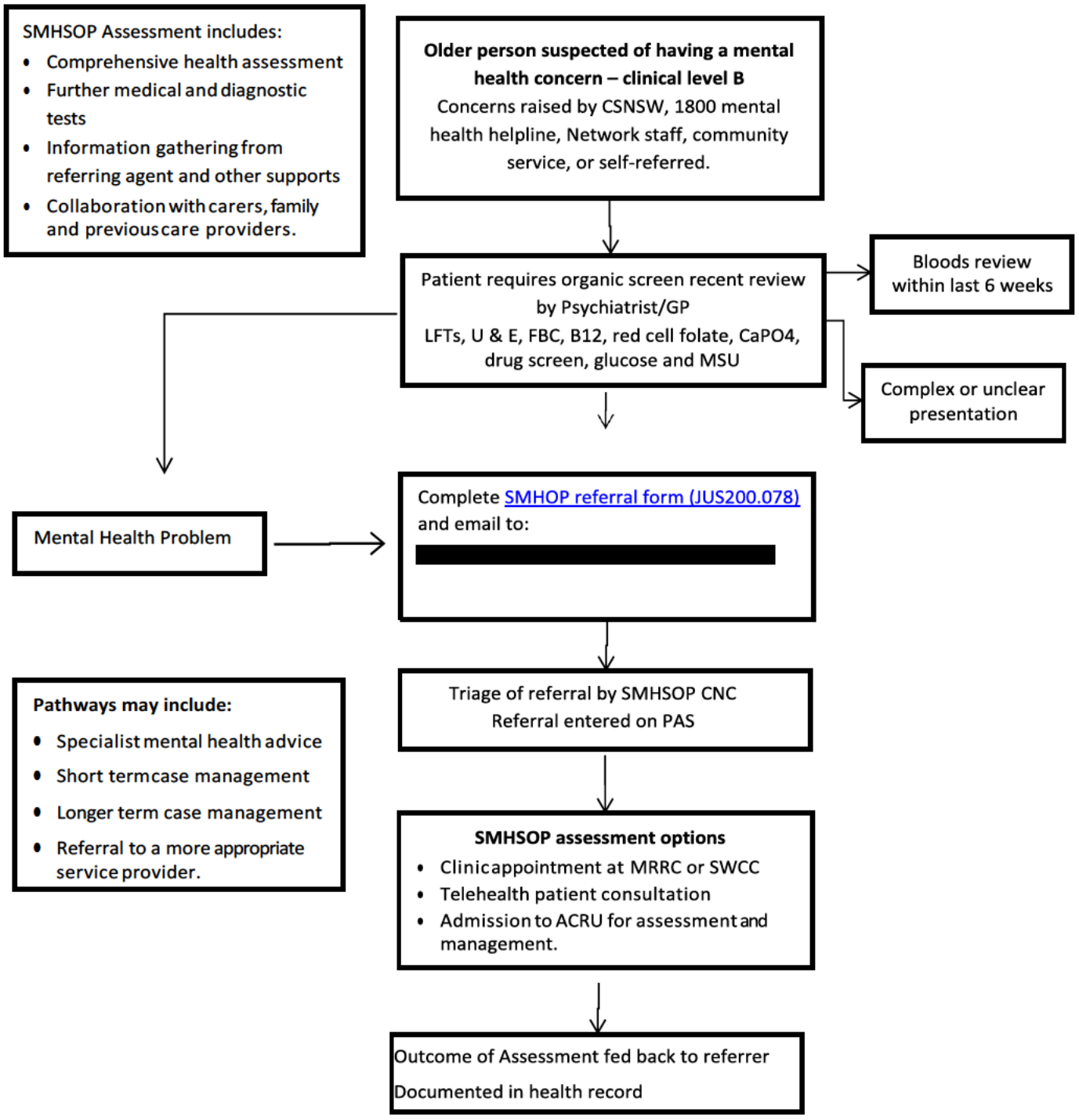
Core functions of SMHSOP

- Consultation-liaison service within the custodial setting and the FH.
- Delivery of an outreach service to custodial settings in the metropolitan and rural areas via onsite clinics or telehealth.
- Case management of older forensic patients who meet the SMHSOP criteria.
- Development of pathways to support discharge planning for forensic patients and older people within the correctional setting.
- Co-ordination of discharge planning for older people requiring community services or residential placement.
- Provision of support to other key services to ensure care co-ordination for older people with co-existing mental health problems that may not be the primary focus of care, and long standing mental health problems but no acute symptoms.
- Support and psychoeducation to carers and family of patients.
- Provision of education to Network and CSNSW staff.
- Ability to admit patients to the LBH Aged Care and Rehabilitation Unit (ACRU) for a period of assessment and management in conjunction with the aged care team.

Options following SMHSOP assessment

- Provision of specialist mental health advice to the referrer for ongoing management of patients assessed as stable and low risk.
- Acceptance for short-term case management to stabilise a patient's mental state with handover back to the referrer once stabilised.
- Acceptance for ongoing case management by SMHSOP.

- Referral to CSNSW Psychology.
- Referral to D&A specialistservices
- Referral to State-Wide Disability Services (SDS)
- Arrange for a period of admission to the ACRU for further assessment and management.


SMHSOP Assessment includes:
• Comprehensive health assessment
• Further medical and diagnostic tests
• Information gathering from referring agent and other supports
• Collaboration with carers, family and previous care providers.
Older person suspected of having a mental health concern – clinical level B
Concerns raised by CSNSW, 1800 mental health helpline, Network staff, community service, or self-referred.
Patient requires organic screen recent review by Psychiatrist/GP
LFTs, U & E, FBC, B12, red cell folate, CaPO4, drug screen, glucose and MSU
Bloods review within last 6 weeks
Complex or unclear presentation
Mental Health Problem
Complete SMHOP referral form (JUS200.078) and email to:
[redacted]
Pathways may include:
• Specialist mental health advice
• Short term case management
• Longer term case management
• Referral to a more appropriate service provider.
Triage of referral by SMHSOP CNC
Referral entered on PAS
SMHSOP assessment options
• Clinic appointment at MRRC or SWCC
• Telehealth patient consultation
• Admission to ACRU for assessment and management.
Outcome of Assessment fed back to referrer
Documented in health record

Women's Mental Health Services

Women make up 7.7 per cent of the estimated population in NSW correctional centres, with approximately 1000 women in full time custody on any one day. The number of women in custody in NSW has increased significantly over the last 10 years.

Many women in prison have high levels of mental illness and drug or alcohol dependence as well as histories of sexual/physical abuse and violence. There are several correctional centres in NSW which accommodate female patients, including SWCC in the Silverwater Correctional Complex, Dillwynia Correctional Centre, Emu Plains Correctional Centre, and several other mainly male correctional centres which can accommodate small numbers of female patients, such as Wellington.

SWCC is the largest correctional centre in NSW accommodating women and is the main remand centre. As such, it is the main focus for mental health services for female patients.

Silverwater Women's MHSU

SWCC is a remand centre and has the highest concentration of mental health services amongst these centres. It contains the MHSU which was commissioned as a collaborative project between CSNSW and the Network. The SWCC MHSU is intended to enhance the delivery of mental health services to women in custody who have a mental illness. It provides a therapeutic environment within a custodial setting for 10 patients and is located alongside the health centre in SWCC.

Target Population/Admission Criteria

Women who:

- have a diagnosed or suspected mental illness and are a risk to themselves or others, or who are at risk of harm from others due to mental illness. Mental illness includes the presence of one or more of the following symptoms: delusions, hallucinations, severe mood disorders, serious disorders of thought form, and sustained or repeated irrational behaviour that may indicate the previous symptoms.
- are awaiting placement in a specialist forensic/psychiatric bed at the FH or LBH.

Unit Management Principles

Communication and consultation between CSNSW, the Network and all relevant stakeholders is an obligation of all staff working within the SWCC MHSU.

Admission to and discharge from the SWCC MHSU is a clinical decision by the Network mental health team.

All Network and CSNSW MHSU staff will participate in mental health training/ education delivered by mental health professionals.

Close supervision of patients is provided by CSNSW and Network staff to maintain a safe working environment best suited to facilitating mental health care, security and managing the special needs of patients.

Legislative Framework

The MHSU is managed under the provisions of the Crimes *(Administration of Sentences) Act 1999*. Like the make MHSU, the unit is not a declared mental health facility which means treatment cannot be given involuntarily. However, a patient in any correctional centre may be scheduled under the MHCIFPA for transfer to the Forensic Hospital or LBH for involuntary treatment. Patients may also be scheduled under the MHA, if they are being released from detention into the community and require psychiatric

admission for management of severe mental illness upon release.

Multidisciplinary Team and Joint Case Management

The NUM 1 SWCC is responsible for the day to day operation and organisation of mental health services within SWCC. The NUM1 is supported by MHNs and works in collaboration with psychiatrists, a psychiatry registrar and in close association with other clinical staff in the main clinic (the SWCC Health Centre).

The multidisciplinary team is comprised of interagency staff including, psychiatry, psychology, mental health nursing, welfare, community offender services, custodial staff, education staff, AOD workers and case officers. The team uses a collaborative model of care to carry out a comprehensive assessment. This ensures a wide range of experts are involved in the assessment, treatment, and development of a comprehensive Discharge Management Plan for each patient.

The team meetings promote effective liaison between the Network, Community Offender Services, and the Inmate Classification and Placement services, enabling referral to other services including community mental health services, non-custodial programs, or outreach mental health services, as well as follow up of the individual outcomes. Joint case management entails principles of team management and case management.

Case management issues are addressed in the Fortnightly Multidisciplinary Meetings.

Collaborative Partnerships

The SWCC MHSU is located alongside the SWCC Health Centre and there is a very strong working relationship between the two facilities.

Nursing care of the patients in the SWCC MHSU is undertaken by the MHNs. More complex primary health needs are referred to O&N or PC Care clinicians as required via PAS.

There is strong collaboration between other mental health services, both internally and externally, to provide an effective, integrated care system for patients with a mental illness, providing the right care at the right time.

Unit Description

The SWCC MHSU has 9 cells, which can hold 10 patients, with three additional Assessment Cells.

This unit is designed for patients who are acutely unwell requiring a low stimulation environment.

The three assessment cells, are under constant camera observation.

The unit has a separate courtyard that allows close supervision by staff and separation from the larger population.

There is one cell for a patient with a disability.

Cells	No Camera	Camera
Double Cell	0	1
Single Cells	3	5
Assessment Cells	0	3

Clinical Pathway

Referral Process

Every patient received at SWCC must follow the established procedures for the Network Reception Triage Assessment and the CSNSW Reception/Screening Process.

If a patient meets the admission criteria for the SWCC MHSU, the patient will be managed by the RIT or the MHN until they are admitted to the SWCC MHSU.

If a bed is not available in the SWCC MHSU, the patient will be housed in appropriate accommodation, such as the **Induction Unit** or **Mum Shirl Unit** (MSU).

Admission / Discharge Guidelines

Referrals are received from either RIT, MHN, NPMH or other correctional centres. All admissions must be for clinical reasons.

Management of the SWCC MHSU Admission Waiting List is facilitated through the Multidisciplinary Case Conference led by the CMH NUM1 and discussed at the SWCC MHSU bed demand meeting, with acceptances forwarded from the NUM when placement is allotted.

Discharge from MHSU

The Network and CSNSW are jointly committed to forwarding patient's Discharge Management Plans along with any relevant documentation to the ambulatory mental health team and the relevant Community Offender Service staff as part of proper handover processes.

The nurse must ensure that the transferred documents have been received.

SWCC MHSU staff should liaise directly with CFMHS and Custodial Diversion CNC where appropriate, to link people with appropriate services.

Mum ShirlUnit (MSU)

The 'Mum Shirl Unit' is a Therapeutic Unit and Behavioural Management Unit for women in custody and is managed by CSNSW Psychology services with support from Network psychiatrists. The unit houses women with behavioural issues including severe and sustained self-harm behaviours. There are 20 beds in the Unit. People can be referred to the MSU from the SWCC MHSU. This will occur following

Discussion between the Therapeutic Manager (MSU) and the team from the SWCC MHSU with a clearly stated Discharge Management Plan from the SWCC MHSU.

SWCC Mental Health Step down Unit (MHSDU)

The MHSDU is a 10 bed unit for patients who may be unwell but do not require intensive mental health services. It has two double cells and six single cells. Patients in the MHSDU can engage more fully with correctional centre services than is possible in the MHSU.

Mental health services to MHSDU are provided by MHSU staff.

The Multi–Disciplinary team is to ensure this option is well articulated in the patient's Discharge Management Plan.

Access to General Health Services

The Network provides health care programs within the fields of:

- Primary Care (GP services)

- Population Health
- Drug and Alcohol
- Women's Health
- Oral Health Services, Pharmacy Services, Physiotherapy Services and Radiography
- Sexual Assault services (via referral to Grevillia Cottage for recent pre-incarceration assaults or via Public Health for assaults occurring in custody).

People entering the SWCC MHSU have access to the above services. This may require escort of the person to the main SWCC Health centre to access some of these services.

General Operations of SWCC MHSU

The unit is staffed 24 hours a day by CSNSW custodial staff. Network staff are in attendance from 0700 to 1900 hours.
After hours, Network night staff in the main health centre provide emergency health care. The contact Number is [redacted]

Handovers

The Network and CSNSW conduct handovers at shift changes, at about 0715 hours in MHSU seven days per week.

CMHN and psychiatry handover is at 0830 hours Monday to Friday

There is a weekly multidisciplinary case conference.

SWCC MHSU Staff Guidelines

The following guidelines apply to all SWCC MHSU staff:

- Each discipline is expected to participate, in accord with their particular roles and responsibilities within the Unit, in the development of a Discharge Management Plan.
- All staff members contribute written notes towards the compilation of the Discharge Management Plan.
- A Network Nurse and, preferably, a CSNSW psychologist, but can also be other OS&P staff or a Custodial Officer complete a Discharge Management Plan in consultation with the patient and all three sign-off on completion of the plan.
- SWCC MHSU staff participate in the fortnightly multidisciplinary case conference.

Staff are expected to complete training and education as required and participate in ongoing professional development.

Roles and Responsibilities – the Network

Nursing Unit Manager 1

This position has the primary responsibility for the efficient administration and day-to-day functioning of the Community Correctional Mental Health Service at the Silverwater Women's Correctional Complex (SWCC). This position is responsible for managing the MHSU and Step Down and Outreach Services in SWCC. The position is also responsible for the co-ordination and monitoring of service provision, implementing and monitoring activity relating to service planning and development and policy development, as requested.

Psychiatry

The SWCC Psychiatrist reviews the PAS list of referred patients with the NUM1 or delegate. Priority for assessment is decided according to clinical need and acuity, and length of time waiting.

The Psychiatrist then assesses referred patients by interview and file review, documents history, mental state examination, clinical impression and management plan in the Network health record progress notes, and together with the nursing staff, is responsible for arranging appropriate treatment, referral, follow – up arrangements and cell placement recommendations via a HPNF.

Note: Psychiatry and mental health staff complete Alcohol and Other Drug (AOD) assessments, and refer people as required for Drug and Alcohol follow–up.

Mental Health Nurse

Mental Health Nurses are responsible for the provision of daily mental health and general health needs. Principle duties include coordination and initiating healthcare to patients with mental health needs. This includes:

- Providing mental health care and treatment
- Implementing treatment recommendations
- Participating in multidisciplinary Risk Assessment and Intervention Team(RAIT)
- Undertaking ongoing observation, assessment, and review
- Completing CHIME Standard Measures
- Carrying out medication administration and delivery of care to patients
- Attending to individual discharge and transfer of care needs.

Care of Forensic Patients in the Custodial Setting

The care of forensic patients in the custodial setting is a designated service within CMH; the primary function of which is to provide case management to forensic patients who have been found unfit, subject to a special verdict of APNCR, the subject of a limiting term or their status as a forensic patient has been extended,

When a correctional inmate becomes a forensic patient or when a forensic patient enters custody, the Tribunal notifies the Forensic Mental Health Liaison Officer (FMHLO). The FMHLO notifies the Clinical Director Custodial Mental Health (CDCMH) and other delegates of the change in status of the patient. The Court orders and all related documents such as reports, judgement, and Police facts are emailed to the treating team and saved on HPRM, JHeHS and on the G: drive at: G:\S&P\CMH\FORENSIC & FCTO Patients.

Team involved in Case Management of Forensic Patients:

- Treating Psychiatrist
- Clinical Nurse Consultant Forensic Patient
- Ambulatory Mental Health Nurses
- Aboriginal Mental Health Support Worker for Aboriginal patients
- Forensic Mental Health Liaison Officer (FMHLO)
- Forensic Hospital representatives

Core aspects of the services provided to forensic patients in custody

Key aspects of the services provided to forensic patients in custody include:

- maintaining appropriate case management of forensic patients
- identifying and providing information and support to Family and Carers
- ensuring that forensic patients have access to appropriate mental health care and other appropriate services, for example, cultural/spiritual, interpreter services, drug and alcohol, psychology, Inmate Support and Programs staff, or chaplain
- consultation-liaison service within the custodial setting and the FH
- coordinating and participating in MHRT hearings
- informing the Tribunal of any significant changes in the patient's circumstances
- participating in Custodial Mental Health (CMH) Forensic Patients Case Management meetings
- participating in State-wide Forensic Patient Flow Committee (SFPFC) meetings
- Ensure that continuity of care is maintained for patients who are being transferred to another correctional centre for any reason.
- Provide telehealth services to forensic patients in remote centres
- Coordinating transfer of forensic patients with the Forensic Hospital and medium secure units

Designated carers and principal care providers

Section 72 of the *Mental Health Act 2007* sets out the rights and importance of involving carers in a person's mental health treatment and recovery. A person may nominate up to two persons to be a designated carer.

The Network has mandatory obligations under such legislation for the following:

- ❖ Patients on Forensic Community Treatment Orders; and
- ❖ Patients awaiting transfer to a mental health facility under a s86 MHCIFPA order.
- ❖ Forensic Patients

In addition to the information provided under the law, the treating team will also make every effort to keep in contact with families and carers about other areas of a person's care and treatment.

An authorised medical officer at the Custodial settings can also nominate a principal care provider for a patient. This person can be the same person as the designated carer or can be another person who is primarily responsible for providing support or care to the patient.

Please note: A patient can exclude a person from receiving information about them.

For further information please refer POLJH/1434 http://intranetjh/pol/policylib/1.434_Policy_0220.pdf

Ambulatory Mental Health Nurse

The Ambulatory Mental Health (AMH) clinicians at each Health Centre around the state will develop and implement the local procedures and processes that set out ways of working to achieve a best service outcome. This will take into account the local resources e.g. staff, rooms, and access.

Inclusion of clinical governance for AMH nursing staff will involve an approach to maintain and improve the quality of care within all Health Centres outside of the Silverwater Complex. The core philosophy of the clinical governance will be, that all patients will have timely access to care and treatment in keeping with best practice principles and referral for more intensive services located at the Silverwater Complex as required.

To enable the mental health care to be provided effectively and safely there are some procedures/duties that should remain consistent across the Network. These include:

- Positive working relationships with other Network and CSNSW staff members at the Centre.
- Triage and assessment of patients referred to mental health service
- Referrals for assessment and review by Psychiatrist/NPMH
- Ensuring that all mental health patients are assessed and reviewed at specific intervals or more frequently as clinically indicated
- Case management of patients under the Mental Health Act – FCTO patients and assistance with Forensic Patients which are case managed by the FP CNC.
- Ensuring that the planned care is implemented including internal and external referrals
- Completing relevant CHIME/PAS/JHeHS requirements
- Facilitating custody diversions, where appropriate
- Facilitating continuity of care to community service provider
- Clinical documentation – e.g. Health Records, HPNF

Given the complexity of health care and the frequent movements of patients within the correctional systems, patients' health records are one of the most important information sources available to clinicians and the Service. Clear and consistent clinical documentation is a vital part of all different roles and should not change across the different Health Centres.
The Policy 4.020 Policy 0119 Health Records (ImpG) provides guidelines on the expected documentation.

The HPNF communicates Network advice and recommendations to CSNSW across all Correctional Centres. The Policy 1.231 Health Problem Notification Form (Adults) provides guidelines on the appropriate use of HPNF to ensure that clinical needs, risk and placement are communicated with CSNSW as well as JHFMNH staff.

Cell placement recommendation should not change between Health Centres. Network Policy 1.340 Accommodation-Clinical Recommendation provides clinically based recommendations regarding the patient's cell placement within the NSW correctional system. It is ultimately the responsibility of CSNSW to consider the recommendations.

Correctional Patients: process for Involuntary Treatment

The legal process for enabling transfer of inmates for involuntary treatment at LBH or the Forensic Hospital is as follows::

- A person in custody who requires involuntary treatment under the MHCIFPA, because they have symptoms of major mental illness causing them to be at risk to themselves or others and where there is no less restrictive management available, can only be treated involuntarily in a declared mental health facility, which, in the custodial setting, means the Forensic Hospital or LBH.
- The person must be reviewed by two medical practitioners, one of whom must be a psychiatrist.
- Two **Schedule 1** certificates and a brief typed report to the Delegate of the Secretary of the Ministry of Health are to be completed.
- These must be emailed to the FMHLO at [redacted] A **Section 86** order is then generated, ordering the transfer of the person to the appropriate declared facility.
- The section 86 order is sent to the NUM of the relevant centre. The NUM places the patient on

the PAS waitlist for transfer to the Forensic Hospital or LBH.

- When a suitable bed at the Hospital becomes available, the NUM at the Hospital communicates this to the NUM, via an **Acceptance Form**.
- The NUM then contacts CSNSW to arrange transfer of the person to the declared facility, according to allocated priority (see next section).

Prioritisation Process: Bed Demand Committee

Female and male patients in custody who are subject to a section 86 transfer order to either the Forensic Hospital or LBH for involuntary treatment must be prioritised according to clinical need (acuity), and taking into consideration length of time on waiting list and/or other logistic/security issues.

These patients are discussed at a weekly Long Bay Hospital Mental Health Unit Bed Demand Committee meeting on Mondays at 1300 or the Forensic Hospital Leave and Admission Committee meeting on Mondays at 1200. In these meetings, all patients placed on the PAS Waitlist are discussed with reference to their clinical needs. After discussion of the patients a priority is assigned to the individual patient. The agreed priority is recorded in minutes which are then sent to the key stakeholders.

Custodial Diversion Program

The Custodial Diversion Program is a service provided by Custodial Mental Health (CMH) within the Silverwater Correctional Complex and more recently has been extended to the Long Bay Hospital.

The Service aims to divert mentally ill people out of custody and into treatment in appropriate inpatient or community settings. The Custodial Diversion Clinical Nurse Consultant (CNC) is an integral part of CMH and works closely with other clinicians in CMH to provide integrated care for people with mental illness and mental disorders.

The Custodial Diversion Program focuses on summary offences or offences triable summarily (that is, triable by a Magistrate sitting alone) in the Local Court. People charged with more serious offences, called indictable offences, are not eligible for diversion under sections 14 or 19 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.
Where a person is charged with both summary and indictable offences, the person is eligible to have the summary offences dealt with under section 14 or 19 of the MHCIFPA.

The operational principles for the Custodial Diversion Program are:

- the promotion of diversion to minimise prolonged periods of incarceration for of mentally ill and mentally disordered people,
- well-reasoned and measured clinical recommendations to the courts so that the most appropriate range of dispositions is available to the courts,
- networking and linking mentally ill and mentally disordered people with the most appropriate mental health service or agency following their disposal from the courts,
- promoting the autonomy, self-determination, and the dignity of mentally ill and mentally disordered individuals within the confines of the law, and
- high professional standards with quality assurance programs to ensure a high standard of service provision.

Further information on the program is available in the *Custodial Diversion Program Procedure Manual*.

Section 25 Procedures

Orders under Section 25 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* - Transfer from a Correctional or Detention Centre to a Mental Health Facility

Section 25 of the MHCIFPA applies to situations where a person is appearing in the Local Court and the Magistrate forms the view that the person should be assessed with a view to transferring the person to a mental health facility. In such a situation, the Magistrate can make an order undersection 25 of the MHCIFPAthat the defendant be examined by two medical practitioners, one of whom must be a psychiatrist and, if appropriate, the relevant Schedule 1 certificates are furnished under section 86 for an order to be issued for the transfer of the defendant to a mental health facility.

Procedure for Section 25 Court Orders

1. The CSNSW Senior Project Officer (Forensic Liaison) receives the section 25 Order from the Court and forwards on to the Network Forensic Mental Health Liaison Officer (FMHLO) at: [redacted]
2. The Network FMHLO will check the next court date of the defendant on OIMS, and, where that person is detained in a correctional centre, forward the section 25 Order to the:
   a. CDCMH
   b. DCDCMH
   c. NMCMH
   d. Administration Officer CMH
   e. And CC the SDCMH.
3. The CDCMH or DCDCMH will arrange for the person to be examined by two medical practitioners, one of whom must be a psychiatrist. Where possible, the psychiatrists visiting the centre will complete the examinations and where a second medical officer is required the CMH Outreach Telehealth Service Psychiatrist will conduct the examination.
4. If, after assessment, the person is found to be a mentally ill person, the two medical practitioners each write out a Schedule 1 certificate, which are then sent to the Network MH Orders inbox at [redacted] in accord with the usual process for an order to be made under section

86 for transfer to a mental health facility.

5. The Administration Officer CMH must place the person's name on the Long Bay Hospital wait list and the person should be managed according to usual processes
6. If the person is assessed as not a mentally ill person, the person should be followed up by CMH or PC as considered appropriate.
7. Section 25(2)(c) orders that the Network's Chief Executive must notify the Magistrate of the action, if any, taken under section 86 of the MHCIFPA. .
8. The Network FMHLO must be informed of the result of each examination at [redacted] in the form of a typed medical report, setting out the current presentation of the person being assessed, in order for a letter to be signed by the Chief Executive to be provided to the Court for the purposes of section 25(2)(c) of the MHCIFPA.
9. The Network's FMHLO will then inform, prior to the defendant's next Court appearance, the following persons of the actions taken:
   a. Local Court
   b. CSNSW Senior Project Officer (Forensic Liaison)
   c. CDCMH
   d. DCDCMH
   e. NMCMH
   f. And CC the SDCMH.

Section 89 Procedures

Section 89 of the Mental Health and Cognitive Impairment Forensic Provisions Act 2020 - Reviews by the Tribunal of Persons Awaiting Transfer to a Mental Health Facility

The Tribunal is required, in accordance with clause 7(1) of the Mental Health and Cognitive Impairment Forensic Provisions Regulation 2021, and section 89(1) of the MHCIFPA, to review the case of such persons who are not transferred to a mental health facility within 14 days of a section 86 order being issued. Section 89(4) provides that for the purposes of a limited review, a report about the person's condition and the reason for delay in transfer must be provided to the Tribunal by the Secretary NSW Health The Secretary has delegated that power to certain Network officers (hereafter, the Delegate).

Procedure for section 89 Limited Review Requests

1. The Network Forensic Mental Health Liaison Officer (FMHLO) receives a request from the MHRT for a limited review under section 89 of the MHCIFPA.
2. The FMHLO checks the location of the person on OIMS, and then informs the following people of the proposed limited review:
   a. CDCMH
   b. DCDCMH
   c. NMCMH
   d. SDCMH.
3. The CDCMH or the DCDCMH will arrange for the person to be examined.

4. A report on the person's condition and the reason for delay in transfer to a mental health facility must be provided to the Delegate as soon as possible at JHFMHN-MHOrders@health.nsw.gov.au
5. Once the report has been received from the MH Orders Inbox, the FMHLO completes the report from the Delegate using the template saved on HPRM Ref: DG36281/17 and has one of the Delegates sign approval.
6. The FMHLO will forward the letter by the Delegate and the section 89 limited review report to the following recipients
   a. MHRT
   b. Mental Health Advocacy Service
   c. CDCMH
   d. DCDCMH
   e. NMCMH
   f. SDCMH.
7. Should the person's presentation improve and the person no longer require admission to a mental health facility, a report must be provided to the Delegate at [redacted] outlining the reasons and a request for the s86 transfer order to be revoked.

Forensic Community Treatment Orders

A Forensic Community Treatment Order (FCTO) is a legal order made by the MHRT. It is equivalent to a Community Treatment Order under the *Mental Health Act 2007*, but is issued under the Mental Health and Cognitive Impairment Forensic Provisions Act 2020 and applies to those in custody.

The order sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation or other services whilst detained as a forensic patient, a person on remand or a person serving a custodial sentence.

It is implemented by Network clinical staff in a correctional centre. A FCTO authorises compulsory care for a person not in a mental health facility.

FCTOs can be made for any period of time up to 12 months. It is possible for a person to have more than one consecutive FCTO.

If a person is on a FCTO in custody, and they are due for release, then an application to the MHRT can be made to vary the FCTO to transfer management of the person's treatment to a community mental health service on release. The community mental health team have to however, engage in the process of varying the FCTO or seeking to vary the FCTO to a CTO by presenting a new treatment plan for the community setting.

If a FCTO patient is no longer in custody, but their FCTO remains unvaried, the Network remains legally responsible for implementing the FCTO.

What are the aims of FCTOs?

The aims of FCTOs are to:

- reduce the risk of relapse by ensuring a patient has contact with mental health professionals
- promote good mental health for the patient
- improve the patient's understanding of the benefits of being adherent to treatment
- provide the authority to treat the patient
- enable identification of relapse and early intervention

- assist the Network to achieve best practice in the management of mentally ill patients.

For the most up to date MHRT guidelines and procedures see the *Forensic Guidelines* at the MHRT's website: *www.mhrt.nsw.gov.au*. The *Civil Hearing Kit* has further detailed information on how to apply for a CTO.
Should you require further information on the care of patients under a FCTO, please refer to the *FCTO Procedure Guidelines*.

National Disability Insurance Scheme

What is the NDIS?

The National Disability Insurance Scheme (NDIS) is an Australia-wide scheme designed to support people with permanent and significant disability.

People with all types of disability may be eligible for the Scheme, including:

- physical disability,: for example, wheel chair user, amputee
- sensory disability: for example, blindness, deafness
- cognitive disability: for example, intellectual disability, brain injury, autism
- psychosocial disability: for example, chronic schizophrenia

The Network 2018-2022 Strategic Plan states that the Network will:

- 2.2 (c) Strengthen collaboration with government and non-government organisations to support transition of eligible patients to the National Disability Insurance Scheme.

Assisting patients to apply for the NDIS whilst in custody may enable some supports in their current environment and significant community based supports.

What is psychosocial disability?

Psychosocial disability is the term used to describe disabilities that may arise from mental health issues. The health system continues to provide treatment and care for mental illness. Many people with severe and persistent mental illness have an ongoing functional disability; whether they are currently acutely unwell or whether there symptoms are currently well managed. Whilst not everyone who has a mental health issue will experience psychosocial disability, those that do can experience severe effects and social disadvantage.

The functional disability may mean that the person would have considerable difficulties with a range of activities of daily living. They may not be able to read or understand important letters; may not be able to make and keep medical appointments; may have significant difficulties managing a tenancy, shopping, cooking, budgeting and remembering to pay the rent on time; they may not be able to join in and participate in activities that would improve their well-being and may need to learn skills in areas such as anger management and problem solving. The NDIS can fund supports to assist people with psychosocial disability in all these areas.

How can the NDIS help Custodial Mental Health Patients?

Most NDIS supports can help people transition to the community and live in the community.

In a few cases NDIS may be able to fund supports while a person is in custody. These must be specifically disability focused supports and not services that the Network or CSNSW should be expected to provide. Some examples are aids and equipment; allied health and other therapy directly related to a person's disability, including for people with disability who have complex challenging behaviours; and disability

specific capacity and skills building supports which relate to a person's ability to live in the community post-release. The NDIS will NOT fund the day-to-day care and support needs of a person in custody, including supervision, personal care and general supports.

The NDIS can fund transition focused supports such as assisting a person to find accommodation and community based services.

When is the best time to assist a CMH patient to apply for the NDIS?

Unless the patient has specific disability needs that must be met in custody (such as those described above), patients should apply to access the NDIS when they are sentenced and are approximately six months prior to release.

Patients who are close to the age of 65 should also be considered for NDIS access, even if they will not need funded supports at this time. You must be under 65 to apply for the NDIS but once you have been accepted you can access supports at any time, including when you are over 65.

Patients on remand who need services in place in order to meet bail or diversion conditions could also be considered.

What to do and how to do it?

There are a range of guidelines and resources to assist with NDIS applications on the Network intranet.

You can also contact contact: [redacted] or [redacted], Network Coordinator Cognitive Disability Services on [redacted]

Appendix 1 - Medical Officers Clinic Session Guidelines

1. Background

Following a series of clinical incidents relating to handwritten external referrals, it became apparent that consensus needed to be reached regarding the use of PAS by Network Medical Officers (MO).

A number of consultation meetings occurred with the Clinical Directors Medical and Dental Advisory Committee (CDMDAC) and Service Directors. Following these consultation sessions, guidelines were developed to guide MO as to when PAS should be used.

There was complete agreement by the CDMDAC that all salaried and contracted MO, regardless of specialty are required to have a level of competency in using PAS. Refer to Section 3 of this document for details. Clinical Directors also outlined concerns relating to the level of administrative support for MOs within Health Centres. These concerns are addressed through the support structures outlined in this guideline document (Section 4).

2. Scope

This document will stipulate expectations in the following areas:

I. MO Responsibilities

II. Support Structures for MOs Within Health Centres and Inpatient Facilities

III. Exemptions

3. MO Responsibilities

Recent audits carried out by internal and external auditors have identified that where PAS is used appropriately, the clinical risk surrounding patient transfers and continuity of care is reduced. The PAS application has somewhat reduced the organisation¡¦s reliance on the paper health record. Summary level patient health information is available electronically via PAS in all Network sites around the state.

In a medicolegal context, the information contained within PAS forms an integral part of the health record and has the capacity to be used in legal proceedings.

For the reasons above, PAS is mandatory for all MOs, regardless of specialty or designation (see exemptions Section 5). The Network is cognisant of the need to reduce the undue administrative impost on MOs and maximise clinical time spent with the patient.

This guideline aims to limit the tasks which must be completed by MOs to the following:

1. Review patient history and alerts on PAS (F8 function).
2. Apply appropriate clinical alerts on PAS if alert not already flagged.
3. Referrals to the Network Outpatients Department, Network Inpatient Facilities and to external health entities.
4. Discharge summaries (LBH and The FH only).

4. Support Structures for MOs within Health Centres

Outlined below is the structural support that a MO can expect when they arrive at a Health Centre to conduct the MO Clinic. The NUM)/NiC is expected to ensure an appropriate level of support is available during the MO session.

MO should conduct a handover post consultation to ensure the support person enters the correct information in PAS. It is recommended that the appointment list printed from PAS is used to assist with this process. All clinical decisions must be documented in the paper health record in accord with normal documentation requirements.

Prior to the commencement of a MO session:

- The Clinical Support Officer (CSO) or Health Centre Clerk (HCC) to print the MO waiting list from PAS and provide to NUM/NIC or delegate clinician.
- NUM/NIC or delegate clinician to triage the waiting list and rank in order of urgency.
- CSO/HCC to book appointments in PAS for the MO Clinic in accordance with the triaged waiting list.
- HCC/CSO to retrieve health record of all patients on the appointments list.
- CSO/HCC to provide both appointments list and waiting list to the MO for further triaging and amendments if required.

During the MO session:

- The CSO or another staff delegated by the NUM/NIC is to be teamed with the MO for the duration of the clinic session.
- CSO or another staff delegated by the NUM/NIC to “arrive” and “depart” patients in PAS in real time as patients attends the MO Clinic.
- CSO or another staff delegated by the NUM/NIC to place patients on the appropriate waiting list for follow up appointments in accord with instructions from the MO.
- CSO or another staff delegated by the NUM/NIC to make internal requests for services (waiting list entry in PAS) in accord with instructions from the MO. Include in comments: In accord with dictation by Dr <name>.
- NUM or delegate clinician to complete any HPNFs as instructed by the MO.

Appendix 2 - Sample Daily Duties

Mental Health Nurse – Outreach Team

0700	Receive handover from the Primary Health nurses at the main clinic.
0715	Sign on in the register located in the M block nursing station. Receive handover from the MRRC Outreach mental health team. Review email for any patients of concern that need a more urgent assessment. Discuss with CSNSW and Outreach team for any patients that need a more urgent assessment. Prioritise who needs to be seen for the day. If MRRC Outreach NUM is not present, nurse-in-charge is to print MRRC Outreach psychiatrist's waiting list.
0730	If MRRC NUM is not present, nurse-in-charge is to collect health records for MRRC Outreach psychiatrist. Review recent patient progress notes on JHEHS for patients that are scheduled to be seen.
0800	Conduct mental health assessment (A1) or triage (T1) as necessary for each patient. Complete appropriate CHIME Paperwork (F1, A1 SM1 and K10), HPNF, update progress notes in JHEHS and PAS. Make recommendation re placement in wing and normal, one out or two out cell placement on the HPNF Make referrals to psychiatrist, detox, D&A and O&N as required. If patients are unwell, refer to the psychiatrist for further specialist assessment Obtain information about previous treatment and ask patients to sign release of information form (ROI). Document in diary for later input of CHIME statistics
1030 - 1050	Tea break
1050 - 1120	Meal break
1120	Recommence assessments etc. in accord with morning session.
1400	If MRRC Outreach NUM is not present, attend handover with the Primary Health team in the main clinic.
1415	Update patient progress notes on JHEHS. Update PAS to reflect patients that were reviewed and follow-up appointment/referrals if required. Scan and email the CMH Clinic Tracker that records the psychiatrist's appointments and recommendations of the day to the CMH admin team.
1430	Receive and provide handover to the MRRC Outreach team in the M block clinic nursing station
1515	Return files to the main clinic.
1530	Sign off in the register located in the M block nursing station. End of shift

Mental Health Nurse – Registered Nurse – MHSU

A MHN is employed in each of the three MHSU PODs (8/24 with a floater position to assist where required from 0700 to 1530 hours.

One MHN is employed for the MHSU (8/24) from 1030 to 1900 hours.

The daily routine day for the MHN 0700 start:

0700	Pick up MHSU medication chart trolley from the main clinic. Receive handover from the Primary Health nurses at the main clinic. Sign on in the main office of the MHSU – check The disposition sheet to determine which area you have been allocated for the day. Print the MHSU clinic list for the day on PAS
0730	Pre–dispense morning medications to be administered after the morning handover –. Complete morning BGLs. Review handover folder and advise CSNSW of any patients of concern
0800	Attend and participate in MDT huddle in the MHSU handover room
0830	Administer routine morning medications. Check S4D and S8 registers in each MHSU pod. Check sharps trolley (Pod 19). Check emergency trolley (Pod 20)
0900	Administer Opiate Substitution Therapy (OST)
0930	Attend to the clinic list (Admissions, release planning, discharge planning, complete joint assessments with psychiatrists, prepare reports for the MHRT, complete clinical entry for patients, update electronic handover tool). Document progress notes in JHEHS and update PAS
1040 - 1100	Tea break
1100 - 1130	Meal break
1130	Administer routine midday medication. Complete midday BGLs. Attend to the clinic list (Admissions, release planning, discharge planning, complete joint assessments with psychiatrists, prepare reports for the MHRT, complete clinical entry for patients, update electronic handover tool). Document progress notes in JHEHS and update PAS
1400 - 1500	Attend and participate in daily Clinical case review meeting with the MDT.
1500	Update electronic handover document
1515	Handover to the MHSU afternoon nurse
1530	Sign off in the main office in main office of the MHSU. End of shift.

Daily Routine MHN MHSU afternoon shift

1030	Sign on in the main office of the MHSU. Commence duty and assist other staff members with delivery of care. Attend to medical emergencies whilst the morning MHSU staff are on their break
1130	Assist pod 19 and 20 with the clinic list (depots, venepuncture, mental health review, metabolic monitoring, MHSU discharge planning, CMHT referral, FCTO management, stores order, etc).Document in JHEHS and/or PAS
1340	Tea break
1400	Pre-dispense routine nocte medication for all MHSU patients. Attend to medical emergencies whilst morning MHSU staff are in case review
1515	Receive handover from morning MHSU staff Continue pre-dispensing routine nocte medication Attend to tasks that need to be followed up as requested by the morning MHSU staff
1530 - 1600	Meal break
1600	Check vaccine fridge temperatures for each MHSU pod. Complete afternoon BGLs. Attend to tasks that need to be followed up as requested by the morning MHSU staff
1730	Administer nocte medication with CSNSW officer to all MHSU patients. Update patient's progress notes on JHEHS for any refusal or withholding of medication. Update MHSU Handover template to reflect the same.
1830	Sign off in the main office of the MHSU. Handover any patients of concern that need to be followed up at night to the Hamden afternoon nurse Transfer MHSU medication chart trolley to the main clinic. Provide handover the night duty primary health nurse.
1900	End of shift

Special/Other duties

Monday – Check pharmacy supplies and medical stock – order sufficient medication for the week.

Tuesday – As directed.

Wednesday – check there is sufficient pharmacy stock for the weekend – order estimated shortfalls

Thursday – As directed.

Friday – As directed.

Saturday – As directed

Sunday – As directed.

Daily Routine MHN morning shift Hamden 15

0700	Receive handover from the Primary Health nurses at the main clinic.
0715	Sign on in the register located in the M block nursing station. Receive handover from the MRRC Outreach mental health team. Review email for any patients of concern that need a more urgent assessment. Discuss with CSNSW and Outreach team for any patients that need a more urgent assessment. Prioritise who needs to be seen for the day. If MRRC Outreach NUM is not present, nurse-in-charge is to print MRRC Outreach psychiatrist's waiting list.
0730	If MRRC NUM is not present, nurse-in-charge is to collect health records for the MRRC Hamden psychiatrist. Review recent patient progress notes on JHEHS for patients that are scheduled to be seen.
0800	Conduct mental health assessment as necessary for each patient. Complete appropriate CHIME Paperwork (F1, A1 SM1 and K10), HPNF, update progress notes in JHEHS and PAS. Make recommendation re placement in wing and normal, one out or two out cell placement on the HPNF Make referrals to psychiatrist, detox, D&A and O&N as required. If patients are unwell, refer to the psychiatrist for further specialist assessment Obtain information about previous treatment and ask patients to sign release of information form (ROI). Document in diary for later input of CHIME statistics
1030 - 1050	Tea break
1050 - 1120	Meal break
1120	Recommence assessments etc. in accord with morning session.
1400	If MRRC Outreach NUM is not present, attend handover with the Primary Health team in the main clinic.
1415	Update patient progress notes on JHEHS. Update PAS to reflect patients that were reviewed and follow-up appointment/referrals if required. Scan and email the CMH Clinic Tracker that records the psychiatrist's appointments and recommendations of the day to the CMH admin team.
1430	Receive and provide handover to the MRRC Outreach team in the M block clinic nursing station
1515	Return files to the main clinic.
1530	Sign off in the register located in the M block nursing station. End of shift

Extra Duties

Monday: As directed

Tuesday: As directed

Wednesday: As directed

Thursday: As directed.

Friday: As directed

SWCC Mental Health Nurse, MHSU

0700	Collect MHSU medication chart trolley from clinic treatment room and records room. Check the Diary and handover folder. Sign on in SWCC MHSU admin area
0715	Attend handover, which includes staff from MHSU (nurses, CSNSW officers, Psychology) and Outreach.
0730	Pre-dispense and administer routine morning medications. Check if any medication charts need rewrites. Check if any depot medications due. If NUM not present, print out the psychiatrist list for the day. Dispense medications for patients after breakfast (methadone and buprenorphine dispensed in clinic not MHSU). Attend primary health needs of patients and make necessary referrals. Do observations and BSLs. If accredited, collect any Bloods and if not arrange for Bloods to be collected. Administer depot injections. Daily PPE stocktake
1030	Complete MHSU discharge plans for all patients who have been cleared from the MHSU by the treating psychiatrist. Plans are done in collaboration with OS&P staff and patient. The three page document is done and saved on PAS, then signed by the Network, OS&P, and the patient. Three hard copies are required, one each for health, case management, and Psychology files.
1130 – 1150	Tea break
1150 – 1220	Meal break
1220	Pre-dispense and administer routine midday medication. Conduct MSE / Risk assessments on patients. Document patient progress notes on JHEHS For patients who were at court, chase up court outcomes, if released refer patients on to their community mental health team. Admit Patients to MHSU – Admit patient and collect health record and treatment sheets from transfer location, orientate patient, document patients MSE on admission, ensure medications are in stock, admit patient on PAS, print front sheet and place in health record, remove patient from MHSU waitlist, complete HPNF, make referrals for psychiatrist/AOD/OS&P, complete MHSU management plan, document vital signs and BSL in progress notes, ensure patient completes ROI and update patients alerts. **Discharge Patients within centre –** Discharge on PAS, complete HPNF, complete CHIME paperwork, update patient alerts on PAS. **Discharge Patients to community** – ensure authority to release information is signed and refer them to Community mental Health (Do discharge summary, contact community team by phone, fax discharge summary and recent notes and, if recent, send A1). Inform patient of any appointments made, contact numbers etc. If patient is on Methadone/Buprenorphine need to fax.

	Send copy of medication chart to Pharmacy for discharge medications. On day of release, give patient discharge meds as leaving centre. Do not give to patient while in unit. Discharge patient on PAS and fax front sheet to HIRS.
1500	Update MHSU handover template
1530	Return patients files and medication charts to health centre Give handover to Primary health nurses. Sign off in SWCC MHSU admin area. End of shift

Other Tasks

- Prepare reports and other paperwork to go to the MHRT, for example, for patients who are recommended for a CTO.
- Weekly weights and BSL.
- Clozapine Bloods (Monday)
- Fax clozapine results and chase up new prescription (Tuesday)
- Order stores
- Medication stocktake and ordering through Pharmacy (Thursday)
- Put Stores away (Thursday)
- Put Pharmacy away (Friday)
- Update Management Plans.

Other Duties

Complete Discharge Summaries for patients being released from custody and make referrals to Community Mental Health Teams. If patient is unsafe, liaise with psychiatrist or GP or Accredited Person re scheduling the patient and arrange with CSNSW and Police to transport patient to Westmead/Cumberland Hospital.

SWCC Mental Health Outreach Nurse

The Outreach Nurse provides mental health care for MSU, MHSDU and all the other wings of the centre.

0700	Sign on in SWCC MHSU admin area Check PAS and print off the mental health list Attend the primary clinic handover Check with CSNSW staff in MSU and MHSDU about patients who need review.
0715	Attend MHSU handover
0730	Prioritise patients to be seen today Patients may be seen in the health centre or in their wing Conduct mental health assessment (A1) or triage (T1) as necessary for each patient. Complete appropriate CHIME Paperwork (F1, A1 SM1 and K10), HPNF, update progress notes in JHEHS and PAS. Make recommendation re placement in wing and normal, one out or two out cell placement. Make referrals to psychiatrist, detox, D&A and O&N as required. If patients are unwell arrange for transfer to MHSU in consultation with NUM or Psychiatrist. Obtain information about previous treatment and ask patients to sign release of information form (ROI). Document in diary for later input of CHIME statistics
1130 - 1150	Tea break
1150 - 1220	Meal break
1220	Recommence assessments etc. in accord with morning session.
1400	Triage PAS list and prepare SWCC Outreach clinic for the next day
1530	Sign off in SWCC MHSU admin area. End of shift

Other Duties

- Liaise with CSNSW officers and OS&P Staff in MSU and MHSDU.
- Liaise with psychiatrist, D&A, O&N, GP and other clinicians.
- Refer patients to the Ambulatory MHN when being transferred to another centre.
- Complete Discharge Summaries for patients being released from custody and make referrals to Community Mental Health Teams. If patient is on a CTO, contact the MHRT about transferring care to community team.