MENTAL HEALTH SERVICE POLICY COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Cost Allocation for General Hospital Patients with Multi-Service Needs and Mental Health Consumers Accommodated in General Hospital Beds
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	General Manager, Mental Health Service SESLHD
AUTHOR	Melanie Munro Manager Finance and Performance Mental Health Service SESLHD
POSITION RESPONSIBLE FOR THE DOCUMENT	Policy and Document Development Officer, Mental Health Service SESLHD-MentalHealth-PoliciesandDocuments@health.nsw.gov.au
FUNCTIONAL GROUP	Mental Health
KEY TERMS	Financial responsibility, budget, allocation, resources
SUMMARY	This policy describes the points at which patients in an Emergency Department (ED) or in a general hospital bed become the financial responsibility of the Mental Health Service (MHS), and limited circumstances in which the Mental Health Service budget allocates resources to patients accommodated in general hospital beds.

Cost Allocation for General Hospital Patients with Multi-Service Needs and Mental Health Patients Accommodated in General Hospital Beds

SESLHDPD/294

1. POLICY STATEMENT

This policy has been developed in consideration of the:
SESLHD MHS Short Term Escalation Plan (S.T.E.P) Matrix (T21/24315), SESLHDGL/051 Access and Patient Flow Operational Framework for Mental Health Service and NSW Health PD2016_039 Care Type Policy for Acute, Sub-Acute and Non-Acute and Mental Health Admitted Patient Care

It complies with the NSW Work Health and Safety Act (2011) objective to achieve a healthier and safer working environment (through the appropriate allocation of patients) and the NSW Mental Health Act (2007) principle of the best possible care and treatment in the least restrictive environment.

2. AIMS

The aim of this policy is to describe the points at which patients in an ED or in a general hospital bed become the financial responsibility of the Mental Health Service (MHS). It should be used to inform negotiations at the site Mental Health Service/site Executive level.

3. TARGET AUDIENCE

This policy applies to all staff of the SESLHD, whether clinical or managerial, when determining cost allocations for patients whose medical condition may include mental health concerns.

4. RESPONSIBILITIES

It is the responsibility of all MHS staff to refer to this policy and bring it to the attention of SESLHD staff from other services/specialties in determining cost allocations for patients with mental health concerns. Negotiations should occur at unit level wherever possible. If a successful outcome cannot be reached, negotiations should be escalated to a site and/or SESLHD Executive level.

5. POLICY COMPONENTS

5.1 General Principles

The designated SESLHD Mental Health budget is quarantined as a matter of NSW Ministry of Health policy. It is allocated specifically for the provision of specialised Mental Health Services in designated units including Acute Mental Health Inpatient Units, Psychiatric Emergency Care Centres (PECCs) and the Mental Health Intensive Care Unit (MHICU).

The MHS budget allocates resources primarily to managing peak/high acuity and risk events within mental health services. This includes temporary increases in staffing in inpatient units, and continuous care 'special' staffing for individual patients in Acute Mental Health Inpatient Units, PECCs and the MHICU.

The general hospital budget also allocates resources for the management of patients with risk related to behavioural disturbance. In addition to standard services provided, some general hospital patients require additional resources to manage these risks. This may include patients demonstrating challenging behaviours related to delirium, brain injury, dementia, sepsis or other disorders.

Provision of safe care and a timely response to challenging behaviours within the general hospital remains the responsibility of the general hospital budget. The MHS budget is not responsible for addressing behavioural or risk issues in patients admitted for physical health issues in general hospital wards/units, or in EDs.

There are some limited circumstances outlined below in which the MHS budget allocates resources to patients accommodated in general hospital beds.

5.2 Emergency Department Presentations

- The ED is the portal for a significant proportion of presentations for admission to the general hospital, including Mental Health admissions.
- A high percentage of patients transported to EDs under the NSW Mental Health Act (2007) are found – on specialist clinical examination – not to be suffering from mental illness but often from a mix of intoxication, substance abuse, antisocial behaviour, domestic conflict and/or homelessness.
- Costs incurred in the initial phase of assessment and care in an ED are the responsibility of the general hospital if the patient is under the care of an Emergency Physician, until:
    - it is established that the consumer does not require acute medical, surgical or other treatment; and
    - the consumer has been clinically assessed and accepted by a Consultant Psychiatrist for admission to a Mental Health Inpatient Unit, PECC or MHICU directly under the care of Psychiatry
- Once a patient has been clinically assessed and accepted for inpatient mental health care, the patient will be admitted under the Mental Health Care Type and the costs of care become the responsibility of the MHS.

5.3 Patients with Multiple Service Needs (i.e. Patients transferred from a Mental Health Unit to the General Hospital for Medical Reasons)

- This applies to Mental Health Unit inpatients transferred to a general hospital bed for medical reasons and ongoing physical health treatment.

- On transfer to a general hospital bed, a patient's care type changes to 'Acute Care', until there is no continuing requirement for ongoing physical health treatment and the patient is for discharge (or, if required, repatriation to a Mental Health Unit).
- Whilst the patient is a general hospital patient, they may have specific management needs associated with their acute mental illness (e.g. risk of self-harm, risk of harm to others, behavioural disturbance). The MHS budget contributes to the psychiatric management of acute patients in these circumstances through the provision of specialist mental health services provided by Consultation Liaison clinicians. Requirements are determined on an individual basis by a joint clinical management plan.
- Note that patients transferred to a general unit for ECT will remain under the care type of Mental Health and should be admitted to a mental health ECT bed type. The costs should remain the responsibility of the Mental Health Service.

5.4 General Hospital Inpatients requiring Transfer to a Mental Health Unit for Mental Health Care and Treatment

- Standard risk and safety procedures apply to general hospital patients displaying behavioural disturbance, resulting in concern about immediate risk to the patient or others.
- Resources for risk management prior to a Mental Health assessment are allocated from the general hospital budget.
- The scheduling of a patient under the Mental Health Act, or the presence of Mental Health Act documentation, does not represent a mental health assessment and is not a referral tool. A formal request for Mental Health assessment is still required. The presence of Mental Health Act, documentation (including Schedule 1) does not indicate transfer of care or funding to the MHS.
- General hospital patients requiring transfer to a Mental Health Unit for inpatient Mental Health treatment must first be clinically assessed, handed over and accepted for inpatient care by the admitting Consultant Psychiatrist. The handover and Consultant Psychiatrist's acceptance of care should be indicated by relevant documentation in the patient's medical record.
- Patients with continuing and significant physical health needs, or serious mobility restrictions, may be considered unsuitable for transfer to a Mental Health Unit for safety reasons.
- A general hospital patient who has been clinically assessed, handed over and accepted for transfer to a Mental Health Unit, and who cannot be transferred within 24 hours of the decision being made, due to lack of bed availability, is classified for funding purposes as an over-census overflow Mental Health patient accommodated in a general hospital bed. The MHS budget costs of this overflow (i.e. a mental health inpatient accommodated in a general hospital bed) are limited to additional mental health nursing and supervision costs.

- Mental Health inpatients occupying a general hospital bed for accommodation purposes do not generate non-Mental Health related medical costs (e.g. drugs or procedures).

6. DOCUMENTATION

N/A

7. REFERENCES

NSW Health

- PD2016_039 - Care Type Policy for Acute, Sub Acute and Non-Acute and Mental Health Admitted Patient Care

SESLHD

- SESLHD MHS Short Term Escalation Plan (S.T.E.P) Matrix (T21/24315)
- SESLHDGL/051 MHS Guideline - Access and Patient Flow Operational Framework for Mental Health Service

Other

- NSW Mental Health Act (2007)
- NSW Work Health and Safety Act (2011)
- NSQHS Second Edition: Standard 1 Clinical Governance Standard (1.05) Organisational Leadership

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
February 2009	2	Endorsed by Area Mental Health Executive.
July 2015	3	Initial draft prepared by Victoria Civils-Wood, SESLHD MHS Policy and Document Development Officer, following advice from SESLHD MHS Director of Operations David Pearce. Consultation with designated author, SESLHD MHS Manager Finance and Performance, SESLHD MHS Clinical Nurse Manager and Eastern Suburbs MHS Clinical Operations Manager.
October 2015	3	Endorsed by MHS Clinical Council.
June 2018	4	Updated by Louise Boardman, Performance Support Officer, SELSHD MHS. Reviewed by Patricia McCormick, A/Finance & Performance Manager, SESLHD MHS. Reformatted by Trinh Huynh, Policy and Document Development Officer, SESLHD MHS. Revised by Angela, Karooz, Clinical Nurse Manager, SESLHD MHS.
September 2018	4	Consulted Access and Service Integration team. Updated by Angela Karooz, Clinical Nurse Manager, SESLHD MHS. Endorsed by MHS Clinical Council.
October 2018	4	Minor review. References and links updated. Processed by Executive Services prior to publication.
April 2021	5	Routine review commenced.
October 2021	5.1	Minor feedback from DDCC incorporated within document.
November 2021	5.1	Endorsed by SESLHD MHS DDCC
December 2021	5.1	Minor review: minor changes to wording. Endorsed by SESLHD MHS Clinical Council Executive Sponsor approved for publication
January 2022	5.1	Processed and published by SESLHD Policy.
15 January 2025	5.2	Routine review commenced. Links checked and updated. Endorsed for publication by Executive Sponsor. 12 month review period to allow for more in-depth review.