NSW GOVERNMENT | Health South Eastern Sydney Local Health District

MENTAL HEALTH SERVICE BUSINESS RULE SESLHDBR/071

<table>
<tr><td>Name</td><td colspan="3">Consumers in the Community with Complex Needs</td></tr>
<tr><td>What it is</td><td colspan="3">This business rule is to assist local mental health services with the assessment, treatment, risk management, planning, review and transfer of care for consumers with complex needs living in the community.</td></tr>
<tr><td>Risk Rating</td><td>Medium</td><td>Review Date</td><td>October 2028</td></tr>
<tr><td>What it is not</td><td colspan="3">This document does not describe or replace processes already required for triage and assessment, plus outcomes and assessment tools.</td></tr>
<tr><td>Who it applies to</td><td colspan="3">This business rule applies to all nursing, allied health and medical staff working in mental health non-acute community settings involved in the care of people with lived experience, their carers and stakeholders, where community living and wellbeing is at risk due to complex care needs.</td></tr>
<tr><td>Definition for complex needs-profile of people experiencing complex issues (Craig et al., 2004, Menezes et al., 2006, Friis, 2011) (Killaspy et al., 2013; 2016)</td><td colspan="3"><u>Complex:</u> Consumers of South Eastern Sydney Local Health District Community Mental Health Service (SESLHD MHS) with complex needs.

• Persistent ‘positive’ symptoms not relieved by current treatments, and/or significant ‘negative’ symptoms
• Cognitive impairments
• Eating Disorders with severe symptoms, associated functional impairment and/or treatment resistance.
• Co-occurring conditions
  o intellectual disability/developmental disabilities, including autistic people
  o trauma-attachment conditions
  o physical health comorbidities, other mental health symptoms, substance use
  o Severe difficulties in social/emotional function, coping with the social environment
  o Everyday function (ADLs and community)
• Highly vulnerable to self-neglect and exploitation
• Family/home/care environment, which is in some way chronically toxic, risky, highly conflictual, unsafe, disconnected, fragile.
• Long periods in hospital and high community support needs
• Several systems involved in care eg NSW Health, National Disability Insurance Scheme (NDIS), Housing and Accommodation Support Initiative (HASI), Justice and Forensic Health Mental Health Network (JFMHN), Housing NSW, Therapy Alliance Group (TAG), Public Guardian NSW, Aged Care Community and Residential Services.</td></tr>
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	AND/OR • Their risk is highly changeable due to dynamic risk factors • They require intensive support, including coordination of multiple services. **High Risk Civil:** As per 3.4 of the Service Level Agreement regarding forensic and high risk civil patients between the NSW Justice Health and Forensic Mental Health Network (JHFMHN) and SESLHD: "A *high risk civil patient* is a consumer of LHD mental health services. The high risk status is defined by the LHD's clinical assessment rather than by the courts or by JHFMHN. A high risk civil patient is assessed to have significant ongoing risk of danger to self or others."
What to do	**1.1 Triage and Assessment Process** a) A bio-psychosocial comprehensive mental health assessment and risk assessment must be undertaken (including outcome measures and additional assessments as required), using the standardised electronic Medical Record (eMR) documentation (see SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health) b) This initial assessment will inform the process of needs identification and care planning and will clarify whether the consumer is classified as exceptionally complex or high risk civil as early as possible. This includes identification of the most appropriate community service and/or continuing care coordination or rehabilitation treatment. NB: If the consumer has been recently transferred to community mental health from a SESLHD mental health inpatient unit (including PECC) and has a current bio-psychosocial comprehensive mental health assessment, the initial assessment does not need to be redone, rather the "Continuing assessment" as per SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health) should be followed. **1.2 Referral** a) A consumer's suitability for community options provided by SESLHD MHS will be determined at the relevant community referral forum. Once suitability is established, a nominated senior clinician will begin service planning for the consumer until a suitable primary clinician is allocated. Persons living in the community who do not receive case management services, experiencing a mental illness where there are ongoing and unmet, complex care needs that have not been successfully resolved with acute care service follow up, are to be escalated to the site Community Services Manager to determine if a care coordination service is needed

	1.3 Treatment Planning, Risk Management and Review All consumers of the MHS require care planning and review every 13 weeks, plus a Consultant Psychiatrist medical review every six months, as per SESLHDPR/642 Clinical Review in Mental Health. **High risk civil and consumers on a Forensic Order** require an updated risk assessment – including a home visit risk assessment stipulating whether the consumer can be home visited or must have centre-based appointments only – and updates to the management plan every 13 weeks, plus a Consultant Psychiatrist medical review every six months. Consider use of the Historical Clinical Risk Management-20 (HCR-20) for consumers identified as extremely high risk of violence. Under the *Forensic Provisions Act 2020* and NSW Ministry of Health Policy Directive PD2012_050 Forensic Mental Health Services, risk assessments for all forensic consumers are logged into a Forensic Governance Report which is to be updated quarterly. a) Consumer **case conferencing** is an important element of effective, integrated multidisciplinary care planning for consumers who have complex needs and who have involvement with multiple services. Consumer case conferencing involves bringing together all relevant parties involved in a consumer's care to identify/review the consumer's needs and to develop a clear, comprehensive plan for treatment, with defined roles and responsibilities. Case conferences can be used to: identify or clarify issues, strengths, needs and goals; review activities including progress and barriers towards goals; map roles and responsibilities; resolve conflicts or develop solutions; prevent critical or adverse events; and adjust current treatment plans. Case conferencing should also consider referring to local specialist teams for involvement such as the SESLHD Intellectual and Developmental Disability Mental Health Service. Each site requires a forum for case conferences, with a structured agenda and designated senior staff (such as a Clinical Manager and/or Clinical Coordinator) to organise them. b) If the consumer case conference is unable to resolve identified issues, local escalation process to site Clinical Director and/or Service Director should occur. If issues are still unresolved, the Clinical Director and Service Director should escalate as appropriate. c) If issues cannot be resolved at a local site complex care conference then referral should be made to the SESLHD Complex Care Committee as per SESLHDBR/029 Referral to the Mental Health Service (MHS) Complex Care Review Committee d) It is part of the JHFMHN role to provide SESLHD with clinical leadership, training and education regarding high

	risk civil consumers, as per their Service Level Agreement and NSW Ministry of Health Policy Directive PD2012_050 Forensic Mental Health Services. **Forensic supervision** is conducted on a monthly basis between each SESLHD site and the Community Forensic Mental Health Service, whereby high risk civil consumers' current treatments and risks can be discussed and clinical supervision provided. A referral to the Community Forensic Mental Health Service may be an outcome of the supervision, where appropriate. Community MHS managers or delegates at each site are responsible for coordinating this supervision with the Community Forensic Mental Health Service. e) For consumers with complex needs associated with an Eating Disorders Clinical Support Team for consultation and collaboration around care planning and referral options. **1.4 Transfer of Care/Discharge** a) Consumers with complex needs, and high risk civil consumers, may require transfer of information to multiple agencies at points of transition. Methods of communication could include case conferencing, clinical handover (using ISBAR principles as per SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR)), eMR and – where consumer consent is given – sharing of relevant assessments and plans with other supports, such as community managed organisations.
When to use it	This business rule is to be used in mental health community settings when a person has been identified as a complex and/or high risk civil consumer.
Why the rule is necessary	This business rule is necessary to achieve: • Safe, effective and efficient determination of need for community services for complex and high risk civil consumers • Safe, effective and efficient prioritisation of referrals for consumers with complex needs, and for high risk civil consumers • continuous active planning for consumers • Safe, efficient and effective matching of consumer needs to available clinical resources • accurate and consistent documentation, transfer of information and data collection in eMR • informed consumers and staff, who understand their roles and responsibilities • regular system evaluation, monitoring and improvement.
Who is responsible	Responsible staff are those of all disciplines working in mental health community settings.
References	**SESLHD** • SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health • SESLHDPR/642 Clinical Review in Mental Health

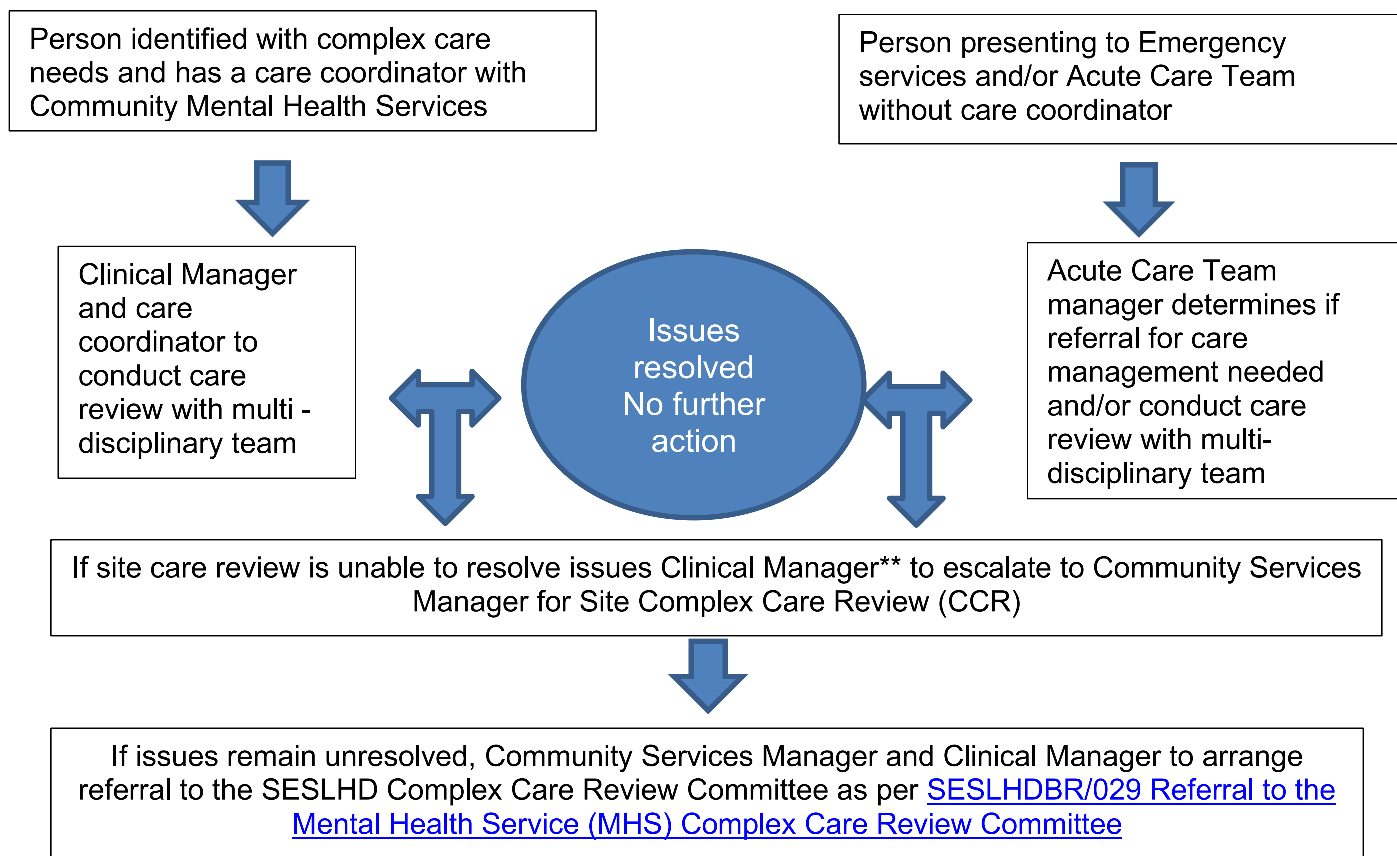
	• SESLHDBR/029 Referral to the Mental Health Service (MHS) Complex Care Review Committee • SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR) **NSW Health** • PD2012_050 Forensic Mental Health Services • PD2024_030 Responding to the health care needs of people with a disability **Other** • NSQHS Standards User Guide for the Health Care of People with Intellectual Disability
Functional Group	Mental Health
Executive Sponsor	Chris Hay, General Manager, MHS
Author	Access and Pathways to Care Lead, MHS

Revision and Approval History

Date	Revision Number	Author and Approval
Sept-Nov 2015	0v1/0v2	Original draft prepared by TSH MHS staff in response to Clinical Incident Review (CIR) and circulated broadly for feedback, with some comments incorporated.
Dec 2015	0v3	SESLHD MHS District Document Development and Control Committee (DDDCC) requests referral back to author and Ellen McFarlane, STG/TSH MHS Quality Manager, to ensure appropriate definitions are included, ensure review by Chief Psychiatrists and to conduct a closer examination of whether CIR requirements could be fulfilled by amending an existing policy document.
Feb 2016	0v4	Document reassigned to SESLHD MHS Risk Manager by DDDCC due to staff movements. Further consultation with Community MHS Managers and Staff Specialists requested.
Mar 2016	0v5	Frontline staff report that a separate document is required – one which assists in fulfilling requirements for this consumer cohort as per SESLHD Service Level Agreement with the NSW Justice Health & Forensic Mental Health Network. Two further rounds of consultation conducted; no further comments received.
May 2016	0v5	Endorsed by SESLHD MHS Clinical Council.
May 2019	v1.0	Confirmed correct template. All references to “District” have been replaced with “SESLHD”
May 2019	v1.1	Circulated for routine review to relevant stakeholders: Service Directors, Clinical Directors, Clinical Operations Managers, SESLHD MHS Clinical Director for Child and Adolescent, Community Service Managers, Pathways to Community Living Clinician, TSH Clinical Nurse Consultant MH ID Co-ordinator, Consumer Partnerships co-ordinator- no comments received. Access and Service Integration Manager - changes made to collation of forensic Governance report from SESLHD MHS Risk Manager to Access and Service Integration Manager,
June 2019	v1.2	Minor Review – addition of reference to Historical Clinical Risk Management-20 (HCR-20) added to document Endorsed by the SESLHD MHS DDCC Endorsed by the SESLHD MHS Clinical Council
July 2019	1.2	Processed by Executive Services prior to publishing.

July 2019	1.3	Reference to rescinded procedure removed and replaced with SESLHDGL/074 Clinical Documentation in Mental Health
October 2021	2.0	Updated by Danielle Coppleson to reflect the needs of, and processes for Consumers within the Community with Complex Needs
November 2021	v2.1	Reviewed by MHS Document Development and Control Committee. Minor feedback.
August 2022	v2.2	National Standards updated. Section added on appropriate local escalation. GM details updated. Endorsed Executive Sponsor.
29 October 2025	v3.0	Routine review commenced. Circulated to DDCC for review and feedback. Minor changes identified including inclusion of Eating Disorders Clinical Support Team. Sent to Clinical Council for review and endorsement. Endorsed for publication Executive Sponsor

APPENDIX 1: Trigger points for Community Complex Care Review



Site Complex Care Review Team Members

Required

- Clinical Director for the Site
- Consultant Psychiatrist working with team making request
- Community services manager
- Relevant member of SESLHD Partnerships team (Access team/PCLI/NDIS/IDMH Coordinators)

Optional content guests depending on areas of need:

- IPU Manager
- Community Team Manager where contact has been made
- Ambulance/Police liaison and/or PACER
- ED managers/staff
- Alcohol and/or other Drug services
- Aged care
- Physical health
- External Service providers including
  - Housing and/or homelessness such as DCJ
  - Aboriginal health
  - Forensic and/or correctional/legal services (e.g. IDRS)
  - Aged care
  - Primary care
  - Private practitioners
- Intellectual Disability Mental Health services
- Integrated care services such as ED to community team
- NDIS stakeholders
- Guardian

** Community services that do not report to a Community Service Manager should escalate to the Clinical Operations Manager (or site equivalent).

APPENDIX 2: Complex Care Planning Template

Items to consider for inclusion when preparing the agenda for the Complex Care Review

Presentation of person situation including:

- Stated purpose and desired outcome for the review
- Proposed least restrictive treatment options considered by the Team
- Person's goals/family goals

The person's history

- Developmental history
- Mental health history
- Intellectual Disability/Cognitive Ability
- Alcohol and other Drug use/history/treatment providers
- Physical health and other treatment providers
- Legal/forensic/Violence including physical, verbal sexual
- Financial and Living situation – suitability, risks, supports
- Decision making (guardianship)
- Family
- Cultural/diversity needs

History of experience of mental illness and other comorbidities,

- Treatments trialed, with the authority of the treating psychiatrist and site Chief Psychiatrist.
- Results of previous routine physical health screening and assessments as well as appropriate interventions offered
- Synopsis of outcomes of care and unresolved actions

Critical investigation and assessment reports

- OT assessment – full functional assessment
- Cognitive assessments
- Consumer rated assessments (RAS DS etc)
- Strengths assessment
- Family and Carer assessments
- Risk – CRAM, Community Forensic, incident reports
- ED plan documented
- Frequent presentation plan documented
- Details of current or previous partnerships with CMO/NDIS in relation to the person
- All previous second opinions and case conference minutes

The person's Voice

- Wellness/relapse prevention developed
- Care plan with consumer goals
- Peer workers involvement

Mental Health services role to date

- Consultant reviews
- Care coordination
- Other

Details of current or previous supports with CMO/NDIS in relation to the person

- What are NDIS supports in place
- HASI supports

Formulation and actions

- Hypotheses
- What needs to be in place
- Challenges – priority areas for action
- Least restrictive models of care proposed

Areas for action

- Actions and include person/s responsible
- Time frame for action updates

APPENDIX 3: Case Formulation Template (The 5 Ps)

Factor	Identified issues
Contributing background factors *(Predisposing factors)*	
Triggers *(Precipitating factors)*	
Behaviour of concern *(Presenting issues)*	
Consequences \ maintaining factors *(Perpetuating factors)*	
Strengths – individual and systemic *(Protective factors)*	

Hypotheses: ______________________________