

# NSW Health - NSW Police Force Memorandum of Understanding 2018

Incorporating provisions of the  
*Mental Health Act 2007* (NSW) No 8  
and the *Mental Health Forensic  
Provisions) Act 1990* (NSW)



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# Foreword

This revised Memorandum of Understanding (MOU) is entered into by NSW Health (including NSW Ambulance) and NSW Police Force. It sets out the principles which guide how agencies will work together when delivering services to people with mental health problems.

The high-level guiding principles contained within this document aim to deliver person-centred care when staff are assisting people to access appropriate care, underpinned by the principles of recovery. Recovery is a journey undertaken by people with lived experience of mental illness who have the right to expect to live fulfilling lives and to pursue their own choices about how they live and about the support they accept (*Mental Health Coordinating Council and Living Well – Putting People at the Centre of Mental Health Reform in NSW – A Report*). Person-centred care is health care that is respectful of and responsive to the preferences, needs and values of patients and consumers. The widely accepted dimensions of person-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care (*Australian Commission on Safety and Quality in Health Care*).

NSW Health and NSW Police Force acknowledge that the safety of all concerned is paramount. Both recognise that resources across all the services vary and fluctuate particularly in rural and remote areas. A flexible, solution focussed approach across the partnership will optimise outcomes for the person, the safety of everyone involved and the efficiency of the broader emergency response system.

For people with a mental illness or a mental disorder, this MOU is underpinned by the objects of the [Mental Health Act 2007 No 8](#) (MHA) namely:

- a) To provide for the care and treatment of, and to promote the recovery of persons who are mentally ill or mentally disordered, and
- b) To facilitate the care and treatment of those persons through community care facilities, and
- c) To facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and
- d) While protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others, and
- e) To facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.

The MOU has been broadened beyond people in a mental health emergency. It includes a section on situations involving patients in police custody (other than under the MHA or *Mental Health (Forensic Provisions) Act* (MHFPA) and a section on the management of public safety issues in health settings.

This MOU is the product of extensive consultation between and within the key agencies involved. Its successful implementation and operation requires a commitment from all agencies to work cooperatively and to develop local protocols and procedures that address the needs of people with a mental illness or a mental disorder. Education across and within agencies is central to its success. NSW Health and NSW Police Force encourage collaborative and innovative practices to achieve better outcomes for people accessing these services.

This MOU supersedes all previous versions and is effective from the date of the last signature. It will remain in effect unless it is revoked, varied or modified in writing by the partner agencies.

We commend this MOU and fully endorse its implementation.

Elizabeth Koff  
Secretary of Health

Dated: 22 December 2017

  
Michael Fuller AM  
Commissioner  
NSW Police Force  
20 NOV 2017

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# Section 1

# Introduction

## 1.1 PURPOSE OF THE MOU

The purpose of this MOU is to assist staff of NSW Health (including NSW Ambulance) and the NSW Police Force to work collaboratively in responding to situations involving people with mental health problems in a manner that best meets the clinical and safety needs of the person and the safety of staff and others. This MOU provides an overarching framework for local MOU committees to develop local operational protocols to meet local needs and resource availability and which are consistent with this MOU.

## 1.2 GUIDING PRINCIPLES UNDERPINNING THE MOU

People with a mental illness or a mental disorder may have experienced trauma in their lives affecting their mental and physical health and wellbeing. It is therefore important that care and interventions are trauma informed. The core principles of trauma informed care are safety, trustworthiness, choice, collaboration and empowerment, in parallel with the core tenets of a recovery-informed approach. Most fundamentally, it represents a move away from a sole focus on diagnosis and towards the provision of holistic care based on lived experience and individual need. There is an expectation that services will ensure staff have a basic understanding of how trauma affects the life of a person and accommodate the particular sensitivities and vulnerabilities of trauma survivors. The impact of restrictive procedures such as searching, restraint, sedation and seclusion on these individuals may increase their distress. Staff are to make every effort to minimise potential distress through clear communication and respectful, sensitive interactions.

The following principles underpin this document:

- a. There is a commitment to ensure that people are treated with dignity and respect and that services are provided in a confidential environment.
- b. There is a commitment to respond to incidents and to provide services in a manner that is least restrictive, consistent with the person's clinical and safety needs and the circumstances at the time.
- c. There is a commitment to work together to ensure that people with mental illness have timely access to appropriate care and treatment in a safe environment.
- d. Every effort will be made to involve people with a mental illness or mental disorder and their carers where relevant, in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development. This includes obtaining the person's informed consent when collaboratively developing treatment and recovery plans, monitoring their capacity to consent and supporting those who lack capacity to understand their plans.
- e. There is a commitment to respond to people in a mental health emergency with the same urgency as a physical health emergency.
- f. Age, gender, religious, cultural, language and other significant factors should be recognised and accommodated if possible in the circumstances.
- g. For people with a mental illness, care and treatment should aim to support the person, wherever possible, to live, work and participate in the community.
- h. All interventions will be in keeping with the provisions of the MHA.
- i. There is a commitment to a governance structure to support the operational effectiveness of the MOU and early and timely issue resolution. An appropriate structure for this is the local MOU committee.

## 1.3 INFORMATION EXCHANGE

It is recognised that all parties to this MOU are required to comply with the following NSW laws, individual agency policies and protocols in respect to the collection, use or disclosure of personal information and or personal health information:

- The *Privacy and Personal Information Protection Act 1998* (NSW) (PPIPA) as it regulates 'personal information' and any direction, Code of Practice or Regulation made thereunder
- The *Health Records and Information Privacy Act 2002* (NSW) (HRIPA) as it regulates 'health information' and any direction, Code of Practice, Guideline or Regulation made thereunder.

The type of information that is typically exchanged falls within the legislative definitions of 'health information' in both the PPIPA and HRIPA.

Information regarding the criminal history of individuals is managed by the NSW Police Force via their COPS database and is covered under the provisions of the PPIPA, and HRIPA. Information regarding the criminal history of individuals will not generally be provided to other agencies or entities unless by virtue of a warrant or subpoena.

Relevant personal health information that could be exchanged may, depending on the circumstances, include, but not be limited to:

- the name of the person
- their date of birth
- their address or usual place of residence
- presence or availability of carer, trusted family members or significant others and relevant information gained from them
- need for an interpreter
- locations frequented by the person
- general description of presenting problem focusing primarily on associated behaviours
- strategies for managing the person if the person comes to the attention of police and/or ambulance

- history of violence or other behavioural indicators including any known triggers for violence
- de-escalation techniques that have been effective in the past
- information and advice regarding potential behaviour associated with the person's medication
- information and advice regarding whether the person is at risk of withdrawal, overdose or over-sedation due to risky alcohol and/or drug use
- risk factors for transporting the person
- medical health information that police and/or ambulance need to be aware of when transporting the person (for example, person's allergies to certain drugs, whether they are on pharmacotherapy)
- other agencies involved.

When attending (or preparing to attend) a mental health incident, information may be shared between partner agencies in a number of circumstances, including the following:

- for the purpose of providing necessary services; or
- as authorised by the MHA, in particular information which can be provided to Police and/or NSW Health at presentation or which can be provided in order to detain a person who has left the hospital without leave or which is necessary to disclose to comply with the MHA; or
- as necessary to lessen or prevent a serious and imminent threat to the life, health or safety of any person, or a serious threat to public health or public safety; or
- to promote effective service delivery, planning and improvement; or
- to enable NSW Police Force to exercise their law enforcement functions but only where there are reasonable grounds to believe that an offence may have been or may be committed.

## Section 2

# Partner Agencies – Structure

This section lists the MOU partner agencies, describes their organisational structure and briefly summarises their role and powers relating to this MOU.

In this document a reference to agency staff mean staff employed by NSW Health (including NSW Ambulance) and NSW Police Force.

### 2.1 NSW HEALTH

There are 15 Local Health Districts (LHDs), St Vincent's Health Network and two Speciality Health Networks (Justice Health and Forensic Mental Health Network and Sydney Children's Hospitals Network) in NSW.

#### Emergency Departments

Most public hospitals in NSW have an emergency department (ED). The availability of on-site mental health staff depends on the location and size of the ED. Some major hospital EDs have mental health staff on-site 24 hours a day. Others may have access to on-site mental health staff during business hours or, in larger hospitals, for extended hours. In some regional, rural and remote hospitals, there may only be access to mental health staff via audio visual link. All EDs can access mental health consultation via the 1800 011 511 Mental Health Line.

Some EDs have been declared a mental health facility (DMHF) under the MHA (refer to 3.3.4). These EDs are authorised to detain people for assessment, immediate care and where necessary, arranging transport to an inpatient unit.

#### Mental Health Services

Public mental health services are accessible 24 hours a day, seven days a week. The availability of on-call and on-site mental health staff, particularly after hours, varies across sites and in rural and remote locations. There are two main streams of mental health service provision, namely, community and inpatient care. Services range from acute through to community-based care to psychosocial support services.

The 1800 011 511 Mental Health Line is a 24 hour mental health telephone service staffed by mental health professionals who can provide assistance with mental health triage and referral. The line can also be used by paramedics, police and other service providers, to make a referral or seek advice on an individual's clinical presentation, their urgency of the need for care and local service options.

All doctors and accredited persons are authorised to complete a schedule under section 19 of the MHA should the requisite criteria be met. A section 19 schedule authorises a person to be taken to and detained in a DMHF for a mental health assessment. Health staff may request assistance from other partner agencies in transporting a person to a DMHF.

#### NSW Ambulance

NSW Ambulance is responsible for the delivery of front line out of hospital care, retrieval and health related transport.

There are four control centres which coordinate all NSW Ambulance resources. People requiring urgent clinical care are prioritised first.

All qualified paramedics are authorised to detain a person who meets the criteria under section 20 of the MHA and take them to a DMHF for assessment. They are also authorised to restrain a person under section 81 of the MHA using the mechanical restraint device for the purposes of safely transporting the person. Appropriately authorised paramedics can administer sedation but only where necessary to enable safe transport.



## 2.2 NSW POLICE FORCE (NSWPF)

In NSW, there are 76 Local Area Commands (LAC), located within six Regions. Each LAC has a Mental Health Contact Officer (Inspector) who is a member of the relevant local MOU committee and liaises with relevant agencies if issues arise. Each Region has a Region Mental Health Contact Officer (Superintendent).

The NSWPF Mental Health Intervention Team provides specialised, intensive mental health training to frontline police and operational advice and guidance to the field on mental health and suicide related issues. In addition, the MHIT operates as a point of high level liaison between the NSWPF and other agencies in this space.

All police officers are authorised to use Section 22 of the MHA to apprehend and transport a person to a DMHF to receive an assessment, should the requisite criteria be met.

Under sections 20(2) 21, 49 and 59 of the MHA, Police may be called upon to assist other staff in the detention and transport of a person where there are serious concerns relating to the safety of the person or others.

## Section 3

# Mental Health – A Person’s Journey

This section is structured to follow a person’s potential journey from first contact with emergency services in the community, to hospital and beyond.

### 3.1 RESOURCES AVAILABLE IN THE COMMUNITY

This section describes resources available to individuals in the community who may not need to be taken to hospital or for people who do not meet the criteria for detention under the MHA. These options may assist a person to access community-based services rather than acute (involuntary) hospital care. A person may seek to voluntarily admit themselves to hospital.

#### 3.1.1 Carers, family and friends

Carers play an important role in the lives of people living with a mental illness. Partner agencies should make every effort to work with carers who can assist, provide information and critical knowledge regarding how best to work with the person with mental health issues. Information gained from family and carers may be highly relevant in determining the best care plan for the individual.

It is important to ensure that all relevant information provided to staff by carers, family and friends, is documented and shared as part of the handover of care.

#### 3.1.2 1800 011 511 Mental Health Line

The 1800 011 511 Mental Health Line is a statewide 24 hour telephone service which connects people with their local mental health service. Staffed by mental health professionals, the line gives NSW residents who are seeking mental health assistance, access to specialist mental health advice, triage and referral to the most appropriate care.

Other service providers are able to speak with a mental health professional for advice about a person’s clinical symptoms, the urgency of the need for care and local treatment options.

Partner agencies can ring the line for advice, guidance and referral options for people with whom they come into contact.

Consumers and carers should be referred to this service where appropriate.

#### 3.1.3 Community mental health teams

Community mental health teams (CMHT) operate across the State providing assertive outreach and centre-based care options. CMHTs are an excellent source of advice and information.

Accredited Persons (APs) are authorised to write a schedule under section 19 and section 19(A) of the MHA (where the relevant criteria is met), which authorises the person to be taken to and detained in a DMHF for an assessment. In the absence of an authorised medical officer and where relevant criteria is met, an AP is also authorised to undertake a face-to-face review of a person under section 27(A) of the MHA. APs can call upon emergency services to assist in managing and transporting a person.

Partner agencies should be aware of their local CMHT and the capacity to refer people to them when appropriate. In some areas, community mental health staff can be called upon to attend the scene of an incident. The response will vary dependent upon the location and other factors including the size of teams and the number of sites outreached to.

Some people will already have active contact with the mental health service and may have a care co-ordinator or a mental health care plan. Partner agencies should enquire as to the existence of such a plan and follow the strategies offered where appropriate in the circumstance and if necessary or required, where agreed to by the person.

CMHTs can access or provide referrals to mental health services for young people, older people, mental health recovery, care coordination, drug and alcohol or other specialist services.

### 3.1.4 General Practitioners

General Practitioners (GPs) are often the first point of contact for people with mental health issues. GPs are able to liaise with local CMHTs to coordinate care for people with mental health issues.

GPs can refer their patients to other GPs with specialist mental health training, psychiatrists and psychologists under the Better Access initiative. GPs can also refer patients to psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with mental health qualifications under the ATAPS (Access to Allied Psychological Services) initiative. These services may be private or public mental health services.

Partner agencies may provide assistance to GPs in working with their patients. Partner agencies may refer people to their GP, if appropriate.

GPs are authorised to write a schedule under section 19 of the MHA (where the relevant criteria is met), which authorises the person to be taken to and detained in a DMHF for a mental health assessment. GPs can call upon emergency services to assist in managing and transporting a detained person for a mental health assessment.

### 3.1.5 Specialist services

Consider the following referral options where available, including:

- **Children and Adolescents (16 years of age and under)** – for whom consultation with specialised child and adolescent services should be considered. Consideration also needs to be given to the needs of children of parents with a mental illness or mental disorder, including reporting to the NSW Family and Community Services, if appropriate.
- **Older People (65 years of age and over)** – for whom consultation with specialised older persons mental health services, Severe Behaviour Response Teams / Dementia Behaviour Advisory Service and Aged Care services should be considered.
- **Aboriginal and Torres Strait Islander People** – for whom consultation with specialised Aboriginal health services or Aboriginal medical services should be considered.
- **Culturally and Linguistically Diverse populations** – for whom contact with specialised care and interpreter services should be considered (e.g. NSW Health Care Interpreter Service; Transcultural Mental Health Centre).

- **Dual Diagnosis populations** – for whom contact with specialised Drug and Alcohol services should be considered (e.g. the Alcohol Drug Information Service (ADIS) Helpline; the LHD Drug and Alcohol Intake line; or the Drug and Alcohol Specialist Advisory Service DASAS)
- **Cognitively Impaired populations** – for whom contact with specialised Intellectual Disability services should be considered.

### 3.1.6 Other telephone and web-based services

There is a wealth of information available on mental health and related issues and suicide prevention. Many of these providers have a telephone and on-line presence and information can be readily obtained.

The availability of other services may be specific to local areas. Partner agencies should familiarise themselves with these service options and utilise them as appropriate.

## 3.2 INITIAL RESPONSE AND ATTENDANCE IN THE COMMUNITY

This section will deal with the information that is relevant when agencies are attending (or are considering attending) a mental health related incident.

### 3.2.1 Risk assessment

Incident response, timeframes and resources will be informed by the nature and degree of risk.

Complex situations often require a collaborative multi-agency response. In these circumstances, staff will consider a range of factors when assessing risk. However discussions to determine the response which best provides for the safety and wellbeing of the person and the safety of staff involved, should include consideration of the following factors:

- access to and communication of all available information including information on previous incidents involving the individual and observed current behaviour at the scene
- awareness that situations are often dynamic (situations may escalate or de-escalate with little or no notice), and therefore require regular review of risk
- a discussion regarding the resources that are currently available and those that could become available.

- options for effective response and the benefits, risks and limitations of each
- consideration of the consequence of the risk, including the harm that may arise in the absence of another agency attendance
- the ideal timeframe for effective response.

Where necessary, agencies should make appropriate records of these discussions and actions taken.

Staff are to make every effort to come to a shared agreement about how to respond to a particular situation. Where agreement cannot be reached about the nature and degree of risk or requirement for attendance, staff will escalate the matter without delay in order to avoid compromises to the person's care and the safety of staff. Where agency staff are dissatisfied with the on-site resolution of an interagency dispute, they should refer the issue to the local MOU committee for discussion and resolution using the MOU Dispute Resolution form (Appendix E).

### 3.2.2 On-site attendance

Attendance at an incident involving a person displaying signs of a mental health issue may involve single or multiple agencies. Initially, the role of partner agencies is to ensure the safety of those involved. Police may be required to attend situations which pose a threat to public safety, e.g. involving violence or the imminent threat of violence, or where weapons are involved or where a crime is being committed.

Once everyone's safety is established, the attending agencies will consult with each other to determine the best course of action to facilitate the person accessing appropriate care in a safe and timely manner including the options listed in Section 3.1.

If a decision is made to exercise powers under the MHA to take a person to a DMHF to be detained there for an assessment, the following principles should apply in determining appropriate agency attendance and involvement:

- The safety and welfare of the person being detained and the safety of others are primary factors in partner agency negotiations.
- Different criteria for detention applicable to agency staff, i.e. the provisions under section 19 of the MHA (medical officers and accredited persons) are different to the provisions under section 20 of the MHA (paramedics), which is different again to the provisions under section 22 of the MHA (police officers).

- The agency detaining the person need not be the transporting agency. For example, police may detain a person under section 22 of the MHA and paramedics may transport the person to hospital. Using this example, the person is able to be transported to hospital without the need for police attendance. However, should the person's presentation and behaviour be deemed by attending staff to present sufficient risk, police may provide escort.
- The agency who detains the person may not necessarily have been the agency first on the scene.
- The decision to exercise powers under the MHA is based on an individual staff member's assessment of the person. A staff member from one agency cannot insist that a staff member from another agency exercise their powers under the MHA in lieu of the first staff member exercising their powers.

### 3.2.3 Police assistance

The NSWPF primary responsibility in relation to its response to incidents is to ensure public safety. A request for police assistance is to be limited to situations which pose a threat to public safety or where there is significant or imminent risk to staff involved. Officers have the training, equipment and resources to manage these situations. Police may also be called upon by other agencies to assist them in fulfilling their role, including under the MHA.

If there is actual or imminent danger to a person then police should be notified immediately through 000. Where a less urgent attendance is required, contact with the nearest police station is suggested. For general enquiries, the Station Supervisor (Sergeant) or Duty Officer (Inspector) at the nearest station are the best points of contact.

For the most part, attendance by police at non-urgent mental health related incidents is associated with poor outcomes for mental health consumers and should be a last resort. Resourcing issues at another agency should not be the sole reason for the involvement of police.

### 3.2.4 Voluntary persons under the MHA

A person may seek to be admitted to a mental health facility as a voluntary patient. In these circumstances the person may be transported by their carer, family or friends or by a member of NSW Health, e.g. a community mental health team. NSW Ambulance may complete the transport if the person requires clinical monitoring. Police vehicles should not be utilised for transporting voluntary patients.

### 3.2.5 People with complex needs accessing emergency services

Some people frequently come into contact with emergency services including police, paramedics, emergency departments and mental health services. These individuals may have complex needs requiring assistance from a range of services. Partner agencies should collaborate to assist these individuals. Some will have a mental health care plan or an interagency management plan.

#### Mental health care plan

A mental health care plan is a document utilised by mental health services to capture objectives and strategies for a person's care. A mental health care plan is developed in collaboration with the person and where relevant, their carer. The person and their carer should ideally be provided with a copy of their mental health care plan. Mental health services will need to seek the person's consent for sharing the plan with other agencies, once the person has been oriented to the benefits of this.

#### Interagency management plan

Interagency management plans are usually developed in response to people who frequently access emergency services. The person may not be a current patient of mental health services but due to their complex needs, the need for an interagency approach has been identified. The formulation of an interagency management plan should be considered when a structured and consistent approach to the person's presentations or contacts is likely to have positive impact on clinical outcomes, their safety and the safety of responding services. Information provided by carers and family may be useful in the development of these plans.

Interagency management plans are often discussed at local MOU committee meetings. The availability of interagency management plans should be limited to agency staff providing services to these individuals. Care should be exercised to protect the person's confidentiality and to ensure that these plans are regularly reviewed and cease to operate when no longer required.

### 3.2.6 Escalation

Staff are to make every effort to come to a shared agreement on how to respond to a particular situation. Where agreement cannot be reached about the nature and degree of risk or requirement for attendance escalation will occur to avoid compromises to the person's care and the safety of staff. Where agency staff are dissatisfied with the on-site resolution of an interagency dispute, they should refer the issue to the local MOU committee for discussion and resolution using the MOU Dispute Resolution Form (Appendix E).

Partner agencies are to ensure that local escalation pathways and the contact details of the person to whom issues are to be escalated are well understood by their staff. Local MOU committees have a key role in ensuring that the local escalation path is clearly documented and communicated within each agency and reviewed appropriately.

Senior staff responding to the escalation are to have delegated authority to arrive at decisions to resolve the matter. The clinical and safety needs of the patient will be paramount in decision-making.

The table below identifies the person within each agency with whom issues should be escalated. People identified may vary at a local level.

Agency	Role	Rank/Position
NSW Police Force	Supervisor	Sergeant
	Duty Officer	Inspector
Emergency Department	Nursing Unit Manager or delegate or After Hours Nurse Manager	Registered Nurse
	Medical Director or delegate	Registered Nurse
	Executive On Call	Doctor
Mental Health Service	Supervisor / Manager	Manager or Director
	Executive on call	Team Leader or Service Manager
NSW Ambulance	Ambulance Control Centre	Manager or Director
	Duty Operations Manager	Supervisor
		Inspector

## 3.3 TRANSPORT

This section deals with transporting a person to hospital.

### 3.3.1 General transport principles

These general principles seek to guide decision making regarding the most appropriate mode of transport to hospital and agency involvement.

Transporting a person to hospital:

1. Must protect the person's rights and dignity
2. Must be the least restrictive in the circumstances which best meets the clinical and safety needs of the person and the safety of staff involved in the transport.

The mode of transport used and agency involvement is based on risk and other circumstances at the time.

Under this MOU, people who have been detained under the MHA may be taken to the nearest DMHF. Transporting agencies may consider travelling further to a specific DMHF in a number of circumstances including:

- where this would enhance clinical and safety outcomes for the person and staff involved in their care and is supported by interagency discussion
- where the additional travel time does not distress the person further
- where there is a pre-existing agreement as part of the person's mental health care plan or interagency management plan to take the person to a specific DMHF
- where the transporting agencies have the resources to do this.

### 3.3.2 Transport from the community to hospital

The three main transport options available are NSW Ambulance vehicle, NSW Police vehicle and a community mental health or hospital vehicle. Where multiple agencies are in attendance, it is important that there is open communication between attending staff to determine whether the person requires transport to hospital and if so, the most appropriate mode of transport and agency involvement. The primary factor in determining this is the safety and wellbeing of the person and the safety of others including the staff involved in the transport.

Attending staff are encouraged to seek information from the person's carer, family and friends as this information can assist in the assessment of risk, the potential for behaviour to escalate during transport, and influence planning for the management, care and transport of the individual.

Transport and timely handover to the Health system of people detained under the MHA is particularly challenging in rural NSW due to the distances involved. Staff should be cognisant of environmental factors, particularly hot and cold climatic conditions and its impact on long distance transports. Where long distance transports are involved, strong consideration should be given to a less restrictive mode of transport such as Ambulance vehicles as they are air-conditioned, provide for observation with appropriate clinical escort and rest stops where necessary.

### Ambulance

The most appropriate means of transport for a patient requiring clinical monitoring or clinical intervention is an ambulance.

Requests for NSW Ambulance to attend the scene of an incident involving a person in a mental health emergency can be made through 000 or by contact through police radio (for police officers). All calls will be triaged and a vehicle dispatched accordingly. Partner agencies are to provide as much information as possible, including current behaviour, risk of violence, medical conditions, medication taken, mental health diagnosis if known and substance use and effect of this on the patient's behaviour. This will enable NSW Ambulance to prioritise the request and to respond accordingly.

If a person is willing to be transported to hospital by Ambulance, it may not be necessary for paramedics to exercise their powers under section 20 of the MHA and will depend on the circumstances of each case. When determining whether or not to exercise powers under section 20 of the MHA, attending paramedics should take into consideration the person's willingness to voluntarily receive care and treatment once the person is in the hospital and the risk to the person should they leave the hospital before being assessed.

To ensure the safety of paramedics and the person, prior to transport by ambulance, a comprehensive joint risk assessment of the person is to be undertaken by attending staff. This assessment will consider the likelihood of the person's behaviour escalating during the

transport and interventions to manage this, e.g. use of sedation and Mechanical Restraint Device. Should the person's presentation be deemed by attending staff to present a serious risk to the person and/or others, paramedics may request the assistance of NSW Police. Attending police officers, if practicable, should assist in the transport of the person or make arrangements for another police officer to do so. Police can assist in a number of ways such as physically restraining the person, accompanying the paramedics during transport or following an ambulance in an escort capacity to ensure safety.

## Police

Police officers may transport a person detained under the MHA to hospital in a police vehicle. NSWPF policy indicates that such persons should be transported in a police caged vehicle. However these vehicles are not designed for such transports and do not offer the ability to effectively monitor persons who have medical issues or serious mental health issues. Police vehicles should therefore be viewed as a last resort for transport.

Additionally, police vehicles are an undignified method of transport and their use should be limited to situations which pose a threat to public safety which cannot be safely managed within the resources available to other agencies. Lengthy journeys in police vehicles potentially expose people to increased risks i.e. clinical deterioration and adverse climatic conditions.

Police vehicles should only be utilised where the person is at risk of serious harm to themselves or others, or where their behaviour presents a threat to public safety, including a risk to paramedics during transport that cannot be safely managed by the paramedics, and the police vehicle is the safest transport option. It is acknowledged that in remote areas of NSW, other considerations may apply.

Where a person has been detained by police under section 22 of the MHA, Police may seek the assistance of NSW Health to transport the person to a DMHF. In these circumstances, police complete a section 22 form, provide a comprehensive verbal handover which includes communication of all factors relevant to enable an assessment of the current and potential risk of the person's behaviour escalating, and hands the person and the form to the transporting NSW Health staff.

The person may be transported to a DMHF in a NSW Health vehicle without the need for police attendance. However, should the person's presentation and behaviour be deemed to present sufficient risk following a joint risk assessment, a police officer may provide escort in the NSW Health vehicle and/or can follow the NSW Health vehicle to the hospital. Any concerns with the application of this arrangement should be escalated as per the section on Escalation at section 3.3.4.

The intention of this arrangement is to minimise the involvement of the NSWPF in transporting people with mental health issues, where it is safe to do so.

## Community mental health vehicle

NSW Health staff are authorised under section 81 of the MHA to transport a person to a DMHF. Community mental health vehicles may be used to transport people to hospital where it is safe to do so.

Community mental health staff can be called upon by other agencies to attend a scene and facilitate a transport where appropriate. Local agreements and arrangements need to be established to provide for this. Given the nature of the type of transport, persons who are considered low risk are appropriate for this particular arrangement. In facilitating this mode of transport, community mental health staff may ask for police assistance.

Community mental health teams are not available 24 hours a day and their response to requests for transports will be within the context of hours of operation and availability. Effective liaison within the local MOU committee will clarify their capacity to respond to such requests for assistance.

### 3.3.3 Searching of people with a mental illness or a mental disorder for transport

Section 81 of the MHA police officers, paramedics and NSW Health staff are authorised to conduct an ordinary or frisk search (comparative to a general search for NSWPF officers under the *Law Enforcement (Powers & Responsibilities) Act 2002* (LEPRA)) of a person who is being transported to a DMHF, and to seize and detain the item. The search should only be conducted if attending staff suspect that the person is carrying anything that would present a danger to themselves or others or that could be used to assist the person escape.

The decision to search is made by individual

agency staff and is carried out to ensure the safety of the person and the attending agency(s) during the transport. Each agency receives training in search procedures.

The act of conducting a search will wherever possible, include consideration of trauma informed care principles and protection of the person's dignity.

If both NSW Health staff and police officers arrive at a scene, preference should be given to the police to carry out the search. This is consistent with the police role and their higher levels of training in this area. In the absence of police attendance, paramedics or community mental health staff should search the person themselves if they reasonably suspect the person may be carrying an object or objects that can be used as a weapon or that pose a threat to the safety of the person or others during the transport. If it becomes apparent during an interaction with a person that a search needs to be conducted, the decision to search should not be delayed until another agency arrives. Safety of all in attendance should be the primary focus of such decision making.

Police also have additional powers under LEPPRA which enables them to perform a 'strip search' under certain circumstances.

The outcome of the search is to be shared with all attending agency(s), including when the patient is handed over to another agency. Where responsibility for a person detained under the MHA is handed over to another agency, information relevant to the outcome of a search must be shared (e.g. suicide note, unidentified substances, etc.)

For inter hospital transfers, a search of the person and their belongings may be conducted by the responsible senior treating clinician or delegate (under the direction of the authorised medical officer) to facilitate the safe transport of the patient, and the results shared with staff involved in the transport.

### **3.3.4 Declared Mental Health Facilities**

A person detained under the MHA may only be taken to, detained, assessed and involuntarily treated in a DMHF. The exception is where the person also requires treatment for a non-mental health condition. In these cases, the person may be taken to and detained in a non-declared facility to receive this treatment. Where a person under the MHA is receiving treatment in a non-DMHF for a matter unrelated to the mental illness,

the provisions of the MHA and this MOU apply in the same way as if the person were being transported and detained in a DMHF.

There are currently three classes of DMHFs:

- mental health emergency assessment class (to provide for short-term detention for assessment, immediate care and arranging transport to an inpatient unit. Certain EDs have been declared under this class of DMHF);
- mental health assessment and inpatient treatment class (to provide the full range of inpatient functions under the Act); and
- community or "health care agency" class (to administer community treatment orders).

Where a person is being taken to a DMHF to be detained under section 19, 20 and 22 of the MHA and section 33 of the MHFPA, the person must not be taken to a community or health care agency class DMHF.

Agency staff should be aware of the DMHFs operating in their area.

### **3.3.5 Escalation**

See section 3.2.6 for information on escalation.

## **3.4 ARRIVING AT THE HOSPITAL**

This section deals with information that is relevant when agencies present a person at hospital for assessment.

### **3.4.1 Triage/handover/information exchange**

When agencies present a person to hospital for assessment, the exchange of information, written and verbal, is crucial to the effective and safe management of the person and the staff who will be providing care to the person. This must include providing clinical staff at the hospital with information on all relevant risk factors pertaining to the person and as set out in Section 3.2.1 of this MOU. In addition relevant factors would also include:

- The observed behaviour of the individual when the agency arrived at the scene.
- The behaviour and interaction of the person with the agency staff prior to and during transport.
- The outcome of a search if a search has been conducted.



Where paramedics have not exercised their powers under section 20 of the MHA but are concerned about the person's safety or the safety of others, the paramedics must communicate these concerns to clinical staff at the hospital as part of their clinical handover. This information will assist to inform the subsequent actions of clinical staff in providing for the safety of the person. This may include arranging appropriate observation and expediting assessment by the ED medical officer or an Accredited Person to review the person's status under the MHA.

If the person has been transported involuntarily under the MHA, the triage nurse or assessment clinician must be provided with any relevant completed legal documentation (section 19, section 20, section 22, section 33).

Documentation is to include all relevant information known to the detaining and presenting agency.

The presenting agency must seek out the triage nurse or assessment clinician and provide a comprehensive verbal handover as set out above. Presenting agencies actively contribute to the triage process. Hospital staff should feel free to seek clarifying information from the presenting agency or to request additional information, if needed and relevant. This interchange should focus on facilitating the effective and safe management of the person and maintaining the safety of staff. The handover discussion should include an assessment of the likelihood of the person's behaviour escalating to become a safety issue particularly once any mechanical restraints are removed and/or the police or paramedics withdraw.

For presentations under section 22 of the MHA and under section 33 of the MHFPA, presenting police are to clearly communicate with clinical staff of the need to notify police prior to the person being discharged. Hospital staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers.

People brought to a hospital under this MOU are not to be handed over to NSW Health security staff directly.

The submission of any relevant paperwork and the verbal handover represents the formal transfer of the person from the presenting agency to the hospital. This information is essential to support the ongoing, clinical management and

security of the person, and for people detained under the MHA, their ongoing detention, which becomes the responsibility of hospital staff.

Presenting agencies will not withdraw prior to the completion of the handover process.

Presenting agencies are requested to maintain a copy of the paperwork presented to the hospital for their own records. The hospital should afford the presenting agency with access to photocopying facilities to allow them to do this.

### **3.4.2 Section 33 orders**

Under section 33 of the MHFPA, a magistrate can order an accused person to be taken to and detained in a DMHF for a mental health assessment.

All DMHFs should have the resources and access to mental health advice (including via audio visual link) to deal with people presenting under section 33 unless otherwise agreed locally. Locally agreed arrangements which support the timely and safe assessment of these individuals should be supported by the development of local protocols. Locally agreed arrangements should be conveyed to all relevant Courts as this information will help magistrates to understand local resources and to inform decisions they make about which DMHF they order individuals to be taken to for assessment.

Wherever possible, Police will make every effort to bring people on a section 33 to the DMHF early in the day when staff are more readily available to complete the assessment in a safe and timely manner. However, the timing of presentations may be dictated by court processes.

The same processes for sharing of relevant information; joint risk assessment and handover as described in this document apply to the management of section 33 presentations. As part of police handover to the hospital, police are to clearly communicate with the receiving clinician that the person is to be apprehended by police following a determination by the authorised medical officer that the person is no longer to be detained in the hospital. Hospital staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers.

The same examinations are to be followed for a person who is taken to a mental health facility under section 33 of the MHFPA as for any other person who is taken to and detained in a mental

health facility under the MHA. That is, the examinations in section 27 and section 27(A) of the MHA are to be conducted. In operationalising these procedures, consideration should be given to the impact on resourcing for all agencies involved in managing these presentations.

If after the assessment the person is found not to meet the criteria for ongoing detention under the MHA and the police officer who brought the person to the facility is no longer on site and police have asked to be notified, then section 32 of the MHA requires an authorised medical officer to notify police that the person is not to be further detained in the facility and is to be discharged. Having considered matters communicated by police regarding their intended apprehension of the person, the authorised medical officer may detain the person for up to 2 hours pending their apprehension by police.

If the person has been ordered to be brought back before a magistrate under section 33 (1) (b) of the MHFPA, section 32 of the MHA requires the authorised medical officer to notify police that the person is not to be further detained in the facility and is to be discharged. Police are to attend the mental health facility to apprehend the person as soon as practicable after notification. The authorised medical officer must detain the person until apprehended by police.

### **3.4.3 Avoiding handover delays for paramedics and police officers**

All reasonable steps are to be taken by hospital staff to facilitate attending paramedics and police officers leaving the hospital as soon as possible, where it is safe to do so. Delays to the handover of the person are to be avoided as far as is reasonably practicable and hospital staff are to provide attending paramedics and police officers with ongoing updates relating to this process.

### **3.4.4 Security in the hospital**

Once the person has been formally handed over to the hospital, hospital staff are responsible for the care and the management of behavioural issues. Where the person presents a security risk, hospital staff may engage the assistance of health security staff where necessary and available to the extent of the role they undertake in NSW Health (refer to Sections 3.4.5 and 3.4.6). Where the level of risk is unable to be safely managed within all the resources available to Health, including the involvement of health security staff, police may be called upon to assist (refer to Section 3.5.3).

There may be occasions where a person detained under the MHA is taken to a non-DMHF for treatment of an acute physical health issue. Where a person detained under the MHA is receiving treatment in a non-DMHF for a matter unrelated to the mental illness, the provisions of the MHA and this MOU apply in the same way as if the person were being detained in a DMHF. If the joint risk assessment indicates there is a risk, immediate steps are to be taken to ensure the safety of the person, staff and the general public. If the level of risk is unable to be safely managed within all the resources available to Health, police may be called to assist (Refer to Section 3.5.3). To ensure the person receives care for the mental health condition which prompted their detention they are to be transferred to a DMHF as soon as possible.

There is no expectation that paramedics will provide a security function in a hospital.

### **3.4.5 Role of health security staff in a NSW Health facility**

If, following assessment, police have withdrawn and the behaviour of the person then escalates, health security staff can assist, under the direction of a registered health professional, to the extent set out below, until the person's behaviour is managed or the police attend. Health security staff can, as an option of last resort, use reasonable force to:

- Physically restrain a person who has assaulted or is threatening to assault staff, another patient or a visitor and where security staff believe the restraint is necessary to defend themselves or others.
- Physically restrain a person who has destroyed or damaged or is threatening to destroy or damage significant hospital property and where the security staff believe the restraint is necessary.
- Physically restrain a person who is incapable of giving consent, on the direction of a doctor for the purposes of carrying out urgent and necessary medical treatment to save the life of the person or to prevent serious harm to the person.

Health security staff may also assist other staff in carrying out these tasks.

'Reasonable force' means the minimum amount of force required to respond to the situation. The amount of force used must be reasonable in the circumstance and there must be a reasonable proportion between the circumstances involved and the response to it.

### 3.4.6 Health security staff role for patients detained under the MHA and MHFPA

In responding to incidents relating to patients detained under the MHA and MHFPA, health security staff are required to follow the direction of a registered health professional. Health security staff may provide assistance in accordance with NSW Health policies, to:

- Physically restrain the patient
- Assist in the application of mechanical restraints
- Prevent a patient from leaving the hospital in unauthorised circumstances.
- Retrieve a patient who attempts to leave the hospital in unauthorised circumstances. If the patient has left the hospital grounds and there are serious concerns about their safety or the safety of others, the police may be called to locate and return the patient. See Section 3.4.7 for further guidance.
- Accompany a non-sedated patient when they are being transferred between facilities, where the patient has been assessed by the treating registered health practitioner to be co-operative, a low risk to safety and does not require active monitoring or medical care during the transfer
- On the direction of the authorised medical officer frisk/pat down search a patient and their belongings.

Health staff must not place themselves, or be expected by others to place themselves, at unnecessary risk in carrying out their duties. Where there are concerns about public safety the police should be called.

Chapter 14 of the [NSW Health Protecting People and Property manual](#) provides additional information on the role of health security staff, particularly in responding to incidents. Health staff including health security staff should also comply with the NSW Health policy PD2012\_035 [Aggression, Seclusion & Restraint in Mental Health Facilities in NSW](#).

### 3.4.7 Absconded patients

This section applies to a patient detained under the MHA or MHFPA who leaves the hospital (including ED), without permission or fails to return to an inpatient unit in accordance with approved conditions for leave; or a voluntary patient who has not negotiated leave who is considered at risk.

### Patients detained under the MHA who abscond while on escorted and unescorted leave

While the MHA allows for patients to be involuntarily detained for treatment, every effort is made to provide care in the least restrictive manner as part of recovery oriented practice to ensure a successful return to the community. Recovery-oriented practice is how workers and services support people in their individual recovery journey. It is respectful of the person's autonomy and engages the person in a therapeutic relationship which makes space for self-agency in all areas of a person's life (*Mental Health Coordinating Council and Living Well- Putting People At The Centre of Mental Health Reform in NSW – A Report*). This means that patients should be given the opportunity to take periods of leave away from the inpatient setting when appropriate. Unnecessary restrictions on leave for inpatients recovering from illness delays recovery, prolongs hospitalisation and contributes to a perception that their illness requires a custodial rather than a therapeutic response. The decision to grant leave is always informed by careful, regular clinical review by senior clinicians.

### Interagency response to absconding patients

Patients who abscond from care may represent significant risk to themselves or others. Hospital staff will complete a risk assessment of the person and the hospital's subsequent actions will be guided by that risk assessment.

Use of Health resources to locate the person is preferable in the first instance and should include the following actions:

- Searching the hospital grounds
- Notifying health security staff who may conduct a further search of hospital grounds
- Instigating the hospital's absconded patient policy
- Calling the person's mobile phone
- Contacting carers, family or the substitute decision-maker
- Seeking assistance from the community mental health team to visit the address of the person and places the person frequents
- For patients under the MHFPA, making necessary notifications.

If the risk is deemed to require an immediate police response, the hospital is to phone the Police Duty Officer or delegate at the Police

Station nearest to the hospital. A request for police assistance is based on the risk the person poses and not solely on their legal status. However, as the legal status of the patient may affect the response, police must be informed of the patient's legal status. The hospital is to send the Absconded Patient Form (Appendix A) to the Police Station by fax or email as agreed. The Police Duty Officer is authorised to allocate resources to assist to locate the person. A discussion will occur between the hospital and police regarding the role of each agency and any need for other agency involvement, in searching for the person. When involving the police, the hospital should:

- Provide the most recent risk assessment conducted on the person
- For an involuntary patient, legal paperwork confirming the person is being lawfully detained under the MHA e.g. a Schedule 1 or Form 1. Attention should be paid to the expiry date of legal documentation as a person cannot be legally detained under section 48 and section 49 of the MHA if legal documentation has expired.
- A recent photograph or other material that will assist in locating the person.

If a person is detained in a mental health facility under the MHA and they subsequently abscond, section 48 of the MHA provides for authorised persons to locate and return the person to the hospital from which the person absented themselves. While NSW Ambulance will not be involved in locating the person there may be occasions when they are involved in transporting the person to the hospital from which they absconded. Requests for Ambulance transport will be subject to NSW Ambulance prioritising processes.

Section 49 of the MHA allows for the authorised medical officer to request police assistance in locating and returning the person. The hospital remains the lead agency in locating and returning the patient, with police, or others, providing assistance. Wherever possible in the first instance, the patient should be returned to the hospital from which they absconded. Under this MOU, police may take the person to the nearest DMHF. If this is not the hospital from which the person absented themselves, police are to notify the hospital of their imminent presentation. All parties should liaise with each other to facilitate the safe and timely transport of the person to the hospital from which they absented themselves. This includes the

conduct of a joint risk assessment to determine appropriate agency involvement in the transport.

It is the hospital's decision to initiate a search for a voluntary patient who is considered at risk who absconds from care. If the person does not agree to return to hospital, attending agency staff should consider exercising powers under the MHA (section 19, 20 or 22) in order to facilitate the person's transport and detention in a DMHF.

Health staff are to maintain ongoing liaison and communication with police throughout the process of searching for the absconded or missing person. Standard principles of information sharing apply in this circumstance. For patients under the MHFPA, communications should include the Mental Health Review Tribunal.

In all circumstances where the person's absconding status changes, i.e. Health staff locate the person, the person returns or health staff decide on new information to discharge the person, Health staff must contact police to verbally update them as well as forward police a completed Absconded Patient Outcome form (Appendix B). Following the verbal update and the acknowledged receipt of Appendix B, police will cease their search for the person and update their statewide database accordingly.

### **3.4.8 Restraint and sedation in hospital for people detained under the MHA and MHFPA**

Restraint (physical and mechanical) can only be used where less restrictive alternatives are ineffective or not appropriate. Restraint should only be used to respond to an immediate risk of harm with no more force used than is reasonable and necessary to deal with the risk. Restraint should only ever be used as the last resort to deal with a risk of harm.

The use of restraint is to be consistent with the policies and procedures applying to the respective agencies.

The following principles underpin the use of restraint:

- Restraint is a temporary intervention – the main aim is to treat the underlying condition
- Restraint is only to be used for the welfare and safety of the person and of others – not for staff or operational convenience.

Hospital staff, including health security staff may be directed by an authorised medical officer, or other registered health professional, to detain or restrain a patient including for the purposes of administering medical treatment. Staff are to act in accordance with the direction and to use the minimum amount of force necessary in a given situation.

Police officers may assist in the restraint of a patient for the purpose of administering sedation when asked to do so by an authorised medical officer or other registered health professional. In these circumstances, police will be acting at the request of and under the direct supervision of the authorised medical officer or registered health professional.

### 3.4.9 Escalation

See section 3.2.6 for information on escalation.

## 3.5 AFTER ARRIVING AT THE HOSPITAL

This section deals with information that is relevant following a person's arrival at the hospital.

### 3.5.1 Inter-hospital transport

A person who has presented to a hospital may need to be transferred to another hospital for clinical or other reasons. NSW Health has the primary responsibility for the transport of patients between hospitals.

NSW Health and NSW Police recognise that resources across all the services vary and fluctuate particularly in rural and remote areas. For patients who are being managed in a smaller rural hospital who require transfer to a larger hospital for definitive treatment, a flexible, solution focussed approach across the partnership to facilitate the transport will optimise outcomes for the patient and the safety of everyone involved. The clinical and safety needs of the patient will be paramount in decision-making.

The following people are authorised under the MHA to transport a person to or from a mental health facility or another health facility:

- a member of staff of the NSW Health Service
- a paramedic
- a police officer

### Inter-hospital transports involving NSW Ambulance

The process for organising an inter-hospital transport by Ambulance is as follows:

1. The senior treating clinician phones the relevant NSW Ambulance Control Centre to provide details of the transport including any assessed risks
2. The hospital completes Box 1 of Appendix C ('Inter-hospital Transfer Form') and emails it to the NSW Ambulance Control Centre (hospital to confirm email address for NSW Ambulance Control Centre)
3. Upon receipt of this information, the Ambulance Control Centre Supervisor will assess the information provided in order to prioritise the transport and if necessary seek further clarifying information from the treating clinician
4. The NSW Ambulance Control Centre will contact the hospital regarding the timeframe for the transport and to make the necessary arrangements
5. If, in Ambulance's opinion, there is risk present that is beyond the capacity of NSW Ambulance paramedics and the hospital to safely manage, the Ambulance Control Centre contacts by phone and fax (again, utilising Appendix C) the Police Duty Officer at the Police Station closest to the hospital
6. A joint assessment of the situation and the transport is made between the senior treating clinician, NSW Ambulance and NSWPF. Such an assessment should follow the guidance provided in section 3.2.1 'Risk Assessment'
7. NSW Ambulance then contacts the hospital regarding the final outcome and arrangements.

If the decision is made to use parenteral sedation for the transport, the patient is to be transported by Ambulance with appropriate clinical escort staff. Where the hospital has provided a clinical nurse escort, Patient Transport Services may be considered.

Police may be asked to assist in inter-hospital transports where the situation poses a threat to the safety of the patient and staff involved in the transport which are unable to be managed within the resources available to Health. NSWPF does not utilise police vehicles to transport patients between hospitals. NSWPF assistance in inter-hospital transports may include assistance to restrain the person or placing a police officer in

the rear of the transport vehicle and/or following behind the transport vehicle. Staff should be aware that a violent person in a confined and moving vehicle presents significant risk. Unless otherwise clinically indicated these patients should be stabilised prior to transport.

When health security staff are to accompany ambulance paramedics or clinical staff during transport, it is the responsibility of the hospital requesting the transport to make arrangements for a suitable health security escort to be made available.

### **Inter hospital transports by Patient Transport Services**

Patients of the mental health service must be assessed by a mental health professional at the sending facility to determine the level of escort for the transport. In the case that the sending facility does not have access to a mental health professional, the level of escort should be determined by the sending medical officer.

The Patient Transport Service (PTS) fleet may be used to transport patients of the mental health service who are:

- assessed as low risk with an appropriate escort
- assessed as medium risk with a mental health escort and/or security escort.

Patients deemed as high risk are out of the scope for PTS.

For further information on patient eligibility and booking PTS, go to [Patient Transport Services](#)

### **3.5.2 Police assistance in health facilities**

On occasion, the assistance of police may be required to manage incidents within a health facility which pose a threat to public safety.

If a situation is potentially life threatening, health staff are to call 000 immediately and provide details of the situation. Health staff should not delay such contact if the situation is urgent. If police are called to such an incident, they will attend and seek to resolve it. Provision of relevant information, including the outcome of a comprehensive risk assessment (based on the information contained in Section 3.2.1) and cooperation between agency staff is essential to the successful resolution of such incidents. If required, police officers may request the assistance of specialist police which may include tactical officers, detectives or crime scene examiners, as appropriate.

If general advice or assistance is required, health staff are to call the Station Supervisor at their nearest Police Station.

### **3.5.3 Police assistance with breached community treatment orders**

Police have powers under section 59 of the MHA to assist another agency to detain a person who has breached a community treatment order and for whom a breach order has been made.

Requests for police assistance are to be made in the context of police's role of ensuring public safety. In responding to another agency's request, the police are acting at that agency's request. The agency requesting police assistance retains overall carriage of the matter with police providing specific assistance under section 59 of the MHA.

Police are empowered under section 59 of the MHA to enter a person's premises for the purpose of detaining them by virtue of the breach order. Police cannot use force to enter a person's premises for this purpose without a warrant. The agency requesting police assistance is responsible for applying for and having the warrant issued by a Court. Any subsequent transport of the detained person is to be arranged in accordance with the principles contained within this document and in the best interests of the person. Requests for involvement of NSW Ambulance in transporting the person will be subject to standard NSW Ambulance prioritising processes.

### **3.5.4 Air transport**

Air transport may be required where road transport is inappropriate in meeting the clinical needs of the patient in a timely manner and where risks can be effectively contained.

In NSW, air transport of persons with behavioural disturbance involves a number of agencies. Requests for air transport will be discussed with the NSW Ambulance Aeromedical Control Centre or other air transport service provider. It will require compliance with criteria for air transport, an accompanying medical assessment and patient management plan. Arrangements and protocols for local responses vary across locations and service providers and agency staff should familiarise themselves with local arrangements. The pilot of the aircraft has the final decision on carriage of any person.

Police involvement in the air transport of mental health patients will require case-by-case discussion between the agencies involved, including the air transport provider, the Duty Officer at the relevant Police Station and the senior treating clinician at the referring health facility. Police involvement should be a last resort and only where it is consistent with their role of ensuring public safety. All firearms must be carried in accordance with CASA regulations.

### 3.5.5 Patients with access to firearms

Under section 79 of the *Firearms Act 1996* (NSW), a health professional who is of the opinion that a person to whom they have been providing professional services may pose a threat to their own safety or to others if in possession of a firearm may notify police of their concerns.

Notification to police regarding ED patients or inpatients should occur as soon as practicable before discharge.

Where health staff have concerns about a serious or imminent risk to the safety of another individual arising out of a patient's access to or proposal to obtain access to firearms, they should notify police immediately.

In the instances above, NSW Health staff should utilise the Notification to NSWPF and Firearms Registry Form (Appendix D).

### 3.5.6 Notification to police prior to discharge

Section 32 of the MHA provides provisions regarding the circumstances under which Health staff are to notify police when a person who has been presented under section 22 of the MHA or section 33 of the MHFPA is no longer to be detained, including following a period of admission.

For presentations under section 22 of the MHA, police officers must complete and sign the section of the section 22 form that relates to notification to police prior to discharge. Additionally, as part of police handover, police are to clearly communicate with clinical staff of the need to notify police. As soon as practicable after the authorised medical officer is aware the patient will no longer be detained, the authorised medical officer must notify police that the person will not be further detained. The authorised medical officer may detain the patient in the DMHF for a period of up to 2 hours to allow police to apprehend the person.

For presentations under section 33 of the MHFPA, please refer to section 3.4.2 of the MOU.

Hospital staff should be cognisant of the significant risk posed if they fail to notify police of the imminent discharge of the person, where police have asked to be notified. Hospital staff are to ensure this information is conveyed to staff as part of safe clinical handover between shifts and upon ward transfers. At a local level, NSW Health and NSWPF staff should work together to ensure that there is sufficient interagency clarity around these arrangements.

### 3.5.7 Police firearms in NSW Health facilities

Police attend health facilities for a variety of reasons. Upon arrival at a facility, staff at the facility should ensure that the attending police officers are fully informed of any risk in relation to the situation they are entering. Based on the information available, police officers should assess the risk regarding the carriage of firearms and may choose to store their firearm within a receptacle if:

- it complies with the *Firearms Act 1996*; and
- the police officer believes that storing it is the safest course of action. If a police officer decides to store their firearm, they should retain their Conducted Electrical Weapon as a tactical option.

Other agency staff cannot dictate what a police officer does with their firearm. Admittance to a health facility cannot be denied to a police officer who decides to retain their firearm or any other appointment.

For further information refer to GL2013\_002 [Management of NSWPF Firearms in Public Health Facilities and Vehicles](#).

### 3.5.8 Escalation

See section 3.2.6 for information on escalation.

### 3.5.9 Inter-State Agreements

Inter-state Ministerial Agreements are in place between NSW and certain States and Territories to govern procedures for the apprehension and return of involuntary and forensic mental health patients who have absconded inter-state. These agreements are made pursuant to Chapter 8 of the NSW MHA.

These Agreements provide a mechanism to recognise orders for apprehension made by another jurisdiction. To allow police or other authorised persons to apprehend interstate persons, NSW Health must be in receipt of an Interstate Apprehension Order from the Health Department of the jurisdiction.

A forensic patient can also be returned from interstate under a warrant issued under section 72 of the MHFPA. The warrant allows interstate police to apprehend and detain the person until they are able to be apprehended by NSWPF. This happens infrequently but should it be necessary to enact section 72 of the MHFPA, the following process applies:

- The Mental Health Review Tribunal will arrange for the warrant to be issued
- NSWPF will liaise with police in the relevant jurisdiction to apprehend and detain the person
- NSWPF will make practical arrangements, e.g. booking air flights, for their staff and where necessary, a clinician. While NSWPF is prepared to facilitate the interstate transfer of the person, the relevant NSW mental health service will pay the airfares incurred and accommodation costs if required. NSWPF will forward the invoice to the mental health service.
- NSW Health is responsible for the transport of the person from Sydney Airport to the DMHF identified in the warrant. This transport will be undertaken in accordance with the transport principles in the MOU. All parties should collaborate to facilitate the safe and timely return of the person to the hospital.

Where an Interstate Apprehension Order or warrant has not been provided, an interstate person can only be detained if they meet the criteria for detention under the NSW MHA.

General principles for the application of Interstate Agreements are as follows:

1. The apprehension and return of a mental health patient should be managed locally. Agreements provide for the facility from which an Interstate Person is absent without leave to liaise directly with other services including Police.
2. Police should only be asked to apprehend an Interstate Person in exceptional circumstances, for example if there is a public safety risk and the person's whereabouts is unknown. Police assistance is dependent upon the risk assessment provided on the Interstate Person. Police will take the Interstate Person to the nearest DMHF. Parties should liaise with each other to facilitate the safe return of the Interstate Person.
3. NSW Health facilitates the administration of the Agreements. The Executive Director, NSW Mental Health Branch, or their delegate, is the NSW contact officer for issues or disputes which are unable to be resolved locally.

For further advice regarding the apprehension of Interstate Persons, contact:

- Mental Health Branch of the NSW Ministry of Health on (02) 9391 9000 M-F 9am - 5pm
- Mental Health Review Tribunal on (02) 8876 6315 M-F 9am - 5pm
- NSWPF Mental Health Intervention Team on 0448 444 808 24 hours

Existing Agreements may be accessed on the Ministry's website at: [Mental Health Agreements](#).



## Section 4

# Patients in Police Custody

This section applies to people detained by the NSWPF (other than under the MHA and MHFPA), and police are concerned about the person's physical or mental welfare which requires the person to be seen by a medical practitioner. This section will usually relate to persons in NSWPF custody at a police facility under the provisions of Part 9 of the *Law Enforcement (Powers & Responsibilities) Act 2002* (LEPRA).

Standard police protocols for persons in custody will apply with regard to ambulance paramedics' attendance at the police facility to assess the person in situ.

For Health staff, refer to Chapter 6 (Patients in Custody) of the [Protecting People and Property Manual](#) for further information on security risk management standards.

For presentations under section 33 of the MHFPA, refer to Section 3.4.2 of this MOU.

### 4.1 Transport from police cells to hospital

If following assessment by Ambulance paramedics it is determined that the person needs to be transported to hospital, the mode of transport and agency involvement is based on overall risk. As a general rule, the transport of a person with physical injuries or mental health concerns should be facilitated by NSW Ambulance so as to afford the person an appropriate level of clinical monitoring and supervision during transport. The use of a police vehicle to transport the person should be a last resort and only in exigent circumstances. Police officers must escort the person in custody in the ambulance vehicle to ensure the safety of all parties and to prevent the potential escape of the person.

### 4.2 Triage/information exchange/handover

When a person in police custody is presented to hospital for medical assessment and treatment, the exchange of information, written and/or verbal, is crucial to the effective and safe management of the person and the staff who will be providing care to the person.

The presenting agencies will provide the triage nurse, or assessment clinician with a comprehensive verbal handover. Police must advise clinical staff if the person is under arrest under Part 9 LEPRA. Police are to provide clinical staff with any known and relevant risk information relating to their safety while the person is in the health facility. This includes:

- Consideration of the likelihood and consequence of the risk, including the likelihood of the person's behaviour escalating to become a public safety issue once any mechanical restraints are removed.
- Consideration of the capacity and appropriateness of the health facility to manage the risk.
- Any other relevant information regarding the person's detention and assessment.

Hospital staff should feel free to seek clarifying information from the presenting agencies or to request additional information if needed and relevant.

Ambulance staff assisting with the transport of the person may leave at the completion of the handover process.

Police are required to maintain a guard on a person within the health facility who is brought there in their custody under Part 9 of LEPRA and who remains in their custody.

Police and hospital staff should effectively communicate on the medical prognosis and short to mid-term treatment plan so that appropriate decisions can be made regarding the person's custody status. Next steps may include the establishment of a police hospital guard utilising existing agency protocols until such time as the person can be transported back into police custody, or a bedside court hearing can be arranged, or the person is released from custody.

Where the person is to be released from police custody, attending police will clearly communicate with clinical staff their intention to release the person from NSWPF custody. Attending police will complete a handover of the patient and communicate to clinical staff any identified risks in order to determine appropriate ongoing security requirements. Police will not withdraw before this process is completed.

If after police have left the hospital, the patient's behaviour escalates to present a risk to public safety, Section 5 of the MOU is to be followed.

It is an accepted fact that the safety of all agency staff members involved in this process is paramount. The flow of information and liaison between involved agency staff should be maintained so that all parties are aware of the current status of the management of the person in custody and that subsequent risks are mitigated wherever possible.

### **4.3 Inter-hospital transport of patients in police custody**

Refer to 3.5.1 for guidance on processes to be followed for the transport of patients in police custody between hospitals.

Police will provide escort for patients who are in police custody under Part 9 of LEPR.

### **4.4 Police firearms in NSW Health facilities**

Police attend health facilities for a variety of reasons. Staff at the health facility should ensure that attending police are fully informed of any risk in relation to the situation they are entering.

Based on available information, police officers should assess the risk regarding the carriage of firearms and may choose to store their firearm within a receptacle if it:

- Complies with the *Firearms Act 1996*; and
- The police officer believes that storing it is the safest course of action. If a police officer decides to store their firearm, NSWPF protocol calls for the officer to retain their Conducted Electrical Weapon as a tactical option.

Other agency staff cannot dictate what a police officer does with their firearm. NSW Health staff must not make the removal of a police officer's firearm a condition of a police officer's entry to a public health facility or vehicle.

For further information refer to [GL2013\\_002 Management of NSWPF Firearms in Public Health Facilities and Vehicles](#).

## **4.5 Escalation**

See section 3.2.6 for information on escalation.

## Section 5

# Management of Public Safety Issues in Health Settings

People can display behaviour that puts themselves or others at immediate risk of serious harm. This behaviour may include threatening, combative or aggressive behaviour, extreme distress and serious self-harm which could cause major injury or death. This section provides guidance on the management of public safety issues in Health facilities involving people who display this behaviour who are brought to hospital by partner agencies, who self-present, who are patients already in care and who are visitors.

To facilitate the safety of the person and others involved in their care, it is essential that there is appropriate consultation and communication between involved agencies at every point of the person's journey including at each handover point and for transport.

If at any time it is considered that a person has a mental illness or mental disorder and could be detained under the MHA, staff should consider exercising powers under the MHA. Where the MHA has been enacted, Section 3 of the MOU should be followed.

### 5.1 Attendance in the community

When responding to incidents in the community, police, paramedics and community mental health staff may need to deal with people who display behaviour that puts themselves or others at immediate risk of serious harm but who do not display signs of mental illness or mental disorder. Each agency will generally utilise their own practices and protocols to de-escalate the situation and have the option of calling for assistance from another agency as required. A priority response to such calls is usually generated so as to ensure a co-ordinated approach to mitigate the risk of injury to the individual, agency staff in attendance and others.

Once everyone's safety is established, the attending agency staff will consult with each other to determine the best course of action to facilitate the person accessing appropriate care in a safe and timely manner.

### 5.2 Transport to hospital

If the person needs to be taken to hospital, the attending agencies will consult with each other to determine the safest and most efficient manner in which to facilitate the transport. This will include a joint risk assessment that takes into account the behaviour of the individual, the potential for escalation during the transport and any clinical factors.

As a general rule, the transport of persons with physical injuries should be facilitated by paramedics. A police escort may be a consideration if there is a risk of violence from the person during the transport.

### 5.3 Searching

Police have various powers of search and seizure under LEPPRA including in relation to dangerous articles.

For a person not detained under the MHA, NSW Health staff cannot search them or property in their possession without the consent of the person. If Health staff have concerns that the person may have in their possession weapons or implements that may threaten the safety of the person and staff, the assistance of Police to search the person may be sought.

## 5.4 Triage/Information exchange/handover

The exchange of information, written and verbal, between involved agencies is crucial to the effective and safe management of the person and the staff who will be providing care to the person.

Presenting agency staff must seek out the triage nurse or assessment clinician and provide a comprehensive verbal handover. Clinical staff should feel free to seek clarifying information from the presenting agency or to request additional information, if needed and relevant. This aim of this interchange is to facilitate the effective and safe management of the person and maintaining the safety of staff while acknowledging that these situations are often dynamic and the situation may escalate or de-escalate with little or no notice.

Presenting staff are to provide clinical staff with information on all relevant risk factors pertaining to the person in terms of public safety including:

- Communication of all available information including information on previous incidents involving the person and observed current behaviour and interaction of the person during the transport.
- The observed behaviour of the person when the agency arrived at the scene
- The observed behaviour and interaction of the person with agency staff prior to and during transport
- Consideration of the likelihood and consequence of the risk, including the likelihood of the person's behaviour escalating to become a public safety issue, once any mechanical restraints are removed and/or police or paramedics withdraw.
- Consideration of the capacity and appropriateness of the health facility to manage the risk.

People brought to a hospital under this MOU are not to be handed over to health security staff directly.

Where police bring a person to hospital, they are to advise clinical staff at handover if they need to be informed when the decision is made to discharge the person.

Presenting agency staff will not withdraw prior to the completion of the handover process.

## 5.5 Inter-hospital transport

See section 3.5.1 for guidance on the transport of patients between hospitals.

## 5.6 Avoiding handover delays for paramedics and police officers

All reasonable steps are to be taken by hospital staff to facilitate attending paramedics and police officers leaving the hospital as soon as possible, where it is safe to do so. Delays to the handover of the person are to be avoided as far as is reasonably practicable and hospital staff are to provide attending paramedics and police officers with ongoing updates relating to this process.

## 5.7 Security in the hospital

Once the formal handover of the person has been completed, hospital staff are responsible for the care and the management of behavioural issues. Where the person's behaviour presents a risk to themselves or others, hospital staff may engage the assistance of health security staff where necessary and available to the extent of the role they undertake in NSW Health. Where the level of risk is unable to be safely managed, police may be called upon to assist.

If, following assessment, police have withdrawn and the behaviour of the person subsequently escalates, health security staff can assist, to the extent set out below, until the person's behaviour is managed or the police attend. Health security staff can, as an option of last resort, use reasonable force to:

- Physically restrain a person who has assaulted or is threatening to assault staff, another patient or a visitor and where security staff believe the restraint is necessary to defend themselves or others.
- Physically restrain a person who has destroyed or damaged or is threatening to destroy or damage significant hospital property and where the security staff believe the restraint is necessary.
- Physically restrain a person who is incapable of giving consent, on the direction of a doctor, for the purposes of carrying out urgent and necessary medical treatment to save the person's life or to prevent serious harm to the person or to others.

Health security staff may also assist other staff in carrying out these tasks.

‘Reasonable force’ means the minimum amount of force required to respond to the situation. The amount of force used must be reasonable in the circumstance and there must be a reasonable proportion between the circumstances involved and the response to it.

Restraint should only be used to respond to an immediate risk of harm with no more force used than is reasonable and necessary to deal with the risk of harm. Restraint should only ever be used as the last resort to deal with a risk of harm.

Chapter 14 of the NSW Health Protecting People and Property manual [NSW Health Protecting People and Property Manual](#) provides additional information on the role of health security staff, including in responding to incidents. All Health staff including health security staff should also comply with the NSW Health Policy PD2012\_035 [Aggression, Seclusion & Restraint in Mental Health Facilities in NSW](#) and PD2015\_005 [Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint](#).

## 5.8 Police assistance in health facilities

On occasion, the assistance of police may be required to manage incidents within health facilities which pose a threat to public safety.

If a situation is life threatening, Health staff are to call 000 immediately and provide details of the situation. Health staff should not delay such contact if the situation is urgent. If police are called to such an incident, they will attend and seek to resolve it. Provision of relevant information and cooperation between agency staff is essential to the successful resolution of such incidents. If required, police officers may request the assistance of specialist police which may include tactical officers, detectives or crime scene examiners, as appropriate.

If general advice or assistance is required, health staff are to call the Station Supervisor at their nearest Police Station.

## 5.9 Patients with access to firearms

Under section 79 of the *Firearms Act 1996* (NSW), a health professional who is of the opinion that a person to whom they have been providing professional services may pose a threat to their own safety or to others if in possession of a firearm may notify police of their concerns.

Notification to police regarding ED patients or inpatients should occur as soon as practicable before discharge.

Where Health staff have concerns about a serious or imminent risk to the safety of another individual arising out of a patient’s access to or proposal to obtain access to firearms, they should notify police immediately.

In these instances, NSW Health staff should utilise the Notification to NSWPF and Firearms Registry Form (Appendix D).

## 5.10 Police firearms in NSW Health facilities

Staff at the health facility should ensure that attending police are fully informed of any risk in relation to the situation they are entering. Based on available information, police officers should assess the risk regarding the carriage of firearms and may choose to store their firearm within a receptacle if it:

- Complies with the *Firearms Act 1996*; and
- The police officer believes that storing it is the safest course of action. If a police officer decides to store their firearm, they should retain their Conducted Electrical Weapon as a tactical option.

Other agency staff cannot dictate what a police officer does with their firearm. NSW Health staff must not make the removal of a police officer’s firearm a condition of a police officer’s entry to a public health facility or vehicle.

For further information refer to GL2013\_002 [Management of NSWPF Firearms in Public Health Facilities and Vehicles](#).

## 5.11 Escalation

See section 3.2.6 for information on escalation.

## Section 6

# Governance and Interagency Structures

The following governance and inter-agency structures are in place to support agencies to deliver coordinated responses to situations involving people with a mental health concern, patients in police custody and people who pose a threat to public safety, and to monitor the operation of this MOU in practice. These structures are in place at the local, district and state levels.

### 6.1. GOVERNANCE

The operational effectiveness of this MOU will be overseen by a senior executive sponsor from NSW Health (including NSW Ambulance) and the NSWPF whose role is to ensure that the MOU remains relevant to the operational environment and reflects any legislative change that may impact on the MOU.

Issues identified locally are to be discussed and addressed through the interagency committee structure described below.

The senior executive sponsors from each agency will meet to review the MOU at least once each year, or more often if required.

### 6.2 MOU COMMITTEES

Cooperation between agencies is essential to the successful management and resolution of situations covered by this MOU. This requires a commitment from all partner agencies to attend and actively participate in MOU committee meetings. These committees should develop local protocols, consistent with this MOU, to address any specific local considerations or disputes that may arise.

Membership of each committee will include senior staff from each partner agency who holds a level of responsibility for decision making within the respective agency commensurate with the level of committee. This will facilitate the satisfactory resolution of issues.

Partner agencies who routinely do not attend, who are obstructive, or who are unable to resolve issues in a timely manner should be referred to the appropriate higher level committee.

It is important to maintain communication and the flow of relevant information between the district MOU committee and local MOU committees.

#### 6.2.1 Local MOU Committee

##### Role:

- Advise local agencies about their roles and responsibilities under the MOU
- Monitor the operation of the MOU at a local level
- Develop and implement local operational protocols, including ensuring that escalation paths are clearly documented and communicated within agencies.
- Ensure local agency staff are fully informed about the operation of the MOU and the application of specific legislation within the MOU so that all agencies have a shared understanding of the MOU to limit the occurrence of local disputes
- Resolve local inter-agency disputes
- Keep their own agency and partner agencies informed about local interagency developments
- Consider the specific needs of Aboriginal patients and support stronger relationships with local services
- Discuss frequent users of emergency services including the need to develop joint management plans
- Advise the district MOU committee if a potential district-wide issue is identified.

**Membership:**

- NSW Health:
  - Emergency Department – ED Director and NUM (co-chair)
  - Mental Health Service Manager / Network Manager (co-chair)
  - Hospital General Manager
  - Community Mental Health
  - Mental Health In-Patient Unit
  - NSW Ambulance
  - Drug and Alcohol Service
  - Health Security
- NSW Police Force
- May also include Primary Health Networks, Aboriginal Medical Services, relevant non-government organisations and other service providers at the discretion of the committee.
- Reports to: District MOU Committee
- Meeting frequency: At least every two months.

### 6.2.2 District MOU Committee

**Role:**

- Monitor the district wide operation of the MOU
- Identify and address operational issues requiring a district wide response
- Address disputes referred by local MOU committees
- Keep partner agencies informed about inter-agency developments within the district
- Oversee and support the operation of local MOU committees
- Advise the NSW MOU Committee if a potential state-wide issue is identified.

**Membership:**

- NSW Health
  - Emergency Department executive (co-chair)
  - Director, Mental Health Service (co-chair)
  - General Hospitals
  - NSW Ambulance
  - Drug and Alcohol Service
  - Health Security
- NSW Police Force

- May also include Primary Health Networks, Aboriginal Medical Services, relevant non-government organisations and other service providers at the discretion of the Committees necessary.
- Reports to: NSW MOU Committee
- Meeting frequency: At least every three months.

### 6.2.3 NSW MOU Committee

**Role:**

- Monitor statewide implementation and operation of the MOU
- Promote clarification of the roles and responsibilities of MOU agencies
- Monitor and support the effective operation of district MOU committees
- Address disputes escalated by district MOU committees
- Promote the MOU between partner agencies
- Oversee statewide interagency initiatives as required
- Identify and address interagency operational issues that require a statewide response.

**Membership:**

- NSW Health
  - Strategy and Resources / Mental Health Branch (co-chair)
  - System Purchasing and Performance / System Performance Support Branch (co-chair)
  - Legal and Legislative Services Branch
  - NSW Ambulance
  - LHD Emergency Departments (nominated by the NSW Emergency Care Institute)
  - LHD Mental Health Services (nominated by the LHD MH Directors)
  - Drug and Alcohol Services (nominated by the Centre for Population Health)
- NSW Police Force
- Primary Health Networks
- Justice Health and Forensic Mental Health Network
- Meeting frequency: Every three months.

## 6.3 RESOLUTION OF DISPUTES

Preventing and minimising interagency disputes will be aided by staff of all agencies receiving training on this MOU; by the effective operation of local and district MOU committees and by fostering effective local working relationships across the agencies. Satisfactory and timely resolution of incidents is more likely to occur where there are established working relationships between committee members. Resolution that occurs directly between partner agencies outside the committee process is encouraged.

Where disputes arise, they should ideally be resolved on site at the time of the incident, in the best interests of the individual involved. When disputes are resolved on site, it is not usually necessary to use the MOU Dispute Resolution form (Appendix E) or to escalate the situation further. An exception to this is when the incident represents systematic or larger scale issues or if agency staff are dissatisfied with the on-site outcome.

Where disputes are unable to be resolved on site, agency staff are to follow their respective agency's escalation protocols to resolve the matter (see Section 3.2.6). The issue should then be referred to the local MOU committee for discussion and resolution. This may include the development of local protocols. The referral of specific disputes will allow the interagency committee to identify systemic issues and trends and to ensure these are addressed in a timely manner. Operational staff are urged to raise issues in this way so that they can be resolved promptly and will contribute to improved interagency cooperation. Unresolved incidents can create division and ill feeling amongst agency staff.

Where resolution is not able to be reached at the local MOU committee level, the matter should be referred to the district MOU committee.

If the issue is unable to be resolved by the district MOU committee, the matter may be referred to the NSW MOU Committee.



## Section 7

# Conclusion

Successful implementation and operation of this MOU will require each partner agency to promote it within their organisation and to train their staff on its intent and contents. This may include:

- Distributing this MOU to staff members and ensuring that staff can easily access the document as needed (including on-line).
- Conducting information sessions on the MOU for staff.
- Including the MOU in the orientation / induction package for new staff.
- Providing refresher or regular in-service education on the MOU.
- Facilitating interagency training including desktop scenario exercises.
- Supporting the effective operation of local and district MOU committees by regular and consistent attendance.

Sustaining the effective operation of this MOU will be a key task of local and district MOU committees, including by:

- regular and consistent attendance at interagency committee meetings by senior staff from each agency
- regular cross- agency interaction and collaboration
- development of local protocols consistent with this MOU
- monitoring and reviewing local protocols where necessary, for example in response to service developments
- ensuring that operational staff are aware of their roles and responsibilities in working with other agencies to respond effectively to people's physical and mental health needs.

# Appendix A: Absconded Patient – Report to Police



Facility \_\_\_\_\_  
 \_\_\_\_\_

## Absconded Patient – Report to Police

DMHS67 A

FAMILY NAME		MRN
GIVEN NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Patient Information					
Surname		Other Names		Gender	
DOB	Admission date	MRN	Photo available	Yes	No
Residential address			Mobile Ph:		
Language used:			Cultural Considerations:		

Patient Description (Circle appropriate option)					
Height (cm)			Weight (kg)		
<b>Build:</b>	Medium	Muscular	Obese	Solid	Thin
<b>Hair:</b>	Blonde/white	Brown	Black	Fair	Bald
	Grey	Red/ginger	Light/brown	Coloured (Specify)	
<b>Eyes:</b>	Black	Blue	Blue/Grey	Brown	Green
	Green/Hazel	Grey	Glasses? Yes No	Other (Specify)	
<b>Facial Hair:</b>	Moustache	Beard	Sideburns	Goatee	Shaven
<b>Complexion:</b>	Fair	Medium	Dark	Pale	Olive
	Tanned	Freckled	Ruddy	Acne/spotted	
<b>Racial Appearance:</b>	Aboriginal/ Torres Strait Islander	African	Asian	Caucasian	Indian/Subcontinent
	Mediterranean	Middle Eastern	Pacific Islander	South American	
<b>Distinguishing features:</b>	Tattoo	Scar	Disability	Piercing	Impairment (e.g. limp)
	Other Features:				

Next of Kin/Carer	
Name:	Relationship:
Address:	Phone:
GP / Doctor: <i>Print name</i>	Phone:

Incident Information			
Date:	Time:	Ward:	Facility:
Possible Destination/s:			
Clothes when last seen:			
Circumstances of Disappearance:			

Worksheet

Absconded Patient – Report to Police

Worksheet



## Absconded Patient - Report to Police (cont'd)

FAMILY NAME		MRN
GIVEN NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

**Risk Assessment** (Circle appropriate response)

Absconded on leave	Yes	No	<b>Current Risk Assessment</b>			
Absconded from care	Yes	No	<b>Assessed Risk level</b>	High	Med	Low
Access to firearms	Yes	No	<b>Risk to Self</b>	High	Med	Low
Current client of CMHT <i>Team Name:</i>	Yes	No	<b>Risk to Others</b>	High	Med	Low
Current CTO: <i>Expiry date:</i>	Yes	No	<b>Risk to specific person/s:</b>			
Current MH Act Legal Status is:	Vol	Invol	<i>Name:</i>			
			<i>Contact/location details:</i>			

<b>Copy of Legal Status paperwork attached</b>	Yes	No
--	-----	----

**Other relevant information/reasons for concern** (e.g. medical issues, medication etc):

**Response/Actions** (Circle appropriate response)

<b>PECC / CMHT/ Mental Health Service response</b>	Primary Carer/Family informed	Yes	No	Home address visited	Yes	No
	GP informed	Yes	No	Search facility & surrounds	Yes	No
	Search LHD PAS	Yes	No	Alert created on PAS	Yes	No
	Mental Health Duty NM informed?	NM Name:				

**Other actions taken:**

<b>Client to be returned to Unit?</b>	Yes	No	
<b>Suggested Police Response:</b>	Routine	Prompt	Immediate

**Reporting details**

Police Officer Reported to: <i>(Print name)</i>	Station & Phone number:	Date:	Time:
Staff name: <i>(Print name)</i>	Designation	Signature	Phone:

<b>Police Use Only:</b> COPs entry no. <b>E:</b>	Uploaded to iMEW:	Yes	No
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Health staff are to use DHMS67B Absconded Patient Outcome form to record progress of search and outcomes.

# Appendix B: Absconded Patient - Outcome



Facility \_\_\_\_\_

## Absconded Patient - Outcome

To be completed by hospital or health service staff in conjunction with the DMHS67A Absconded Patient Report to Police to record progress and/or outcome of search for absconded patients.

DMHS67 B

FAMILY NAME		MRN
GIVEN NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Date /Time reported missing:		Unit:	
<b>Outcomes</b>			
Person Sighted <input type="checkbox"/> Yes		Person located/contacted <input type="checkbox"/> Yes	
Person deceased <input type="checkbox"/> Yes			
<b>Circumstances of Location/Sightings:</b>			
Date /Time	Details:		Staff Name/Designation/Signature
Person returned to unit (Self/Community/Carer)		<input type="checkbox"/> Yes	
Person returned to health facility by Police		<input type="checkbox"/> Yes	
Police Officer's Name (if applicable):		Station:	
<b>Date returned to unit:</b>		<b>Time returned to unit:</b>	
Person was NOT sighted, located or returned <input type="checkbox"/>		Date/time search ceased:	
Absconded person discharged <input type="checkbox"/>		Name of authorising medical officer:	
<b>Notification of Patients return or change in status:</b> Advise Police by telephone immediately if missing person returns or is located elsewhere or Police assistance is no longer required and forward them this form. Police will cease the search for the person.			
<b>Police notified of patient's return</b>		<input type="checkbox"/> Yes <input type="checkbox"/> N/A (specify)	
Police Officer's Name & Station:		Date:	Time:
<b>Relative / Primary Carer notified</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (specify)	
Name of Relative/Carer:		Date:	Time:
<b>Senior Manager notified</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (specify)	
Manager name:		Date:	Time:
<b>Patient's Doctor notified</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (specify)	
Doctor Name:		Date:	Time:
<b>Executive notified</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (specify)	
Executive name:		Date:	Time:
<b>Comments:</b>			
<b>Notifications completed by:</b>			
Print Staff Name	Designation	Signature	Date

Worksheet

Absconded Patient - Outcome

Worksheet

## Appendix C: Inter-Hospital Transport Form

### APPENDIX C – Inter-Hospital Transfer Form

This form is to be used when an inter-hospital transfer is required involving NSW Ambulance and/or NSW Police Force.

Information in **Box 1** is to be emailed by health staff to the Ambulance Control Centre. Where Police involvement is required, the Ambulance Control Centre Supervisor phones the relevant NSWPF LAC Duty Officer to advise of the need for Police assistance in the transfer. After phone contact, Ambulance Control will fax this form to the Duty Officer to allow Police to conduct background enquiries and risk assessment.

This form does not replace individual agency's assessment tools or operational or clinical protocols. The purpose of information sharing under this form is to ensure each agency has sufficient information to enable them to provide appropriate services. Collection and disclosure is to be limited to personal health information necessary for and relevant to these purposes in accordance with the *Health Records and Information Privacy Act 2002* (NSW).

#### BOX 1 INFORMATION ON THIS PAGE TO BE PROVIDED BY HEALTH FACILITY STAFF

Booking Time:		Date:	
Patient Name:		DOB:	MRN:
Address:			
Treating Doctor:		Health Facility:	
Name of person requesting transfer:		Phone No.	
<b>Transfer Details:</b>			
Despatching Health Facility:			
Receiving Health Facility:		Contact Name:	
Confirmed Vacancy:	Receiving MO's Name:	Phone No.	
Scheduled Departure Time:	Urgency Justification:		

#### PATIENT INFORMATION

1	Presentation Date:            /        /	Time:                            am                            pm
2	Mode of presentation: (e.g. self / family / Ambulance / Police / CMHT)	
3	<b>Evidence of Risk:</b> <ul style="list-style-type: none"> <li>• Patient Behaviour: Aggressive / Demonstrated Violence / Suicidal / Self Harm</li> <li>• History of concealing weapons / dangerous items</li> <li>• History of absconding</li> <li>• Other (e.g. patient behaviour endangering or likely to endanger staff or public health)</li> </ul>	
4	What medication has patient received?	Medication:                            Dose:                            Route:
5	Patient to be medicated en route? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication:                            Dose:                            Route:
6	Expected condition of patient at transfer, e.g. heavily / mildly sedated:	
7	Patient Searched: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
8	Patient Belongings Searched: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
9	Restraint required during transport: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:

## Appendix C: Inter-Hospital Transport Form

AMBULANCE NOTIFICATION TO NSW POLICE FORCE		
1	Duty Officer (Supervisor) Name:	LAC:
2	Time:        am / pm        Date: / /	Fax No:
Booking Confirmed:		Time:
Name of Ambulance Control Supervisor (PLEASE PRINT):		Signature:
BOX 2 NSW POLICE FORCE RISK ASSESSMENT		
It is the responsibility of the Duty Officer to ensure that appropriate background enquiries are conducted. Information obtained is for use by Police before a decision regarding transport arrangements is made. The completed form is to be retained by Police in the Duty Officer's room.		
COPS Enquiries:		
Warnings:		Date: / /
Previous violence history:		Reference:
Intelligence re escapes, self-harm, etc.:		
Other relevant information:		
Escort arrangements:		
Officer(s) assigned:	Names:	Vehicle Call Sign:
Team leader / Supervisor Informed:	Name:	Time:
Full COPS information on patient forwarded to escort officers	Time:	Date:
DO / Supervisor:	Name:	Signature:
Total Police transfer time:	Police transfer began at:	Police transfer completed at:

# Appendix D: Firearms Registry Notification



www.police.nsw.gov.au  
ABN 43 408 613 180

## NSW POLICE FORCE - FIREARMS REGISTRY

### Disclosure of Information by Health Professionals

Section 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998*

Section 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998* protect disclosures of information to the NSW Commissioner of Police by health professionals where they are of the opinion that a person they are treating may pose a risk to public safety or to the person's own safety if in possession of a firearm or prohibited weapon. Of particular interest are high risk mental health patients known to have access to firearms.

Sections 79 of the *Firearms Act 1996* & section 38 of the *Weapons Prohibition Act 1998* provide protection from civil or criminal liability, that may otherwise arise including a breach of confidentiality, when disclosing information to the Commissioner of Police.

A health professional, is defined in 579 of the *Firearms Act 1996* and for the purposes of section 38 of the *Weapons Prohibition Act 1998*, as any of the following persons: a medical practitioner, psychologist, nurse, social worker or professional counsellor.

#### PROCESS TO FOLLOW

1. Complete the form and Fax to: 0266 708558 and mark 'Attention - Team Leader Licensing', AND
2. Fax this form to the police station nearest the residential address of the patient. If you are unsure of the nearest police station, ring the Police Assistance Line on 131444.

#### PATIENT INFORMATION

LAST NAME	<input type="text"/>	FIRST NAME	<input type="text"/>
DATE OF BIRTH	<input type="text"/>	TELEPHONE	<input type="text"/>
HOME ADDRESS	<input type="text"/>		
	<input type="text"/>		

Where is the patient currently located? eg inpatient, Accident and Emergency, at residential address etc.

If in hospital, anticipated date of discharge. To ensure safety issues can be addressed, please give at least 6 hours notice to Police.

DATE OF DISCHARGE

ADDRESS WHERE PATIENT WILL BE DISCHARGED (if different from residential address).

Describe the circumstances that lead you to believe that the person may pose a threat if in possession of a firearm/prohibited weapon. Include relevant conversation, observations, circumstances, effect of medical condition or treatment on person's capacity etc.

Does the person have access to their own firearms/prohibited weapons?

YES

NO

UNKNOWN

Does the person have access to other firearms/prohibited weapons?

YES

NO

UNKNOWN

If 'YES' indicate below the address where the firearms/prohibited weapons are located?

For example, with friends, neighbours, spouse or other relative.

#### HEALTH PROVIDER INFORMATION

Medical Practitioner    Psychologist    Reg/Enrolled Nurse    Social Worker    Counsellor

NAME

CONTACT NUMBER

SIGNATURE

DATE

Reporting Location (eg hospital, mental health hotline, private clinic, facility etc)

**ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE**

Vers 3.0 February 2013











